WHA52/1999/REC/2

WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTÉ

FIFTY-SECOND WORLD HEALTH ASSEMBLY

GENEVA, 17-25 MAY 1999

VERBATIM RECORDS OF PLENARY MEETINGS AND LIST OF PARTICIPANTS

CINQUANTE-DEUXIÈME ASSEMBLÉE MONDIALE DE LA SANTÉ

GENÈVE, 17-25 MAI 1999

COMPTES RENDUS IN EXTENSO DES SÉANCES PLÉNIÈRES ET LISTE DES PARTICIPANTS

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PREFACE

The Fifty-second World Health Assembly was held at the Palais des Nations, Geneva, from 17 to 25 May 1999, in accordance with the decision of the Executive Board at its 102nd session. Its proceedings are published in three volumes, containing, in addition to other relevant material:

Resolutions, decisions and annexes - document WHA52/1999/REC/1

Verbatim records of plenary meetings and list of participants - document WHA52/1999/REC/2

Summary records of committees and ministerial round tables, reports of committees - document WHA52/1999/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 WHA52/1999/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 end July 1999, the cut-off date announced in the provisional version, and are thus regarded as final.

AVANT-PROPOS

La Cinquante-Deuxième Assemblée mondiale de la Santé s'est tenue au Palais des Nations à Genève du 17 au 25 mai 1999, conformément à la décision adoptée par le Conseil exécutif à sa cent deuxième session. Ses actes paraissent dans trois volumes contenant notamment :

les résolutions et décisions et les annexes qui s'y rapportent - document WHA52/1999/REC/1,

les comptes rendus in extenso des séances plénières et la liste des participants - document WHA52/1999/REC/2,

les procès-verbaux des commissions et des tables rondes ministérielles et les rapports des commissions - document WHA52/1999/REC/3.

On trouvera dans les pages préliminaires du document WHA52/1999/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'à la fin juillet 1999, date limite annoncée dans leur version provisoire, et sont donc considérés comme finals.

ПРЕДИСЛОВИЕ

Пятьдесят вторая сессия Всемирной ассамблеи здравоохранения проходила во Дворце Наций в Женеве с 17 по 25 мая 1999 г. в соответствии с решением Исполнительного комитета, принятым на его Сто второй сессии. Материалы сессии публикуются в трех томах, в которых, помимо других документов, содержатся:

резолюции и решения и приложения - документ WHA52/1999/REC/1

стенографический отчет о пленарных заседаниях и список участников - документ WHA52/1999/ REC/2

протоколы заседаний и заседаний круглого стола для министров, доклады комитетов - документ WHA52/1999/ 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 WHA52/1999/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 июля 1999 г., как о том было объявлено в предварительных протоколах, и потому настоящая редакция считается окончательной.

INTRODUCCIÓN

La 52ª Asamblea Mundial de la Salud se celebró en el Palais des Nations, Ginebra, del 17 al 25 de mayo de 1999, de acuerdo con la decisión adoptada por el Consejo Ejecutivo en su 102ª reunión. Sus debates se publican en tres volúmenes que contienen, entre otras cosas, el material siguiente:

Resoluciones y decisiones, y anexos: documento WHA52/1999/REC/1

Actas taquigráficas de las sesiones plenarias y lista de participantes: documento WHA52/1999/REC/2

Actas resumidas de las comisiones y de las mesas redondas ministeriales e informes de las comisiones: documento WHA52/1999/REC/3.

En las páginas preliminares del documento WHA52/1999/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 final de julio de 1999, fecha límite anunciada en la versión provisional, y por consiguiente se consideran definitivas.

مقدمة

انعقدت جمعية الصحة العالمية الثانية والخمسون في قصر الأمم بجنيف في الفترة من ١٧ الى ٢٥ أيار/ مايو ١٩٩٩، طبقا لما قرره المجلس التنفيذي في دورته الثانية بعد المائة، وتنشر محاضرها في ثلاثة مجلدات تتضمن، بالاضافة الى بعض المواد الأخرى ذات الصلة، ما يلي:

القرارات والمقررات الاجرائية والملاحق وقائمة المشتركين العرب - الوثيقة ج ص ع٥٢/١٩٩٩/ سجلات/١،

المحاضر الحرفية للجلسات العامة - الوثيقة ج ص ع٥٢/١٩٩٩/ سجلات/٢،

المحاضر الموجزة وتقارير اللجان والموائد المستديرة الوزارية - الوثيقة ج ص ع٥٢/١٩٩٩/ 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 ج ص ع٥٢/١٩٩٩/ سجلات/١.

وترد الكلمات التي ألقيت بالعربية أو الصينية أو الانكليزية أو الفرنسية أو الروسية أو الأسبانية في هذه المحاضر الحرفية باللغة التي تكلم بها المتحدث، أما الكلمات التي ألقيت بلغات أخرى فترد ترجمتها الانكليزية أو الفرنسية. وهي تتضمن التصويبات التي تم تلقيها حتى تموز/ يوليو ١٩٩٩، وهو الموعد النهائي المعلن في النسخة المؤقتة، وهي بالتالي تعتبر نهائية.

序　　言

根据执行委员会第一 O 二届会议的决定，第五十二届世界卫生大会于 1999 年 5 月 17 日至 26 日在日内瓦万国官举行。会议记录分三卷出版，除其它有关材料外，其内容包括:

决议、决定和附件一文件 WHA52/1999/REC/1

全体会议逐字记录及与会人员名单一文件 WHA52/1999/REC/2

各委员会和部长级圆桌会议摘要记录及各委员会报告一文件 WHA52/1999/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 WHA52/1999/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 1999 年 7 月底以前收到的更正，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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FIRST PLENARY MEETING

Monday, 17 May 1999, at 10:00

President: Dr F.R. AL-MOUSAWI (Bahrain)

PREMIERE SEANCE PLENIERE

Lundi 17 mai 1999, 10 heures

Président: Dr F.R. AL-MOUSAWI (Bahreïn)

1. OPENING OF THE SESSION
OUVERTURE DE LA SESSION

The PRESIDENT:

The Assembly is called to order. Distinguished delegates, ladies and gentlemen, as President of the Fifty-first World Health Assembly, I have the honour to open the Fifty-second World Health Assembly.

I now have pleasure in welcoming, on behalf of the Assembly and the World Health Organization our special guests: Mr Vladimir Petrovsky, Director-General of the United Nations Office at Geneva and representing the Secretary-General of the United Nations; Mr M. Ülkümen, Chief of Protocol, United Nations Office at Geneva; Mr Guy-Olivier Segond, Councillor of State, Department of Social Action and Health of the Republic and Canton of Geneva, representing the Geneva State Council; Mr Jean Spielmann, President of the Parliament of the Republic and Canton of Geneva; Mr Walter Gyger, Ambassador, Permanent Representative of Switzerland to the International Organizations at Geneva and Permanent Observer to the United Nations; Professor Peter Suter, Dean of the Faculty of Medicine, University of Geneva; Mr Carlos Fortín, Assistant Secretary-General, United Nations Conference on Trade and Development; Mr Patrice Robineau, representing the United Nations Economic Commission for Europe; Dr Brian Gushulak, representing the Director-General, International Organization for Migration; Mr Cornelio Sommaruga, President, International Committee of the Red Cross; Mr George Weber, Secretary-General of the International Federation of Red Cross and Red Crescent Societies; the representatives of the United Nations specialized agencies; the representatives of the various United Nations bodies; and the delegates of Member States.

I also welcome the observers of non-Member States, the observers from the Order of Malta, the International Committee of the Red Cross, the International Federation of Red Cross and Red Crescent Societies, and from Palestine; and the representatives of intergovernmental and nongovernmental organizations in official relations with WHO. I also welcome the representatives of the Executive Board.

2. ADDRESS BY THE DIRECTOR-GENERAL OF THE UNITED NATIONS OFFICE AT GENEVA
ALLOCUTION DU DIRECTEUR GENERAL DE L'OFFICE DES NATIONS UNIES A GENEVE

The PRESIDENT:

Mr Petrovsky, Director-General of the United Nations Office in Geneva and representing the Secretary-General of the United Nations, will now address the Assembly.

Mr PETROVSKY (Director-General of the United Nations Office at Geneva):

Mr President, Madam Director-General, Excellencies, ladies and gentlemen, I am really very pleased to have been given the opportunity to address this distinguished Assembly of the World Health Organization. I would like to convey to all of you the good wishes of the Secretary-General of the United Nations, Mr Kofi Annan. I would like also to say a word of appreciation to Dr Gro Harlem Brundtland, whose leadership at WHO is contributing significantly to achieving the goals and objectives of the United Nations system as a whole.

Your Assembly is meeting at an important time - at the threshold of a new millennium when economic globalization and tremendous scientific and technological advancements are reshaping the world. If properly utilized, these advancements can contribute a great deal to the realization of the goals and ideals of the people of the United Nations for the twenty-first century, namely peace, stability and well-being.

The dramatic evolution of technology over the past 100 years has had a profoundly positive effect, in particular, on human health. Advances in our understanding of disease, hygiene and the secondary effects of our daily consumption of such things as food, cigarettes and alcohol have transformed our way of thinking about our health. This knowledge has empowered people to improve their health dramatically and has deepened our comprehension of the source and impact of different elements in our daily environment.

Nevertheless, a disturbing problem has emerged as a result of these improvements, namely the disparity in the quality of health of the rich and poor. Unfortunately, the distribution of important medical information and the ability to shield oneself from the harmful effects of industrialization and population growth are unevenly broken down along economic lines. The gap between the rich and poor communities of the world can first and foremost be seen in the quality of the health care available to each group. This disparity exists today on an unprecedented scale and is one of the major challenges facing bodies such as the World Health Organization.

Health is the core priority of all efforts in development and is a fundamental element of what we call "human security". Nothing can be achieved at the micro or macro level in a community unless the individuals in that community feel safe from such recurring threats as hunger, disease and repression, and are able to enjoy a wide range of choices and opportunities. In other words, a more people-centred vision in the approach of the international community to human security would be symbiotic with its development efforts and, together, would form a constructive mechanism for meeting the challenges of improving the quality of life of all people, regardless of their economic status. As Dr Brundtland has said, "health is both a condition and an outcome of development". The pursuit of lasting improvements in health can bring about considerable social and economic gains. However, sustainable development cannot come about without the assurance of continuity in one's daily activities. As the old adage goes, "you are nothing without your health". Adequate health care is one of the most important elements in both sustainable development and human security. People must always be placed at the centre of development, as they are entitled to a healthy and productive life in harmony with the environment. In order to achieve this we need a more holistic approach to development, one that responds more effectively to the material and spiritual needs of individuals, their families, and the communities in which they live. This will require an effective and equitable system of social security, ecological or environmental monitoring and, most of all, a dedicated investment in human capital.

The opportunity to improve the lives of humans all over the world is the tremendous gift of medical advancement but is also a monumental undertaking. I completely agree with Dr Brundtland when she says, "with opportunity comes responsibility". WHO understands very well its role of working to improve the quality of life for all. It also recognizes that the ultimate responsibility for such efforts remains at the national government level. Governments bear the primary responsibility for providing an adequate measure of health and educational services to their populations. Through such mechanisms as the WHO country offices, these governments have at their disposal the best knowledge and expertise in the field. However, the governments must take the initiative to address these issues in such a way as to maximize the health

benefits that can be achieved with limited resources and guarantee the most equitable distribution of these benefits among various groups of society.

WHO also understands that there is an important role for the international community to play in helping to improve the standards of health worldwide. The dissemination of information to all countries and communities, the early warning of and response to serious epidemics, medical norm-setting, the provision of a forum for discussion and action on behalf of vulnerable or poorly represented groups, the funding of research and the targeting of programmes to benefit the poor are all ways in which the international community can contribute to a global effort to improve health standards in all countries. To this end, the United Nations Development Assistance Framework (UNDAF) was created as a mechanism to focus the efforts of a broad base of organizations active in the development field with a view to formulating strategic approaches to large-scale problems. Through the participation of WHO, UNDAF has deepened its commitment to the health aspects of many developmental initiatives.

In reviewing and updating its mandate regarding humanitarian assistance and emergency relief, WHO is contributing to improving United Nations' efforts in this field. Today, WHO is committed to playing a greater role in response to serious humanitarian crises with large movements of population such as in Kosovo and in other parts of the Federal Republic of Yugoslavia, the former Yugoslav Republic of Macedonia, and Albania. In such difficult circumstances, health is the most vital issue to take into consideration, and WHO successfully tries to work as effectively as it can with donor governments, UNHCR and other United Nations agencies to protect and promote the health of displaced people.

I strongly support the Director-General's determination to launch the project on Partnerships for Health Sector Development. We know that a broad health agenda will require WHO to cooperate closely with its partners in all fields relevant to the health sector. This agenda cannot function without strong links to national governments, the private sector and elements of civil society. The project is a means of strengthening the Organization's work in and with countries. It is a way of ensuring that ministries of health will be able to work with other parts of their governments and to regulate the private sector so as to provide quality health care for all.

I believe that the deliberations on health in the context of human security and development that will take place during this Health Assembly will provide valuable input to next year's Millennium Assembly of the United Nations. As his contribution to this Assembly, the Secretary-General of the United Nations will prepare a report addressing the key challenges which the international community will face in the decade ahead, together with proposals for ways in which Member States can respond effectively to those challenges. In this context, the Millennium Assembly will become an essential mechanism for bringing together all relevant actors to focus on issues of global importance, and to generate agreements and specific commitments that provide a comprehensive framework for further mutually supportive international cooperation. The Millennium Assembly will help to ensure that the twenty-first century will be more peaceful than the last and that all the people of the United Nations will be able to have a bright and healthy future for themselves and their families, regardless of their economic means.

Let me conclude by wishing you all once again much success in your work during this important Fifty-second World Health Assembly. I thank you for your attention.

The PRESIDENT:

Thank you, Mr Petrovsky.

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

The PRESIDENT:

I now give the floor to Mr Guy-Olivier Segond, Councillor of State, Department of Social Action and Health, of the Republic and Canton of Geneva.

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

Monsieur le Président, Madame la Directrice générale, Mesdames et Messieurs les délégués, Excellences, Mesdames et Messieurs, à l'occasion de l'ouverture de la Cinquante-Deuxième Assemblée mondiale de la Santé, j'ai le plaisir de vous souhaiter, au nom des autorités fédérales, des autorités cantonales et des autorités communales, la bienvenue à Genève et en Suisse.

En cinquante ans, depuis la fondation de l'OMS, le monde a bien changé politiquement, économiquement et socialement. Après l'effort de reconstruction qui a suivi la Seconde Guerre mondiale, après les luttes de libération nationale et après l'indépendance de nombreux nouveaux Etats, la rivalité Est-Ouest a été progressivement remplacée par la dynamique Nord-Sud. La globalisation de tous les problèmes a bouleversé le cours ordinaire des choses et, grâce au prodigieux développement des nouvelles technologies de la communication, le monde est devenu un.

Chacun le sait et chacun le voit, ces dernières années, de formidables forces de changement sont nées. Les attitudes politiques et culturelles à l'égard de l'Etat se sont profondément modifiées. D'importants problèmes démographiques et sociaux liés aux migrations, au vieillissement et à l'exclusion se sont développés et, partout dans le monde, il y a des mouvements amples et puissants en faveur d'une réforme des systèmes de santé.

L'OMS a pris sa part de ces grands changements mondiaux. Ainsi, la Conférence d'Alma-Ata en 1978 n'a pas seulement défini les objectifs de la santé pour tous en l'an 2000. Elle a aussi imposé le passage d'un système de santé centralisé privilégiant la pathologie urbaine à une pratique communautaire de soins de santé primaires. Grâce à l'amélioration de l'accès aux soins de santé primaires voulue par la Conférence d'Alma-Ata, les taux de mortalité infantile ont baissé dans la plupart des pays pendant que l'espérance de vie à la naissance augmentait régulièrement. Mais là aussi le temps a passé. De nombreux pays qui n'étaient pas en 1978 à Alma-Ata sont devenus des Etats. De nouvelles technologies et de nouveaux modes d'intervention ont vu le jour et une nouvelle génération de professionnels de la santé a pris la relève. Plusieurs facteurs déterminants de la santé, qu'ils soient environnementaux, sociaux, politiques, économiques, démographiques ou épidémiologiques, ont affecté le profil sanitaire des populations. Plusieurs problèmes de santé spécifiques vont croissant, tels que la résistance aux antimicrobiens, la mortalité liée au tabac et le VIH/SIDA.

Enfin, dans trop de pays encore, les inégalités concernant l'état de santé continuent de s'élargir en fonction du niveau de développement et des classes sociales. Comment cette situation s'explique-t-elle ? Car après tout, au cours de ces cinquante dernières années, la médecine a davantage progressé qu'au cours des cinquante derniers siècles. Après des millénaires d'impuissance, la médecine nous a donné le pouvoir de triompher de nombreuses maladies fatales, telles que la tuberculose, la syphilis, la variole. Aujourd'hui, des transplantations d'organes sont possibles et les lois qui président à la formation de la vie et à la définition de l'identité personnelle sont découvertes. Pourquoi donc la recherche, si active dans le domaine de la reproduction et de l'hérédité, n'arrive-t-elle pas à maîtriser les maladies ordinaires qui frappent la grande majorité de la population de la planète ? La réponse, Mesdames et Messieurs, est simple; vous la connaissez. Cinquante-six milliards de dollars sont consacrés chaque année à la recherche publique et privée en matière de santé. Mais moins de 10% de cette somme impressionnante sont consacrés aux problèmes de santé affectant 90% de la population mondiale. Pour aider à corriger ce déséquilibre, dont les coûts économiques et sociaux sont énormes, cent institutions, publiques et privées, ont constitué le Forum mondial de la recherche en santé, dont le secrétariat est ici à l'OMS. Dans son premier rapport annuel, le Forum mondial analyse les causes de ce formidable déséquilibre et présente des plans d'action pour contribuer à le corriger. L'une des causes expliquant ce déséquilibre dans la recherche est la mauvaise information des décideurs et - La Palice l'aurait trouvé -, pour que les décideurs puissent prendre de meilleures décisions concernant l'attribution des fonds pour la recherche, ils ont besoin de meilleures informations. C'est l'une des tâches de l'OMS, qui doit rappeler aux chefs d'Etat, aux premiers ministres, aux ministres des finances qu'ils sont eux-mêmes des ministres de la santé. En investissant mieux dans la recherche en santé, on luttera mieux contre les problèmes de santé qui touchent 90% de la population de la planète. On obtiendra une amélioration de la qualité de la vie et on constatera un accroissement de la productivité, ce qui permettra de s'attaquer à l'une des causes fondamentales de la pauvreté.

Je suis personnellement convaincu que, par un plaidoyer efficace à l'échelle mondiale, l'OMS, sous la ferme direction du Dr Gro Harlem Brundtland, atteindra au début du XXI^{e} siècle l'objectif d'une meilleure santé pour tous entraînant un vrai changement de la qualité de la vie des habitants du monde entier. Je vous remercie.

The PRESIDENT:

Thank you, Mr Segond.

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

The PRESIDENT: الرئيس:

أصحاب المعالي والسعادة رؤساء وأعضاء الوفود، صاحبة السعادة المديرة العامة للمنظمة، أيها السيدات والسادة، السلام عليكم ورحمة الله وبركاته.

يسعدني أن أتحدث اليكم اليوم، في افتتاح جمعية الصحة العامة الثانية والخمسين، بعد عام كامل شرفت خلاله بالعمل معكم رئيسا لجمعية الصحة العالمية الحادية والخمسين. ويسرني، في هذا المقام، أن أشيد بالمساندة والدعم الكبير اللذين حظيت بهما من حكومة بلادي، وبالتعاون الذي لمسته من مختلف الدول الأعضاء ومن الزملاء العاملين بالمنظمة في المقر الرئيسي وعلى رأسهم المديرة العامة الدكتورة برونتلاند، وعلى مستوى المكاتب الاقليمية بقيادة المديرين الاقليميين. ولقد كان لهذا الدعم أكبر الأثر في مساعدتي على ممارسة مهامي الرئيسية خلال هذه المدة. وأعتقد أنكم قد تابعتم معي التغييرات التي طرأت على المنظمة من خلال الجهود الحثيثة التي بذلتها السيدة المديرة العامة في اعادة هيكلة المقر الرئيسي للمنظمة، وذلك بغية الارتقاء بمستوى العمل وتحسين كفاءته وزيادة مردوده، وتركيز الجهود في مواجهة تحديات القرن الحادي والعشرين الذي نقف اليوم على أعتابه. كما أنكم قد اطلعتم على التوجه نحو انشاء وتطوير عدد من البرامج ذات الأولوية التي تركز على مشاكل صحية ذات أهمية قصوى، مثل التحرر من التبغ بما في ذلك وقاية مئات الملايين من البشر من آثاره الصحية السلبية، خاصة اذا تم تكثيف الجهود الموجهة الى البلدان النامية. اذ تدل جميع المؤشرات على حجم المعاناة الخطيرة التي يتعرض لها سكان الأرض من جراء التدخين. ولو أن هذا الارتفاع الكبير في الأمراض غير السارية التي يحدثها التدخين لن يحجب أهمية عدد من الأمراض السارية ولاسيما تلك الأمراض المستجدة أو المنبعثة من مرقدها مثل الحميات الفيروسية النزفية والملاريا والسل وشلل الأطفال الذي اقتربنا كثيرا من الأجل المحدد لاستئصاله من العالم بأسره. وانني لعلى يقين كذلك من أنكم تتابعون معي جهود الزملاء العاملين بالمقر الرئيسي للمنظمة في اعداد البرامج الاستراتيجية والخطط التفصيلية للأنشطة التي تضطلع بها أقسام المقر الرئيسي. وقد سبق أن نوقشت تلك البرامج في اجتماعات المجلس التنفيذي، كما نوقشت في اجتماع السيدة المديرة العامة بممثلي المنظمة في مختلف دول العالم. كما أنني على ثقة كبيرة من أن السيدة المديرة العامة والزملاء العاملين معها يأخذون بعين الاعتبار كافة الاقتراحات التي تقدم بها، بهذا الصدد، أعضاء المجلس التنفيذي وممثلو المنظمة في الدول الأعضاء.

ولعل من أبرز معالم البرنامج المقترح لعمل المنظمة ذلك الدعم الكامل للبلدان الأقل نموا، ولاسيما ما كان منها في القارة الأفريقية، وذلك بهدف تحقيق العدالة في اتاحة استخدام الخدمات الصحية والعمل على ردم الفجوة في المستوى الصحي بين مختلف البلدان ومجابهة التحديات التي تواجه البرامج الصحية.

أصحاب المعالي والسعادة، أيها السيدات والسادة، ان جدول أعمال جمعية الصحة العالمية الثانية والخمسين يتناول موضوعات في غاية الأهمية، ويهمني في هذا الشأن أن أشيد بالاتجاه الجديد باستخدام نظام الموائد المستديرة لوزراء الصحة لمناقشة المشاكل الصحية العالمية، والتي يمكن مناقشة حلولها من خلال تبادل آراء وخبرات الدول المشاركة، كما أن الدول الأعضاء تتوقع من منظمة الصحة العالمية أن تدعم جهودها الوطنية التي أصبحت تبرهن يوما بعد يوم على أن الانفاق الصحي هو استثمار ذو عائد كبير على التنمية الشاملة، وأن الانفاق على برامج مكافحة المشاكل الصحية الخطيرة كالتدخين وسائر أنماط الحياة المنافية للصحة والانفاق على حفظ الصحة وتعزيزها سوف يكون له مردود مرتفع بكل المقاييس الاقتصادية. ثم ان عالمنا يواجه العديد من الكوارث الطبيعية والكوارث التي هي من صنع الانسان، ولابد في هذا الصدد من توجيه شطر من الموارد لترسيخ عملية الاستعداد للطوارئ وحماية النظام الصحي، ومواصلة تقديم الخدمات الصحية خلال هذه الكوارث.

أيها السيدات والسادة، لقد تبنت منظمة الصحة العالمية باجماع أعضائها هدف توفير الصحة للجميع بحلول عام ٢٠٠٠، والذي تم تطويره وتحديثه ليضمن استمرارية توفير الصحة للجميع في القرن الحادي والعشرين، كما تبنت باجماع مماثل أسلوب الرعاية الصحية الأولية لبلوغ هذا الهدف. وها نحن الآن على مدخل الألفية الثالثة، ومن أجل هذا، فانني أناشدكم وأناشد المديرة العامة للمنظمة أن نعمل على تركيز وتضافر جهودنا جميعا من أجل بلوغ هذا الهدف النبيل، وأن نذكر أنفسنا دائما به في جميع محافلنا، وأن ندرك أن هذا الهدف لن يتحقق الا بتوثيق الجهود وتجديد العزم على العمل في اطار من المثل العليا التي

تجعل الصحة حقا أساسيا من حقوق الانسان، وتصر على تحقيق العدالة والمساواة في توفير الرعاية الصحية وتعلي من شأن الأخلاقيات في العمل الصحي بمختلف وجوهه وأساليبه. لقد ركزت منظمة الصحة العالمية في سنواتها الخمسين المنصرمة على البعد البدني والبعد النفسي للصحة، وقد أنجزت من خلال ذلك انجازات ضخمة ومهمة.

ونحن نتطلع للمنظمة في سنواتها الخمسين المقبلة الى أن تواصل التركيز على هذه الأبعاد الاجتماعية والنفسية والروحية للصحة لتحقيق ما تصبو اليه شعوب كوكبنا من بلوغ الرفاهية الصحية في جميع بلدان العالم. ان التقدم الكبير في مجالات العلوم والاتصالات وتبادل المعلومات والتطور السريع في ميادين البيوتكنولوجيا والتغيرات الديمغرافية والوبائية وما الى ذلك من مظاهر التقدم تحتاج لمواكبتها الى استنفار جميع الطاقات واستنفار كافة الهمم وحشد الموارد البشرية والمادية. ولن يتأتى ذلك الا بجعل الصحة مسؤولية كل فرد من الأفراد وكل مجتمع من المجتمعات وليست فقط مسؤولية الدولة وحدها أو القطاع الصحي وحده. وهذا، أيها السيدات والسادة، هو لب فلسفة الرعاية الصحية الأولية التي تدعو المنظمة في عهدها الجديد الى المناداة بها بكل قوة والى العمل الجاد الدؤوب على اشراك كل ساكن من سكان الأرض في هذه الحملة المستمرة من أجل توفير الصحة للجميع.

أصحاب المعالي والسعادة، أيها السيدات والسادة، اسمحوا لي بأن أختم كلمتي هذه بما ختمت به كلمتي في العام الماضي من أن منظمة الصحة العالمية هي مجموع دولها الأعضاء، فكل نجاح لهذه المنظمة هو نجاح لكل دولة منا وكل دعم يقدم اليها مهما كان متواضعا يسهم اسهاما فعليا في تحقيق الصحة التي هي المعافاة الكاملة جسديا ونفسيا واجتماعيا وروحيا لكل فرد من أفراد هذا العالم. أكرر الشكر والتقدير لكل من لاقيت منه دعما وعونا خلال العام المنصرم متمنيا لجميعة الصحة العالمية الثانية والخمسين ولرئيسها المقبل كل نجاح وتوفيق.

والسلام عليكم ورحمة الله وبركاته.

The PRESIDENT:

Before proceeding we shall have a brief pause to allow our distinguished guests to leave the hall, and on behalf of the Assembly, I thank them for having honoured us with their presence.

I would ask all delegates to kindly remain seated, as we shall soon resume our work.

5. APPOINTMENT OF THE COMMITTEE ON CREDENTIALS
CONSTITUTION DE LA COMMISSION DE VERIFICATION DES POUVOIRS

The PRESIDENT:

We shall now proceed with the Appointment of the Committee on Credentials. The Assembly is required to appoint a Committee on Credentials in accordance with Rule 23 of the Rules of Procedure of the Assembly. In conformity with this Rule, I propose for your approval the following 12 Member States: Andorra, Angola, Colombia, Costa Rica, Cyprus, Guinea, Iceland, Maldives, Palau, Portugal, United Republic of Tanzania, United Arab Emirates.

Are there any objections? If there are no objections, I declare the Committee on Credentials, as proposed by me, appointed by the Assembly. Subject to the decision of the General Committee, and in conformity with resolution WHA20.2, this Committee will hold its first meeting on Tuesday, 18 May at 14:30.

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

The PRESIDENT:

We shall now proceed with the Election of the Committee on Nominations. This item is governed by Rule 24 of the Rules of Procedure of the 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 Assembly for its consideration. May I explain that, in compiling this list, the following distribution by Region has been applied: Africa: six Members; Americas: five Members; South-East Asia: two Members; Europe: six Members; Eastern Mediterranean: three Members; Western Pacific: three Members.

I therefore propose to you the following Member States: Bangladesh, Botswana, Brazil, China, Dominica, Ecuador, Ethiopia, France, Greece, Honduras, Hungary, Islamic Republic of Iran, Liberia, Myanmar, Namibia, Nigeria, Paraguay, Poland, Qatar, Russian Federation, Rwanda, Solomon Islands, Tonga, United Kingdom of Great Britain and Northern Ireland (*ex officio*: Bahrain).

Are there any observations? In the absence of observations, 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".

The Committee on Nominations will meet at 11:00 in Room VII. I repeat: members of the Committee on Nominations are invited to go to Room VII where the meeting will start punctually at 11:00. The next plenary meeting will be held at 12:00. The meeting is adjourned.

The meeting rose at 10:50.
La séance est levée à 10h50.

SECOND PLENARY MEETING

Monday, 17 May 1999, at 12:00

President: Dr F.R. AL-MOUSAWI (Bahrain)
later: Mrs Maria de Belém ROSEIRA (Portugal)

DEUXIEME SEANCE PLENIERE

Lundi 17 mai 1999, 12 heures

Président: Dr F.R. AL-MOUSAWI (Bahreïn)
puis: Mme Maria de Belém ROSEIRA (Portugal)

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

The PRESIDENT:

The Assembly is called to order. The first item on our agenda this afternoon is the consideration of the first report of the Committee on Nominations. This report is contained in document A52/28 which I will now read.

The Committee on Nominations, consisting of delegates of the following Member States: Bangladesh, Botswana, Brazil, China, Dominica, Ecuador, Ethiopia, France, Greece, Honduras, Hungary, Iran (Islamic Republic of), Liberia, Myanmar, Namibia, Nigeria, Paraguay, Poland, Qatar, Russian Federation, Rwanda, Solomon Islands, Tonga, United Kingdom of Great Britain and Northern Ireland, and Dr F.R. Al-Mousawi, Bahrain (*ex officio*) met on 17 May 1999.

In accordance with Rule 25 of the Rules of Procedure of the Health Assembly and respecting the practice of regional rotation that the Assembly has followed for many years in this regard, the Committee decided to propose to the Assembly the nomination of Mrs Maria de Belém Roseira (Portugal) for the Office of President of the Fifty-second World Health Assembly.

Are there any observations?

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, it will not be necessary to proceed to a vote since only one candidate has been put forward. In accordance with Rule 80 of the Rules of Procedure, I therefore suggest that the Assembly should approve the nomination submitted by the Committee and elect its President by acclamation.

(Applause/Applaudissements)

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[1] See reports of committees in document WHA52/1999/REC/3.
[1] Voir les rapports des commissions dans le document WHA52/1999/REC/3.

Mrs Maria de Belém Roseira is thereby elected President of the Fifty-second World Health Assembly and I invite her to take her seat on the rostrum.

Mrs Maria de Belém Roseira (Portugal) took the presidential chair.
Mme Maria de Belém Roseira (Portugal) prend place au fauteuil présidentiel.

The PRESIDENT:

Your Excellencies, Honourable Ministers, Ambassadors, delegates, Madam Director-General, I would like to thank this august Assembly for the trust in electing me as the President of the Fifty-second World Health Assembly. Taking this opportunity, I would like to express my appreciation to Dr Al-Mousawi, my predecessor for his contribution to the last Health Assembly. I shall deliver the customary address later today and we will now continue with our work.

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

The PRESIDENT:

I now invite the Assembly to consider the second report of the Committee on Nominations. This report is contained in document A52/29 which you have before you. I invite the Assembly to pronounce, in order, on the nominations proposed for its decision.

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 Assembly. The following names have been proposed: Dr T.J. Stamps (Zimbabwe), Mr J. Junor (Jamaica), Dr E.F. Ehtuish (Libyan Arab Jamahiriya), Mr S.U. Yusuf (Bangladesh), Mr M. Telefoni Retzlaff (Samoa).

Are there any comments? There being no comments, I propose that the 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 on five separate sheets of paper which I am going to draw by lot.

The Vice-Presidents will be requested to take the chair in the following order: Mr M. Telefoni Retzlaff (Samoa), Dr E.F. Ehtuish (Libyan Arab Jamahiriya), Dr T.J. Stamps (Zimbabwe), Mr S.U. Yusuf (Bangladesh), Mr J. Junor (Jamaica). I request the Vice-Presidents kindly 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 A.J. Sulaiman (Oman) is proposed. Are there any comments? There being no comments, I invite the Assembly to declare Dr Sulaiman elected Chairman of Committee A by acclamation.

(Applause/Applaudissements)

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[1] See reports of committees in document WHA52/1999/REC/3.
[1] Voir les rapports des commissions dans le document WHA52/1999/REC/3.

We have now to elect the Chairman of Committee B. Dr R. Tapia (Mexico) is proposed. Are there any comments? There being no objections, I invite the Assembly to declare Dr Tapia 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 proceed with the establishment of the General Committee. In accordance with Rule 31 of the Rules of Procedure, the Committee on Nominations has proposed the following 17 countries, the delegates of which, added to the officers just elected, would constitute the General Committee of the Assembly. These proposals provide for an equitable geographical distribution of the General Committee: Argentina, Benin, Burkina Faso, Cape Verde, China, Cuba, France, Israel, Japan, Kenya, Lebanon, Lithuania, Russian Federation, Sri Lanka, United Kingdom of Great Britain and Northern Ireland, United States of America, Zambia. If there are no observations I shall declare these 17 countries elected. I see that there are none and therefore they are so elected.

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

Before adjourning this plenary meeting, I would like to remind you that the General Committee of the Assembly will meet at 13:00 in Room VII. Sandwiches will be served in the delegates' lounge next to Room VII for the participants at the General Committee when this meeting adjourns. Also at 13:00 there will be a technical briefing in room XIX on the Overview of legal and technical aspects of the framework convention for tobacco control. The next plenary meeting will be held this afternoon at 14:30. The meeting is adjourned.

The meeting rose at 12:25.
La séance est levée à 12h25.

THIRD PLENARY MEETING

Monday, 17 May 1999, at 14:30

President: Mrs Maria de Belém ROSEIRA (Portugal)

TROISIEME SEANCE PLENIERE

Lundi 17 mai 1999, 14h30

Président: Mme Maria de Belém ROSEIRA (Portugal)

1. PRESIDENTIAL ADDRESS
DISCOURS DU PRESIDENT DE L'ASSEMBLEE

The PRESIDENT:

Your excellencies, honourable ministers, ambassadors, distinguished delegates, Dr Brundtland, dear colleagues and friends. Allow me to thank you for honouring the European Region, my own country Portugal and me personally by electing me as President of this Fifty-second World Health Assembly. I do appreciate your trust. We all come to this Health Assembly each year to contribute to a better world. Our contribution is made through our work to improve health. I also know that we are committed to act in the interests of the whole world, even when this might sometimes be at the immediate expense of our own interests. I shall rely on all of you to help us to reach the right conclusions, as in fact we usually do.

Over the past few years, we, the Member States of WHO, took important initiatives to make our common health organization a better one. We shall be considering reports from the Executive Board on a year of change. The Director-General and her staff have responded effectively in reshaping the way WHO works. We shall be able to join the special briefing on change in WHO during Wednesday lunch time. It is now up to us once more to take the policies we hear about to each and every one of our communities. May I also refer to the World Health Declaration that we adopted last year. This was a wonderful expression of the spirit of health for all. I believe we have all, during the past year, renewed our efforts to live up to the ethical concepts of equity, solidarity and social justice, and to the incorporation of a gender perspective into our national strategies. We are doing this by paying the greatest attention to those most in need, to those who are burdened by ill health, to those who are not receiving adequate health services, or are affected by poverty, and also by reducing social and economic inequities and addressing directly the basic determinants and prerequisites for health.

I am pleased to tell you that the Regional Committee for Europe has taken last year's World Health Declaration very seriously. In September our 50 active Members States adopted Health 21 as the health-for-all policy framework for the WHO European Region - twenty-one targets for the twenty-first century. The World Health Declaration and our new health-for-all policy framework have given us a new opportunity for action. Health is the flesh and bones of human development. It is the precondition for a state of well-being. It is a prerequisite for the satisfaction of other needs. Health concerns every individual. It is easily understood by everyone, in fact, health is everybody's business. It concerns the private and public sectors, professionals, nongovernmental organizations, political leaders and other partners who must be rallied around our common agenda. That is surely the democratic way.

However, for this to become reality and not just wishful thinking, we must create clear mechanisms for all these partners to come together at different levels of society. At national, regional and local levels, we need more and better work across different social and economic sectors. We must remember the

importance of our health professions, and involve them openly and consistently in shaping policies for professions as part of our health strategies. In cities and local communities we need to pull together city leadership, government and nongovernmental organizations and many others to create healthy city or healthy community movements. In schools, teachers, pupils and parents should form school health councils for action. At the work-site similar principles should apply. All these structures should use national health policies as their inspiration and guide for development. In this way synergy and cohesion can be created throughout society, relying on the participating and democratic partnerships. The key to achieving health for all is leadership, if it is a leadership that recognizes the formidable potential of health development, not just to improve people's health, but also to strengthen social cohesion and purpose. Only in this way can we create a truly healthy society. We need public health leaders who are willing to learn not only from a careful analysis of their own experience and that of other countries, but also by setting targets and systematically measuring progress towards them. In this way, we can reach out, inspire and release a tremendous human potential for creating movement for a healthy society, preconditioned for healthy people. We are determined to continue to push ahead with the development that we started in this very hall 21 years ago, when we agreed that health development throughout the world should be inspired by a mutually agreed upon common policy framework. I believe health for all is a wonderful combination of today's realities and tomorrow's dreams.

Today between us we have an unparalleled collective knowledge, tools, technologies and experience to promote health very effectively. Let us use them all well. May I also recall that last November we celebrated the twentieth anniversary of the Alma-Ata Declaration on primary health care. I am pleased to tell you that in the European Region we firmly believe that those basic aims, which were agreed 20 years ago, are still very appropriate for us and equally valid for the twenty-first century. We are working towards community-based health promotion and disease prevention, coming together with high quality primary and hospital care.

Dr Gro Harlem Brundtland, let me salute you very warmly on behalf of all of us here on the occasion of your first Health Assembly as WHO's Director-General. Let us now look at the work that has been taking place in WHO since you have been appointed. We have been impressed by the energy with which you have approached the task of reforming our Organization. We are looking forward with great interest to listening to you tomorrow morning when you tell us again about your plans for the future. We well remember your inauguration address to us last year. I would like to refer especially to your bold Roll Back Malaria and Tobacco Free Initiative projects and the wholehearted efforts that you have since directed towards these projects. And it is particularly important that you have taken on board the needs and ongoing initiatives of the WHO regions. I particularly refer to the expansion of the Roll Back Malaria project, and the inclusion of the malaria-infected countries of the European and other regions in the project.

The discussion of the technical issues listed on our agenda in Committee A will provide us with up-to-date information on WHO's coordinating role and allow us to report on developments in our own countries. The proposed programme budget for the next biennium presented to us in a new format seems to be much easier to understand. That is important for us. We are all very busy and often do not have too much time to work our way through columns of figures, cross-references and difficult formulations. I believe that we shall now be able to pick up the programme budget document and know just what WHO is doing. That will be helpful to us and helpful to WHO's Secretariat too. This I know has meant a lot of work by the Director-General and her staff for which I offer you our thanks.

The Committee issues on management and financial matters are of course just as important.

One of the most interesting and innovative changes for us this week is the way our Assembly programme is shaped. We must thank you, Dr Brundtland, for this. We look forward with excitement to the round-table discussions. They will allow us to exchange experiences and ideas and learn from each other. This, after all, is one of the main reasons why we are here. We are privileged to join the first round tables at this Fifty-second World Health Assembly, the start of a new assembly tradition, I am sure.

We are unfortunately still facing conflict and wars in many parts of the world. There are many areas in the world where people do not enjoy the most basic human rights of security, democracy and health. I know you all join me in a prayer for peace as we think of the unwanted and disabled people and refugees. We feel for the millions of children and other vulnerable groups such as sick persons and the aged. We fervently believe that the United Nations and its organizations and bodies must play very active roles in taking humanitarian assistance to the civilian populations, in dealing with the enormous problems of refugee groups, and ultimately in brokering peaceful solutions. It has been particularly rewarding to see the stronger role that WHO now plays in such crises, but I believe we have to be prepared for playing an even stronger role in such situations in the years to come. In those situations do people suffer more than when war erupts? WHO's scientific, coordinating and brokering role is a key factor in bringing cohesion, synergy and purpose to such complex situations.

Lastly, may I assure you that the elected officers of the Health Assembly will try to guide the work of this Assembly impartially and effectively so that all our discussions achieve a mutually satisfactory conclusion by the close of business next week. With your cooperation and the assistance of the Director-General and her staff I know we shall succeed. Thank you.

2. ADOPTION OF THE AGENDA AND ALLOCATION OF ITEMS TO THE MAIN COMMITTEES
ADOPTION DE L'ORDRE DU JOUR ET REPARTITION DES POINTS ENTRE 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 meting earlier today.

The General Committee examined the provisional agenda for the Fifty-second World Health Assembly (document A52/1) as prepared by the Executive Board and sent to all Member States.

The General Committee recommended the following changes to the provisional agenda: deletion of item 6, "Admission of new Members and Associate Members [if any]," since no new applications have been received; and deletion of item 15, "Assessment of new Members and Associate Members [if any]".

Does the Assembly agree with these recommendations?

I see no objections. It is so decided.

I wish to convey to the Assembly the Committee's proposals regarding agenda item 5, "Round tables: lessons learned in world health" as a new initiative. This item has been included in response to Executive Board resolution EB103.R19 in order to enhance the involvement of ministers of health in policy discussions. It is proposed to have several round tables to discuss the following four issues: "Priority-setting in the health sector: challenges to ministers", "Investment in hospitals: dilemmas faced by ministers", "Finding the money: dilemmas facing minsters" and "HIV/AIDS: strategies for sustaining an adequate response to the epidemic". However, in order to agree on the agenda and so as to fit these round tables properly within the context of the rules governing the functioning of the Health Assembly, the General Committee proposed that they should be considered as committees of the Assembly. This would mean that the Health Assembly would establish special committees for this purpose, which it is entitled to do under Rule 42 of the Rules of Procedure. The General Committee also agreed to recommend that the round tables should be dealt with in six committees which would subsequently report back to the Plenary. If the Plenary agrees with this recommendation, the committees dealing with these issues would not consider any proposals for draft resolutions, as the purpose of the discussions on the four topics in these committees was to permit ministers of health to report on national lessons with global potential and to enhance the involvement of ministers of health in policy discussions. I repeat that reports of the discussions will be presented to Plenary at a later stage.

With this clarification, and unless there are any comments on the general proposal to hold the round tables and that they should be committees of the Assembly, I propose that we proceed with our consideration of the agenda and come back to the details later.

Does the Assembly agree to the recommendation of the General Committee to deal with item 5 in this way?

I see no objection. It is so decided.

Inclusion of supplementary items on the provisional agenda
Inscription de points supplémentaires à l'ordre du jour provisoire

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 "Inviting the Republic of China (Taiwan) to participate in the World Health Assembly as an Observer". The Committee took the same position as the Assembly did last year when presented with the same proposal and recommended not to include this item on the agenda. Are there any comments? I call on the delegate of Nicaragua.

La Sra. McCOY SÁNCHEZ (Nicaragua):

Señora Presidenta, respecto al informe de la Mesa, lamentamos profundamente que la propuesta de incluir como punto suplementario del orden del día el de invitar a la República de China (Taiwán) a participar en la Asamblea Mundial de la Salud como observador, enviada a la Directora General de conformidad con el artículo 12 del Reglamento Interior de la Asamblea, no haya sido aceptada por la Mesa. Fundamentamos nuestra recomendación en la necesidad de garantizar la salud para todos, ya que la salud no es un asunto político y ningún país debería ser excluido, menos aún en estos tiempos en que la civilización está llegando al principio del tercer milenio, cuando se presupone que nuestras naciones han alcanzado grandes conocimientos y madurez. Es una petición a la sensibilidad humana, ya que las enfermedades no tienen fronteras.

Afirmamos el aporte que la República de China (Taiwán) ha brindado en aquellos países en vías de desarrollo que han solicitado la cooperación y el intercambio bilateral en el área de ayuda médica, humanitaria y en emergencia ante desastres naturales. Ante estos requerimientos, la República de China (Taiwán) se ha hecho presente de inmediato promoviendo los principios y el espíritu de nuestra Organización Mundial de la Salud. Queremos destacar, en particular, la ayuda humanitaria inmediata brindada por la hermana República de China (Taiwán) ante el desastre del huracán Mitch en Centroamérica y la respuesta rápida y generosa ofrecida a la región para apoyar sus esfuerzos de reconstrucción y transformación. Este espíritu de apoyo humanitario internacional se ha manifestado también en la colaboración médica y financiera a la Ex República Yugoslava de Macedonia a fin de recibir refugiados procedentes de Kosovo. Asimismo, se ha expresado en donativos de fondos dirigidos a financiar programas mundiales de salud, apoyando de esta manera estrategias impulsadas por esta magna Organización.

Creemos que es hora de que los más de 22 millones de personas que habitan la República de China (Taiwán) estén formalmente representadas, y de que ésta goce de los beneficios y del honor de ser miembro de la magna comunidad de las Naciones Unidas con la aspiración de alcanzar un mejor nivel de salud para sus habitantes, cumpliendo de esa manera el mandato de la Declaración de Alma-Ata de Salud para Todos en el Año 2000. Rechazar los aportes de la República de China (Taiwán) a la salud mundial, y en particular a esta Organización, no contribuye al espíritu de esta Organización y afecta a las naciones más pobres y vulnerables del mundo. Vemos en esta decisión de la Mesa una oportunidad perdida para que los países desarrollados y en vías de desarrollo puedan beneficiarse de una relación amistosa y de cooperación en materia sanitaria. Por otra parte, debe reconocerse la universalidad de los derechos humanos y queremos recalcar que la salud tiene que ser para todos los seres humanos de este globo terrestre.

Estamos ingresando en el siglo XXI en esta frágil nave llamada Tierra, en la cual surcamos los espacios infinitos, lo cual nos debe hacer reflexionar en omitir límites. Lo que debe hacer la humanidad para alcanzar la prosperidad es la unidad de los seres humanos, sin distinción de raza, sexo, religión, opinión política; ése será nuestro porvenir. Cada vez somos más conscientes de los grandes retos que enfrentamos, los cuales sólo podremos vencer conjuntamente.

Con todo respeto, estimados delegados ante esta magna Asamblea Mundial, lo que hemos expuesto en este contexto es para que el beneficio sea de todo el género humano, y queremos recordar el Preámbulo de la Declaración Universal de Derechos Humanos que reconoce la dignidad intrínseca y los derechos iguales e inalienables de todos los miembros de la familia humana; esperamos que para la Asamblea del milenio esto sea una realidad. Que Dios los bendiga y los ilumine. Muchas gracias.

The PRESIDENT:

I thank the delegate of Nicaragua, and I call on the delegate of China.

Professor WANG Longde (中国):

王陇德教授（中国）：

主席女士，中国代表团支持总务委员会关于不将所谓“邀请台湾以观察员身份参加世界卫生大会”的提案列入本届卫生大会议程的建议。上述提案在前两年的世界卫生大会上均被否决。此问题早有定论，本不应该再次出现。但少数国家在台湾当局的唆使下，无视世界卫生组织绝大多数成员国的意愿，老调重弹，这种做法是极不明智、不得人心的，中国代表团坚决反对。

中国代表团已在总务委员会上表明了对这一问题的严正立场。我们认为，世界卫生组织是主权国家参加的联合国专门机构。世界上只有一个中国，台湾是中国不可分割的一部分。中国在联合国的代表权和在世界卫生组织的代表权早已在 1971 年联大通过的 2758 号决议和根据联大决议 1972 年世界卫生大会通过的 WHA25.1 号决议所解决。台湾作为中国的一个省，没有资格以任何方式、任何名义参加世界卫生组织和世界卫生大会。提出台湾参加世界卫生大会的问题显然是出于政治目的，是明目张胆地分裂中国，在国际上制造“两个中国”、“一中一台”。这种做法严重违背联合国宪章和国际法基本准则，侵犯中国的主权和领土完整、干涉中国的内政，中国政府和人民坚决反对。

中国是世界卫生组织成员国。中国大陆和回归了祖国并保留了自己社会制度的特别行政区香港的居民享受到世界卫生组织的服务，并不是因为他们所在的省、自治区、直辖市或特别行政区是世界卫生组织的成员或作为观察员参加世界卫生大会,而是由于他们作为中国的组成部分而享受到这种服务。台湾没有资格作为观察员参加世界卫生大会，并不意味着没有渠道使台湾的二千二百万同胞享受到世界卫生组织的服务。事实上，现在两岸在卫生领域已有许多交流。中国政府一向重视维护台湾同胞的合法权益，关心台湾同胞的健康，并愿意就有关问题通过两岸适当渠道协商解决。我们去年在世界卫生大会上就说过，关于台湾同胞享受世界卫生组织服务问题，只要台湾当局本着一个中国的原则，向中央政府提出，我们相信海峡两岸一定能找到妥善解决办法。这句话今天和今后依然有效。台湾当局迄今对此没有任何积极的回应，而是一而再、再而三地唆使少数国家提出观察员地位的问题，只能说明他们企图以关心二千二百万台湾同胞的健康为借口，进行政治宣传，以达到在世界卫生组织中制造“两个中国”或“一中一台”的政治目的，这当然是决不能允许的。

我们呼吁大会支持中国代表团的立场，通过总务委员会不将洪都拉斯等国的提案列入大会补充议程的建议。

谢谢主席女士。

The PRESIDENT:

I thank the delegate of China, and I call on the delegate of Dominica.

Mrs PAUL (Dominica):

Let me take this opportunity to offer my sincerest congratulations to you on your election as President. The Commonwealth of Dominica supports the application of the Republic of China (Taiwan) for observer status of the Health Assembly. WHO establishes as its priority a global strategy on the principles of equity and health for all. WHO is a benign organization working to eradicate and control disease and to improve the health of people around the world. The Director-General of WHO has proposed an aggressive programme to roll back malaria and to fight the impact of tobacco-smoking. WHO is also continuing its efforts to eradicate measles, poliomyelitis and combat HIV/AIDS. The Republic of China (Taiwan) has a population of 22 million, which is larger than that of three-quarters of the Member States of WHO. It is of concern that the epidemiological profile of the Western Pacific, and indeed the world as presented by WHO, does not take into account that of the Republic of China (Taiwan). This is a significant omission. Notwithstanding, Madam President, the Republic of China (Taiwan) has made considerable achievements in the health sector. Its infant and maternal mortality rates are comparable to those of developed countries. It has eradicated infectious diseases such as cholera, smallpox, plague and

poliomyelitis. It is the first country in the world to provide children with hepatitis B vaccine. Apart from the US$ 17 million presented by Rotary Clubs of the Republic of China (Taiwan) to support WHO's global poliomyelitis eradication programme, the Taiwanese Government and its Rotary Clubs have committed a further US$ 10 million through Rotary International in support of this vital programme. Given the serious challenges of HIV/AIDS and other new, emerging and re-emerging diseases and in response to natural and man-made disasters, WHO should not deny itself the opportunity to access the significant resources both human and financial that the Republic of China (Taiwan) is prepared to contribute to world health. Indeed, diseases know no international boundaries. The efforts at rolling back malaria recognize that it spreads through migration. If we were to achieve success in all other countries, and malaria continues to exist in Taiwan, we will not have achieved true success and malaria will indeed still be with us. I therefore regret that the General Committee failed to recommend the inclusion in the agenda of the supplementary item to consider the Republic of China (Taiwan) for observer status in the Health Assembly, and I would urge the Assembly to accept its inclusion. Thank you.

The PRESIDENT:

I thank the delegate of Dominica, and I call on the delegate of Myanmar.

Mr AYE (Myanmar):

Madam President, I have requested the floor to respond to the proposal to invite Taiwan to participate in this Fifty-second session of the World Health Assembly as an observer. For those among us who have participated in the work of the Health Assembly during the past two years it may come as no surprise that this irrelevant and needless exercise is once again being deliberated at the current session of the Assembly. It is our earnest hope that this proposal will not be adopted and that it will be rejected just as it was in the years past. The proposal for observer status for Taiwan had been repeatedly rejected for a number of fundamental reasons that are all crystal clear and accepted by us. The distinguished delegates gathered here will recall that United Nations General Assembly resolution 2758(XXVI) recognizes that the representatives of the People's Republic of China represent China and are the only lawful representatives to the United Nations. Furthermore, resolution WHA25.1 pertaining to China's representation in the World Health Organization reiterates and acknowledges this state of affairs.

The reality is obvious. There exists only one China, and Taiwan is a part of the People's Republic of China. Thus it would naturally follow that any unnecessary and prolonged consideration of the proposal at this Assembly would be tantamount to gross interference in the internal affairs of a sovereign country. In this case, that country is the People's Republic of China, and delegates will surely concur that non-interference in the internal affairs of a sovereign State and a Member of the United Nations is a cardinal principle of the Charter of the United Nations. Indeed the proposal runs counter to the stipulations of the WHO Constitution itself, which we are all gathered here today to collectively uphold. As such there exists no valid ground whatsoever for granting observer status to Taiwan.

But, Madam President, let us for a brief moment reflect in an objective manner on the health-related merits of the situation before us. Expressions to the effect that health is a basic right of all and that diseases respect no national boundaries, have often been used in attempts to lend credence to the proposal in question. For their part, the health authorities of the People's Republic of China have never questioned the right of all their compatriots to good health. On the contrary, as the delegate of the People's Republic of China has just clarified, the Chinese Government places great emphasis on good health care and proper medical facilities for their Taiwan compatriots. Furthermore, the delegate of the People's Republic of China in that earlier explanation outlined the various ways and means by which the inhabitants of Taiwan can enjoy the services and the benefits of the World Health Organization. Hence it is evident that satisfactory solutions to the matter must necessarily be arrived at by the Chinese people themselves, free from outside interference. We have no doubt that such endeavours will be successful and we take this occasion to wish them every success.

Meanwhile, we on our part must demonstrate what is expected of us as called for in the Charter of the United Nations and the Constitution of the World Health Organization. The General Committee has already undertaken to review the proposal to place the Taiwan issue as a supplementary item on the agenda. The report of the General Committee on the matter and its recommendation is now before us. The delegation of the Union of Myanmar is confident that this august Assembly will deem it appropriate to oppose the proposal to place the Taiwan issue on the agenda and at the same time to uphold the recommendation of the General Committee. We hereby add our own appeal to the distinguished delegates gathered here to do so.

The PRESIDENT:

Thank you. I see no further requests for the floor. May I therefore assume that the Assembly agrees with the General Committee not to include this supplementary agenda item? It was so decided.

The second proposal was to include a supplementary agenda item on "The use of languages in WHO". The General Committee reached a consensus to recommend inclusion of this supplementary agenda item. May I therefore assume that the Assembly agrees to adopt the provisional agenda as amended with the addition of this supplementary agenda item.

I see no objection, it is so decided.

The agenda is adopted as amended. Document A52/1 Rev.1 reflecting the changes will be distributed tomorrow morning.

Allocation of items to the main committees
Répartition des points de l'ordre du jour entre les commissions principales

The provisional agenda of the 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 Assembly has agreed to consider the supplementary agenda item on "The use of languages in WHO", does the Assembly agree that this item be discussed in Committee B as recommended by the General Committee?

I see no objection. It is so decided.

The General Committee has recommended that the items appearing on the agenda of the Plenary as amended, which have not yet been disposed of, should be dealt with in Plenary. With regard to item 5 of the provisional agenda "Round tables: lessons learned in world health", we have already agreed that these round tables will be considered as committees of the Health Assembly. The proposals considered within the Executive Board for the establishment and functioning of these round tables are quite innovative. The intention when establishing them was to provide a forum for health ministers of Member States to discuss in an informal manner major issues of concern to the health community. It is hoped that these discussions will be lively, interesting to all concerned, and that the discussions will evolve taking into account the exchange of views. In order to achieve these objectives, it is felt necessary to restrict participation in each round table to ensure that all participants have the opportunity to take part actively in the debate.

Consequently, and using the authority provided under Rule 85 of the Rules of Procedure for the Assembly to make special arrangements for the conduct of business of committees, the General Committee made the following proposals:

> On Tuesday afternoon, there will be three round tables: two will discuss "Priority-setting in the health sector: challenges to ministers", and the third will discuss "Investment in hospitals: dilemmas facing ministers". On Wednesday morning, there will be another three round tables, two of which will discuss "Finding the money: dilemmas facing ministers", and the other discussing "HIV/AIDS: strategies for sustaining an adequate response to the epidemic".
>
> Each of these round tables will be considered as a separate committee of limited membership. They will be limited in membership to those ministers of health or delegates at ministerial level representing Member States at this Assembly who have registered for participation in one or more specific round tables. 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 of the round tables. All other delegations and representatives of associate Members and observers to the Health Assembly, including members of the delegation of the Minister of Health participating in the round table, may attend as observers.

During the discussion, Argentina proposed that an observer should be able to participate in the discussion. However, it was explained that the legal status of observers, who normally only took the floor to make a statement at the end of an agenda item, was not consistent with the nature of the intended discussions which was to involve an active exchange of views between the participating ministers of health. Therefore, this proposal was not supported. Consequently, only the participants - that is to say, the ministers of health constituting the membership of each of the round tables - will be permitted to speak in order to ensure a full debate between all ministers present.

As the purpose of the round tables is to permit everyone to profit from an exchange of views between the participants, and not necessarily to an agreed position in all cases, the round tables will not have a mandate to approve resolutions, but rather only to submit to the Plenary a summary of the discussions.

Each of the round tables will be chaired by one of the Vice-Presidents of the Assembly, the first Vice-President having kindly agreed to chair two round tables. In order to promote a lively discussion on each of the subject matters being discussed, the Chairmen of each of the round tables will be assisted by a moderator provided by the Secretariat. The Chairmen of each of the round tables will submit to the Plenary an oral report summarizing the discussions between the participants.

With regard to the items appearing under the two main committees in the provisional agenda, there has been some interest in considering the issue of casual income (under item 15), along with the budget. The Committee agreed to recommend to the Plenary moving consideration of this item from Committee B to Committee A, and taking it up under item 12, "Proposed programme budget for 2000-2001". 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.

Does the Assembly agree with this proposal? I see no objection. It is so decided. A revision of document A52/1 will be distributed tomorrow.

3. ANNOUNCEMENTS COMMUNICATIONS

The PRESIDENT:

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 as amended by resolution WHA50.18 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 Assembly not later than Tuesday afternoon, 18 May, at 16:00, in order to enable the General Committee to meet to draw up its recommendations to the Assembly.

When considering the tentative programme of work of the Assembly, the General Committee, realizing that the list of speakers for item 3, Looking ahead for WHO after a year of change, may not be completed by Wednesday, 19 May, recommended holding an additional plenary meeting. It would be held on Thursday, 20 May, at 9:00 simultaneously with Committee A; on adjournment of the Plenary, Committee B would hold its second meeting. Is this agreeable to the Assembly? I see no objection. It is so decided.

The programme of work for tomorrow, Tuesday, 18 May will be as follows: in the morning, the Plenary will deal with item 2, A year of change: reports of the Executive Board on its 102nd and 103rd sessions, item 3, Looking ahead for WHO after a year of change, Report of Dr Gro Harlem Brundtland, Director-General, and item 4, Health in development, presentation by Professor Amartya Sen, Master of Trinity College, Cambridge, Nobel Laureate in Economics, followed by the review of *The world health report 1999*. In the afternoon, at 14:30, the round tables will meet to deal with the topics "Priority-setting in the health sector: challenges to ministers" and "Investment in hospitals: dilemmas faced by ministers". The Committee on Credentials will hold its first meeting at 14:30. On Wednesday, 19 May, the Plenary will hold its fifth meeting at 9:00 to consider the report of the Committee on Credentials, after which the ministerial round tables will continue on the topics "Finding the money: dilemmas faced by ministers", and "HIV/AIDS: strategies for sustaining an adequate response to the epidemic". In the afternoon, the sixth Plenary meeting will continue its review of item 3 and simultaneously Committee A will meet. The General Committee will then hold its second meeting at 17:30.

I would like to mention already at this stage that, at the request of a Member State, it is proposed to reschedule the discussion of item 17, Health conditions of, and assistance to the Arab population in the occupied Arab territories, including Palestine so that it is considered in Committee B on Thursday, 20 May, instead of Friday, 21 May. Does the Assembly agree with this request? It is so decided.

I would also like to remind the few delegates who have not yet submitted their formal credentials that they should hand them over to the secretariat of the Credentials Committee in office A.671 of this building, before 12:00 tomorrow.

The main committees will now meet to elect their officers.
The next plenary will meet tomorrow at 9:00. The meeting is adjourned.

The meeting rose at 15:40.
La séance est levée à 15h40.

FOURTH PLENARY MEETING

Tuesday, 18 May 1999, at 9:00

President: Mrs Maria de Belém ROSEIRA (Portugal)

QUATRIEME SEANCE PLENIERE

Mardi 18 mai 1999, 9 heures

Président: Mme Maria de Belém ROSEIRA (Portugal)

1. A YEAR OF CHANGE: REPORTS OF THE EXECUTIVE BOARD ON ITS 102ND AND 103RD SESSIONS
UNE ANNEE DE CHANGEMENT: RAPPORTS DU CONSEIL EXECUTIF SUR SES CENT DEUXIEME ET CENT TROISIEME SESSIONS

The PRESIDENT:

We shall now pass on to item 2, A year of change: reports of the Executive Board on its 102nd and 103rd sessions. Before giving the floor to the representative of the Executive Board, I should like to explain briefly the role of the Executive Board representatives at the Health Assembly and of the Board itself, in order to avoid any uncertainty on the part of some delegates on this matter. The Executive Board has an important role to play in the affairs of the Health Assembly. This is quite in keeping with WHO's Constitution, according to which the Board has to give effect to the decisions and policies of the Health Assembly, to act as its executive organ, and to advise the Health Assembly on questions referred to it. The Board is also called upon to submit proposals on its own initiative.

The Board, therefore, appoints four members to represent it at the Health Assembly. The role of the Executive Board representatives is to convey to the Health Assembly, on behalf of the Board, the main issues raised and the flavour of the Board's discussions during its consideration of the items which need to be brought to the attention of the Health Assembly, and to explain the rationale and nature of any recommendations made by the Executive Board for the Assembly's consideration. During the debate in the Health Assembly on these items the Executive Board representatives are also expected to respond to any points raised whenever they feel that a clarification of the position taken by the Board is required. Statements by the Executive Board representatives, speaking as members of the Board appointed to present its views, are therefore to be distinguished from statements of delegates expressing the views of their governments. I now have pleasure in giving the floor to the representative of the Executive Board, Dr Calman, Chairman of the Board.

Dr CALMAN (Chairman of the Executive Board):

Madam President, Madam Director-General, your excellencies, distinguished delegates, I should first of all congratulate you, Madam President, on your election, and on behalf of the Executive Board extend to you our full support, and wish you well. It has been a very great privilege to have been the Chair of the Board over a year of such change and excitement. It has also been an honour to represent WHO at a number of events including a meeting of the European Parliament. WHO is a great organization whose expertise and influence are essential if we are to improve the health of the people of the world. A glance at its Constitution makes it clear that this is our primary purpose, and I quote, "The objective ... shall be

the attainment by all peoples of the highest possible levels of health." Health, using the broad WHO definition, must also include quality of life and happiness. As I have suggested to the Secretary of State for Health in the United Kingdom, perhaps a better title for the Department of Health might be the Department of Health and Happiness, reflecting the importance I attach to well-being and a whole person approach to health. We must not forget that this is our overall purpose, and to achieve this will require a great deal of hard work, energy, commitment, initiative, good will, clear strategic aims and the collaboration of many partners.

The theme of this presentation of the work of the Executive Board is that there is an enormous potential to improve health now, if we were to harness the knowledge, skills and expertise that we already have. I will develop this theme in a moment, but first a review of what has happened in a year of change. The full details are in the formal report[1] and at this stage I will highlight only some important developments. There was a change in the way in which Members are represented on the Board. In the past it was in a personal capacity; now we represent our countries. The long-term significance of this remains to be seen. There was a change in the Director-General, from Dr Nakajima, to whom we gave our best wishes for his retirement, to Dr Gro Harlem Brundtland, whom we welcomed and to whom we pledged our support. There has also been a considerable change in the working methods of the Board. We have worked in smaller and more focused groups. A virtual working group was created to look at some constitutional issues. There have been shorter and, I hope, more effective contributions to the Board. We cut the January session by two-and-a-half days. There have been fewer resolutions to the Assembly this year, all of them are on major issues. There was an important private session of the Board with Dr Brundtland to get to know each other and share our optimism for the future. A newsletter from the Chairman of the Board has been initiated to improve communication between members of the Board, and this has been well received. An Executive Board retreat was held, and I will discuss this more fully in a moment. There have been very good working relationships with the Administration, Budget and Finance Committee and the Programme Development Committee. I would like to thank the Chairmen of these committees for their hard work and achievements. All in all we have been busy in the process of change and improvement in the work of WHO.

The Executive Board retreat in October at Leysin, Switzerland, was a first, and one which, I hope, will be repeated regularly. It was very useful and allowed a frank exchange of views between members, the Director-General and Executive Directors. We got to know each other better and in more informal surroundings. If there is to be another retreat I would hope that Regional Directors will be invited. It provided an excellent opportunity to consider the long-term vision of the Organization and for the Board members to feel part of the process. In the middle of the Retreat the group ascended the local mountain and walked back in unison. A symbolic vision of our work together.

The work of the Executive Board itself was focused on the January meeting where we had an opportunity to take part in creating "one WHO". There was a very important discussion on vision and strategy, and some key decisions and resolutions were adopted. They included those on the eradication of poliomyelitis, the Roll Back Malaria project, a framework convention on tobacco control, the revised drug strategy, the role of the Executive Board, and reform of the Health Assembly - some of which have been introduced at this Assembly. The Board also discussed health systems development, and the role of country offices. The employment and participation of women in the work of WHO was discussed in depth. We agreed, following full discussion, that Articles 2 and 73 of the Constitution should remain unchanged.

Sir George Alleyne and Dr Uton Muchtar Rafei were reappointed as Regional Directors and Dr Shigeru Omi was appointed as the new Regional Director for the Western Pacific. We said thank you to Dr Han for all his work over the years for WHO. The proposed programme budget for 2000-2001 was also debated in detail. Additional information was requested and this will be the subject of further discussion at this Assembly. All very important issues. I am most grateful to the members of the Board for their hard work and constructive thinking on these matters. I am particularly grateful to Professor Girard for his work on the revised drug strategy.

Being the Chairman of the Executive Board, even for a single year, leads to a single conclusion. WHO is needed as never before to put forward the voice of health in the world as it works through its Member States with the many other partners involved. This also provides me with an opportunity to pay tribute, on behalf of the Executive Board to all the staff of WHO, here in Geneva, in the regions, and in countries. They have great skills, expertise and courage to do the things they do in difficult conditions and with huge problems. Their commitment to WHO and to improving the health of the peoples of the world is both real and tangible. We thank you. You maintain the values of WHO, combining caring and

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[1] Document A52/2.

compassion with being at the leading edge of innovation, research and education. The hard edge of the evidence base is brought together with the values of quality and a concern for others.

The world health report 1999 sets out both the past contributions of WHO and its future direction. The Declaration of Alma-Ata, health for all, an effective primary care service, the eradication of smallpox, the great achievements of the Expanded Programme on Immunization represent some of the first category. The Roll Back Malaria project, the Tobacco Free Initiative, the eradication of poliomyelitis, and the improvements in the delivery of care represent the second. It is an exciting prospect. It emphasizes that local initiatives can be made global as the tobacco initiatives in Europe have shown. Someone needs to take the lead and to show the way. WHO has that responsibility working with its Member countries. This leadership role is one of the most important of all WHO's functions.

The report continues to emphasize the importance of partnerships, from the voluntary sector to government agencies to intergovernmental bodies, from universities to industry, from people to politicians. It is the people of the world who will change health, and it is our responsibility to be there to help them. The European Environment and Health Committee and the ministerial conference on environment and health to be held in London in June of this year show how successfully such programmes can be developed if we all work together in partnership.

Let me now return to one of my earlier comments, that of the potential for health. The key determinants of health are well known: poverty, unemployment, education, violence and other socioeconomic factors, all of which contribute to inequity and inequality; the environment, and its sustainability; personal factors such as lifestyle, diet, tobacco, drugs and alcohol; genetic and biological factors; communicable disease; health services, and access to them, with particular concerns here for the health of women and children, mental health and the health of the elderly. The role of primary care is central to this. The refugee problems around the world show how relevant all these factors are, and how acute they are. To help achieve our objectives we need competent practitioners with energy, curiosity and enthusiasm, motivated by compassion and concern. We need an educational process, which delivers this worldwide.

These factors have been known for generations, yet still need action today. We already have the knowledge and thus the potential to deal with many, though not all, of these issues. We will always need more information, more research. Yet with what we already know we could improve the health of the people of the world now. We need to act, we cannot wait. The potential can be realized if we implement our existing knowledge of hygiene, nutrition, the environment and lifestyle issues, including tobacco smoking, and the eradication of poliomyelitis worldwide would be the outstanding example of this. We can do it. We must do it.

It has been a privilege and a pleasure to be part of WHO for almost 10 years. I have seen many changes and considerable improvements in health in many areas, though new problems in others. May I thank the members of the Executive Board and the Secretariat for their help and support, coupled with a special thanks to those members of the Board who are leaving. We wish the Organization, the Director-General and the Executive Board well.

Before I close let me read to you two quotations which I hope summarize my comments on the potential for health. The first comes from Robert Burns, Scotland's national poet. As it happens, the anniversary of his birth fell on the first day of the January Board session and I used this quotation then. It symbolizes the idea towards which we should strive and comes for a poem on poverty:

"Then let us pray that come it may
As come it will for a' that
That sense and worth o'er a' the earth
May all agree with a' that
For a' that and a' that
It's coming yet for a' that
That man to man the warld o'er
Shall brithers be for a' that."

This highlights the importance of common sense, of working together and of the brotherhood of man. The second quotation is from Martin Luther King, which I first heard from Sir George Alleyne in his acceptance speech as Regional Director of the Americas, and shows how far we still have to go to get there:

> "Human progress is neither automatic, nor inevitable ... every step towards social justice requires sacrifice, suffering and struggle, and the passionate concerns of dedicated individuals. This is no time for apathy or complacency. This is a time for vigorous and positive action."

WHO is needed as never before and I know that WHO, as an organization, as Member States, and as individual staff members, will rise to the challenge as we move into the new millennium.

The PRESIDENT:

Thank you, Dr Calman, for your excellent statement. I should like to take this opportunity of paying a 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.

2. LOOKING AHEAD FOR WHO AFTER A YEAR OF CHANGE: REPORT OF THE DIRECTOR-GENERAL (INCLUDING *THE WORLD HEALTH REPORT 1999*) L'AVENIR DE L'OMS APRES UNE ANNEE DE CHANGEMENT: RAPPORT DU DIRECTEUR GENERAL (Y COMPRIS LE *RAPPORT SUR LA SANTE DANS LE MONDE, 1999*)

The PRESIDENT:

And now I give the floor to Dr Gro Harlem Brundtland, Director-General, so that she may present, under item 3 of the agenda, her report on the work of WHO, including a review of *The world health report 1999*.

The DIRECTOR-GENERAL:

Thank you Madam President. Let me first congratulate you upon your election as President of the Fifty-second World Health Assembly. We are pleased to have such an experienced minister to lead our work. I have, in fact, consulted the records of the Assembly, and find that you are the first woman President since 1981, so it is a double pleasure to see you in the Chair.

(Applause/Applaudissements)

Let me wish all the health leaders gathered here today a heart-felt welcome to the 1999 World Health Assembly. In the days to come many will be looking to Geneva. We will be setting the future direction for global health policy. That is our role. Our responsibility is to capture the aspirations of the millions of people on earth who wish for better health, for equal opportunities and the right to enjoy the benefits of development and progress.

The health gains of the twentieth century count as one of the biggest social transformations of our times. Living conditions dramatically improved for the large majority of human beings. But the century left a legacy. More than a billion fellow human beings have been left behind in the health revolution. We must bring the excluded billion on board. This can be done. The world has the knowledge and the means to address the unfinished health agenda of the twentieth century. We know what it will take and we can go a long way in the next decade. We have to do so while being ready to confront new challenges from re-emerging infections, an ageing world population and a dramatic increase in noncommunicable diseases. And - not to forget - to unveil and to address seriously the growing burden of mental illness.

We have to address difficult questions: What will be the health consequences of climate change? Can the world manage to feed a growing population, meet its energy needs and secure clean water for all? How can we be sure that ethical norms will govern the scientific advances that offer hope, but also carry risks? How can we care for the growing migrant and displaced populations? And will humanity continue to experience conflict and violence - killing and mutilating people and hampering development in so many parts of the world?

Look to the Balkans. In just a few months more than a million people have been deprived of their identity, their homeland and their future security. The toll on human health will weigh for a long time throughout the entire region. WHO alongside the entire United Nations system will do what it can to assist people forced into tragic misery. Let us also remind ourselves that similar disasters have happened and are happening in other parts of the world - in areas where the television cameras do not tell the stories or spread the images. All people who suffer deserve our attention.

This is a time for leadership. Humankind has never made progress by giving in to complexity. This is a time for cool heads and warm hearts. We can make a difference. My message is that with vision, realism and commitment the world could end the first decade of the twenty-first century with some notable accomplishments. It will take global leadership to set the process in motion and this Organization is ready to play its role. Times may be changing, and we will be on the side of the change process.

WHO has done this before. Health for all unleashed a powerful movement. Inspiration and guidance from Alma-Ata in 1978, with its emphasis on the critical role of primary health care, contributed in no small measure to the health revolution and tangible health gains in the last two decades of the twentieth century. Looking ahead, WHO can do it again. The world is fast discovering how better health can drive development. We have long known that poverty is a fundamental cause of ill-health. Now we are learning a more powerful lesson - that health gains trigger economies to grow and poverty to be cut. Think about it: in poor countries, it would take very little to increase life expectancy by addressing the main killers of children and adolescents. A five-year difference in life expectancy may yield an extra annual growth of 0.5% per year. It is a powerful boost to economic growth which will happen. Modest improvements in health can help children, women and men to better achieve their potential, unlocking value in every area of their lives. We are not aiming at modest gains. In East Asia life expectancy increased by over 18 years in the two decades that preceded the most dramatic economic take-off in history. Repeat these gains and we could be launching a new leap forward for human progress and development.

This knowledge is made available to us by people who have searched for a deeper understanding of development. One of them will address us later this morning. I wish to pay tribute to Professor Amartya Sen, Nobel Laureate in economics. Having placed poverty and development at the core of economic theory, linking the social and economic dimensions of human development, he has been instrumental in shaping international development thinking. He deserves our warm appreciation.

(Applause/Applaudissements)

This year's World health report highlights four key challenges. First and foremost, there is a need to greatly reduce the burden of excess mortality and preventable disability suffered by the poor. The goal of halving the number of people living in absolute poverty by the year 2015 is attainable, but will require major shifts in the way governments all over the world use their resources. In several regions of the world we need more money for health. But, equally important, we should have more health for our money. It means giving renewed attention to diseases like HIV/AIDS, tuberculosis, malaria and other childhood killers. It will mean investing more in women's health, reducing maternal mortality and improving maternal and childhood nutrition. It will mean revitalizing and extending the coverage of immunization programmes and ensuring access to cost-effective health technologies such as essential drugs.

Second, there is the need to counter threats to health resulting from economic crises, from unhealthy environments and risky behaviour. In health the success stories often give rise to new challenges. If we succeed in curbing poverty and giving populations a real chance to climb the development ladder, then new health threats will follow, from noncommunicable diseases, from the very fact that people live longer, from changing lifestyles, and from exposure to threats such as tobacco. So the message is: let us prepare wisely.

Third, we need to develop more effective health systems. In many parts of the world, health systems are ill-equipped to cope with present demands, let alone those they will face in the future. Pressure for change provides an opportunity for reform. But reform requires a sense of direction. Better health for all, securing equitable health services, must guide that change.

Fourth, there is the need to invest in expanding the knowledge base that made the twentieth century revolution in health possible. A key message in *The world health report* is the critical role played by the generation and application of knowledge. Knowledge about diseases and their control. Knowledge about the effectiveness of interventions and healthy behaviour. Knowledge made available through research - through experiences - through learning from successes and failures. Our search for knowledge - the research agenda - cannot be limited to diseases and risk factors or the right technical interventions. Many governments find it difficult to shift resources away from expensive curative services, which primarily serve their wealthier and more influential constituencies, to basic services that benefit the majority of the population.

We must also better understand the impact and politics of priority-setting. This is one of the themes at the round tables for ministers this afternoon. Poor countries, and the poor in rich countries, are inadequately protected from financial exploitation or treatment of varying efficacy when they use the private sector. We need to know how the required regulatory mechanisms can be developed to protect the public without deterring innovation. On the other hand, public service providers often fail to treat people with respect and dignity. We need to re-examine how to improve public sector performance - including giving people a real voice in holding service providers to account.

In the global economy there are things that the market cannot buy. There are critical tasks that will not be fulfilled unless someone does it on behalf of all. WHO is a repository of public health knowledge for the whole world. Today I plead with you to safeguard this vital public good. There are functions that the economic actors cannot fulfil, such as setting global standards for blood safety; establishing and

reporting objectively from a global surveillance system, which monitors new and emerging diseases; determining every year's influenza vaccine; providing unbiased figures on the global burden of disease; or maintaining updated international health regulations, a road map to a safe future for all generations. WHO can provide the mirror in which Member States see a reflection of their own performance. If this performance is weak - particularly if the poor do not participate in health gains - we must be prepared to say so on the basis of solid evidence from reliable health indicators. I am pleading the cause for global advocacy and normative functions - a well-informed voice in a complex and changing world. Maintaining a solid and reliable global agency is a cost-effective investment that benefits everyone. This year your countries - all our countries - will spend some US$ 2300 billion on health care. The knowledge generated and made available by WHO can positively influence how wisely this money - 10% of the world's GDP - is spent. You are the owners of the World Health Organization. Take good care of it.

When I was elected Director-General I pledged that WHO can and must change to become more effective, more accountable, and more receptive to a changing world. Today, looking back at months of intense work with my staff, I feel I can say that we are moving decisively in that direction. Let me highlight some of the main features. Priorities are coming back to the World Health Organization. World health is an immensely broad and complex area to cover. Even a global organization would lose its focus if it tried to do everything. The programme budget we propose to you is a first major step. We have sharpened our focus and shifted resources to priority areas. The budget for the next biennium represents a shift from the past, but it is only a beginning. The next programme budget will be prepared from scratch with a focus on how WHO as a whole - in countries, regions and headquarters - can make the most substantial impact - by our own activities and through those of our partners. At headquarters we have refocused our work around nine clusters, sending a very clear message of what business we are in. For the first time there is an empowered senior management team - 10 Executive Directors with real corporate responsibilities. Representing all WHO regions, they make a truly global team.

Last year I told you that the time has come to increase the number of women in the World Health Organization. Women represent half of the world's population, but carry much more than half of the world's health burden. How can we then accept massive under-representation of women at WHO? The answer is simple: we will not accept it. Time has come for a change. We will do what we can to take the gender balance towards parity. It cannot be done overnight, but we will work steadily to get there. Cabinet has set a target of 60% of new recruits being female.

Of my Executive Directors, five are women and five are men. Last July, when I took over, only four out of more than 50 directors were women. We have taken advantage of a process of rotation and mobility to change that equation. Today, 10 out of 33 department directors are women. The ratio has gone from a few per cent to close to 30%. We are on track. We are developing a gender policy in WHO. We need to evaluate how men and women are served by health systems. The aim is clear: they should benefit equally from the fruits of health and development.

Let me say from this rostrum: I pay tribute to WHO staff who have been through a profound process of change. With their technical skills and capabilities they constitute our ultimate resource. They deserve our appreciation. I am proud of my staff.

(Applause/Applaudissements)

In 10 months we have been through a major administrative overhaul. We have invested in priority areas by "sunsetting" other activities. This is not a one-time operation; it will continue. We have moved management support near to the managers. The management support units are an innovation in the United Nations system. The role of administration and management, remember, is truly to support, facilitate and back up all our technical work.

During these months we have worked closely with the Regional Directors seeking to assure consistency throughout WHO. We are one WHO, not seven: we are seeking more unity of purpose, and each regional office has undertaken studies of its own structure and direction better to pursue new priorities and strategic directions.

The real untapped resources of this Organization, however, are not located in Geneva or in the regional offices. They are in countries. For the first time ever in the history of WHO we brought the WHO Representatives and Liaison Officers to Geneva for a week in February. During that week we started a process of change towards a more determined focus on how we can make a tangible difference in our work in and with countries. That is where people live. That is where they struggle to make ends meet, combat disease and strive for a healthy future. That is where our focus must always be.

What lies ahead? Let me share with this Assembly how I see the next stage in the process of change of the World Health Organization. The real change, and the change that really matters, is where we must now focus our attention. I am talking about increasing our effectiveness as an organization, so that we can

maximize the impact we have on people's health. The next stage will be pursued with determination. If the only change we make is to repack and dress up in new clothes, we will achieve little, and we will convince no one. Making a difference is our watchword. In everything we do we have to ask: how can we best - through our own efforts - and through those of others with whom we work - make the biggest impact and difference in people's health? For too long, our spending patterns have been driven too much by traditions and not enough by the real needs of a changing world. This is now changing.

WHO is not itself a funding agency. WHO is first and foremost a technical agency devoted to the support of sustainable health systems, offering its advice strategically to support the real needs of countries. We have a clear mandate. But our role is also to be catalytic - to unleash the resources of national governments, development banks and bilateral partners. We hear the call from Member States: they want to see one WHO, acting to maximize what its contribution can achieve. We will respond to that call. But we also need to challenge the Member States. If we are to be more strategic and continue to shift resources to priority areas - then we need your support for these changes at the regional committees.WHO's contribution to the national health budget should not be spread thinly across a large number of inputs and activities. To take just one example: in one country US$ 4.9 million from WHO's regular budget was allocated to cover the cost of 428 priority activities in 44 different national health programmes. That is not the best way to make a difference, and it should now be considered past history.

WHO is the lead agency in health, one of several key players. I have called for a change in our working relationship with the other players, many of which should be our natural partners. Since July we have pursued a policy of reaching out to these partners, knowing that it is the combined impact of our efforts that will make a lasting difference. In doing so we preserve our public health values and our integrity. We have created and recreated partnerships - within the United Nations family, with the Bretton Woods institutions, with the private sector, with nongovernmental organizations, with research and with civil society.

First of all we work differently and more closely with the Member States. We have increased communications with governments through frequent interaction with the missions here in Geneva. We have developed more strategic methods of work in and with the Executive Board. Last year's retreat with the Board will be repeated this fall. Let me take this opportunity to thank the Chairman of the Board, Sir Kenneth Calman, for his support and creativity during this important year of change.

(Applause/Applaudissements)

Most importantly, we wish to see a politically strong and vocal Health Assembly - and it is my hope that discussions and decisions during the coming days will send a clear health message to the world.

Last week I met the leading providers of voluntary contributions to WHO and representatives of developing countries from the regions. Our objective was to start a discussion on how the major financial players in health can pull in the same direction - on how we can target our effort so that what we do really spurs development and benefits the poor. WHO will pursue this agenda and take the emerging consensus further towards concerted action.

I am pleased with the way we have come closer to our fellow organizations and bodies of the United Nations system. UNICEF and WHO have strengthened collaboration for the home stretch of the poliomyelitis eradication campaign. I have met with Dr Nafis Sadik of UNFPA and we have agreed to collaborate more closely in the areas of sexual and reproductive health, in particular at country level. I will meet again with Carol Bellamy of UNICEF to review how we can have more impact through joint activities related to child health and development, not least in the area of immunization. I have enjoyed working closely with Peter Piot and UNAIDS, to take our joint efforts further. WHO has chaired the Committee of Cosponsoring Organizations, and for the first time we have developed and set in motion an Organization-wide strategy within the context of a unified response from all the UNAIDS cosponsors. And as we speak, WHO is working closely with UNHCR to address the public health challenge from the refugee crisis in the Balkans.

During my visits to countries I have met representatives of the United Nations partners and I have seen what we can achieve when we work well together at a country level. I support the Secretary-General's call for closer interagency collaboration and from what I have seen and learned this year I believe the time has come for WHO to make a significant move. We are ready to formalize and intensify our collaboration with our United Nations partners in countries, including joining them on common premises when that is appropriate and when it will add to our efficiency. I announce today that the World Health Organization is ready to join the United Nations Development Group.

We have intensified our cooperation with the World Bank. We welcome ideas such as the comprehensive development framework that has been proposed by its President, Jim Wolfensohn. This framework takes sector-wide thinking a stage further - making the links between the overall economy, the

structure of government, and the many facets of human development much more explicit. We have engaged in a new dialogue with the International Monetary Fund, speaking out for the need to better protect health and social services in times of financial turmoil.

We have taken new steps with the private sector. Over the past 10 months we have held a number of round tables with industry and with nongovernmental organizations, exploring how we can provide drugs and vaccines to the most vulnerable populations. Gradually we are getting closer to doing away with many of the old obstacles.

We have conducted external and internal studies of WHO's own research agenda to ensure that we can meet the needs of the next century. We are now better equipped to interact with the global research community and to pursue our own role in setting the public health agenda in research. We are also completing an evaluation of the way we work with WHO collaborating centres. There are several thousand of these centres, and they add a crucial dimension to our work. With this evaluation we will be able to deepen our cooperation and to take it further into new areas of work.

Can we achieve this change in the way we work as an organization and the way we work with our partners? My answer is yes - and we have some very concrete examples of this already happening. When I was elected I introduced two specific projects: Roll Back Malaria and the Tobacco Free Initiative - one in the area of communicable diseases and the other in the area of noncommunicable diseases. In both cases WHO needed to respond with increased and focused action. Malaria is a killer. We need to confront it with both traditional and innovative means. Roll Back Malaria is drawing on existing initiatives, especially in Africa, and introduces new ways of taking malaria control and prevention forward. At country level Roll Back Malaria is evolving into a social movement - integrating with the health sector, but also going beyond it to reach all those vulnerable populations that a fragile health sector does not reach. Success will require commitment from governments in malaria-affected countries. It will require also new sources of funding. This Assembly is invited to adopt a resolution to endorse Roll Back Malaria. This new drive has the ambition to cut by half the number of deaths from malaria within a decade through better access of all people in malaria-affected areas to a range of effective interventions. If we succeed - and we will - what we learn will reach beyond malaria. The ultimate ambition is to strengthen the health sector and build capacity in that system as well as in people - in their communities and in the prime arena for health - the home and the family. This is a new way of working for WHO, for governments and for our other partners. As we proceed, what we learn will benefit our work in other areas, not least in our fight against HIV/AIDS and tuberculosis.

Tobacco is also a killer, and we must confront it. I repeat what I said from this rostrum last year. Tobacco should not be advertised, subsidized or glamorized. We need urgently to curb a growth rate that is about to turn tobacco use into the single foremost cause of death and instability - 10% of the global burden of disease - some 20 years from now. Some point to the threat that effective tobacco control would represent for tobacco growers. Let us remind ourselves. The issue here is human health. Succeeding in a lasting change will take years - enough time for other sectors to adapt. And do not let second agendas take the high ground. At this Assembly we present a World Bank study on the economics of tobacco. The truth is simple: tobacco is not only bad for health, it is also bad for the economy, and it is particularly bad for the developing world. The tobacco epidemic is about to hit the developing world, penetrating countries which at present have very weak means of defence. In 20 years it will add an extra 7 million premature deaths and yet another load to already overburdened health systems. We invite the Member States of WHO to initiate work on a framework convention for control - to take the first step in a process that the Health Assembly has called for before. The convention will offer important support to countries. But the treaty will only be effective if it works in conjunction with, and builds upon, sound domestic interventions. Last month I invited the International Conference of Drug Regulatory Authorities to look into the way tobacco products are regulated. I was encouraged to note that their response was positive. It is an amazing fact. A product which kills every second of its consumers is not regulated. The fact is this: tobacco is the only product on the market which when used as intended leads to death. That we must change.

Looking ahead we see that all our knowledge is about the past, whereas all our challenges lie in the future. Think for a moment of the researcher. She needs to build on evidence. But she also needs to take risks. She needs to go for her vision - to reach one step further than anyone has done before. In health we have seen it so many times. Decades ago, a poliomyelitis vaccine was just a dream. A debate was raging between those who fought for it, and those who wanted better iron lungs and rocking beds to help alleviate the suffering of the poliomyelitis victims. As we approach the historic event of poliomyelitis eradication - made possible by the development of effective oral vaccines - we often forget how difficult the decision was to keep investing in a dream that no one could know would become a reality. Now we have new vaccines for pneumonia and new tools for attacking major killers of children. But when will we see the dream come true of getting them to those who have the need but lack the means? That is a challenge as big as developing the vaccines themselves.

Let us repeat a well-known fact: whereas 90% of the disease burden is in the developing countries, these countries only have access to 10% of the resources going to health. It cannot change overnight, but it must change. Take the HIV/AIDS pandemic. The pandemic of the twentieth century will succeed in entering the twenty-first century in full force. It has become the first cause of death in Africa, it is on the rise in Asia and in large parts of Europe. A historic human, social and economic setback is unfolding. We must not walk away. We need to confront the epidemic with renewed energy and commitment. As long as HIV/AIDS affects any community or any country, our world is in danger. In the new WHO we are not confining our HIV/AIDS activities to a single department. It is the entire Organization, through its technical resources and skilled people, which is now being marshalled. We will actively play our role - also in taking forward the emerging partnership against the pandemic in Africa.

Health is a fundamental human right. We need public voices - and you can count WHO as one - to speak out for all those who are denied their human rights to health. You can count on WHO to speak out for the most courageous of all - the woman who gives birth. We need to renew our commitment to combat maternal mortality. No other indicator so starkly reflects the disparities between rich and poor, between the haves and the have nots, between the developed and developing worlds. Each death is a tragedy. The death of a young woman, who may have other children, is a multiple tragedy. These deaths are preventable with simple and cost-effective interventions. We can make pregnancy safer. A newborn healthy baby is hope, expectation and promise.

Let us go to work. Together we can make a difference.

3. HEALTH IN DEVELOPMENT
SANTE ET DEVELOPPEMENT

The PRESIDENT:

Thank you, Dr Brundtland, for your eloquent words.

We shall now proceed to item 4 of the agenda, Health in development. It is a great honour for me to welcome, on behalf of this Assembly, Professor Amartya Sen, Master of Trinity College, Cambridge, Nobel Laureate in Economics. Professor Sen has very kindly agreed, in spite of his very heavy schedule, to address this Assembly on "Health in development", and it is with pleasure that I give you the floor, Professor Sen.

Professor SEN (Nobel Laureate in Economics):

Madam President, Director-General, Chairman and members of the Executive Board, ladies and gentlemen, I feel very honoured - and of course delighted - to have the opportunity of giving this lecture at this extraordinarily important conference. I feel triply privileged, first because the occasion is so significant (the World Health Assembly is a gathering of people who can influence the health and longevity of billions of people in the world), second because the agenda is so momentous (we have just heard the priorities that have been outlined by the Director-General for a year of change), and third because it is so wonderful to be here on the invitation of Dr Gro Harlem Brundtland for whom I have the greatest of admiration. My admiration is now even greater, after hearing her speech about the programmes in which WHO will play a leading role in the world. We are all very dependent on the community of doctors and medical professionals across the globe. I have had my own encounters with them: at the age of 12 I had malignant malaria; at the age of 18 I had cancer. So if I am alive today, it is to a great extent due to doctors on the one hand and the arrangements for medical delivery on the other hand. I therefore welcome the programme of preventive and curative medical action outlined by the Director-General.

I have been asked to speak on the subject of health in development. I must take on the question - the very difficult question - as to how health relates to development. At one level the question admits of a simple answer: surely the enhancement of the health of people must be accepted more or less universally to be a major objective of the process of development. But this elementary recognition does not, on its own, take us very far. We have to ask many other questions as well. How important is health among the objectives of development? Is health best promoted through the general process of economic growth which involves a rising real national income per capita, or is the advancement of health as a goal to be separated from the process of economic growth *per se*? Do all good things go together in the process of development, or are there choices to be made on the priorities at stake? How does our concern for equity reflect itself in the field of health and health care? I shall have to go into these issues also.

However, to motivate what is perhaps the most basic issue, let me begin with the report of a very old conversation between a husband and wife on the subject of earning more money. It is, of course, not

unusual for couples to discuss the possibility of earning more money, but a conversation on this subject from around the eighth century B.C., nearly 3000 years ago, is of some special interest. As reported in the Sanskrit text *Brihadaranyaka Upanishad*, Maitreyee and her husband Yajnavalkya are discussing this very subject. But they proceed rapidly to a bigger issue than the ways and means of becoming more wealthy: how far would wealth go to help them get what they want? Maitreyee, the wife, wonders whether it could be the case that if "the whole earth, full of wealth" were to belong just to her, she could achieve immortality through it. That is the question. "No", responds Yajnavalkya, "like the life of rich people will be your life. But there is no hope of immortality by wealth". Maitreyee then remarks, "What should I do with that by which I do not become immortal?"

Maitreyee's rhetorical question has been cited again and again in Indian philosophy to illustrate both the nature of the human predicament and the limitations of the material world. I have too much scepticism of other-worldly matters to be led there by Maitreyee's worldly frustration, but there is another aspect of this exchange that is of rather immediate interest to economics and to understanding the nature of development. This concerns the relation between incomes and achievements, between commodities and capabilities, between our economic wealth and our ability to live as we would like. While there is a connection between opulence, on the one hand, and our health, longevity and other achievements, on the other, the linkage may or may not be very strong and may well be extremely contingent on other circumstances. The issue is not the ability to live forever on which Maitreyee - bless her soul - happened to concentrate, but the capability to live really long (without being cut off in one's prime) and to have a good life while alive (rather than a life of misery and unfreedom) - things that would be strongly valued and desired by nearly all of us. The gap between the two perspectives, that is, between an exclusive concentration on economic wealth, and a broader focus on the lives we can lead, is a major issue in the conceptualization of development. As Aristotle noted at the very beginning of *The Nicomachean Ethics* (resonating well with the conversation between Maitreyee and Yajnavalkya 3000 miles away): "wealth is evidently not the good we are seeking; for it is merely useful and for the sake of something else".

The usefulness of wealth lies in the things that it allows us to do - the substantive freedoms it helps us to achieve, including the freedom to live long and to live well. But this relation is neither exclusive (since there are significant other influences on our lives apart from wealth), nor uniform (since the impact of wealth on our lives varies with other influences). It is as important to recognize the crucial role of wealth on living conditions and on the quality of life, as it is to understand the qualified and contingent nature of this relationship. An adequate conception of development must go much beyond the accumulation of wealth and the growth of gross national product and other income-related variables. Without ignoring the importance of economic growth, we have to look well beyond it.

The ends and means of development require examination and scrutiny for a fuller understanding of the development process; it is simply not adequate to take as our basic objective merely the maximization of income or wealth, which is, as Aristotle noted, "merely useful and for the sake of something else". For the same reason economic growth cannot be treated as an end in itself. Development (as I have tried to argue in my forthcoming book, to be entitled "Development as Freedom") has to be primarily concerned with enhancing the lives we lead and the freedoms that we enjoy. And among the most important freedoms that we can have is the freedom from avoidable ill-health and from escapable mortality. It is as important to understand the qualified and contingent nature of the relationship between economic prosperity and good health as it is to recognize the crucial importance of this relationship, qualified and contingent though it may be.

Let me illustrate the conditional nature of the relationship with some empirical examples. It is quite remarkable that the extent of deprivation for particular groups even in very rich countries can be comparable to that in the so-called Third World. For example, in the United States, African Americans as a group have no higher - indeed have a lower - chance of reaching advanced ages than do people born in the immensely economically poorer economies of China or the Indian State of Kerala (or in Sri Lanka, Jamaica or Costa Rica). Since I do not have the opportunity of showing you any overhead projection in this hall, you have to imagine the picture of the relative life expectancies yourself. I presented charts on this in my article entitled "The economics of life and death" in the *Scientific American* in 1993, which show how the African Americans as a group are overtaken in terms of the proportion of survival by some much poorer people in the world.

Even though the income per capita of American blacks in the United States is considerably lower than that of the American white population, they are, of course, very many times richer in income terms than the people of China or Kerala (even after correcting for cost-of-living differences). In this context, the comparison of survival prospects of African Americans with those of the very much poorer Chinese, or Indians in Kerala, is of particular interest. African Americans tend to do better in terms of survival at low age groups (especially in terms of infant mortality) *vis-à-vis* the Chinese or the Indians, but the picture changes over the years. It turns out that Chinese men and those in Kerala in India decisively outlive

American black men in terms of surviving to older age groups. Even African American women end up having a similar survival pattern for the higher age groups as the much poorer Chinese, and decidedly lower survival rates than the even poorer Indians in Kerala. So it is not only the case that American blacks suffer from relative deprivation in terms of income per head *vis-à-vis* American whites, they also are absolutely more deprived than the low-income Indians in Kerala (for both women and men), and the Chinese (in the case of men), in terms of living to ripe old ages. The causal influences on these contrasts (that is, between living standards judged by income per head and those judged by the ability to survive to higher ages) include social arrangements and community relations such as medical coverage, public health care, elementary education, law and order, prevalence of violence, and so on.

The contrast on which I have just commented takes the African American population as a whole, and this is a very large group. If instead we consider African Americans, in particular deprived sections of the community, we get an even sharper contrast. The recent work of Christopher Murray and his colleagues show how very different the survival rates are for American people in different countries. If, for example, we take the African American male population in, say, the District of Columbia, St Louis City, New York, or San Francisco, we find that they fall behind the Chinese or the Keralan at a remarkably early age. And this despite the fact that in terms of income per head, which is the focus of attention for standard studies of growth and development, the African Americans are very much richer than the poor population with whom they are being compared in terms of survival patterns.

These are striking examples, but it would be right also to note that, in general, longevity tends to go up with income per head. That is a point which has to be accepted. Indeed, this is the case even within particular countries studied by Chris Murray and others. Is there something of a contradiction here?

There is really none. What must be understood is the following. Given other factors, higher income does make an individual or a community more able to avoid premature mortality and escapable morbidity. But other factors are not, in general, the same. So income is a positive influence, and yet - because of the variation of other factors (including medical facilities, public health care, educational arrangements, etc.) - there are a great many cases in which much richer people live much shorter lives and are overtaken by poorer people in terms of survival proportions. It would be just as silly to claim that higher income is *not* a contributory factor to better health and longer survival as it would be to assert that it is the *only* contributory factor. Also, on the other side, better health and survival do contribute, to some extent, to the ability to earn a higher income, given other things - a point also emphasized by the Director-General in her report - but then again we have to remember the fuller picture that other things are not necessarily given.

Perhaps the relationship between health and survival, on the one hand, and per capita income levels, on the other, is worth discussing a bit more, since literature on the subject is sometimes full of rather misleading conclusions. The point is often made that while the rankings of longevity and per capita income are not congruent, nevertheless if we take the rough with the smooth, then there is plenty of evidence in intercountry comparisons to indicate that by and large income and life expectancy move together. From that generalization, some commentators have been tempted to take the quick step of arguing that economic progress is the real key to enhancing health and longevity. Indeed, it also has been argued that it is a mistake to worry about the discord between income-achievements and survival chances, since - in general - the statistical connection between them is observed to be quite close.

Is this statistical point correct, and does it sustain the general inference that is being drawn? The point about intercountry statistical connections, seen in isolation, is indeed correct, but we need further critical scrutiny of this statistical relation before it can be seen as a convincing ground for taking income to be the basic determinant of health and longevity and for dismissing the relevance of social arrangements, going beyond income-based opulence. It is interesting, in this context, to refer to some statistical analyses that have recently been presented by my colleagues, Sudhir Anand and Martin Ravallion. On the basis of intercountry comparisons, they find that life expectancy does indeed have a significantly positive correlation with GNP per head for the poorer countries, but that this relationship works mainly through the impact of GNP on incomes, specifically of the poor, and public expenditure, particularly in health care. In fact, once these two variables are included on their own, as independent variables, in the statistical exercise, little extra explanation can be obtained, indeed none, from including GNP per head as an additional causal influence. Indeed, with poverty and public expenditure on health as explanatory variables on their own, the statistical connection between GNP per head and life expectancy appears to vanish altogether.

It is important to emphasize that this does not show that life expectancy is not enhanced by the growth of GNP per head, but it does indicate that the connection tends to work particularly *through* public expenditure on health care, and *through* the success of poverty removal. Much depends on how the fruits of economic growth are used. This also helps to explain why some economies such as South Korea and Taiwan have been able to raise life expectancy so rapidly through economic growth, while others with similar record in economic growth have not achieved correspondingly in the field of longevity expansion.

The achievements of the East Asian economies have come under critical scrutiny, and some fire, in recent years, because of the nature and severity of what is called the "Asian economic crisis". That crisis has indeed been serious, and also it does point to particular failures of economies that were earlier seen - mistakenly - as being comprehensively successful. Nevertheless, it would be a serious error to be dismissive about the great achievements of the East and South-East Asian economies of Japan, Korea and China over several decades, which have radically transformed the lives and longevities of people in these countries. I go into the positive and negative aspects of the East Asian experience more fully in my forthcoming book on development as freedom, but will not pursue them further here.

Briefly, for a variety of historical reasons, including a focus on basic education and basic health care, and early completion of effective land reforms, widespread economic participation was easier to achieve in many of the East and South-East economies in a way it has not been possible in, say, Brazil or in my own country India or Pakistan, where the creation of social opportunities have been much slower and have acted as a barrier for economic development. The expansion of social opportunities has served as facilitator of high-employment economic development in East Asia and has also created favourable circumstances for reduction of mortality rates and for expansion of life expectancy. The contrast is sharp with some other high-growth countries - such as Brazil - which have had almost comparable growth of GNP per head, but also have quite a history of severe social inequality, unemployment and neglect of or inequality in public health care. The longevity achievements of these other high-growth economies have moved more slowly, although remedial action is now being taken, including in Brazil, which is very welcome.

There are two interesting and interrelated contrasts that I wish to emphasize. The first is the disparity between different high-growth economies, in particular between those with great success in raising the length and quality of life (such as South Korea and Taiwan), and those without comparable success in these other fields (such as Brazil). The second contrast is between different economies with high achievement in raising the length and quality of life, in particular the contrast between those with great success in high economic growth (such as South Korea and more recently China), and those without much success in achieving high economic growth (such as Sri Lanka, pre-reform China, or the Indian state of Kerala).

I have already commented on the first contrast (between, say, South Korea and Brazil), but the second contrast too deserves policy attention. In our book, *Hunger and Public Action*, Jean Drèze and I have distinguished between two types of successes in the rapid reduction of mortality, which we called respectively "growth-mediated" and "support-led" processes. The former process works through fast economic growth, and its success depends on the growth process being wide-based and economically broad (strong employment orientation has much to do with this), and also on the utilization of the enhanced economic prosperity to expand relevant social services, particularly health care, education and social security. In contrast with the "growth-mediated" mechanism, the "support-led" process does not operate through fast economic growth, but works through a programme of skilful social support of health care, education, and other relevant social arrangements. This process is well exemplified by the experiences of economies such as Sri Lanka, pre-reform China, Costa Rica, or the Indian state of Kerala, which have had very rapid reductions in mortality rates and enhancement of living conditions, without much economic growth. In the case of China, the growth experience is primarily in the post-reform period.

The "support-led" process does not wait for dramatic increases in per capita levels of real income, and it works through priority being given to providing social services (particularly health care and basic education) that reduce mortality and enhance the quality of life. In a comparison on which I have commented elsewhere, we may, for illustrative purposes, look at the gross national product per head and life expectancy at birth of six countries (China, Sri Lanka, Namibia, Brazil, South Africa and Gabon) and one sizeable state (Kerala). Even though it is a state within a country (India), it has a large population (30 million), somewhat larger than Canada. Despite their very low levels of income, the people of Kerala, or China, or Sri Lanka enjoy enormously higher levels of life expectancy than do the much richer populations of Brazil, South Africa or Namibia, not to mention Gabon. Even the direction of the inequality points oppositely when we compare Kerala, China and Sri Lanka, on one side, with Brazil, South Africa, Namibia and Gabon, on the other. Since life expectancy variations relate to a variety of social opportunities that are central to development (including epidemiological policies, health care, educational facilities, and so on), an income-centred view is in serious need of supplementation, in order to have a fuller understanding of the process of development. These contrasts are of considerable policy relevance, and bring out the importance of the "support-led" process.

People in poor countries are, of course, persistently disadvantaged by many handicaps; the picture is one of diverse adversities. And yet, when it comes to health and survival, perhaps nothing is as immediately important in many poor countries in the world today as the lack of elementary medical services and provisions of basic health care. The nature and reach of pervasive deprivation of biomedical services is brought out most vividly by Paul Farmer's recent study, *Infections and Inequalities: the Modern Plagues*. The failures apply to perfectly treatable diseases (such as cholera, malaria, etc.) as well as to more

challenging ailments (such as AIDS and drug-resistant tuberculosis). But in each case, a major difference can be brought about by a public determination to do something about these deprivations.

Surprise may well be expressed about the possibility of financing "support-led" processes in poor countries, since resources, it may be argued, are surely needed to expand public services, including health care and education. The need for resources cannot be denied in any realistic accounting, but it is also a question of balancing the costs involved against the benefits that can be anticipated in human terms. It must be emphasized that financial prudence is not the real enemy here. Indeed, what really should be threatened by financial prudence, not to mention conservatism is the use of public resources for purposes where the social benefits are very far from clear, such as the massive expenses that now go into the military in one poor country after another (often very many times larger than the public expenditure on basic education or health care). It is an indication of the topsy-turvy world in which we live today that the doctor, the schoolteacher or the nurse feels more threatened by financial conservatism than does the general and the air marshall. The rectification of this anomaly calls not for the chastising of financial prudence, but for a fuller accounting of the costs and benefits of the rival claims. In a different context, namely the programmes outlined by the Director-General, the same applies to smoking. For the costs in terms of loss of revenue to the government are often much clearer than those of future savings on medical care required for illnesses caused by smoking, not to mention the human costs of suffering and death associated with the habit.

The very important issue of the contrast between military expenditure and health care also relates to two central aspects of social living, in particular the role of participatory politics, and the need to examine economic arguments with open-minded scrutiny. If the allocation of resources is systematically biased in the direction of arms and armaments today, rather than in the direction of health and education, the remedy of that has to lie ultimately in informed public debate on these issues, and on the role of the public in seeking a better deal for the basic requirements of good living, rather than efficient killing. Nothing perhaps is as important for resource allocation in health care as the development of informed public discussion, and the availability of democratic means, for incorporating the lessons of a fuller understanding of the choices that people in every country face.

With regard to economic scrutiny, it is particularly important to see the false economics involved in an argument that is often presented against early concentration on health care. Lack of resources is frequently articulated as an argument for postponing socially important investments until a country is already richer. Where (as the famous rhetorical questions go) are the poor countries going to find the means for "supporting" these services? This is indeed a good question, but it also has a good answer, which lies very considerably in the economics of relative costs. The viability of this "support-led" process is dependent on the fact that the relevant social services (such as health care and basic education) are also very labour intensive, and thus are very inexpensive in poor - and low-wage - economies. A poor economy may have less money to spend on health care and education, but it also needs less money to spend to provide the same services, which would cost much more in the richer countries with higher-wage economies. Relative prices and costs are important parameters in determining what a country can afford - and we do need clear-headed economic analysis here. Given an appropriate social commitment, the need to take note of the variability of relative costs is particularly important for social services in health and education.

So what conclusions do we draw from these elementary analyses? How does health relate to development? The first point to note is that the enhancement of health is a constitutive part of development. Those who ask the question whether better health is a good instrument for development, seeing development as economic growth, may be overlooking the most basic diagnostic point that good health is an integral part of good development; the case for health care does not have to be established instrumentally by trying to show that good health may also help to contribute to the increase in economic growth, although it does do just that.

Second, given other things, good health and economic prosperity tend to support each other. Healthy people can more easily earn an income, and people with a higher income can more easily seek medical care, have better nutrition, and have the freedom to lead healthier lives.

Third, "other things" are not given, and the enhancement of good health can be helped by a variety of actions, including public policies (such as the provision of epidemiological services and medical care). While there seems to be a good general connection between economic progress and health achievement, the connection is weakened by several policy factors. Much depends on how the extra income generated by economic growth is used, in particular whether it is used to expand public services adequately, especially in health care, and to reduce the burden of poverty. Growth-mediated enhancement of health achievement goes well beyond mere expansion of the rate of economic growth.

Fourth, even when an economy is poor, major health improvements can be achieved through using the available resources in a socially productive way. It is extremely important, in this context, to pay

attention to the economic considerations involving the relative costs of medical treatment and the delivery of health care. Since health care is a very labour-intensive process, low-wage economies have a relative advantage in putting more - not less - focus on health care.

Finally, the issue of social allocation of economic resources cannot be separated from the role of participatory politics and the reach of informed public discussion. Financial conservatism should be the nightmare of the militarist, not of the doctor, or the schoolteacher, or the hospital nurse. If it is the doctor or the schoolteacher or the nurse who feels more threatened by resource considerations than the military leaders and advocates of military expenditure, then the blame must at least partly lie on us, the public, for letting the militarist get away with these odd priorities.

Ultimately, there is nothing as important as informed public discussion and the participation of the people in pressing for changes that can protect our lives and liberties. The public has to see itself not merely as a patient, but also as an agent of change. The penalty of inaction and apathy can be illness and death.

The PRESIDENT:

Thank you Professor Sen for a very stimulating and inspiring presentation. On behalf of the Assembly, I wish to thank you warmly for having honoured us with your presence.

(Applause/Applaudissements)

We shall have a short pause to allow our distinguished guest to leave the Hall. I would ask all delegates to remain seated.

4. LOOKING AHEAD FOR WHO AFTER A YEAR OF CHANGE: REPORT OF THE DIRECTOR-GENERAL (INCLUDING *THE WORLD HEALTH REPORT 1999*) (resumed) L'AVENIR DE L'OMS APRES UNE ANNEE DE CHANGEMENT: RAPPORT DU DIRECTEUR GENERAL (Y COMPRIS LE *RAPPORT SUR LA SANTE DANS LE MONDE, 1999*) (reprise)

The PRESIDENT:

Before we start the review of item 3, I would call the delegates' attention to resolution WHA50.18, recommending that delegates should limit their statements to five minutes and that statements should give special attention to the theme of *The world health report 1999*, namely "Making a difference". Delegates wishing to report on salient aspects of their health activities could make such reports in writing for inclusion in the record, as provided for in resolution WHA20.2.

Delegations wishing to participate in the debate are requested, if they have not done so already, to announce their intention to do so, together with the name of the speaker and the language in which the speech is to be delivered, to the officer responsible for the list of speakers. Before we proceed, I wish to inform you that the speakers list will be closed today at 12:00. Should a delegate wish to submit - in order to save time - a prepared statement for inclusion *in extenso* in the verbatim records, or whenever a written text exists of a speech which a delegate intends to deliver, copies should also be handed to the officer responsible for the list of speakers in order to facilitate the interpretation and transcription of the proceedings.

Delegates will speak from the rostrum. In order to save time, whenever one delegate is invited to come to the rostrum to make a statement the next delegate on the list of speakers will also be called to the rostrum, where he or she will sit until his or her time to speak has come.

In order to remind speakers of the desirability of keeping their address to not more than five minutes, a system of lighting has been installed; the green light will change to amber on the fourth minute and finally to red on the fifth minute.

Before giving the floor to the first speaker on my list, I wish to inform the Assembly that the General Committee has confirmed that the list of speakers should be strictly adhered to, and that inscriptions should be handed to the Office of the Assistant to the Secretary of the Assembly, or during Plenary to the officer responsible for the list of speakers. The list of speakers will be published in the Journal. I would like to remind those delegates who have to leave Geneva and are not able to deliver their speech before they leave that they can ask for their text to be published in the records of the Assembly. The debate on item 3 is now open.

The first two speakers on the list are Bangladesh and the United Republic of Tanzania, who will speak on behalf of the Southern African Development Community: Angola, Botswana, Democratic Republic of the Congo, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Zambia and Zimbabwe, and on behalf of his own country. The delegates of these Member States will be seated on the rostrum. May I invite them to come to the rostrum. I give the floor to the delegate of Bangladesh.

Dr YUSUF (Bangladesh):

Mr President, excellencies, distinguished delegates, ladies and gentlemen, it is a great pleasure for me to share ideas with you on *The world health report 1999*. The report, entitled "Making a difference", recognizes the need for changes in the health sector in the context of prevailing health situations. At the outset I wish to congratulate the Director-General on taking this pragmatic step to sensitize the health planners on this issue. It is undoubtedly an attempt to bring lasting changes in the health sector. Supported by strong political commitments, dynamic leadership and vision this can ensure considerable gains in social and economic fields, along with improvement in status of health of the people.

The developing countries have identical goals, like reduction of poverty, improvement of living standards and investment for human resource development. Most of the countries do not have adequate resources and technical capabilities to achieve them and need support from the development partners. In a situation of scarce resources, more emphasis is now given to the balance between public and private sector financing. Direct government intervention is needed in the developing countries to finance public health activities and essential health care services, nutrition, and reproductive health services and protecting people from catastrophic diseases.

All these need reform in the health sector. Bangladesh has already initiated widespread reform. A sector-wide management approach has been adopted for the delivery of an essential service package, with priority for women, children and the poor. Within this framework we envisage developing cost-effective methods and innovative partnerships with nongovernmental organizations and the private sector.

One of the main messages that *The world health report* emphasizes is our future commitment to deployment of resources in a more rational way to fulfil pressing needs. WHO has over 50 years' experience of working for mankind. I strongly believe that countries would greatly benefit from the guidelines provided in this report. While, globally, health status has improved over the last few decades, still we have many more challenges to face. We do hope to overcome these obstacles and bring substantial changes in the health sector of our nations in the near future.

Finally, I offer my heartiest thanks and gratitude to WHO for bringing out this report and also thank the Director-General, Dr Gro Harlem Brundtland, in particular, for taking this pragmatic step in setting reforms. What we need to do now is to make efforts for successful implementation of the recommendations of the report.

Mr CHIDUO (United Republic of Tanzania):

Madam President, Madam Director-General, honourable delegates, ladies and gentlemen, I feel very privileged to represent the Southern African Development Community (SADC) in addressing the Health Assembly. All in all we are 14 Member States, as announced by the President. On behalf of the SADC Member States and on my own behalf, I would like to congratulate the Director-General on her report and express our support.

With regard to health status, the SADC Member States share common features of high mortality rates, an increased burden of infectious diseases, low nutritional status and all other health indicators signifying a poor level of development. There are differences among countries or communities within the Member States, but the general picture is that of poor health status. With respect to the increased inequity in access to drugs and modern biotechnology between developed and developing countries, it is likely that such issues will continue to feature on the international health policy agenda for the foreseeable future in SADC.

Of late, health problems in the region have been aggravated by ongoing civil strife within some Member States. These wars - in Angola, the Democratic Republic of the Congo, Burundi and Rwanda - have had devastating effects on the supply of food and on the spread of disease and violence among refugees and the populations of recipient countries. All of these sufferings contribute to deteriorating health conditions among the populations of the affected Member States.

Changing climatic conditions that began in 1998-1999 with the El Niño rains and La Niña have resulted in a fall in food production, leading to famine and an increase in water-borne diseases in the region.

Diseases which were considered epidemics in the 1970s are now becoming endemic, e.g. cholera and meningitis.

Moreover, these countries are facing a wind of change in the organization and management of health services based on health-sector reform strategies. The reforms as we understand them do not comprise global formulae, and there is no predetermined, tested way of implementing them. As a result, countries of sub-Saharan Africa, including SADC countries, which have scarcely the resources to provide routine basic minimum health services, have sometimes to invest in health reforms whose outputs and outcomes are not certain. Furthermore, most of the suggestions for reforms are geared more towards implementing and improving clinical services than towards preventive services.

A balance of these two equally important services in the jigsaw is even more difficult in these countries because of their dependence on external resources. Investors in health development in these countries prefer to carry out a number of pilot and research projects before providing support for the alleviation of ill-health in communities. The pilot and research projects may consume both material resources and time at the expense of a general improvement in health service delivery.

Against the background of all these problems relating to health systems and diseases, the technical issues that were addressed by the WHO Executive Board at its 103rd session are of equal importance to the SADC region. I would therefore like to take a few minutes to apprise you of the position in the region regarding those issues.

On the Tobacco Free Initiative, the danger of tobacco smoking to the health of smokers and passive smokers need not be emphasized. All technical reports that are available point towards the existence of an association between tobacco smoking and diseases related to tobacco. Tobacco control activities in the SADC region are made more difficult by the fact that tobacco is grown, processed and consumed in the region. Its production in most of the Member States is indirectly supported by the governments, which benefit from the revenue it generates through taxation.

Nevertheless, some steps have been taken in the region to control the consumption of tobacco, including the use of fiscal policies, government guidelines stipulating that all tobacco advertising should be accompanied by a warning, and the development of legislation. The region has yet to challenge the power of the multinationals in these endeavours.

Two devastating epidemics threaten the lives of tens of millions of people worldwide. The first of these epidemics is caused by HIV, which leads to AIDS. The impact of AIDS is greatest in sub-Saharan Africa, where 83% of AIDS deaths worldwide have occurred and nearly 21 million people are currently living with HIV. In most SADC Member States, the data show that 40% to 50% of hospital beds are occupied by HIV/AIDS patients. To us, this is more than an urgent public health issue; it is an emergency. The second epidemic is caused by tuberculosis, which already kills three million people worldwide, annually. HIV/AIDS and tuberculosis are closely associated. Like most of the countries of sub-Saharan Africa, SADC Member States face the problem of how to provide, with severely limited economic resources, the best level of care and support for all those affected by HIV/AIDS and tuberculosis. This is one of the most daunting challenges facing governments throughout sub-Saharan Africa, and SADC in particular.

Malaria remains the major health problem in the world, exposing about 40% of the whole world population to risk. It is estimated that 100 million people suffer annually from malaria in Africa south of the Sahara. In Tanzania, malaria is the leading cause of morbidity and mortality and accounts for about 31% of all outpatient attendance. The situation is not different in other SADC Member States. The global political commitment to malaria control, which was lost after the 1969 official declaration ending the campaign for malaria control and eradication, has been revived. In June 1997 the Assembly of Heads of State and Government of the Organization of African Unity issued the Harare Declaration on malaria prevention and control in the context of African economic recovery and development. The Assembly pledged to support the implementation of the global and regional strategies recommended by WHO. In 1998, our heads of State and government committed themselves to Roll Back Malaria, a new and expanded initiative by WHO aimed at reducing malaria mortality by 50% by 2025.

The SADC countries have made considerable progress in the achievement of poliomyelitis eradication. They adopted the global goal of poliomyelitis eradication following the 1996 Yaoundé Summit, at which African heads of State and government declared their support for the poliomyelitis eradication initiative. The initiative is reducing the incidence of poliomyelitis in SADC Member States.

SADC countries were among the 36 countries which implemented national immunization days in 1997. President Nelson Mandela of South Africa was at the forefront of the "Kick polio out of Africa" campaign, which emphasized social mobilization for the success of the immunization days. Some SADC countries are now part of the poliomyelitis-free zone being formed in South Africa. No wild poliovirus is being reported from Botswana, Malawi, Namibia, South Africa, Swaziland, Zimbabwe, or, most recently, from Tanzania. SADC Member States would like to acknowledge the efforts made by WHO, UNICEF,

Rotary International, USAID and other international organizations to provide support, both technical and financial, for our endeavours to eradicate poliomyelitis.

Finally, the serious impact of iodine deficiency upon the health and development of individuals and societies in our region makes the control of iodine deficiency disorders one of the key health priorities. Most countries in the SADC region have made steady progress during the decade towards universal salt iodization. We are committed to eliminating iodine deficiency. Implementation of this policy has required advocacy and communication, in order to persuade key opinion-formers to act. These have included politicians, civil servants, salt producers and traders, and the public. The supply of iodized salt in Africa has increased from less than 5% in most markets in 1990 to more than 60% in most countries. Despite this remarkable achievement, many countries still face a set of barriers that threaten to delay the effectiveness of their programmes and limit the chance of long-term elimination of iodine deficiency.

Madam President, honourable delegates, what I have presented to you is just a sketch of our health activities within SADC countries.

Dr SHALALA (United States of America):

Madam President, Madam Director-General, distinguished delegates, it is an honour once again to address the Health Assembly. Let me first congratulate our President and the Director-General for their outstanding and thoughtful presentations. Not long after the First World Health Assembly, an American historian wrote that leadership is the ability to give direction. If that is true, then we have certainly witnessed strong leadership in the initial work of our new Director-General. Over the past year, she has set a new direction for WHO that has the potential to make this Organization the pre-eminent global force for health in the twenty-first century. Her administration has initiated structural changes that have made WHO more responsive and more focused. It has forged new international partnerships to fight international threats like malaria and tobacco, and it has put health firmly on the global agenda. Dr Brundtland's initial work proves that we have a new Director-General who is seizing the opportunity to change things for the better.

But we gather here not just to celebrate new leadership or past accomplishments, but to chart a course for the future. We are the first leaders of the new millennium. We, the leaders of WHO, must ask ourselves what will be our agenda for public health? In what direction will we go? I believe the answer is threefold: we must continue the fight against infectious disease; we must find new ways to battle noncommunicable disease; and we must be ready to respond to emerging public health challenges.

When it comes to battling infectious disease, we know what we must do. We must recognize that diseases respect no border or boundary. We must form global partnerships and strengthen global systems. We must link up our national and regional surveillance systems. We must strengthen public health infrastructures. We must harness health experts from every organization and nation into effective teams led by WHO; and we must hasten the exit of killers like malaria, tuberculosis, AIDS and poliomyelitis from the world stage. The United States is firmly committed to working in partnership with WHO to achieve our goal of poliomyelitis eradication by the end of 2000 and to ensure the success of the new Roll Back Malaria campaign and the Stop Tuberculosis project. We are also firmly committed to the leadership of UNAIDS.

But it is not just infectious diseases that pose significant public health challenges; noncommunicable diseases continue to be the leading cause of death and disability. We must find new ways of educating our citizens to prevent them. We must find ways to ensure that women have full access to health services across the entire arc of life - while not neglecting the important issues of maternal mortality, of female genital mutilation and of violence against women.

And we must also find ways to protect our children from the dangers of the new epidemic - tobacco. By the middle of the next century, tobacco is predicted to be the leading cause of disease burden in the world - causing about one in eight deaths. In the United States, we are redoubling our efforts to curb childhood tobacco use. And we are pledged to working with WHO to achieve the goals of its recently inaugurated Tobacco Free Initiative - and to participating in the negotiations for the framework convention. In addition, we are prepared to share with the world our data base on the health effects of tobacco - and this will eventually include tobacco industry documents.

But as we tackle the public health challenges of today - like tobacco - we must also be ready to address those that may emerge - challenges like bioterrorism. An obscure threat just a few years ago, bioterrorism has only recently emerged as one of the thorniest problems of the post-Cold War era. The threat has undeniably changed and evolved - so we must be ready to change and adapt our response. And since microbes spread across boundaries of culture, language and territory, we must work together to prepare for an incident that - we hope - will never happen.

Bioterrorism is just one more world health problem that requires a world health solution. Because we all share a common future - we must all stand on common ground. So the challenge of leading WHO into the millennium - of leading it in the right direction - does not only belong to the Director-General, or to the able staff of WHO. It belongs to all of us - to every nation - to every organization - to every individual. Rich or poor, North or South. Together, let us pit our wits and our wills and our resources to the task at hand to make a difference and to ensure that the new century will be a time of health and hope for every woman, man and child in our global family.

Professor SALLAM (Egypt): الأستاذ الدكتور اسماعيل سلام (مصر):

السيدة الرئيسة، معالي الرؤساء وأعضاء الوفود، السيدات والسادة،

نتابع باهتمام الجهود العالمية من أجل رعاية صحة الانسان في كل مكان.وانني أتوجه بالشكر للمدير العام الدكتورة بروتلاند على تقريرها القيم الخاص بالصحة لعام ١٩٩٩، والذي يستعرض التقدم الذي أحرزته والتحديات المطروحة عشية القرن الواحد والعشرين. ونحن اذ نهنئها على ذلك، فاننا على ثقة أن منظمة الصحة العالمية قادرة على احداث التغيير المطلوب لمواكبة تطور العصر. مما لا شك فيه أن هناك جهدا كبيرا مبذولا من منظمة الصحة العالمية، ونحن كحكومات نبذل أيضا جهدا واسعا. وفي مصر خلال السنوات الأربع الماضية أعطينا أولوية للصحة وتم في هذه الأولوية وضع استراتيجية جديدة ووضعنا التنمية البشرية في مقدمة الأولويات، ولكن في الأولويات وضعنا أيضا الرعاية الأساسية، ولكن في منهج طبيب الأسرة وصحة المرأة بمفهوم شامل ثقافيا واجتماعيا وسياسيا. وأيضا وضعنا الفئات المحرومة في المقام الأول.

السيدة الرئيسة، على الرغم من أننا نتكلم دائما عن مفهوم الصحة للجميع، وانها لحق أساسي من حقوق الانسان، الا أن هناك مشاكل ملحة يجب أن تقوم المنظمة بوقفة قبلها: أولها معاناة الانسان نتيجة الحروب والخلافات والكوارث الطبيعية. وان ما نشاهده اليوم في مواقع كثيرة من العالم يدعونا أن نؤكد أن دور المنظمة أساسي في حماية هؤلاء وأن نتكاتف جميعا في سبيل ذلك، وان ما نراه اليوم يجب أن يكون درسا لما يجب أن تكون عليه سلوك المساعدات لمثل هذه المناطق.

السيدة الرئيسة، ان ما نراه اليوم من ازدياد للفقر في أماكن متعددة من العالم وارتفاع تكلفة الخدمة الصحية يجعلنا نتساءل هل حقيقة سيأتي يوم لنجد الصحة للجميع واقعا لهؤلاء الفقراء؟ هل حقيقة ستمتد حقوق الانسان الى حقه في الصحة والعلاج والحصول على الدواء، وما أحوجنا في داخل هذه المنظمة العريقة أن تكون هناك مظلة واقية لاحتضان هؤلاء لأننا جميعا، كما أسمع، نؤمن بأن التنمية الصحية هي جزء أساسي، وجزء أساسي أيضا من مقاومة الفقر وأن التنمية الصحية هي أعظم استثمار للانسان. اننا، ياسيادة الرئيسة، نرفض الانعكاسات السلبية على الصحة نتيجة الحروب أو الخلافات العرقية أو الدينية أو العقوبات المفروضة من مجلس الأمن. الانسان هو الانسان، والطفل في أي مكان هوجزء من أطفالنا في العالم لهم نفس الحقوق وعلينا نفس الواجبات قبلهم. لا يمكن أن تكون النظرة قاصرة على النزاع. ان أملي كبير في أن تتخذ المنظمة مبدأ واستراتيجية ثابتة في هذا التوجه وأن نقف جميعا مع هذه الاستراتيجية ضد هذه الانعكاسات الخطيرة. يجب أن تسمو الانسانية على كل هدف آخر، ويجب أن تسود لصالح البشر الذين لم يرتكبوا اثما ولا وزرا ليجدوا أنفسهم معاقبين باعتلال صحتهم والاضرار بها. يجب أن نؤكد أن البعد الانساني هو أقوى من البعد السياسي الذي في كثير من الأحوال يكون قاصرا عن الموضوعية. اننا نحذر كما أكدت التجارب السابقة، من أن خفض الاعتمادات لمكافحة الأمراض المعدية يمكن أن يؤدي الى عودتها مرة أخرى. ان التقرير الخاص بالصحة في العالم لعام ١٩٩٩ يؤكد من جديد على أن العقود القليلة الماضية شهدت تزايد أثر الفقر وسوء التغذية في الصحة واتساع الهوة بين الفقراء والأغنياء. ويجب أيضا أن أنبه ياسيادة الرئيسة الى أن التقرير يحوي بعض الأرقام التي أخذت من مصادر قديمة، وأطلب تحديثها، وأن تكون المكاتب الاقليمية هي المرصد الرئيسي للأرقام.

في النهاية لا يسعني ياسيادة الرئيسة الا أن أؤكد على التزامنا بهدف تحقيق الصحة للجميع. واننا، كما هو واقع الآن، نتضامن ونتعاون مع المجتمع الدولي من أجل تحقيق هذا الهدف مع تمنياتي لكم بالتوفيق وشكرا.

Dr NEMOTO (Japan):

Madam President, Madam Director-General, distinguished delegates, ladies and gentlemen, on behalf of the Government of Japan, it is my pleasure to present its position concerning promotion of world health.

As *The world health report 1999* indicates, limited resources must be utilized more efficiently to address the increasingly diverse health issues of today. From this point of view, we fully support the position of the Director-General, Dr Gro Harlem Brundtland, who has been actively directly the reform of WHO. The reform process which Dr Brundtland has been leading since taking office last July has been truly remarkable and deserves high praise.

Under the current unstable global economic situation, United Nations organizations such as ILO have wisely and responsibly committed themselves to a policy of zero nominal growth. In order to increase programme budgets for countries in greatest need, administrative costs must be rationalized and brought under control We greatly appreciate the fact that Dr Brundtland's reform process is headed in this direction, particularly because it is apparent that a zero real growth budget is not realistic under the prevailing global economic situation. We can all see that a zero real growth budget would require Member States to increase their assessed contribution, leading to hardship due to further suppression of already stringent national budgets. We strongly hope that Member States recognize these critical points and form a consensus to adopt a zero-nominal growth policy for the 2000-2001 budget.

The importance of priority setting of projects cannot be overemphasized, given our limited resources. The suffering caused by malaria, addressed by Dr Brundtland as one of WHO's top priorities, can be seen in 300 to 500 million clinical cases and one million deaths each year. We agree that fighting this disease is one of the most important global public health issues.

At last year's Birmingham summit meeting, Mr Hashimoto, who was our Prime Minister at that time, presented a report on global parasite control, entitled "The global parasite control for the 21st century", to contribute to the global fight against parasitic diseases including malaria, by proposing control strategies, based on our past experiences in conquering them. We are fully promoting this Hashimoto Initiative and will also actively support WHO's priority project "Roll Back Malaria" in line with our Hashimoto Initiative.

The Tobacco Free Initiative is another high priority WHO initiative. Tobacco is a very important cause of many kinds of noncommunicable diseases, and it is said that four million people die of diseases related to tobacco each year. In line with the Tobacco Free Initiative, WHO will hold the International Conference on Tobacco and Health in Kobe, Japan, this November, utilizing the resources of the Kobe WHO Centre for Health Development. We are pleased to note that with the attendance of Dr Brundtland, the Government of Japan has high expectations for this important event and will actively support the organization of the conference to ensure its success.

We are also pleased to note that, owing to the strong support of Member States, Dr Omi was inaugurated as the Regional Director for the Western Pacific last February. Thanks to the invaluable support given to him by Member States, Dr Omi was able to promote reform at the regional level as soon as he assumed office. We trust that through the reform process at headquarters and in the regions, WHO will become a stronger organization that is even more active and effective in the promotion of public health across the globe. We pledge that the Government of Japan will continue to work closely with WHO to "Make a difference".

Professor STARODUBOV (Russian Federation):

Профессор СТАРОДУБОВ (Российская Федерация):

Уважаемая г-жа Председатель, уважаемая г-жа Генеральный директор, уважаемые коллеги,

Мы положительно оцениваем деятельность Генерального директора и ее сотрудников, которые в течение короткого времени сумели достаточно четко обрисовать контуры обновленной Организации. В представленном докладе даны подробная оценка современного состояния здравоохранения в мире и прогноз развития ситуации в начале двадцать первого века. Мы не столь оптимистичны в оценке реальной ситуации в мире, как на данном этапе, так и на ближайшее будущее. Хотелось бы остановиться на ряде аспектов, прозвучавших в выступлении г-жи Брутланд.

Значительные успехи в области здравоохранения, медицинской науки и технологий на протяжении двадцатого века создали условия для дальнейшего улучшения здоровья граждан во всех странах. К сожалению, существует много факторов, которые мешают этому. Среди них политическая неустойчивость и региональные конфликты; разница в экономическом потенциале стран; увеличивающийся разрыв между индустриально развитыми и развивающимися

странами и отдельными регионами даже внутри стран; между богатыми и бедными гражданами в странах и отсутствии обеспечения реального права граждан в ряде регионов мирового сообщества. Все это вызывает неудовлетворенность развитием здравоохранения в этих странах. Бедность - одна из нерешенных проблем, и она ограничивает доступность для этих слоев населения к медицинской помощи. Все это требует дифференцированного подхода к основным проблемам деятельности ВОЗ в странах и совместно с ними для решения конкретных проблем. Безусловно, особый подход в этом должен быть и в отношении стран с переходной экономикой. Конечно, деятельность ВОЗ должна отражать интересы всего мирового сообщества.

В качестве мирового лидера ВОЗ взяла на себя и осуществляет серьезные обязательства в области здоровья. Дальнейшие успехи Организации зависят от конкретных результатов намечаемых проектов и программ, от того, насколько эффективно будут использованы современные знания и технологии. Средства Организации должны направляться, в первую очередь, в те секторы, которые могут дать значительные результаты в короткие сроки и с наименьшими затратами. Важнейшее значение приобретает проблема определения приоритетов в здравоохранении как на уровне стран и регионов, так и на глобальном уровне. По-видимому, приоритеты в здравоохранении страны должны определять сами; на уровне регионов ВОЗ их число должно быть сужено; а на уровне штаб-квартиры могут стоять глобальные задачи, решение которых может быть полезным для большинства стран. Научно-методическая помощь Организации в этом направлении была бы неоценимой.

Одним из ключевых вопросов является обеспечение ресурсами, прежде всего финансовыми. Финансирование служб здравоохранения в странах-членах зависит от политических решений и экономических возможностей в каждой стране. Мы солидарны с точкой зрения, высказанной Генеральным директором, о том, что чисто рыночные отношения в здравоохранении не всегда эффективны и что государство должно нести определенные обязанности и расходы, а также контролировать частный сектор.

Ресурсы, выделяемые в различных странах как доля валового внутреннего продукта или процент бюджетных затрат, значительно колеблются. Тем не менее, еще ни одна страна мира не может сказать, что она успешно решила все проблемы в области охраны здоровья. Не всегда затрачиваемые ресурсы обеспечивают наиболее высокий уровень состояния здоровья. Нам кажется, что обеспечение наилучшего здоровья при наименьших затратах должно быть одним из критериев эффективности деятельности нашей Организации.

Очевидно, что по многим причинам приходится сдерживать расходы ВОЗ, и кажется вероятным, что взносы в регулярный бюджет не будут увеличиваться, и задачи для решения ограниченных приоритетных направлений, прежде всего профилактические мероприятия, должны быть резко обозначены или определены. Следует расширять связи с промышленным сектором, работающим на охрану здоровья. Понимая важность и неотложность программ обращения вспять распространения малярии и Инициативу по освобождению от табачной зависимости, мы считаем, что необходимо поддержать деятельность ВОЗ в этом направлении, и незамедлительно.

Важнейшим направлением политики ВОЗ по поддержке политики национальных систем здравоохранения, формирования политики в области здравоохранения и законодательной поддержки, поощрению координации научных исследований в области управления экономикой здравоохранения, развития информационных технологий должны оставаться приоритетными для нашей Организации, и они заслуживают всяческой поддержки.

Мы приветствуем усилия Генерального директора снизить административные расходы, повысить контроль за реализацией отдельных направлений работы и программ. Вместе с тем, мы далеки от того, чтобы сказать, что административная

реорганизация, проводимая ВОЗ, даст незамедлительные и только позитивные результаты.

В заключение я хотел бы поблагодарить Генерального директора за прекрасный доклад, пожелать ей успехов в претворении ее идей, направленных на поднятие ВОЗ на новый более высокий уровень деятельности.

Благодарю за внимание.

Dr AL-MADFA (United Arab Emirates): الدكتور حمد عبد الرحمن المدفع (الامارات العربية المتحدة):

بسم الله الرحمن الرحيم، السيدة الرئيسة، السيدة الدكتورة المديرة العامة للمنظمة، السادة المندوبين، سيداتي سادتي، السلام عليكم ورحمة الله وبركاته، انه ليسعدني ويشرفني سيدتي الرئيسة، باسم دول مجلس التعاون لدول الخليج العربية: الامارات العربية المتحدة ودولة البحرين والمملكة العربية السعودية وسلطنة عمان ودولة قطر ودولة الكويت التي توحدت كلمتها أمام جمعية الصحة للعام الثالث على التوالي أن أتقدم بأطيب التهاني لكم السيدة الرئيسة لانتخابكم لرئاسة الجمعية العامة وللسادة نواب الرئيس ورؤساء اللجان وأعضاء المكتب على الثقة الغالية التي أسندت اليكم داعيا الله لكم بالتوفيق وأن تكلل أعمال هذه الدورة ومداولاتها بالنجاح.

ويطيب لي، في هذا المقام، أن أشيد بتقرير الدكتورة برونتلاند المديرة العامة للمنظمة أمام المجلس التنفيذي في دورته الثالثة بعد المائة التي دعت فيها هيئة المجلس الى التطلع الى مستقبل مشرق وآفاق أرحب كما أنوه بما تضمنه التقرير من محاولات جادة لاعادة هيكلة المنظمة وأبارك مبادرتها لمكافحة الملاريا والتصدي لوباء التدخين والمبادئ الاستراتيجية الأربعة التي حددتها في كلمتها أمام المجلس التنفيذي وأعني بها زيادة فعالية العمل مع البلدان، وتركيز أنشطة المنظمة على مساعدة الشعوب لتحقيق نتائج صحية أفضل، ودعم قطاعات صحية حكومية وأهلية لتحقيق الـ ة من أجل تنمية قطاع الصحة، وصياغة تحالفات أكثر أثرا وفاعلية.

السيدة الرئيسة، السادة المندوبين، لقد حقق مجلس وزراء الصحة لدول مجلس التعاون الخليجي العديد من الانجازات منذ انشائه في عام ١٩٧٦ شملت البرامج العلاجية والوقائية والتأهيلية كما تناول المجلس أمورا تتعلق بتخطيط الخدمات الصحية وتطوير وتنمية الكوادر البشرية والنظم الصحية ومعايير ضمان الجودة ومراقبة الأداء في المرافق الصحية واقتصاديات العلاج وبدائل تمويل الخدمات الصحية. وقد انعكست جهود مجلس التعاون الخليجي ايجابيا على المؤشرات الصحية للدول الأعضاء وعلى المستوى الذي بلغته مرافقها الصحية. وما كان كل ذلك ليتحقق لولا تكامل الخدمات الصحية مع خدمات التنمية الشاملة التي عمت دول المنطقة في قطاعات أخرى كالاصلاح البيئي والتعليم والاسكان وتحسن الأحوال المعيشية للأسرة وارتفاع حصة الفرد من الناتج القومي حيث ساهمت مع الخدمات الصحية في تحقيق تلك الانجازات والتي أثنت عليها المديرة العامة لمنظمة الصحة العالمية في مقابلة صحفية معها حيث أكدت على تمتع دول مجلس التعاون الخليجي كافة بمؤشرات صحية تقارب تلك الموجودة في الدول الصناعية، حيث صنفت بعض دول الخليج بين أول عشر دول على مستوى العالم فيما يتعلق بالزيادة التي تحققت في متوسط العمر المأمول عند الميلاد.

السيدة الرئيسة ، السادة المندوبين، اننا ونحن نتطلع اليوم الى آفاق جديدة لنستقبل بها القرن الحادي والعشرين، يجدر بنا أن نتوقف قليلا كي نشهد الانجازات التقنية الهائلة التي حققتها منظمة الصحة العالمية على مدى نصف قرن من الزمان من أجل اسعاد الانسان ورفاهيته، وخلال هذه الفترة انخفض بشكل ملحوظ معدل وفيات الأطفال وزاد متوسط العمر المأمول عند الميلاد، وتم القضاء على الجدري والسيطرة على الكثير من الأمراض المعدية والأمراض الوبائية الأخرى. كما أقامت المنظمة خلال العقد الأخير تحالفات للتخلص من بعض أمراض المناطق المدارية واستحدثت برامج للتحكم بأمراض غير معدية يأتي في مقدمتها أمراض القلب والشرايين والداء السكري والأمراض الوراثية في سبيل الحفاظ على الصحة وتعزيزها وقطعت شوطا كبيرا في تطوير السياسات الصحية من خلال البرامج، وتنفيذ ذات الأولوية كالتغذية والسلامة الغذائية والاصحاح البيئي والتوعية الصحية، باتباع سلوكيات وممارسات صحية أفضل. واليوم ونحن على مشارف حقبة جديدة، علينا أن نستشرف المستقبل بتفاؤل، ونواصل دعم منظمة الصحة العالمية ومساندتها لتظل جهة فاعلة تحتل موقعا رياديا في المجال الصحي، حتى تؤدي دورها طبقا لمتطلبات العصر، واحتياجات دولها الأعضاء، وتتصدى لقضايا الساعة الملحة. ومن هذا المنطلق فاننا مدعوون جميعا للتصدي لمكافحة الأمراض المعدية الجديدة والأمراض التي عاودت انبعاثها. فمرض الملاريا الذي كان التخلص منه في مقدمة أولويات الأهداف التي أنشئت المنظمة من أجلها منذ أكثر من خمسين عاما عاود الظهور مرة أخرى نتيجة

لمقاومة الطفيل المسبب للمرض للعقاقير والتراخي في برامج المكافحة، فأصبح هذا المرض يصيب ما بين ثلاثمائة الى خمسمائة مليون نسمة، ويتسبب في وفاة مليون نسمة كل عام. أما الدرن الذي عاود الظهور وتضاعف خطره مؤخرا فمازال يتصدر قائمة الأمراض المعدية مسجلا نحو ثمانية ملايين اصابة جديدة وثلاثة ملايين وفاة كل سنة. ونحن مطالبون هنا بمضاعفة الجهد لمكافحة هذه الأمراض وغيرها من الأمراض المزمنة لوضع الاستراتيجيات المناسبة لمواجهتها والحد من انتشارها وتأمين دعامة أفضل للفئات الأكثر عرضة للاصابة بها وفي مقدمتها الأطفال والنساء والمسنون والمعاقون. كما أننا مطالبون أيضا بوضع المعايير اللازمة لضمان العقاقير الأساسية والمستحضرات البيولوجية وتوجيه المزيد من الاهتمام للصحة النفسية والعقلية وصحة البيئة التي يتفاقم خطرها ويزداد كل يوم، والاستفادة من تقنية الاتصالات في التطبيب عن بعد وتطوير الهندسة الوراثية للوقاية من الأمراض والالتزام بميثاق أخلاقي في هذا السياق يكفل الحفاظ على المعايير الأخلاقية للتجارب التي تجرى على الانسان. ومع هذا الطوفان المتعاظم للصراعات العرقية وما سيتبعها من زيادة كبيرة في أعداد اللاجئين فان من واجبنا أمام المجتمع الدولي مساعدتهم على مواجهة خطر تفشي الأمراض المعدية وأمراض سوء التغذية التي تنعكس آثارها السلبية خاصة على الأطفال والأمهات وكبار السن.

السيدة الرئيسة، السادة المندوبين، ان الاعلان العالمي بشأن الصحة الذي قدم اليكم لاعتماده في الجمعية العامة الماضية يعيد التأكيد على وضع كرامة الانسان في الاعتبار الأول والقيم التي جسدها دستور المنظمة في ٧ نيسان/ أبريل ١٩٤٨ وما السياسة الجديدة لتوفير الصحة للجميع التي ناقشناها في لقائنا العام الماضي الا ترجمة للاتجاهات الرئيسية لعملنا في القرن الحادي والعشرين وهي تجدد التزامنا بالتعاون الدولي في مجال التنمية الصحية استنادا الى معايير المساواة والتضامن والتكافل والاحترام التي نص عليها دستور المنظمة وهي نفس المعايير التي نسترشد بها ونحن ماضون في مسيرتنا على نفس الطريق نحو الهدف المنشود، هدف تحقيق الصحة للجميع بمشاركة الجميع. والله نسأل أن يبارك كل الجهود المخلصة ويسدد على طريق الخير والتوفيق خطاكم. والسلام عليكم ورحمة الله وبركاته.

Mrs CAPLAN (Canada):

Mr President, Dr Brundtland, ministers, excellencies, ladies and gentlemen, it is a real honour for me to share with you the thoughts of the Canadian delegation as we begin the last Health Assembly of the century.

Last year, we applauded Dr Brundtland's election as the fifth Director-General of WHO, and we heard with satisfaction the high priority she intended to give to the battle against two of the worst global public health scourges, namely tobacco and malaria. Canada welcomed the Director-General's commitment to making a difference, by focusing on priorities with new approaches, new partnerships and new energies. We also welcomed her commitment to transparent, effective and accountable administration.

One year later, we are pleased to note that many of the reforms we have been calling for are being implemented in Geneva and throughout WHO. But as we all know, changing a large organization is never easy, especially within the United Nations system. Our experience with change in Canada has shown us that the keys to success lie in good information, in developing appropriate levels of accountability, and doing this with transparency at every stage.

We also know that the level of change and growth which the Director-General's programme calls for requires resources. We believe that these revenues can be found. Member States must continue to do their part. We also believe that there is room for the absorption of cost increases through efficiency savings by the Organization itself.

But it is not enough to rely on changes in the WHO Secretariat to improve the effectiveness of our Organization and prepare it to respond to the challenges of the twenty-first century. WHO cannot do everything. What it can and should do, it often cannot do alone. We support Dr Brundtland's call for partnership and collaboration with other organizations, both public and private sector. We encourage WHO to create better linkages and focused dialogue with members of the United Nations family such as UNDP and the Bretton Woods Institutions. These will help deliver a more targeted health programme which better reflects regional and country-specific needs. We also encourage Dr Brundtland to look at how WHO might tap into the knowledge and expertise that affinity groups such as the Commonwealth and La Francophonie might be able to offer WHO in its quest to improve global health for all.

For Canada, the fundamental and unique role of WHO is to mobilize the energies of Member States to respond to global health threats. For us, the basic function of our Organization is to develop and promote international health norms and standards which allow effective international health actions. We strongly support the implementation of national programmes based on quality and equity of access. It is for that reason that Canada appreciates the high importance given by the Director-General to the normative work

of WHO in setting global standards in all relevant areas of health. We are particularly conscious of the work of WHO in improving the programmes on pharmaceuticals, including strengthening its relations with the World Trade Organization in this and other areas.

Canada has established clear priorities for our work with WHO. We believe that the expansion of publicly funded and publicly administered health systems is essential for WHO if the tests of equity and sustainability are to be met. Health is not a commodity; it is a right. We must work to ensure that the children of the world grow up with access to health and quality health services which are measured by their needs, not by their wealth, or lack of it. The Director-General has noted that poverty is our greatest challenge. We believe that public health systems can play an important role in mitigating the damaging effects of poverty. We call this distributive justice, and as Professor Sen has noted distributive justice is an important determinant of health.

Canada, and this Assembly, are also called upon to respond to the invitation of the Director-General to tackle one of the worst global health catastrophes - the tobacco epidemic - through WHO's Tobacco Free Initiative. We view this as an opportunity for WHO and its Member States to invest in global health. We support the Director-General and echo her call at this meeting and at the Ninth International Conference of Drug Regulatory Authorities for content and design controls over tobacco products. It is in this spirit that Canada has made voluntary contributions to WHO to help strengthen national anti-tobacco strategies and to develop the framework convention for tobacco control.

We also share the Director-General's priorities with regard to poliomyelitis and malaria. The poliomyelitis campaign offers us a unique opportunity to rid the world of a disease which has caused suffering in both developed and developing countries. The Roll Back Malaria project must succeed if WHO is to be seen as a leader in health. I would note that these diseases have a disproportionate effect on the world's children.

Finally, noncommunicable diseases can be viewed as the new frontier of health and development. One with which we are not yet equipped to deal. Canada believes that WHO has a unique role to play in meeting the challenges in this area in the new millennium.

Canada will continue to invest in WHO, as active participants in its deliberations, technical discussions and through voluntary contributions to those priority areas outlined above. Canada, with Member States and international partners, will support WHO to invest in priority interventions of critical global significance. As the Director-General has so often said, together, we can *make a difference.*

Professor WANG Longde (China):
王陇德博士（中国）

尊敬的主席女士，尊敬的布伦特兰博士，各位代表、女士们、先生们，首先中国政府代表团热烈祝贺 Roseira 女士当选本届大会主席，相信在您的领导下本届大会一定会圆满成功。

在新世纪之交，世界卫生组织各成员国代表再次相聚在美丽的日内瓦湖畔，隆重举行本世纪最后一次盛会—第 52 届世界卫生大会。这次盛会将对指导和推动未来全球卫生工作，迎接新世纪挑战，具有重要的现实意义和深远的历史意义。值此之际，我代表中国政府代表团对第 52 届世界卫生大会的召开表示热烈的祝贺。

过去一年中，在总干事布伦特兰博士的领导下，世界卫生组织进行了重大调整和改革，为应对未来更广泛的全球卫生事务和迎接 21 世纪面临的卫生挑战做了必要的准备。对此中国政府表示高度赞赏和支持，相信这些改革措施将对未来几年世界卫生组织的工作产生深远的影响。

我们注意到，总干事刚才作了一个十分精彩的报告。在报告中，总干事详细阐述了 20 世纪卫生状况的改善对促进人类和社会经济发展、减少贫困所发挥的历史作用，描述了新世纪世界卫生面临的各种问题。面对挑战，总干事在报告中十分明确地提出了指导整个卫生组织工作的四大战略主题，以及世界卫生组织在全球卫生发展中的地位，显示了世界卫生组织新一届领导机构既具有清晰的改革思路，同时又不乏得力的措施保证。总干事的报告对会员国的卫生发展有很好的指导意义，使我们对实现 21 世纪第一个十年全球卫生发展目标充满了信心。

目前，中国卫生系统正在进行广泛而深入的改革。例如，为了使群众能够得到经济、便捷的卫生保健服务，我们正在大力推广和普及社区卫生服务，这也是我国卫生服务体系改革的重要内容。同时，我们欣喜地注意到，世界卫生组织的改革思路与方针，和中国政府的卫生改革政策有诸多吻合之处，这更强化了我们实现中国卫生改革目标的决心。

中国政府十分珍视与世界卫生组织建立和发展起来的良好合作关系。我们将在做好本国卫生工作的同时，继续一如既往地支持世界卫生组织实现全球规划目标，为推动21世纪人类健康事业的发展做出我们的贡献。

谢谢。

Mrs FISCHER (Germany):

Madam President, Madam Director-General, ladies and gentlemen, I have the honour to take the floor on behalf of the European Union. The central and eastern European countries associated with the European Union, which are Bulgaria, the Czech Republic, Estonia, Hungary, Lithuania, Poland, Romania, Slovakia and Slovenia, and the associated country Cyprus, align themselves with this statement.

The first half of 1999 is Germany's turn to hold the Presidency of the European Union. This circumstance affords me the very special honour of speaking to this Assembly as the incumbent President of the European Union's Council of Health Ministers. It also gives me the opportunity to make a number of basic statements about the current state and future perspectives of European Union health policy and, in doing so, to address in particular the relationship between the European Union and WHO.

The Treaty of Amsterdam entered into force on 1 May this year. This was a decisive step towards further integration in the Union but, at the same time, better conditions were created for the strengthening of health policy and health matters within the European Union. The new Article 152 of the Treaty of Amsterdam gives a central place and primacy to the requirement of ensuring a high level of human health protection in the definition and implementation of all Community policies and activities. European health policy must, in addition, become more visible and comprehensive to the general public. It must be responsive to the citizens' needs and concerns.

The increasing interlinking of our economies, including globalization, the changes in the technological environment, especially in the area of information technology, the financial problems facing our health care systems as a result of demographic and labour market factors, the changing values in society, the growing mobility of our populations and, as a result, the emergence of health hazards, often on an international scale - these are all factors which pose comparable challenges to all our health systems. The conclusion is that the European Union and WHO can play a supportive role in the quest for solutions - the decisive prerequisite for any European public health policy.

A European public health policy will facilitate the early detection of problems and hazards and will be able to furnish a basis on which common future perspectives and options for action can be elaborated and developed. A public health policy at European level will also be able to create transparency and give orientation, not only to the 15 Member States, but also to the applicant countries. Such a policy must encompass all areas of activity which can have an influence on, and contribute to health. One key area is development; the European Union is, and will remain a major actor in development aid and humanitarian assistance throughout the world. Secondly, the European Union has continued its efforts to promote environmental health and is looking forward to making further progress in this field at the forthcoming London ministerial conference. Thirdly, the Community has adopted under the German Presidency its fifth Research and Technology Development Programme, which has increasing funding for health research. Research under this programme will have to better serve health policy needs, and it is open to the participation of a large number of third countries.

Given this perspective, there is a need for even closer collaboration between WHO and the European Union, above and beyond the cooperation which already exists on a number of individual programmes. The visit paid to the Commission by the Director-General, Dr Brundtland, on 6 and 7 January 1999, and the upgrading of the WHO Office in Brussels, have set the right course for improved cooperation. Correspondence of 1982, which hitherto constituted the basis for cooperation, will be revised and adapted to suit the changed circumstances. I am therefore optimistic that it will soon be possible to lay the foundations for more intensive collaboration between WHO and the European Union.

This does not mean, however, that agreement does not already exist on a number of important issues. One of the items on the agenda of this Health Assembly is, for example, combating tobacco abuse. The Member States of the European Union welcome the initiatives taken by WHO in this regard. They

welcome them not least because there is broad agreement about what needs to be done to turn the tide on smoking, considered to be the biggest self-imposed burden on health. The European Union has taken a number of legislative measures in this area, which is open for closer cooperation in the future.

Another example, which is also to be discussed here in the coming days, is WHO's revised drug strategy. The Member States of the European Union support the resolution before us, which they have actively helped to elaborate. This resolution provides an appropriate basis for establishing an equilibrium between health needs from the public health perspective and the legitimate interest of the industrial sector.

Finally, the Member States of the European Union fully support the reform process initiated by the new Director-General, Dr Brundtland, since taking office less than a year ago.

Since the 15 Member States of the European Union are members of WHO, they are all intent on pursuing much closer cooperation between both organizations with a view to achieving the expected synergistic effects. As President of the Council, I wish to assure you that the Council of Ministers will most certainly support these efforts.

Professor REINER (Croatia):

Madam President, Madam Director-General, distinguished colleagues and delegates, the report presented by Madam Director-General and this year's *World health report* are immensely promising and call for energetic action. They show we have really new and strong leadership of WHO. The slogan "Making the Difference" is a challenging one because it could be interpreted as referring not only to making the difference inside WHO but to WHO continuing to decrease current differences in health status as well as the economic and social differences that exist at all levels, global, regional and country. Our **one** WHO has to respond to the ongoing process of transition and transformation on all these levels.

WHO has achieved many successes during the past 50 years. But it has also faced a degree of crisis during the last decade. So we can be really satisfied listening to Dr Brundtland's report and reading the summary of *The world health report 1999*. We can feel that it is WHO's firm intention to strengthen its role and reinforce its leadership in world health.

It must be stated that this renewed leadership will be properly based on partnership relations with many other organizations in the world, which are fortunately taking more and more interest in the world's health and health systems. We all also hope that the new structure introduced at WHO will enable the Organization to achieve its many noble and important goals more successfully. We welcome new action introduced, such as the Roll Back Malaria project, Health Systems Development, and especially the Tobacco Free Initiative, in the hope that we will really have a binding document, a convention for tobacco control in the near future.

Distinguished delegates, after these global points allow me to say something concerning my region, Europe. All of us in Europe who are active in WHO have for some years been very enthusiastic about so much needed reform of WHO and the renewal of its Constitution. This Constitution was an advanced and forward-looking document at the time of its first adoption more than 50 years ago. I cannot refrain from mentioning here that my fellow countryman Professor Andrija Štampar was one of its authors.

However, the many changes that have taken place since then at an unprecedented pace require new approaches. New approaches are present in the normative strategies and functions defined for WHO for the next century that will ultimately enable WHO to play a more appropriate role for the entire world's population. The decisions recently adopted have already started to bring about corrections to disproportionate and non-objective budget distribution. We are particularly satisfied with this issue as it has also opened the question of placing WHO's regional arrangements on a new basis and directing funds to countries in greatest need. Although we have not achieved definitive solutions we have taken a huge step forward from adopting a programme budget based on almost no criteria but tradition, impression, intuition and inertia, to a programme-based budget supported by objective and independent criteria.

Europe, more than any other continent except Africa, needs and would like to re-address some other issues as well. We are expecting further advancement in the health status of the populations of the most developed European countries as well as quick action aimed at preventing further degradation of the health status in some other parts of Europe, particularly the countries in transition. Europe is a region with many strong and active intergovernmental organizations, such as the European Union and the Council of Europe. All these organizations are more and more interested in health issues. Some of them have excellent health-oriented, constructive programmes which encourage us to think of ways to improve coordination and cooperation between them and WHO, in Europe as well as globally.

Our common goal in Europe has to be pan-European health, which is to become a counterpart to the general political trend of creating closer ties among countries in Europe, and which might definitely be the best prevention against misunderstandings and political or armed conflict. In striving towards peace and stability we very much support the thesis that one of the most efficient instruments towards such noble aims

is health, as health does not know, nor could know, any boundaries and is an issue of much broader importance with an impact on State security, economy and so on.

I would also like to outline briefly how my country, the Republic of Croatia, is looking ahead after the years of change. I would like to remind you that my country, like all the other countries in transition, has gone through tremendous changes in the last eight to nine years, economic, social, demographic and even epidemiologic changes. These processes call for necessary organizational transitions in all parts of human life, creating the new circumstances we live in. Also, the demands concerning the health of our population have altered accordingly, therefore changes must occur, and this is exactly what has been called "making the difference". I would like to emphasize that despite some economic difficulties, health systems in my country can and must ensure exactly what has been promoted as primary goals of health. As set forth in the Ljubljana Charter on Reforming Health Care in 1995, those are the equity, efficiency and constant bringing about of health gains.

Mrs FLOOD (Saint Lucia):

Madam President, colleague ministers, distinguished delegates, Madam Director-General, I am pleased and honoured to bring greetings on behalf of our group of Caribbean nations known as CARICOM. We congratulate Dr Maria de Belém Roseira on her election as President of this Assembly. We extend warm greetings to you, Dr Gro Harlem Brundtland, on your first year of leadership which bears significance for our region as we presently have a notable number of women in the capacity of ministers of health. Additionally, this reality of representation we also note is juxtaposed with your own expressed proactive views on the need for contributions from women in our political and institutional lives.

The reality of the dawning of a new millennium has its significance, not just for the passage of time but because it also forces us to focus on an end and a subsequent beginning. It forces us to examine where we are, what we have achieved and what is our vision for the future. An examination of the journey of this Organization from the very start shows that the positive advances are tremendous. Within the short span of your period at the helm, Madam Director-General, we can also say that already positive winds of change are blowing within the corridors of WHO, and the Caribbean has already felt the first wave of change in the management and functioning of WHO. We hope that this level of dynamism that has brought the organizational refocusing of WHO will meet the needs of small island States such as ours. There are key priorities for all our Members and these priorities have been defined in the proposed programme budget for 2001-2002, in which one of the most important programmes is Roll Back Malaria. Malaria, a top priority for WHO, is endemic in some countries in the Caribbean and has re-emerged in other countries where it was eradicated. The threat to economic development in Guyana, Suriname and Belize is real, while the possibility of reintroduction in other countries of CARICOM poses a threat to the tourism industry; we look forward therefore to the extension of the Roll Back Malaria initiative to the Caribbean countries. Other priorities are the Tobacco Free Initiative, the paying of more attention to the delivery of higher quality of care for children, adolescents and women, and support for countries in the quest for access to affordable and high quality essential drugs. And to the above and other set priorities we must add the issue of HIV/AIDS.

During my recent attendance at a major AIDS conference in Houston, Texas, it was gratifying to hear from the experts at the cutting edge of HIV/AIDS research that the development of a cocktail of drugs is greatly increasing the survival period for individuals who have contracted AIDS. This sense of euphoria soon turned to despair when I recognized that so many of WHO Member States cannot from their annual budgets afford even one day's supply of the required drugs to treat their infected populations, much less that required for one year. WHO must recognize the extent of this global tragedy, how it is decimating nations, and address it as a matter of urgency. We are concerned about the situation regarding HIV/AIDS and sexually transmitted diseases in the Caribbean, which collectively has one of the highest rates in the increase of incidence in the world. Guyana, Haiti, plus Trinidad and Tobago are seriously adversely affected by this tragedy. As noted above, in my own experience the global response, mainly because of economic constraints and prioritization, still lags behind in addressing the needs of those countries that are most affected by the epidemic, and there is a need for more international support to these countries to develop their capacity to respond effectively to the epidemic. While intersectoral response is necessary, the health sector has an imperative to lead in the expanded response to the epidemic, and this must be reflected in the work and focus of WHO.

We are pleased to see that WHO will be adopting a more strategic approach to work within and with countries. The financial resources for health do lie overwhelmingly within countries as shown by the fact that only 1% to 1.2% of health spending from low- and middle-income countries comes from development assistance, but we must be cognizant of the fact that the strategic placement of this spending by institutions such as WHO is of paramount importance. In many instances, this support may be the only incremental

amount that is imperative to lay the foundation for future growth, capital expansion and rationalization of our health services. International organizations such as WHO should be constantly reminded that microstates such as those found in the Caribbean are particularly vulnerable to external economic shocks, threats to their sovereignty and security, to environmental hazards and other ecological disasters. In addition, there are certain globalization trends that have a potential adverse impact on health and development, such as the issues related to compliance with the World Trade Organization agreements. The recent short-sighted WTO ruling which adversely affects the vital banana industry in some of our Member States is a prime example. Currently the primary challenge facing our countries is that of generating sufficient economic growth to improve the social conditions of our people.

In the Caribbean, we view health as an integral part of this development. This commitment is expressed in a variety of fashions and is largely shaped by the financial resources, or should I say, lack of financial resources available to our individual countries. In some countries such as my own, Saint Lucia, as much as 15% of the national budget is spent on health; in other Caribbean countries, there is considerable evidence to suggest that even in the face of competing priorities our governments have been attempting to ensure that health is placed at the forefront. Because of increased cost, changes in disease patterns and demographic shifts, we are in danger of losing the gains of that health status when compared with our brothers and sisters in the developing world. These achievements include the eradication of poliomyelitis and measles. The irony of the situation is that a paradox has been created by these good results - success equals a drop on the parity list for our countries and a subsequent reduction of funding for technical assistance and other forms of aid, which will result in an undermining of the positive results attained and the quality of life we now enjoy. There is an interesting parallel here with the development of economies in that the expansion of the middle class signifies improved overall economic health of an individual country. Countries like ours are in the middle class of the world economic order. The more we are in number the greater the health of the world economy. The more developed countries must accept the fact that just as if any country will pursue negative policies to abandon its middle class, with a subsequent negative impact on the overall economy, so too the world economy will suffer if the more developed countries abandon and curtail aid to the middle level economies such as ours. From a purely self-serving point of view, the more developed countries should therefore be aware that our falling levels of development, including health sector development, equate to less export markets for them, more desperate illegal immigrants knocking on their doors, and an overall drop in the world's stability.

Developed countries therefore need to invest more in WHO and the promotion of health in developing countries in their own interests and that of humanity. It is therefore of concern that some countries insist that a WHO budget should be restricted. We feel that this Health Assembly must mandate the Director-General of WHO to increase her advocacy for more resources to be invested by developed countries in promoting health in developing countries. In 1984 the Caribbean Cooperation in Health initiative (CCH), a mechanism for increasing collaboration and promoting technical cooperation among countries in the Caribbean, was introduced by the conference of ministers responsible for health. This initiative was reformulated in 1996 for the period 1998-2003 to highlight the areas of regional priority in health and to set concrete and achievable targets. These priority areas range from environmental to family health. Although these areas of priority may be similar for many nations, the CCH initiative is unique because, while giving a regional focus to health sector reform, it allows for sharing expertise, pooling of resources, and accessing and optimizing external resources. The overall concept of the CCH initiative is that we in the Caribbean must help ourselves and one another to improve health in the region. Our efforts, as embodied in the CCH initiative, are consistent with the goals, themes and concepts advanced in *The world health report 1999*, as the Organization seeks to reposition itself for the twenty-first century. We endorse the steps being taken by the Organization to improve the world's health, focusing on those countries where the burden of disease is greatest. We caution, however, that WHO needs to continue its shift from its strong disease-led orientation, and to strengthen its capacity to intervene on the social front and on changing organizational cultures and the behaviour patterns of users and providers of health services.

In the summary of *The world health report 1999*, the following is noted, and I quote: "The purpose of this work is to improve people's lives, to reduce the burdens of disease and poverty, and to provide access to responsive health care for all. WHO must never lose this vision. Thanks to the support of Member States and the commitment of staff, WHO is beginning to see results on the ground. The next report will tell how WHO has made a difference and show the measurable improvements that have been achieved as the world moves into a new century". We in the Caribbean wholeheartedly concur with the above and reiterate that throughout the operation of this Organization there must be quality assurance and assessment, plus on-time measurement of results. As I have said in another forum, we must focus on function and not just form. WHO staff and consultants must take on the result-oriented responsibility that

Member States have given them the authority to carry out. If the above is accomplished, then the start of the new millennium will not just mark the sterile passage of time but will be a dynamic measurement milestone in the success of humankind's cooperation in the area of health.

Mr SJÖBERG (Sweden):

Madam President, Dr Brundtland, distinguished delegates, I congratulate you and your Vice-Presidents on your election to lead this important meeting.

Last year's World health report gave us the opportunity to take stock of the achievements of the past 50 years. This year's Report challenges us to look ahead and to debate what action we must take to meet the vision of a reduced burden of disease and poverty. My Government welcomes the Director-General's ambition to sharpen the focus of WHO. A corporate strategy for **one** WHO is emerging. No doubt this will reinforce the work of the regional and country offices. It will also form a basis for partnerships with other United Nations agencies and international actors. Sweden would like to see a strong WHO that can fulfil its role as the lead agency in international health. The Director-General and her staff have made a commitment to make a difference: in policy direction, in organization, in administration and budgeting, as well as in high-quality, outcome-oriented action. My Government lends its full support to this renewal.

The reforms the Director-General has now set in motion are both impressive and necessary. Not only to restore trust and confidence in WHO, but also to prove that the United Nations system can and will respond to Member States' requests for improved efficiency. The aim of reform must be to do more and better, and not merely to spend less.

Consequently, Sweden supports zero real growth of the regular budget and will contribute voluntary funds on a high level to make it possible to meet the objectives of the total programme budget for the next biennium. It is my Government's strong wish that WHO should regain its place at the centre of the health sector development agenda. It is indeed not easy to put health concerns right at the heart of economic policy-making. It is up to us, ministries of health, together with WHO, to prove that an economy is not sound if it leads to rising levels of poverty or increased health disadvantages for certain groups. Quite the contrary! Investment in health is one of the main avenues towards poverty eradication. We are all aware that WHO has had difficulties in bringing together facts from its vast pool of knowledge into health system policy products. Therefore, the new cross-cutting project Partnership for Health Sector Development must be given high priority within the Organization, not least at country level.

To break the cycle of poverty and disease, we must focus on children and young people. In accordance with the Convention on the Rights of the Child, interventions must reach all children. The failure to recognize reproductive health needs and the rights of young people has meant that many of them are becoming parents far too early or are infected by sexually transmitted diseases and HIV. This situation must be changed! Roll Back Malaria and the Tobacco Free Initiative are two new important partnership projects. The framework convention on tobacco control will be instrumental in placing health interests firmly before other interests. The ambition to link up with other partners must also include increased WHO contributions to the joint UNAIDS effort to combat AIDS.

In both high-resource and low-resource settings, we deal to a large extent with the same problems. We have to be fast-learning and creative in using available interventions as well as developing new ones. WHO's centre-of-excellence function stands for our collective knowledge on how health can be improved. To this end, it is essential that WHO has a clear research policy. The interdependence between countries is increasing. We know today that communicable diseases are here to stay as significant health problems all over the world. No organization other than WHO could secure the imperative global surveillance mandate. Therefore, it is important to improve the system for reporting and early warning.

The Director-General has proposed objectives and structures for the way ahead to reduce the health gaps within and between countries. The dedication of all staff members to join in this effort is highly commendable. All of you, please be assured of Sweden's full support.

Mr KALWEO (Kenya):

Madam President of the Fifty-second World Health Assembly, Madam Director-General, distinguished delegates from Member States and other collaborating institutions, ladies and gentlemen, please accept our best wishes as you steer the deliberations of this Assembly and during your term as President of the current session of the Health Assembly. It is our hope that, as we prepare to enter the twenty-first century, the many technical and health matters listed in the provisional agenda of this Assembly will be addressed through strategies that are based on global partnership within the framework of health development.

The health sector in Kenya is already witnessing this partnership. For instance, the evolution and implementation of health sector reforms in Kenya since 1989 has been a collaborative effort between the Government, the community, the private sector, nongovernmental organizations, and donors, as well as United Nations organizations such as WHO. In particular, WHO, in collaboration with other donors, is at the moment supporting the development of Kenya's national health strategic plan covering the period 1999-2004 and the implementation of essential public health packages at the district level.

Kenya has been implementing primary health care and health sector reform activities for the past 20 and 10 years respectively. First, may I share with you our positive experience in primary health care. Some of the most notable achievements include increased community participation in the financing and management of health-related activities and programmes. Other achievements include increased access to health services, with approximately 77% of the population now residing within a 5 kilometre radius of a health facility, compared to 45% 20 years ago before the Alma-Ata movement was launched. May I take this opportunity to emphasize the fact that, following the introduction of primary health care and health sector reform, communities are now playing leading roles in problem identification, implementation, and monitoring and evaluation of health programmes.

Kenya is also implementing a number of reform measures in the health sector. First, we are restructuring the basic institutional arrangements to make them respond to the reform agenda which aims at improving the provision of health services. We are also undertaking a review of the existing health legislation to make it more responsive to contemporary health demands. Secondly, my Ministry has shifted resources towards promotive and preventive health care activities in our health programmes. Thirdly, we are vigorously exploring alternative financing mechanisms, including the overhaul of our national hospital insurance fund into a comprehensive national health insurance scheme. These reform measures are being pursued within the broad aims of Kenya's health policies, which are to promote equity, enhance efficiency, improve the quality of services and enhance consumer satisfaction.

Our sectoral development efforts hinge on the overall performance of our economy. In recent years, Kenya has registered a sluggish rate of economic growth. The overall impact has affected the government's ability to deliver health services effectively. Secondly, the emergence of the HIV/AIDS pandemic has resulted in unprecedent disease pressures on our health care system, a situation that has been worsened by resurgent health problems such as tuberculosis. Thirdly, despite our concerted efforts in implementing family planning programmes, our population growth continues to strain the resources that are meant for our health services. We are confident that some of the constraints could constitute agenda items for discussion by Member States as a strategy for promoting horizontal technical cooperation in health sector reform in developing countries. We are optimistic that the enhanced cooperation will in turn contribute towards the realization of WHO's global goal of obtaining health for all in the twenty-first century.

In conclusion, may I emphasize the fact that efforts aimed at the promotion of horizontal technical cooperation in health sector reforms among the developing countries will be frustrated if such cooperation is restricted only to health issues. A way out is for developing countries to "hinge" such efforts to broader and sustainable socioeconomic and political arrangements. Such an approach will provide the relevant framework for positively focusing on development aspects of health care, such as global coalition, intersectoral collaboration, development of regional health groupings and joint action against poverty among other roles. Finally, Kenya supports the reforms and initiatives proposed by the Director-General.

El Dr. AGUINAGA (Perú):

Distinguida señora Presidenta de la 52ª Asamblea Mundial de la Salud, distinguida doctora Gro Harlem Brundtland, Directora General de la Organización Mundial de la Salud, señores delegados: El *Informe sobre la salud en el mundo 1999: Cambiar la situación*, resalta la oportunidad, el desafío y la responsabilidad de nuestra sociedad por culminar la primera década del siglo XXI con una adecuada priorización y provisión de aquellos servicios e intervenciones de salud que mejor contribuyen a la reducción de la carga de enfermedades y condiciones discapacitantes que aquejan a la población, especialmente a los más pobres.

Trabajar en salud en un país como el nuestro, el Perú, significa enfrentar perfiles epidemiológicos marcadamente diferentes, siendo sus características principales la diversidad y la desigualdad. Esta situación agrega una mayor complejidad a los retos que en términos generales plantean las megatendencias al trabajo en salud, es decir no sólo el enfrentamiento de la pobreza sino también la búsqueda de la equidad. En ese marco, las estrategias e intervenciones desarrolladas en la última década por el Gobierno peruano han comenzado a mostrar importantes logros en salud, los cuales, además de indicadores epidemiológicos o demográficos, comprendieron mejoras en los recursos disponibles, nuevas condiciones jurídicas y la estabilidad en las políticas relacionadas con ella, buscando la atención a los sectores menos protegidos y más vulnerables de la sociedad.

Como sostiene el informe presentado, el esfuerzo conjunto de los países debe hacer posible la expansión del conocimiento y las capacidades generadas por nuestros sistemas de salud, para enfrentar la amenaza emergente de las enfermedades crónicas y no transmisibles, así como el «programa inacabado» de la lucha contra las enfermedades infecciosas y los problemas ocasionados por las complicaciones de la gestación y el nacimiento, los estilos y condiciones de vida poco saludables, la malnutrición y las limitaciones de acceso de los más pobres a los servicios de salud.

El tabaquismo es presentado como ejemplo de la amenaza emergente de las enfermedades crónicas y no transmisibles. El Perú ha tenido avances en la lucha antitabáquica, reflejados en diversas normas legales que regulan la publicidad y en el impulso de iniciativas multiinstitucionales e intersectoriales de convocatoria e información a la población, las que se articulan a una estrategia integral de promoción del bienestar, la calidad de vida y un medio ambiente saludable. Pero definitivamente, como todos conocemos, el control de esta pandemia requiere una respuesta global e integral por parte de la comunidad internacional, por lo que respaldamos la iniciativa de la OMS y de la OPS en esta dirección.

En relación al «programa inacabado» de la lucha contra las enfermedades infecciosas, a la par de importantes avances obtenidos para la eliminación del sarampión y el tétanos neonatal, así como en el control de la tuberculosis, tenemos que profundizar la lucha contra la malaria y la fiebre amarilla. Como resalta el informe, estas enfermedades tienen un carácter multifactorial, vinculándose a condiciones sociales, económicas, geográficas o climáticas, pero también a sistemas de salud que aún no logran ser suficientes en la respuesta a estos problemas.

El *Informe sobre la salud en el mundo* nos convoca alrededor de una «nueva universalidad», entendida como la cobertura para todos, pero sólo sobre la base de una adecuada priorización de las intervenciones que respondan mejor a las necesidades de salud de nuestros pueblos. En este sentido, el Gobierno peruano avanza hacia una estrategia de aseguramiento progresivo que guarda relación con el ciclo de vida de la población. A nivel del aseguramiento público, resalta el valor social del Seguro Escolar Gratuito y del Seguro Maternoinfantil. Estas propuestas se apoyan en la decisión institucional de articular los programas de salud maternoinfantiles y los de enfermedades transmisibles, orientando su accionar a un abordaje integral en la atención de salud de la persona.

Nuestra intervención se enmarca en los objetivos de lucha contra la pobreza, promoción de un desarrollo humano sostenible y en la búsqueda de una mayor eficacia, calidad y eficiencia en la atención de salud. Para el cumplimiento de estos propósitos es necesaria la participación de la comunidad organizada y de los distintos actores sociales vinculados a la acción sanitaria. Estos procesos, y las lecciones que de ellos se desprendan, consideramos, señora Presidenta, que se verán enriquecidos gracias a la decisión de la Organización Mundial de la Salud de establecer el nuevo programa de Pruebas Científicas para las Políticas de Salud, que contribuirá a la formulación y evaluación de políticas para el desarrollo de los sistemas de salud en beneficio de la población.

Señores delegados: En el umbral del nuevo milenio, el Perú se aúna a la convocatoria de la Dra. Gro Harlem Brundtland para que conjuguemos visión, compromiso y liderazgo en la lucha por alcanzar más y mejor salud para nuestros pueblos. Muchas gracias.

Mr EZHILMALAI (India):

Madam President, Madam Director-General, distinguished delegates, ladies and gentlemen, at the outset may I congratulate the new President and the Director-General for their excellent presentation of the situation prevailing in the present century and the projections set out as we move closer to the new millennium.

It is with a sense of pride that I address the Fifty-second World Health Assembly today. Representing 16% of the world's population, I am conscious of my country's immense achievements, but also of the challenges that daunt us in the years ahead. Five decades ago, when we won our Independence, literacy levels were abysmally low, nearly three-quarters of the population were below the poverty line, with a life span not exceeding 32 years, and negligible human resources or scientific manpower. Since then, the average life span has doubled, the number of persons below the poverty line reduced to one-third, food security has been achieved, a large reservoir of scientific and skilled manpower has been created, and over 80% of the people provided with access to safe water. The expansion of the health infrastructure throughout the country has greatly helped us to achieve high levels of immunization of children, a decline in fertility and death rates, and a significant increase in life expectancy. In view of such an expansion and investment in health, we have been able to achieve significant results, namely the eradication of smallpox and guinea-worm, and the elimination of poliomyelitis, yaws and leprosy within the next two to three years. As we near the end of one millennium and enter the next, our past attainments and technological achievements make me still more optimistic about the future.

In this I am glad to see the direction given by the Director-General, Dr Brundtland, in revitalizing WHO with new initiatives and vigour. Under her determined stewardship and generalship, WHO will be strengthened to face the emerging challenges that confront the regions of the world.

I have read *The world health report 1999: Making a difference*, with interest. In making a difference, I do hope Dr Brundtland will use her special position to persuade the developed countries to share technology on terms that will enhance the health-giving capacity of the rest of the world.

One of the challenges that faces India is to reduce interstate differentials, and in order to achieve this we continue to implement the minimum needs programme. Out of 12 programme components, six relate directly to health: rural health, rural sanitation, rural water supply, rural housing, nutrition, and improvement of slum environments. The focus is on the poor sections of society who predominantly live in rural areas and urban slums. The financial provision for the minimum needs programme cannot be diverted to other programmes or schemes. This programme has received further impetus with the two constitutional amendments that have enabled devolution of authority to the hands of the people by entrusting responsibility to elected local bodies. Rapid detection, containment of epidemics, strengthening of local capacity and selective vector control backed by continuous monitoring are some of the major plans on which this US$ 200 million project is based.

I also applaud the second call for action from WHO which addresses immunization against poliomyelitis. I am glad to inform the Assembly that on two dates in December 1998 and January 1999 India succeeded in vaccinating 135 million children, a world record of which we are justly proud.

One of the most daunting tasks ahead of us is to control the spread of AIDS. A new programme negotiated for the period 1999-2002 seeks to cover the needs of the high- as well as the low-risk groups by using nongovernmental organizations extensively.

Some of our achievements since we last addressed the Assembly include the initiation of a national programme for control of dengue, disease surveillance and phased diethylcarbamazine coverage for filaria-endemic districts. Leprosy is poised for elimination by the year 2000. The tuberculosis programme, and particularly the adoption of the directly observed treatment, short course (DOTS) strategy, is being closely monitored, particularly as its linkage with AIDS manifests itself. The highest priority has been accorded to protecting the public from food-borne diseases, and the supply of essential drugs at affordable prices is a policy commitment which is achievable. The reproductive and child health project seeks the reduction of maternal morbidity, promotes the use of contraceptive as per choice, without being weighed down by targets, augments facilities for safe deliveries and caters for the treatment of reproductive tract infections. Greater attention is being paid not merely to women's health in terms of biological factors but also those impacting on their social, economic and cultural status.

Now I take the opportunity of repeating a request I made to the Director-General last September when she visited India. While reiterating what was decided at the last meeting of the health ministers of the South-East Asia Region I requested the Director-General once again to establish an effective focal point equipped to recognize and draw on the full potential of traditional medicines. A large proportion of the population of many developing countries relies mainly on traditional practitioners for care needs. Although WHO has stated over the years that the Organization promotes the integration of traditional medicine into the national health care system, WHO must set up a forum and mechanism to develop technical guidelines and international standards, particularly in respect of herbal medicines. There has to be an international understanding and an agreement on policies, regulations, registration and standards. I request WHO to give time and attention to this important area endorsed by 10 countries of the South-East Asia Region.

Finally, while conflicts of power and competition among rival groups have been a phenomenon witnessed by the people of the world, there is every need to see that health policies are determined in an international climate which evokes an ethical and emotional response. Essential public health functions cannot be relegated to the private sector or to agencies who lack the mechanisms to safeguard equity. We, as leaders and policy-makers, have to determine and put in place the building blocks that will shape the health of millions of people in the twenty-first century. With foresight and decisive action, we can create a better world for our people, particularly as large numbers will be added to the cohort of the elderly, and noncommunicable diseases will call for attention and increased deployment of scarce resources.

It is in this context that meaningful international cooperation in health can help countries. I recall the old saying that "Health is a matter of time, but it is also a matter of opportunity". Each one of us has been fortunate in having that opportunity. In the words of Benjamin Disraeli, "The health of a people is really the foundation upon which all their happiness and all their powers as a State depends".

Before I conclude, let me express our support for the reform process initiated by the Director-General of WHO, and I hope that together we can make a real difference.

Dr EL FASSI (Morocco):

الدكتور الفاسي (المغرب):

السيدة رئيسة جمعية الصحة العالمية الثانية والخمسين، حضرات السيدات والسادة، باسم وفد المملكة المغربية يشرفني أن أتقدم بأحر التهاني للسيدة الرئيسة بمناسبة انتخابها رئيسة لهذه الجمعية، كما أهنئ نواب الرئيسة وأتمنى لكم جميعا التوفيق والنجاح في تسيير أشغال هذه الجمعية. ويطيب لي كذلك أن أتقدم بأصدق عبارات التقدير الى السيدة المديرة العامة على المجهودات الكبيرة التي تقوم بها ويقوم بها مساعدوها من أجل تطوير المنظمة وانجاح أعمالها بتحسين طرق تسييرها واصلاح هياكلها.

السيدة الرئيسة، لقد بذلت منظمتنا مجهودات كبيرة من أجل تطوير وتحسين المستوى الصحي في مختلف جهات العالم. اذ تم تحقيق عدة نتائج ايجابية في كثير من المجالات واننا نتطلع الى تحقيق المزيد من المكاسب في الميدان الصحي في اطار استراتيجية التغيير واعادة الهيكلة، وتحديد الأولويات التي تعتمدها منظمة الصحة العالمية ونحن على مشارف القرن الحادي والعشرين. لقد كان الهدف المتوخى من اعلان ألما آتا توفير الصحة للجميع بحلول عام ٢٠٠٠، ولكن التقرير الخاص بالصحة في العالم، ١٩٩٩ يظهر أنه اذا كانت هناك بعض المكاسب قد تم تحقيقها في مجال الرعاية الصحية الأساسية، فان عدة عوائق مازالت تعترض بلوغ هذا الهدف. وبالرغم مما حققه العالم من تقدم في المجال الصحي، فان العديد من المشاكل والتحديات لاتزال قائمة وترتبط بضعف الاستثمارات في هذا الميدان وعدم التكافؤ في توزيع الموارد المالية والبشرية والمادية، فضلا عن التكاليف الباهظة للخدمات الصحية والوضعية الانتقالية الديمغرافية والوبائية. كما أن كثيرا من الأنظمة الصحية في العالم لاتزال تعاني من مشاكل تدبير وتسيير، بالاضافة الى عدم مواكبة المستجدات العلمية والتكنولوجيا. وفيما يتعلق بالوضع الصحي، فان العالم لايزال يشهد العديد من الأمراض السارية وغير السارية، والتي تهدد صحة السكان وتعرضهم للمخاطر، وبالرغم من الجهود المبذولة لمكافحة هذه الأمراض والمخاطر، فان المجتمع الدولي مطالب أكثر باعتماد استراتيجية محكمة للتقليص من احتمالات الخطر وتعزيز التعاون الدولي لتبادل المعلومات والخبرات والتجارب في هذا الميدان للحد من وتيرة انتشار الأمراض والاصابات.

السيدة الرئيسة، ان المملكة المغربية تعتمد استراتيجية وطنية في الميدان الصحي تتوخى أساسا تلبية احتياجات السكان في مجال الوقاية والعلاج وذلك بالعمل على تحسين تمويل القطاع الصحي ووضع نظام للتأمين الصحي وضمان العلاج للفئات المعوزة عبر نظام خاص للمساعدة الطبية. كما تسعى هذه الاستراتيجية الى ترشيد استعمال الموارد المالية والمادية والبشرية وتوسيع التغطية الصحية في اطار السياسة اللامركزية الرامية الى تدارك الفوارق بين الجهات والأقاليم وتقريب الخدمات الصحية من السكان، وكذا تطبيق سياسة اجتماعية ناجعة في مجال الأدوية وتحسين سير المؤسسات الصحية في اطار اصلاح القطاع الاستشفائي.

ان المغرب يبذل جهودا كبيرة في مجال محاربة الأمراض السارية حيث حقق عدة مكاسب وخصوصا فيما يتعلق بمكافحة أمراض الأطفال الستة الفتاكة بفضل برنامج وطني للتمنيع والتعبئة الاجتماعية. أما الأمراض غير السارية فانها تحظى أيضا بأهمية خاصة في استراتيجية المكافحة. وفي مجال مكافحة التدخين خطا المغرب خطوة مهمة حيث أصدر قانون منع التدخين في الأماكن العمومية. وفي مجال الصحة الانجابية يتم التركيز على تعزيز رعاية صحة الأم والطفل من خلال مراقبة الحمل وتحسين ظروف الولادة والوقاية من المضاعفات الناتجة عن الحمل والولادة. ويعتبر تقليص نسبة وفيات الأمهات نتيجة مضاعفات الحمل والولادة من أولويات السياسة الصحية التي تنتهجها بلادنا. وفيما يتعلق بالأدوية فان الجهود المبذولة تسعى الى تطوير الانتاج الوطني ودعم نظام المراقبة والتطبيقات الجيدة للانتاج، وكذا تحسين مستوى اقتناء وتوزيع الأدوية وجعلها في متناول السكان بأقل تكلفة، ويتم في هذا الاطار تشجيع انتاج الأدوية النوعية.

السيدة الرئيسة، اننا بمناسبة انعقاد آخر دورة لجمعية الصحة العالمية في هذا القرن نأمل أن تتحقق الأهداف التي رسمتها المنظمة لتحسين المستوى الصحي لجميع الشعوب. وفقنا الله لما فيه الخير لكافة شعوب العالم. والسلام عليكم ورحمة الله.

El Dr. MAZZA (Argentina):[1]

Señora Presidenta, señora Directora General, honorables Miembros: Como lo hemos señalado en las últimas siete Asambleas, reiteramos una vez más el compromiso de nuestro país de trabajar en el marco de la Organización Mundial de la Salud, con el fin de contribuir a mejorar el nivel de salud y la calidad de vida de nuestros pueblos. Durante estos años el Ministerio de Salud y Acción Social de la Argentina ha

[1] Versión completa del discurso pronunciado por el Dr. Mazza en forma resumida.

desarrollado una profunda y progresiva reforma sectorial, cuyos resultados e impacto en el medio sanitario permiten afirmar que la estrategia utilizada es apta, factible y viable en relación con los objetivos propuestos.

Entre las principales reformas implementadas destacan el programa nacional de garantía de calidad de la atención médica, el modelo de hospital público de autogestión, la reconversión de la seguridad social, el control sanitario de alimentos, medicamentos y tecnología médica, la vigilancia epidemiológica y el control de las enfermedades, poniendo especial énfasis en los programas de prevención destinados a disminuir los riesgos evitables de enfermar y morir, especialmente dirigidos a poblaciones marginadas y de pobreza estructural, y en aquellas situaciones biopsicosociales consideradas potencialmente riesgosas.

Nuestro accionar sanitario se orienta fundamentalmente hacia el hombre y la familia; se basa en criterios de equidad, solidaridad, ética biomédica, eficacia, eficiencia, calidad y en la defensa de la dignidad de la persona humana.

El objetivo central de las políticas de salud, implementadas explícitamente en nuestro país a partir de 1992, es lograr la meta de Salud para Todos y por todos en el menor tiempo posible, con eficiencia y el mayor beneficio para toda la población mediante el desarrollo de un modelo humanizado de atención médica integral, que por sus características se constituye en un elemento fortalecedor de la democracia participativa. Nosotros también, como lo señala el informe de la Directora General, miramos hacia el futuro, teniendo en cuenta las debilidades y fortalezas de nuestro sistema, así como los problemas e inconvenientes que debimos superar al frente del Ministerio de Salud. Comprometidos con la Organización Mundial de la Salud, que pertenece a los Estados Miembros que la integran, queremos reiterar en estos momentos algunos de los conceptos ya señalados en Asambleas anteriores, y que mantienen plena vigencia. En tal sentido consideramos que el apoyo de la OMS al desarrollo sanitario de los países siempre debe concretarse respetando las pautas y valores culturales de los mismos. Ese apoyo debe ser canalizado a través de las oficinas regionales y responder a las necesidades de salud detectadas por los respectivos ministerios de cada país, quienes deben ser, necesariamente, los interlocutores válidos con la Organización, con el fin de evitar interferencias y conflictos no deseados a nivel de los propios países. El respeto de estas reglas de juego claras y definidas garantizan el éxito del accionar de la Organización, en el marco de la responsabilidad directa e indelegable que tienen los ministerios de salud.

Es por ello que en el marco de los cambios introducidos en este último año por la Directora General, insistimos en la necesidad de avanzar en el mejoramiento del proceso técnico y administrativo de gestión de la Organización y en la definición de áreas prioritarias. Entendemos que se deben profundizar los cambios estructurales y programáticos para ponerlos al servicio de las necesidades de los países, lo que redundará directamente en el nivel de salud de la población.

También queremos destacar que el sector salud es un sistema abierto, muy complejo, fuertemente interrelacionado con el medio, con múltiples factores intra y extrasectoriales que interactúan no siempre en forma positiva sobre el mismo, lo que exige reorientar el accionar con el fin de disminuir la incertidumbre y de evitar al máximo los posibles conflictos que se puedan generar por la falta de una adecuada articulación y coordinación entre la Organización y los respectivos ministerios de salud. En este orden de ideas consideramos que la actual Constitución de la OMS sirve adecuadamente a los fines para la cual fue creada y no visualizamos la necesidad de enmendarla en estos momentos.

El uso racional de los recursos y una cooperación técnica consensuada con los Estados Miembros constituyen componentes esenciales para asegurar el éxito del trabajo en conjunto. Los cambios mundiales y la globalización de la economía exigen poner especial atención en mejorar la eficiencia de la Organización, tal como lo destacamos en las Asambleas Mundiales de la Salud de los años 1996 y 1997 y, dado que los países no están en condiciones de realizar mayores aportes, proponemos que el nuevo presupuesto de la Organización debe tener un «crecimiento nominal cero», controlando para ello los costos operativos innecesarios. Por ello, consideramos que una de las estrategias a tener en cuenta debe ser, cuando resulte indicado, el de promover la cooperación técnica horizontal entre países que tienen las mismas características sanitarias, los mismos problemas y las mismas raíces socioculturales.

Nuestra delegación comparte ampliamente la propuesta de mejorar la situación sanitaria, reducir la desigualdad en materia de salud; responder mejor a las expectativas legítimas; mejorar la eficiencia; proteger al individuo, a la familia y a la comunidad y mejorar la equidad en el financiamiento y en las prestaciones de la asistencia sanitaria, propuestas en el *Informe sobre la salud en el mundo 1999*. Asimismo consideramos de marcado interés profundizar el estudio de los temas propuestos en el informe, con el fin de mejorar los resultados sanitarios y de avanzar en las iniciativas dirigidas a «Hacer retroceder el paludismo» y «Liberarse del tabaco».

Debemos encarar entre todos un análisis crítico de lo realizado y consensuar una propuesta sistémica frente a la compleja problemática que enfrenta el sector salud en la actualidad.

La transición demográfica, la transición epidemiológica, los cambios culturales, los problemas socioeconómicos y, en particular, los avances científicos y el desarrollo tecnológico, configuran un nuevo

escenario que exige una nueva forma de pensar y de actuar en salud desde la óptica de las necesidades y demandas de la población, y no sólo desde la oferta de servicios.

Es por ello que reiteramos que es responsabilidad primaria de la Organización contribuir a la formulación de los modelos de atención médica, así como los de organización y financiamiento, con anticipación a los cambios.

El desafío es grande y ha llegado la hora de pasar a la concreción de los hechos, mediante una estrategia institucional consensuada con los Estados Miembros. Muchas gracias.

الدكتور الشطي (الجمهورية العربية السورية): Dr AL-CHATTI (Syrian Arab Republic):

السيدة الرئيسة، السيدة المديرة العامة، السيدات والسادة رؤساء وأعضاء الوفود المحترمين، السلام عليكم.

باسم الجمهورية العربية السورية نتقدم بالتهاني الى السيدة الرئيسة والسادة نواب الرئيس ورؤساء اللجان على الثقة التي أولتهم اياها جمعية الصحة العالمية متمنين لهم النجاح في مهمتهم. لقد استعرض وفد بلادي تقارير الأنشطة التي طرأت على المنظمة منذ تولي السيدة برونتلاند مهامها كمدير عام لمنظمة الصحة العالمية، هذه الأنشطة التي تعتبر تكريسا للمنطلقات الانسانية لمنظمة الصحة العالمية. ونود أن نعرب عن تقديرنا لما قدمته السيدة برونتلاند وقدمه معاونوها من جهود ادارية وانسانية خلال الفترة الماضية لما فيه خير ومصلحة الانسان. ونتقدم بجزيل الشكر للسيد المدير الاقليمي لشرق المتوسط الدكتور حسين عبد الرزاق الجزائري ولجميع العاملين في المكتب الاقليمي الذي لا يدخرون جهدا في سبيل تطوير الخدمات الصحية.

السيدة الرئيسة، الحفل الكريم، لقد تطور الوضع الصحي في بلدي سوريا بشكل ملحوظ، لاسيما في الربع الأخير من هذا القرن، حيث حقق قطاع الخدمات الصحية تطورا ملموسا مرده القيادة الحكيمة للسيد الرئيس حافظ الأسد رئيس الجمهورية العربية السورية. وقد أولت جميع الجهات العامة في سوريا اهتماما كبيرا بالمواطن في مناحي الحياة كافة واهتمت بصون صحته والاعتناء بطعامه وكسائه وعناصر البيئة بالاضافة الى تعليمه وتدريبه، حيث تستحدث المؤسسات الصحية ويتنامى تأهيل وتدريب القوى العاملة ويتطور تصنيع الدواء الوطني وتتعزز الصيانة والهندسة الطبية والمعلوماتية ويتعمق البحث العلمي الهادف. أود أن أذكر هنا أحد المشاريع الناجحة الرائدة في سوريا والذي يقام بالتعاون مع منظمة الصحة العالمية ومنظمة اليونيسيف هو مشروع القرى الصحية وهو مشروع تنموي صحي تعليمي بيئي يعتمد على المجتمع المحلي مع دعم من الجهات العامة. لقد أعطت وزارة الصحة الأولوية للطب الوقائي وتوسعت بالتالي برامج تلقيح الأطفال فأصبحت لثمانية أمراض ونسب التلقيح تتراوح من ٩٣ الى ١٠٠ بالمائة. وتكريسا لسياسة الاعتماد على الذات التي تنتهجها سوريا، فقد أصبح الانتاج المحلي الدوائي يغطي ٨٥٪ من حاجة المواطنين وبنوعية تتحسن باستمرار، والتصنيع يتم بالتعاون مع المنظمات الدولية لاسيما منظمة الصحة العالمية. هذه الاجراءات أدت الى تحسن ملموس في صحة المواطن فارتفع معدل توقع الحياة من ٥٣ عاما في بداية السبعينات الى ٦٩ عاما في الوقت الحالي، وانخفضت وفيات الأطفال الرضّع دون السنة من العمر من ١٣٢ وفاة لكل ١٠٠٠ مولود حي عام ١٩٧٠ الى ٢٨ وفاة عام ١٩٩٨.

السيدة الرئيسة، السادة الحضور، قريبا جدا سندخل القرن الحادي والعشرين والذي نتمنى جميعا أن يكون حقبة يسودها السلام ويتمتع فيها سكان العالم كافة بالصحة والعافية ويعم فيها الازدهار. ان تحديات القرن المقبل تتطلب منا مزيدا من العمل ومزيدا من التعاون بعيدا عن الممارسات والسياسات العنصرية والعدائية والتي تقوم بها وللأسف بعض الدول الأعضاء في المنظمة، والتي تؤثر سلبا على صحة الانسان وعافيته، تلك الممارسات التي ندينها بكل قوة وعلى الرغم من وجود تحديات صحية عالمية ومستجدة فان روح التعاون الفعال والاصلاحات الدائمة التي تقوم بها المنظمة ساهمت في مواجهة تلك التحديات. في هذه المناسبة لا يسعني الا أن أستنكر ما تمارسه اسرائيل من قهر وظلم ضد المواطنين العرب في الأراضي التي مازالت تحتلها منتهكة مقررات الأمم المتحدة سواء كان ذلك في الجولان أو جنوب لبنان أو فلسطين المحتلة. هذه الممارسات التي تزيد من معاناة السكان في تلك المناطق وتؤثر سلبا على أحوالهم الصحية. لقد أدان المجتمع الدولي الممارسات الاسرائيلية التعسفية واللاانسانية في الأراضي المحتلة واننا نحمّل الحكومة الاسرائيلية المسؤولية كاملة بسبب تنصلها لا بل تعطيلها عملية السلام.

في الختام، السيدة الرئيسة، السادة الحضور، ان الجمهورية العربية السورية، بقيادة الرئيس حافظ الأسد، ستواصل مسعاها الدؤوب والجاد للمساهمة في احلال السلام العادل والشامل وفق مرجعية مدريد ومقررات الأمم المتحدة مبدأ الأرض مقابل السلام، سنعمل معا لعالم تسوده العافية والمحبة والسلام.

The PRESIDENT:

Before we adjourn, may I remind you that the three round tables scheduled to meet today will commence this afternoon at 14:30. The Committee on Credentials will also meet at 14:30 in Room VII. Also, at 13:00, there will be a briefing meeting in Room VII on "Global surveillance of communicable diseases" and in Room XIX, a briefing meeting on "Curbing the epidemic: governments and the economics of tobacco control". The next plenary meeting will be held on Wednesday at 9:00. The meeting is adjourned.

The meeting rose at 13:15.
La séance est levée à 13h15.

FIFTH PLENARY MEETING

Wednesday, 19 May 1999, at 9:00

President: Mrs Maria de Belém ROSEIRA (Portugal)

CINQUIEME SEANCE PLENIERE

Mercredi 19 mai 1999, 9 heures

Président: Mme Maria de Belém ROSEIRA (Portugal)

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

The PRESIDENT:

Today, the Assembly will consider the first report of the Committee on Credentials which held its meeting yesterday, Tuesday, 18 May, and the chairmanship of Dr C.T.O. Otto (Palau). The report is contained in document A52/32 which you have all received. Does the Assembly wish to comment? Is the Assembly prepared to adopt the report of the Committee? I give the floor to the delegate of Pakistan.

Mr QAZI (Pakistan):

Thank you, Madam President. The Pakistan delegation has read the report of the Credentials Committee and would like to draw attention to a factual and legal inaccuracy it contains with regard to Afghanistan. The report proposes that the Health Assembly should recognize the validity of credentials presented by Afghanistan, among other countries.

The issue of the credentials of Afghanistan was considered at length by the Credentials Committee of the fifty-third session of the United Nations General Assembly; the Committee decided, and I quote: "to defer a decision on the credentials of representatives of Afghanistan on the same basis as taken at the fifty-second session". This decision is contained in paragraphs 7, 8 and 9 of document A/53/556 of the General Assembly.

In accordance with Articles 58 and 63(2) of the Charter of the United Nations, the United Nations shall, and I quote: "... make recommendations for the coordination of the policies and activities of the specialized agencies." We had hoped that the Credentials Committee of the Assembly of the World Health Organization, a specialized agency of the United Nations, would have reflected the true situation prevailing in the United Nations General Assembly with regard to the credentials of Afghanistan. This would have brought the report of the Credentials Committee of the Health Assembly in conformity with the Credentials Committee report of the fifty-third session of the United Nations General Assembly. It would also have made the report of the Credentials Committee of this Assembly factually and legally correct.

As this has not been done, we are constrained to disagree with the Committee's proposal that we recognize the validity of the credentials presented by Afghanistan. We would like therefore to enter a reservation on the report of the Credentials Committee of the Fifty-second World Health Assembly with regard to Afghanistan. We request that this statement be incorporated in full in the records of this plenary session. Thank you.

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[1] See reports of committees in document WHA52/1999/REC/3.

[1] Voir les rapports des commissions dans le document WHA52/1999/REC/3.

The PRESIDENT:

I thank the delegate of Pakistan. The objection will be fully reflected in the report of this plenary meeting. If you agree with this, we can adopt the Committee report. I see no objections. The first report of the Committee on Credentials is therefore adopted.

Before adjourning this plenary, I would like to inform the Assembly that at 13:00 a technical briefing will be held on "Change in WHO" in Room VII. Another technical briefing will also be held on "WHO humanitarian action in South Balkans" at 13:00 in Room XIX. At 9:30, the ministerial round tables will commence. Discussion Group A on "Finding the money: dilemmas faced by ministers" will be held in Room XVII and Discussion Group B on the same topic will be held in Room XXIII. "HIV/AIDS: strategies for sustaining an adequate response to the epidemic" will be held in Room XVIII. This afternoon, as I have an important engagement, the second and third Vice-Presidents will replace me. The next plenary will be held at 14:30 this afternoon simultaneously with the second meeting of Committee A. The meeting is adjourned.

The meeting rose at 9:15.
La séance est levée à 9h15.

SIXTH PLENARY MEETING

Wednesday, 19 May 1999, at 14:30

President: Dr T.J. STAMPS (Zimbabwe)
later: Dr E.F. EHTUISH (Libyan Arab Jamahiriya)

SIXIEME SEANCE PLENIERE

Mercredi 19 mai, 14h30

Président: Dr T.J. STAMPS (Zimbabwe)
puis: Dr E.F. EHTUISH (Jamahiriya arabe libyenne)

LOOKING AHEAD FOR WHO AFTER A YEAR OF CHANGE: REPORT OF THE DIRECTOR-GENERAL (INCLUDING *THE WORLD HEALTH REPORT 1999*) (continued)
L'AVENIR DE L'OMS APRES UNE ANNEE DE CHANGEMENT: RAPPORT DU DIRECTEUR GENERAL (Y COMPRIS LE *RAPPORT SUR LA SANTE DANS LE MONDE. 1999*) (suite)

The PRESIDENT:

I am pleased to take over the presidency and we shall continue with the debate of item 3. The next two speakers in my list are the delegates of the Libyan Arab Jamahiriya and Turkey. I give the floor to the delegate of the Libyan Arab Jamahiriya.

Dr E.F. EHTUISH (Libyan Arab Jamahiriya): الدكتور احتيوش فرج احتيوش (الجماهيرية العربية الليبية):

بسم الله الرحمن الرحيم

السيدة المحترمة رئيسة الجمعية العامة، السيدة المحترمة المديرة العامة، السادة وزراء الصحة، السادة الحضور، أبدأ كلمتي هذه بالشكر للسيدة المحترمة رئيس الجمعية، وأهنئها على اختيارها وهذه الثقة الكبيرة التي وضعت فيها لادارة هذه الدورة. تأتي مشاركة بلادي لهذا العام وقد وصل وفدها مباشرة من مطار طرابلس الى مطار جنيف، بعد أن تم تعليق الحصار الجائر الذي فرض على بلادي لمدة سبع سنوات، ومن خلال ذلك أود التنبيه الى معاناة الانسان، فهذه التجربة علمتنا أن الانسان يعاني من مثل هذا الفعل، ولن نصل بالصحة للجميع وبالجميع اذا كان العالم لايزال يفرض الحصار والتجويع على جزء منه. فمعاناة الانسان من حروب وتهجير وابادة جماعية وحصار وسرقة للثروات، هذا لن يؤدي الا الى تقسيم العالم حتما الى انسان أو الى جزء يتمتع بالصحة وآخر يعاني، ولن نصل الى الصحة للجميع. فعلينا هنا، ومن هذا المنبر، أن ندين وننبذ ونحارب كل هذه الممارسات، فبلادي كانت مثلا فقط للبلاد التي عانت هذه الممارسات، هناك غيرها عشرات البلاد التي تعاني من هذه أو تلك. ان الحصار ماكان ليرفع عن بلادي لولا المبادرات والمواقف الايجابية لبلدي وقائده الذي قدم درسا للعالم في أسلوب ادارة الصراعات الدولية.

أيها السادة ان الأمراض لا تعرف الحدود ولا تحترمها، والتصدي الجماعي المنظم للأمراض خاصة المعدية والسارية منها هو الأسلوب الأمثل وهو أحد أهم التحديات التي تقف أمامنا. لقد واجهت بلادي مشكلة صحية يهمني ذكرها هنا لخصوصيتها. فلقد تم تشخيص عدد ٣٧٠ حالة ايجابية لفيروس العوز المناعي المكتسب "الايدز" خلال صيف ١٩٩٨، ولقد أثبت التقصي الوبائي محدودية المشكلة في الزمان والمكان والشريحة العمرية، لقد أصاب هذا الوباء أطفالا تراوحت أعمارهم بين الشهرين والأربعة عشر عاما،

ولقد كانت اصابتهم نتيجة لايواء هؤلاء الأطفال ولمدد متفاوتة بمستشفى الأطفال بمدينة بني غازي خلال الفترة من الشهر السابع ١٩٩٧ وحتى الشهر السادس ١٩٩٨. وكانت جميع أمهات هؤلاء الأطفال خالية من الفيروس، ولم يثبت انتقال الفيروس عن طريق المشيمة. فلقد كان انتقال المرض أفقيا وليس رأسيا، ولم يكن الانتقال عن طريق نقل الدم ومشتقاته والاصابة، كما أثبت التقصي الوبائي، كانت عن طريق اختراق الجلد، كما أثبتت التحاليل المعملية أن الفيروس من نوع واحد في جميع الأطفال. ان الجماهيرية الليبية أيها السادة من الدول التي ينخفض فيها بشدة انتشار هذا المرض، فمعظم الحالات التي شخصت حتى الحين كانت وافدة وليست وطنية، ولا يعتبر المرض مشكلة صحية في بلادي لولا ما سبق وقلت لكم. واذا ثبت أن ذلك جريمة فستكون أبشع جرائم هذا القرن، والأمل أن تحارب مثل هذه الجرائم حتى لا ندخل الألفية الثالثة ونحن نتخوف من مثل هذه الجرائم البشعة، ولقد تناولت هذا الموضوع في المائدة المستديرة حول العوز المناعي المكتسب هذا اليوم، هنا لا يسعني الا أن أتقدم بالشكر للمكتب الاقليمي لشرق المتوسط على كل ما قدمه من مساعدة، كما يهمني تقديم شكر بلادي لكل من السادة وزراء الصحة في كل من النمسا، وسويسرا وايطاليا وفرنسا، للمساعدة التي قدموها في تقييم وتشخيص هذه الحالات. وكذلك أتقدم بالشكر الى الأستاذ الدكتور مونتانييه الذي ساعدنا بخبرته ورحب بالمشاركة في حضوره لمائدة مستديرة ستقيمها بلادي بخصوص هذا المرض خلال الأشهر القادمة في مدينة بني غازي.

أيها السادة، ان التغيير الواضح في أسلوب ادارة هذه المنظمة واجتماعاتها وطرق اختيار الموضوعات التي تناقش فيها ماكان لها أن تكون لولا جهود السيدة المديرة العامة للمنظمة، أحب أن أشير هنا الى ضرورة مراعاة تحديث كل المعلومات التي تنشر في وثائق المنظمة خاصة في تقريرها العام. لابد وأن تكون أسس هذه المعلومات هو ما تنشره الدول الأعضاء في هذه المنظمة وما تنشره مكاتبها الاقليمية.

اخوتي، الشكر كل الشكر للسيدة المديرة العامة ولجميع مساعديها أتمنى لهذه الدورة كل النجاح، والسلام عليكم ورحمة الله وبركاته.

Mr SUNGAR (Turkey):

On behalf of the Minister of Health of Turkey, who is unable to attend the Assembly because of domestic political developments, I would like to express my Government's best wishes for success to the World Health Assembly and wish to convey our congratulations to the President and the other officers of the Assembly on their election. I would also extend my Minister's best wishes and appreciation to the Director-General and her staff, particularly for the excellent world health report which we have studied with great interest.

This year's report, "Making a difference", evaluates the current health issues and challenges in an objective manner and highlights new approaches and new strategies to face these challenges. In this respect the report echoes most of our concerns. We are approaching the end of the twentieth century with considerable gains in health. The major emphasis on the critical role of primary health care has paved the way in the last quarter of the twentieth century to this success. The primary health care approach has made it possible for us to assess realistically the needs of the communities we are serving in order to pinpoint the real issues and to set up rational policies.

The goals we set in Alma-Ata had a considerable impact on our health policies and, despite some shortcomings, the primary health care approach has visibly influenced policy changes. Thanks to this approach, major successes were recorded in the fight against diseases and mortality. The threat of infectious and, particularly, vaccine-preventable diseases were reduced or became controllable. Major progress was made in healthy environments and water and sanitation. Healthy lifestyles were introduced into our health agenda. Rises in life expectancy at birth and fall of the infant and child mortality rates are clear evidence of where we have made headway.

However, the demographic changes in our societies have introduced further challenges into our health agenda in the form of a new set of diseases. These challenges, coupled with the economic burdens, are calling for a restructuring of health systems. We observe that, while the achievements of health administrations in facing the challenges of the double burden of diseases were commendable, successes in restructuring health systems through rational use of scarce resources fell short of expectations. In many countries, the reform efforts lost sight of the primary health care objectives and were shaped up under the tenets of globalization, market economy and liberalization. We believe that, under the new leadership, WHO would play a more active advocacy role to achieve the broad goal of better health for all, guiding these reform efforts in line with the objectives set out in *The world health report 1999.*

I would like to reiterate here our congratulations to Dr Brundtland and her team for their objective assessments with regard to achievements in health in the twentieth century, as well as the vision presented to us for the next decade. The four interconnected corporate strategy themes for the future work of the

Organization, as identified in the report, should be the basis of the new WHO vision. We feel that, although all of these themes have importance, the finding that WHO needs to be more effective in supporting health systems development should enjoy priority in WHO's future work.

Before concluding my statement, I would like to express our appreciation for the efforts of the Director-General in reshaping WHO and endowing it with a new vision and a more aggressive advocacy role to place health in the centre of the development agenda. We are encouraged by the determination of the new leadership to work in and with the regions and the countries more closely. The report points to the fact that, despite the remarkable gains in health, darker legacies in the form of regional conflicts bring uncertainty to our new vision and continue to be a source of misery. Since the last decade we have indeed been witnessing enormous misery in different parts of the world, including Europe. And obviously I am referring to Bosnia and Kosovo. These regional conflicts are not only causing great humanitarian problems but at the same time affecting negatively internal stability and inflicting irreparable damage to the economic, social and cultural fabric of the countries, with long-lasting effects on the health care systems. WHO, in the European Region, is faced with the challenge of redoubling its efforts in the crisis- and conflict-prone countries. We believe that WHO's response in this regard should be supported by all regions. A display of Organization-wide international solidarity is absolutely essential. Our common goal is to improve the health status of all peoples, to alleviate the burdens of poverty and sickness, and to assure that all people have sufficient access to health care. WHO will continue to enjoy all our support as long as it serves to achieve these goals.

Mr FARMAKIS (Greece) (*interpretation from the Greek*):[1]

Mr President, Madam Director-General, fellow delegates, ladies and gentlemen. I would like to begin my intervention by congratulating the President and the Vice-Chairmen on their election and wishing them every success in their tasks during the Fifty-second World Health Assembly. Allow me also to congratulate the Director-General on *The world health report 1999*, which gave us important action guidelines on which we should focus our policies and activities for the development and improvement of health in our countries.

The conclusions and the guidelines included in this report form the frame in which the actions of WHO and the activities of our countries must be integrated. Thus, one of the most crucial aspects of the report is that, regardless of the efforts pursued during the last two decades and the positive progress seen in many countries, one of the most significant problems in the field of health, probably the most serious one, is the inequities existing between the populations who have improved their health status and those who are still suffering from high levels of disease. As stated in the report, it is not a coincidence that diseases coexists with poverty. The problem to be faced is how the transition from the negative cycle of disease and poverty to the positive cycle of health and prosperity is to be achieved.

We are called upon to refer to our national experience which might have global application to countries facing similar conditions. Greece belongs to the group of countries which have the advantage of high life expectancy. The health improvement of the population is due to specific measures, like the fight against communicable diseases, such as malaria during the 1950s, as well as to the general improvement of living conditions. Habits and lifestyles, nutrition and environmental conditions, as well as the improvement of health care services, realized during the last two decades, have certainly contributed to this situation.

The risk of deterioration of the good health indicators of the Greek population always exist, for example, those related to the reappearance of communicable diseases, such as tuberculosis and poliomyelitis, for many reasons, especially the displacement of people, and to harmful habits like smoking. For all the above reasons, we have to develop public health services and upgrade their infrastructure. Primary health care needs to be improved and extended. These are our policy priorities. Another sector that needs special action is the field of mental health.

We agree with the statement in the report about the necessity of governments to maintain a leading and regulatory role and to endeavour to increase financing and upgrade the health services. I would also like to express our approval of the guidelines that the Director-General has presented for the development of the activities of the Organization for the new millennium. Allow me to declare that we fully support the policies of WHO and the Director-General's efforts as described in *The world health report*.

I would have been glad to have been able to finish my short intervention at this point. Unfortunately, the events happening in the broader area in which my country is situated, force me to remind all of you that the essential condition for development, well-being and health, is peace. My country is making every

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[1] In accordance with Rule 89 of the Rules of Procedure.

possible effort to cope with the problems of the refugees as well as for ending the conflict. I do hope that all of you agree that the war actions in the Balkans and in Europe have to stop as soon as possible, so that there will be no more destructions, deaths, negative ecological consequences and misery. We express our satisfaction at the fact that WHO has been actively involved in supporting efforts to protect the health of the population in the region. We are sure that these efforts will continue with the assistance of the Member States.

Professor MOELOEK (Indonesia):

Madam Director-General, honorable delegates, my delegation wishes to congratulate the President on her election and the Director-General for her comprehensive report on WHO achievements thus far and for the future.

As we are about to enter the new millennium, we can look back with pride at the tremendous progress which has been achieved in the health status of all countries, not least in my own country, Indonesia. As a result of intensive efforts, infant and child mortality rates have been drastically reduced. Access to health services has improved even for those living in remote and poor areas. Nonetheless, the coming decade poses further health challenges. First, we must ensure that those who have not yet been reached by this progress can soon benefit from it. Second, we must prepare for the epidemiological transition and an increase in chronic diseases and injuries. This cannot be accomplished by health ministries alone and therefore requires the building up of the necessary partnerships between the various sectors concerned. Thus, we need to renew our efforts and dedication to guarantee the health of our populations.

The recent political changes and the spirit of reform which have characterized the past year in Indonesia have led us to focus on a new vision and mission for health development in the country. This new vision and mission is entitled Healthy Indonesia 2010. The Ministry of Health should no longer be seen as the sole provider of curative services for the population. We must now concentrate on preventive and promotive health initiatives. While the Ministry of Health has, in the past, emphasized preventive programmes such as immunization, these initiatives must be expanded to other areas. These include environmental health, improved water supplies, the prevention of accidents, both on the road and at the workplace, and discouragement of unhealthy lifestyles such as tobacco consumption. This will require the Ministry of Health to work closely with other sectors in advocating the key steps they need to take in order to improve health. To achieve this, good health must be seen as the result of development efforts in all sectors, which requires political commitment at the highest level. While we are striving to move as quickly as possible in the field of health prevention and promotion, there are still weaknesses in our capacity to ensure the access of all Indonesians to quality basic health services. The major challenges here involve health financing. How can we develop effective financing systems to provide and deliver quality care in an efficient and cost-effective manner? In order to provide these services, Indonesia is presently attempting to develop a managed care system.

The challenge to achieve Healthy Indonesia 2010 will require the support of the international community. We look to WHO to lead the international support for these initiatives. International experience and data can be used to strengthen our advocacy for the involvement of all sectors in health development. Technical guidance and support should help us develop the most effective methods for strengthening health promotion and prevention. WHO can strengthen partnerships with donor health agencies and promote these new approaches to health development. Finally, we urge other Member countries to join us in this new dedication to make health promotion and prevention our foremost priority. If many countries set goals and strategies for this new approach, the momentum will be strengthened, providing the truly worldwide dimension to basic healthcare which we expect to achieve in the next decade.

Le Professeur GUIDOUM (Algérie) :

Monsieur le Président de séance, Madame le Directeur général, Excellences, honorables délégués, Mesdames, Messieurs, je tiens tout d'abord à me joindre aux délégués qui m'ont précédé à l'effet de présenter au Président mes félicitations pour son élection à la tête de cette Cinquante-Deuxième Assemblée mondiale de la Santé. Son expérience et sa compétence augurent de la réussite de cette réunion.

Les rapports qui nous ont été présentés hier matin, particulièrement celui du Dr Brundtland, Directeur général de l'OMS, permettent de constater avec satisfaction que la tenue de cette Assemblée de la Santé marque une date importante dans la reformulation des problématiques de la santé, les perspectives et les enjeux, les dilemmes, les partenariats pour le développement du secteur sanitaire, ainsi que les programmes de prévention et de soins de santé de base, l'intersectorialité et, bien entendu, les changements

structurels. Le recentrage de la santé dans l'action internationale pour le développement, fondé sur l'intangibilité du principe de l'équité, constitue effectivement, à mon sens, l'une des matrices devant caractériser l'approche de la santé.

En Algérie, des progrès notables ont été enregistrés ces dix dernières années en dépit des turbulences socio-économiques qu'a connues le pays. L'espérance de vie est passée de 61 ans en 1981 à 69 ans en 1999, et la mortalité des enfants de moins de cinq ans est de 52 pour 1000, soit un gain de plus de trente points en dix ans. Le taux de mortalité maternelle, même s'il reste pour nous inacceptable, a toutefois été réduit de 30% grâce à un suivi soutenu des grossesses et à une diminution du risque hémorragique. Enfin, nous sommes sur la voie de l'éradication de la poliomyélite puisque, pour la deuxième année consécutive et avec un système de surveillance performant, nous n'avons enregistré aucun cas.

Des actions intersectorielles ont permis d'obtenir des résultats significatifs en matière de santé scolaire, universitaire et en milieu du travail. Il en est de même pour ce qui est de la lutte contre le SIDA, où la prévention, à laquelle participent dix-huit départements ministériels, permet de contenir la progression de l'épidémie. Cependant, en dépit de tous les efforts consentis, force est de constater que la santé demeure une résultante du développement socio-économique : les maladies à transmission hydrique, par exemple, quoique en régression, continuent cycliquement de générer des surcoûts dans la prise en charge sanitaire. Les mêmes phénomènes caractérisent les effets de l'habitat insalubre, du chômage, de l'exclusion sociale. Les services de santé payent la rançon du développement, ce qui n'est ni juste, ni moral. On peut citer notamment les maladies cardio-vasculaires, les accidents de la route qui constituent, hélas, un véritable fléau, et les affections respiratoires dues entre autres à la pollution industrielle.

L'intersectorialité est indiscutable dans le principe, la santé pour tous étant l'affaire de tous. Sa mise en oeuvre opérationnelle, cependant, n'est pas toujours, loin s'en faut, à la mesure des attentes et cet état de fait ne contribue qu'à culpabiliser davantage des services de santé déjà éprouvés par les contraintes financières qui risqueraient de compromettre la préservation des équilibres macroéconomiques. Des formules audacieuses doivent être élaborées et mises en place. Il conviendrait d'agir de manière à consacrer le principe du fauteur-payeur.

Les dilemmes que nous avons abordés lors des tables rondes ministérielles d'hier et de ce matin m'ont permis - et je remercie le Directeur général de cette initiative efficace et originale - d'exprimer ce qui détermine en dernière instance la politique de santé. L'exemple du coût de la prise en charge des malades du VIH/SIDA par le schéma de la trithérapie illustre on ne peut mieux les limites objectives de la capacité d'un système à assumer pleinement ses obligations vis-à-vis de la prise en charge de certaines pathologies comme l'insuffisance rénale avec des séances très onéreuses d'hémodialyse, la greffe de la moelle, sans omettre d'évoquer les coûts de l'acquisition des moyens d'exploration, d'imagerie médicale et de leur nécessaire maintenance. Sur ce point, je tiens à souligner l'effort consenti par les pouvoirs publics. En effet, la contribution du citoyen aux frais d'hospitalisation et de consultation trouve rapidement ses limites objectives.

Le rôle des assurances sociales en matière de financement des services de santé et de remboursement des frais médicaux et d'hospitalisation pose le dramatique problème de l'équilibre entre l'assiette des cotisants et les dépenses incompressibles opérées. Dès lors, actualiser les tarifications et les valeurs monétaires des lettres clefs reviendrait inéluctablement à asphyxier la sécurité sociale et à compromettre les prestations sociales. Tout choix en matière de santé est douloureux, et exige une implication de l'ensemble des acteurs pour la formulation des priorités et des axes majeurs devant imprimer la dynamique dans le domaine de la santé.

C'est ce qui a été fait en Algérie avec la tenue, du 26 au 28 mai 1998, des assises nationales sur la santé qui ont regroupé les représentants des professionnels de la santé, des usagers, du mouvement associatif, des syndicats, des secteurs d'activités et des institutions concernés. Ces assises se sont traduites par l'adoption consensuelle de la charte dite de la santé et d'une série de recommandations qui font l'objet d'un traitement par un comité de suivi. Parmi les recommandations figurent en bonne place la réaffirmation du principe de la prise en charge par l'Etat de l'action de prévention et de lutte contre les maladies épidémiques et endémiques, la gratuité des soins pour les démunis sociaux et l'engagement d'une prise en charge par les pouvoirs publics des dépenses relatives à la prise en charge des urgences, des maladies chroniques et de la formation.

Dans mon pays, le dénominateur commun des actions menées s'articule autour de l'objectif "sécurité-santé", particulièrement autour du binôme "mère-enfant" qui constitue la pierre angulaire du dispositif. Il ne s'agit pas tant de traiter uniquement des effets, mais de dégager des consensus sur un ensemble de mesures devant permettre d'exercer une action sur les causes des différents problèmes qui puisent leur explication dans la dégradation du pouvoir d'achat, l'exclusion scolaire, l'exclusion sociale, l'habitat précaire et qui conduisent à la violence. C'est ce contexte qui interpelle sur l'impérieuse nécessité de la formulation et de la mise en oeuvre d'une stratégie "sécurité-santé". Cette démarche a fait l'objet de plusieurs rencontres et séminaires, dont notamment ceux tenus respectivement à Alger en septembre 1997

et à Constantine en décembre 1998, organisés conjointement avec l'OMS. La sécurité-santé s'articule prioritairement, mais non exclusivement, autour du binôme mère-enfant, de la santé scolaire et de la santé communautaire.

Le Directeur général a souligné la simultanéité de la création de l'OMS et de l'adoption de la Déclaration universelle des droits de l'homme. Gageons que l'avenir de l'OMS après une année de changement s'inscrive résolument dans le cadre de la résolution de l'Assemblée générale des Nations Unies décrétant l'année 2000 comme année de la culture, de la paix et de la non-violence. Je vous réitère la pleine détermination d'oeuvrer dans le cadre des axes et des réformes que vous avez engagés et je formule l'espoir qu'à l'orée du troisième millénaire puisse germer l'esprit d'un nouvel ordre sanitaire mondial.

Professor SHEMER (Israel):

Mr President, Madam Director-General, distinguished delegates, ladies and gentlemen, it is with great pleasure that I address the Health Assembly for the second time. On behalf of my delegation, I wish to congratulate the President on her election to preside over this Assembly.

Modern health care services are based upon moral and ethical codes. The patient-doctor relationship, the informed consent and the clinical trial codes are all part of an expanding awareness that supports the fight against ailments of both the human body and mind. Taking into account *The world health report* and the ministerial round tables in which you are participating, I decided to discuss the realm of lessons learned from the Israeli national health reform. Firstly, I would like to provide you with some basic Israeli health data: our population numbers approximately 6 million citizens; approximately 8% of our GNP is spent on health expenditure; life expectancy for women is 79.9 years, and for men 76.3 years; the average infant mortality for the population is 6.3/1000 live births. In 1995 the new National Health Insurance Law was passed in Israel. One of its basic elements is the basket of national health services which is a list of services and technologies that are covered by the National Health Insurance Law. The Law stipulates that the Minister of Health has the right to direct the addition of a service to the health services, provided that it does not add to the cost of the overall health services.

Until 1998, only a cost comparison was made; the addition of a new medicament required additional budget funding, unless the new drug replaced an old one used for the same indication, the cost of which was identical or higher. In many cases a cost-benefit analysis would show that despite the high acquisition cost of the new medicine, and the need for additional funds, there was an enormous saving in hospitalization days or alternative technologies which offset the cost of the drug. In such a situation, health funds would be obligated to use the new medication without the need for additional budget funding. Another problem was the addition of indications for a drug already included on the drug list; if the new indication was added automatically to the list, there could be a significant rise in the cost of the medication.

In 1998, based upon lessons learnt since the conception of the law, it was decided by the ministers of health and of finance to reform the process by which new technologies are included. A public committee consisting of senior physicians, senior health policy-makers, lawyers and representatives of various public sectors, chaired by the Director-General of the Ministry of Health, was given the mandate to allocate additional funds. This public committee utilizes all available knowledge, based on technical reports assessing medical and economic evaluations, to produce an ethical and social distribution for new technologies taking into account the shortage of available funds. We are waiting to see the impact of these changes on the reform process and hope that we are heading in a positive direction for the benefit of the Israeli population. We continue to learn from our trials, errors and deliberations.

I believe that WHO can play an important role in this sensitive area of management of medical technology, where conflicts between medical advance and economic considerations might influence judgements and decisions. WHO should play a leading role in implementing new medical technology in health care services throughout the world. Furthermore, WHO can assist each country to accommodate its special needs according to its cultural, social, ethical and political values and to maximize the utilization of its resources.

I would like to conclude by expressing the hope that WHO will continue to work to alleviate the health problems of populations throughout the world, in a spirit of cooperation and goodwill. Last and not least, Israel hopes that WHO will become involved in promoting health and raising collaboration in the field of medicine in the Middle East.

Mme BETTONI BRANDANI (Italie) :

Monsieur le Président de séance, Madame le Directeur général, Mesdames et Messieurs les délégués, permettez-moi avant tout de féliciter personnellement et au nom du Ministre de la Santé, Mme Bindi, le

Président et les Vice-Présidents de cette Assemblée ainsi que les Présidents des commissions pour leur élection, et de leur assurer le plein soutien de la délégation italienne.

L'Assemblée mondiale de cette année - la dernière du XX^{e} siècle - constitue une occasion pour souligner les progrès accomplis par la santé internationale durant les dernières années de ce siècle et pour réaffirmer les engagements et les responsabilités face aux défis et aux difficultés qui doivent encore être affrontés. Les excellents rapports du Directeur général attirent précisément l'attention sur le fait qu'il est nécessaire que la santé soit un point focal pour le développement et représente un investissement social indispensable pour la croissance économique des pays et pour la sauvegarde et le respect des droits de l'homme, de la liberté et de la démocratie. A propos des progrès accomplis par la santé internationale, je voudrais mentionner l'éradication de la variole, qui illustre en effet l'importance de la collaboration internationale et le rôle déterminant de l'OMS. Au seuil du XXI^{e} siècle, une autre conquête importante est à notre portée : l'éradication de la poliomyélite. C'est un objectif d'une grande valeur scientifique, qui n'est malheureusement pas encore tout à fait atteint. Le nouveau Plan sanitaire national italien, intitulé "Un pacte de solidarité pour la santé", contient des points importants qui reflètent bien les principes et les priorités énoncés dans le *Rapport sur la santé dans le monde, 1999*. Les objectifs principaux du Plan sanitaire national sont les suivants : renforcer l'autonomie décisionnelle des utilisateurs, promouvoir l'utilisation appropriée des services de santé, diminuer les inégalités face à la santé, favoriser des comportements et des modes de vie plus sains, poursuivre l'intégration sociosanitaire et relancer la recherche.

Suivant les principes des stratégies définies dans le rapport du Directeur général, le Plan sanitaire national souligne l'importance de la collaboration intersectorielle dans le domaine de la santé. Cette collaboration vise à créer des alliances avec des secteurs qui ont un impact direct sur la santé, comme ceux de l'environnement, de l'instruction publique, des transports, de l'industrie et du commerce. Sur le thème de la solidarité, je crois qu'il est important de se souvenir d'un aspect aussi actuel que délicat : le vieillissement progressif de la population mondiale. Il s'agit là, pour de nombreux pays, d'une question sociosanitaire de grande portée qui requiert des interventions intégrées, tant pour la prévention que pour le recouvrement de la santé, et l'élimination des déficits fonctionnels et, par conséquent, des désavantages sociaux qui peuvent en dériver. Les objectifs du Plan sanitaire national italien prévoient, entre autres, la promotion du maintien et la récupération de l'autosuffisance des personnes âgées, selon le concept du "vieillissement actif", et le développement de formes d'interventions qui puissent se substituer à l'hospitalisation et qui soient suffisamment intégrées dans la société.

Le concept de solidarité nous force à réfléchir sur un problème qui, malheureusement, continue à affliger l'humanité au seuil du XXI^{e} siècle : l'insuffisance de l'assistance et de l'aide humanitaires, tout particulièrement grave dans le domaine de la santé. Permettez-moi de rappeler la connaissance acquise dans ce domaine par l'Italie. Les tristes séquelles liées aux conflits armés et leurs répercussions sur la santé des populations voient désormais engagés notre coopération sanitaire, nos institutions et le monde du volontariat, dont le rôle et la participation méritent tout notre soutien et toute notre reconnaissance. Comme on le sait bien, l'Italie, avec d'autres Etats Membres, considère que le Département Secours d'urgence et action humanitaire, qui a été utilement confirmé dans le processus de restructuration de l'OMS, pourrait intervenir aussi sur le terrain face à des situations de crise.

En ce qui concerne l'immigration, l'Italie applique une politique d'hospitalité et d'accueil qui a pour objectif de faciliter l'insertion et la régularisation des immigrés, lesquels ont droit, entre autres, à l'assistance sanitaire gratuite sur tout le territoire national. Notre Plan sanitaire prévoit en même temps que toute vaccination assurée à la population italienne soit étendue également à la population immigrée.

Un mot encore sur les deux initiatives prioritaires citées dans le rapport du Directeur général : Faire reculer le paludisme et Pour un monde sans tabac. Je désire avant tout exprimer mon estime et mon soutien envers le projet Faire reculer le paludisme. Le paludisme a malheureusement acquis dans de très larges parties du monde les caractéristiques d'une maladie sociale. La détérioration progressive de la situation requiert donc des interventions urgentes et appropriées. Nous partageons l'approche qui vise à combattre le paludisme par le biais d'un renforcement des systèmes de santé dans les pays d'endémie, afin de créer les bases d'une continuité d'action indispensable à une lutte efficace contre cette maladie. Cette initiative bénéficie déjà de la collaboration de mon pays, grâce à des engagements de coopération sanitaire, tout aussi bien qu'à travers une collaboration technique avec les institutions italiennes.

En ce qui concerne l'initiative Pour un monde sans tabac, je voudrais confirmer l'engagement du Ministère de la Santé dans la lutte contre le tabagisme à partir des mesures concrètes prévues dans notre Plan sanitaire national. Cette action vise à réduire le nombre de fumeurs et la quantité journalière de cigarettes consommées, en vouant une attention toute particulière aux adolescents et aux femmes enceintes.

Monsieur le Président de séance, permettez-moi de conclure en exprimant le grand intérêt et les attentes de l'Italie en ce qui concerne le processus de réformes internes entrepris par l'OMS. Nous savons qu'un tel processus requiert du temps, mais l'orientation imprimée par le Directeur général nous paraît être la bonne, surtout pour ce qui a trait aux efforts pour limiter les dépenses administratives, concentrer les

ressources sur des activités techniques et développer ultérieurement les capacités, les compétences et l'expérience du personnel de l'Organisation.

Pour ce qui est des bureaux régionaux, je souhaite exprimer l'estime du Ministère italien de la Santé pour le travail accompli et pour l'excellente collaboration en cours avec le Bureau régional de l'Europe. C'est avec plaisir que l'Italie se prépare à accueillir au mois de septembre, à Florence, la quarante-neuvième session du Comité régional européen de l'OMS.

Mr DE SILVA (Sri Lanka):

Mr President, your excellencies, distinguished delegates, at the outset may I take this opportunity to congratulate our dynamic Director-General, Dr Gro Harlem Brundtland, for the conceptual clarity and the practical orientation of the vision contained in her forward-looking report to this Assembly.

Sri Lanka has had Universal Adult Franchise from 1931, and systems of universal health care and education, free at the point of delivery, since it gained Independence in 1948. These social welfare policies have accounted for the steady improvement in the national health indicators such as infant mortality, maternal mortality, a life expectancy in excess of 70 years and a literacy rate exceeding 90% for both men and women. The theme of *The world health report*, "Making a difference", is particularly appropriate in the context of the Sri Lankan Government's recent initiatives in the health sector. Her Excellency the President of Sri Lanka has given creative leadership and direction to a special task force appointed to make proposals on a comprehensive national health policy and strategies to meet the challenges of the coming millennium. The report of the task force provides a framework for government action and reforms in the health sector and is being progressively implemented.

With increasing longevity and improvement in people's living standards and health, the Government has had to contend with a double burden of disease. At the same time, recent advances in medical science and technology and the inevitable publicity associated with such advances, create an apparent demand for them, coupled with the expectation that the Government should provide them, free of charge, as in the past. The scars of mental and physical trauma resulting from terrorist violence, including landmine injuries, will be heavy burdens on the Government health care system for several years to come. Rapid transformation from a predominantly rural agricultural and plantation economy towards one characterized by increasing urbanization, emigration for foreign employment, an increasing influx of tourists, and gradual industrialization are some of the other circumstances that the government of a developing country such as Sri Lanka has to contend with in formulating health policy and strategies, if it is to make a real difference.

The Sri Lanka Government remains committed to continue the policy of free health care services to the needy, well into the next millennium. We are also aware of the important role that the private sector plays in providing health care facilities. While encouraging private sector health services, the Government also believes that the nongovernmental organizations and community organizations must be permitted to play an active role in the health care delivery system. The Government has given high priority to eradication of malaria and malnutrition, control of HIV/AIDS, control of noncommunicable diseases, and minimization of the dreadful harm from tobacco and other addictive substances. I am happy to state that Sri Lanka is in the forefront of actions taken to combat epidemics of tobacco-related diseases. They include the formulation of national policy and strategy; increase in the price of cigarettes; legislation to ban all promotion and advertising of brand names, logos and other symbols of tobacco; a massive island-wide multi-media campaign banning tobacco smoking, and the sale and promotion of tobacco-based products in all State institutions; prohibition on government departments or institutions from accepting sponsorships for any purpose from those who promote tobacco smoking; and instructions to the electronic and print media to adhere to a code of behaviour regarding all tobacco promotion. Mental health, pesticide and herbicide poisoning, self-harm and suicide, traffic accidents and occupational health are also receiving priority attention.

A monthly programme, "Suwa Udana" (Dawn of Health), with full community participation, launched by the Ministry of Health to deliver quality health care to most deprived areas of the country, coupled with provision of specialist curative services and health education, is now being actively implemented. Sri Lanka believes that in "making a difference", the traditional systems of medicine such as Ayurveda, which is still used by large sections of the people, particularly in the rural setting, needs to be developed. Complementary systems of medicine such as homeopathy, which has proved to be cost-effective, should be recognized and fostered. Our Government has already taken a comprehensive set of measures in this regard.

Although Sri Lanka is still a developing country beset with some of the daunting challenges which I have referred to earlier in my statement, the Government will retain its dominant role in providing health care for the people, maintaining and regulating standards of care, and formulating health policy and strategy

at the national level. In conclusion, we are also grateful to organizations such as WHO, UNICEF, UNFPA, World Bank, Asian Development Bank and other bilateral donor countries and agencies for the assistance extended to us in developing our health care services. We look forward to their continued support for our efforts to meet the challenges in order to "make a difference", as envisaged by WHO.

El Dr. DOTRES MARTÍNEZ (Cuba):

Distinguidas delegadas, distinguidos delegados: El énfasis del *Informe sobre la salud en el mundo 1999* es seguramente compartido por los aquí presentes. Infelizmente no alcanzamos la salud para todos en el año 2000. Los objetivos prioritarios de la Organización dirigidos hacia la solución de estos aspectos deberían contar con el respaldo de los gobiernos y deberíamos insistir en la responsabilidad estatal sobre la salud integral de los pueblos. Coincidente con los enfoques de la OMS, Cuba, a raíz del azote de los huracanes Georges y Mitch al Caribe y Centroamérica, elaboró un plan de salud integral para la situación sanitaria poshuracán y para contribuir a la reconstrucción de esos países. Los gobiernos de Centroamérica solicitaron a la comunidad internacional medidas para la rehabilitación y reconstrucción de sus países trágicamente afectados. Cuba apoyó de inmediato las siete medidas de los gobiernos centroamericanos, canceló la deuda contraída por Nicaragua de 50 millones de dólares y expresó su disposición a poner gratuitamente al servicio de dichos países por el tiempo que se requiriese todo el personal médico necesario. Como no puede haber reconstrucción y desarrollo económico sin un programa integral de salud en una región donde mueren en conjunto cada año más de 50 000 personas, en su inmensa mayoría menores de 5 años que podrían salvarse con un costo económico relativamente modesto, Cuba propuso que, si uno o varios países que dispongan de más recursos aportan los medicamentos necesarios, Cuba estaría dispuesta a enviar el personal médico que hiciera falta para llevar a cabo a corto y mediano plazo un programa integral de salud en los países afectados. Suponiendo que hayan perecido, entre muertos y desaparecidos, 30 000 personas, sumando El Salvador, Guatemala, Honduras y Nicaragua, con el programa que mi país propone podrían salvarse cada año tantas vidas como las que se perdieron en el huracán Mitch, entre ellas las de no menos de 25 000 niños de 0 a 5 años de edad. Con relación a Haití, se ejecuta un programa similar de cooperación con 400 médicos y trabajadores de la salud tras el paso del huracán Georges. A pesar de que no se ha recibido todavía ningún aporte especial de países industrializados, este programa de colaboración médica, con la ayuda de diversas organizaciones no gubernamentales, los modestos recursos de los países afectados y las contribuciones de nuestro propio país, cuyos recursos como se conoce son escasos, comienza a ser ya una prometedora realidad.

Se encuentran en estos momentos trabajando en los lugares más recónditos casi 1100 médicos y técnicos de la salud en Belice, Guatemala, Haití, Honduras y Nicaragua, y existe la disposición de enviar cuanto personal sea necesario en forma gratuita y por tiempo indefinido. De igual forma, Cuba elabora un ambicioso programa de cooperación médica con los países más necesitados de la zona comprendida entre el desierto del Sahara y el África subsahariana; en Nigeria se encuentra el primer grupo de médicos.

A nuestro juicio, dicho programa demostrará cómo puede hacerse mucho con poco. Sería imposible lograr las elevadas metas que son accesibles con un mínimo de recursos en medicamentos sin el valioso e imprescindible apoyo de la OMS, que recabamos y estamos seguros de recibir a tono con el informe presentado. Cuba, como ha explicado nuestro Presidente, cuenta con un alto índice per cápita de médicos entre todos los países del mundo. Este programa prevé, además, la formación, también gratuita, en la Escuela Latinoamericana de Medicina, especialmente creada para este plan. Cuba ha ofrecido 1900 becas para 15 países de América Latina este primer año y unas 1250 nuevas becas anualmente. Hoy 1209 estudiantes procedentes de regiones apartadas de Bolivia, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua y República Dominicana ya están recibiendo un curso preparatorio.

En las próximas semanas llegarán más de 600 procedentes de otros países de América Latina. Con relación a África, tomando en cuenta la distancia hemos expresado nuestra disposición a cooperar con profesores en el desarrollo de centros para la formación de médicos. Somos conscientes de que nuestro aporte es modesto, pero no ignoramos que el hecho de que lo realice un país pobre y con grandes dificultades económicas como Cuba se convierte en un estímulo para todos los que, disponiendo de más recursos, puedan contribuir en la medida en que lo requieran y lo merecen los países más pobres y sufridos de América, África y el resto del mundo.

Señor Presidente: Mi país pone en manos de la comunidad internacional y de la OMS este plan y llama a todos a contribuir de una u otra forma para mejorar las condiciones de vida de los pueblos más requeridos de apoyo. Permítame concluir mi intervención con las palabras del Presidente cubano Fidel Castro al analizar el impacto de los desastres naturales y los efectos de la pobreza. Cito: «El huracán permanente de la pobreza y el subdesarrollo mata cada año decenas de miles de centroamericanos cuyos cadáveres no aparecen en las imágenes de televisión flotando en las aguas o envueltos en el lodo

conmoviendo al mundo. Son enterrados en silencio por sus familiares sin que nadie se entere. El problema ahora no es sólo llorar por los que han muerto, sino ocuparnos de salvar a aquellos que silenciosamente mueren cada año». Este concepto, señor Presidente, distinguidas delegadas y delegados, es aplicable a muchos países del mundo. Muchas gracias.

El Sr. ROMAY BECCARÍA (España):

Señor Presidente, señores ministros, distinguidos señoras y señores: En primer lugar quisiera rogarle, señor Presidente, que haga llegar a la Sra. Maria de Belém Roseira mi más cordial felicitación por su nombramiento como Presidenta de la 52ª Asamblea Mundial de la Salud.

Me resulta muy grato participar en calidad de Ministro de Sanidad y Consumo del Gobierno de España en esta Asamblea Mundial de la Salud en la que, atendiendo a la sugerencia de la Directora General, Dra. Gro Harlem Brundtland, trataremos de reflexionar sobre la salud mundial en este final de milenio y sobre los retos y prioridades a los que deberemos atender en los próximos años y que necesariamente debemos relacionar con los profundos cambios producidos en el orden político, social y sanitario. Centrándonos en el ámbito sanitario, observamos que la mayoría de los países han puesto en marcha sistemas asistenciales acordes con su historia, su realidad social y su capacidad financiera. Sin embargo, con independencia de las características propias de cada sistema sanitario, todos los países nos enfrentamos a problemas comunes derivados de los cambios en los patrones de morbimortalidad, el envejecimiento poblacional, los altos costes de la sanidad y la necesidad de reorientar las actividades asistenciales hacia las auténticas demandas y requerimientos de los ciudadanos.

La respuesta ante estos retos no es única y tiene que adaptarse a las peculiaridades e idiosincrasia de cada sociedad, a su grado de desarrollo y a sus antecedentes históricos. A pesar de todas estas circunstancias, en todos los procesos de reforma sanitaria actualmente en marcha subyace un elemento común, como es la búsqueda de una mayor eficiencia y rentabilidad social, lo que a su vez debe traducirse en mejoras en la equidad de los servicios de salud. El desarrollo de las ciencias de la salud y los nuevos descubrimientos en el campo de la genética han dado origen a nuevas formas de intervención en los procesos de reproducción humana y han abierto nuevas posibilidades en la prevención y tratamiento eficaz de numerosas enfermedades vinculadas a defectos genéticos, pero también han planteado nuevos conflictos que deben ser resueltos desde sólidos esquemas éticos y jurídicos, cuya normativa habrá que establecer sin vulnerar las tradiciones culturales y creencias de los países. Igualmente, el avance tecnológico está permitiendo espectaculares resultados en el ámbito de los trasplantes de órganos y tejidos, en las técnicas de diagnóstico o en la obtención de medicamentos cada vez más eficaces. No obstante, no hay que olvidar que siguen subsistiendo enfermedades de enorme trascendencia, como la malaria o el SIDA, que unidas a la lucha contra el tabaquismo ocupan un lugar prioritario dentro de los programas de la OMS.

Este complejo panorama nos lleva necesariamente a coincidir con el criterio de la Dra. Brundtland de la necesidad de un cambio de estrategia en los planteamientos de la OMS. Compartimos el criterio de la Organización en el sentido de que este cambio supone un nuevo concepto de la universalidad de la asistencia sanitaria, entendida como el compromiso que asume el Estado de hacer efectivo el derecho de los ciudadanos a acceder a una asistencia sanitaria de la mayor calidad y eficacia, lo más equitativa posible y que incluya un conjunto de prestaciones acordes con las necesidades de salud y adecuadamente analizadas, en las que junto a los criterios de efectividad, eficiencia y coste-beneficio, se incluya la evaluación en términos de utilidad social. Los cambios demográficos, en especial los que están produciéndose en las sociedades desarrolladas, hacen imprescindible la implantación de programas de atención sociosanitaria que permitan dar la adecuada respuesta sanitaria y social a los procesos crónicos y degenerativos. Gracias a los avances sanitarios y sociales, se han logrado mejoras significativas en la esperanza de vida de nuestras poblaciones. El objetivo para el futuro será lograr no sólo una vida más larga, sino en mejores condiciones, con el menor número de discapacidades y limitaciones posibles. En consecuencia, creemos, al igual que la Dra. Brundtland, que la OMS puede y tiene que renovarse: mayor responsabilidad y transparencia, menor burocratización y más receptividad frente a un mundo en acelerada mutación han de ser sus principales objetivos. Los beneficios del proceso científico y tecnológico deben distribuirse adecuadamente.

Señor Presidente: He intentado expresarles en mi intervención los criterios de mi Gobierno ante la realidad política y social actual. Nuestra primordial preocupación debe ser tanto la humanidad en su conjunto como los individuos que la integran. Consideramos legítima la aspiración de todos los pueblos a tener acceso al bienestar y a la salud.

Antes de finalizar, quisiera transmitir a esta Asamblea la preocupación del Gobierno español, compartida por los países hispanoamericanos, por el deterioro en el cumplimiento de las disposiciones que regulan el estatuto del idioma español en la OMS y los retrasos que en demasiadas ocasiones se producen

en la traducción de los documentos de la Organización al idioma español. Debo por ello reiterar nuestra petición en el sentido de que la OMS mantenga y refuerce el apoyo en recursos materiales y humanos para que nuestro idioma tenga, en pie de igualdad con todos los demás, el tratamiento previsto en las normas vigentes de la Organización. Muchas gracias.

Dr KIM (Republic of Korea):

Mr President, Madam Director-General, distinguished delegates, ladies and gentlemen, on behalf of the delegation of the Republic of Korea, firstly let me congratulate Mrs Maria de Belém Roseira on her election as President of this World Health Assembly. Let me congratulate the Director-General, Dr Gro Harlem Brundtland, for her strong and innovative leadership in the work of WHO and for her efforts to "make a difference" by reaching out, working together and building a partnership. My sincere appreciation goes to Professor Amartya Sen for the stimulating address on "Health in development", in which he referred to my country many times. I am happy to note that he was complimentary.

One of the most pressing concerns of Korea and other nations over the last couple of years has been the severe economic crisis which has affected countries at all levels of development. As health policy-makers, we are all aware of the effects of these financial turmoils on the health and welfare of our peoples. This sad situation makes us even more aware of the inevitable links between economic development and health. In the past, we have been too concerned with economic success and neglected the investment in health and welfare which should go to those who have helped make the economic success stories possible.

Economic development must proceed with development of health and welfare services. As the Director-General has emphasized in the "new universalism", government agencies other than health must be involved in the total integrated movement of economic, health and welfare processes. Developmental drawbacks such as environmental degradation, excessive unplanned urbanization, the loss of traditional family ties, all have an impact on the health of the individual, and all sections of the community should work together to minimize or eradicate these difficulties. The private health and industrial sectors must be involved more and nongovernmental organizations have to play an important part in helping countries cope with the possibly negative aspects of economic development.

Financial restraints and shrinking public revenues caused by the economic crisis also mean that health and welfare services must be provided in a more cost-effective way. Korea, for example, is now exploring the expansion of "home nursing services" in an effort to reduce the cost of treatment of patients needing relatively uncomplicated long-term care or who can be cared for in the home rather than in a hospital. This is only one example of how we can help control the increasing costs of health care. WHO and Member States can work together to explore ways of meeting the new needs for health and welfare services in this age of national and international financial instability. Together we can perhaps develop new policies which will lead to more cost-effective health care and better integration of economic and welfare developments, and will take more account of the poor and marginal sections of the community. I know that these issues have been a concern of the Organization and of Member States in the past, but the new world financial order makes these responsibilities more pressing than ever before.

This is the last Health Assembly before the millennium. By working positively together, with a revitalized Organization and a reformed administration, we can meet the challenges of the next century. Let us make sure that we keep our promises to the peoples of the world to make this new century a happier and healthier one.

Mr SERRA (Brazil):

Mr President, Madam Director-General, delegates, almost one year has elapsed since Dr Brundtland and her staff took office. It seems timely to express the support of the Brazilian Government to the changes that have so far been promoted and to the enormous efforts Dr Brundtland and her team are making to include health issues among the priorities of the world political and economic agenda. We also congratulate their endeavours to show that an efficient health care system constitutes an important factor for any development strategy. All initiatives to improve the health sector must be regarded as investments and not as current expenditures that put more burdens on national budgets. This change of focus is definitely a considerable advance, and we encourage WHO to proceed firmly with the task of convincing governmental decision-makers to adopt this approach. I should add that we fully agree with the report when it analyses the role of government and the private sector on health care. In Brazil, the private sector is and will be supplementary to the public one, not only because the Brazilian Constitution so establishes, but also because 40% of the population cannot afford private services.

In relation to the measures proposed, we are convinced that the Roll Back Malaria project must have a global coverage, since the incidence of the disease is not limited to a determined region. I do believe WHO is willing to consider this programme on a worldwide basis, and therefore, we support this perspective with great enthusiasm. Other important global priorities, that in our view should be supported by all other countries, are the initiative against tuberculosis, the control of poliomyelitis and the control of iodine deficiency disorders, which have produced very promising results.

We would like to focus now on *The world health report*; my comments will be related to some of our recent achievements. In the process of fostering development through health the Brazilian Government has adopted a strategy of investing more decisively in primary health care and promotion of healthy lifestyles. The per capita expenditure in these areas has increased 80% between 1996 and 1999, and even more in the poorest regions. Financial incentives are being provided to local governments to implement programmes, such as that on community health workers, the family health programme, pharmaceutical assistance, and for the control of all forms of malnutrition. We already have 83 000 community health workers in more than 3500 municipalities and more than 3000 family health teams. Our goal is to reach a total of 20 000 teams assisting around 69 million people throughout the Brazilian territory by 2002.

We also recognize the importance of gender issues in the process of development and their close link with health. In partnership with PAHO and other international agencies, we are improving maternity care through the Safe Motherhood project. Among other actions, a maximum proportion of caesarian sections per hospital was established, as well as an increase in payment for natural births. As a consequence, we have noticed in a very short term a decrease of approximately 13% of caesarian surgeries. In 1998, we launched a national cervical cancer screening campaign, the largest so far in Brazil, examining 3 250 000 women.

Another central idea of the report is the need for health systems to define priorities and select interventions. One of our priorities is the prevention and control of HIV/AIDS, and the main aspect we want to emphasize is the provision of free drugs to all HIV-positive and AIDS patients. Thanks to this action we have decreased the number of deaths caused by AIDS by 48% in São Paulo and 32% in Rio de Janeiro, two cities that concentrate around 36% of the total number of notified AIDS cases in Brazil.

An initiative that has been very successful for its humanitarian and social impact, and that has also rationalized the use of available resources, is the national campaign for the elderly. For instance, we have managed to vaccinate more than 7 million people over 65 years of age against influenza and tetanus, covering more than 80% of the Brazilian elderly population. The Brazilian Government is also promoting training programmes in geriatric treatment and care to health professionals and to informal caregivers, enabling them to assist and counsel elderly people.

A significant measure that will certainly have a strong impact on the Brazilian health system is the recent regulation of private insurance and health plans. In this area, I must say that the Brazilian Government is implementing its regulatory mandate emphasized by the Director-General in her report. Also in the area of control and supervision, a national agency for sanitary surveillance has recently been created to control medicines, food, chemotherapeuticals, blood and blood products, tobacco products, cosmetics, agrotoxics and others. It has a modern structure, characterized by its administrative independence, stability of its board of directors, and financial autonomy.

Regarding leprosy, in the last 12 years its prevalence has been reduced by 66%. We are developing a strategy in order to have less than one case for each 10 000 people by the beginning of the next century. The control of malaria, tuberculosis and other important endemic diseases in Brazil as well as the eradication of measles and neonatal tetanus will be greatly supported this year by an agreement with the World Bank. Finally, a tobacco control programme was established with legislative actions and educational campaigns, mainly targeting youth. The Brazilian Government is training professionals in 3000 municipalities to implement actions in schools, health units and work places.

The remarks I have just presented reveal a very high level of symmetry between the actions in Brazil and the priorities defined by WHO. We expect that WHO will continue to lead with great efficiency and sensibility the destiny of public health in the world, and Brazil is ready to join forces to face the challenges ahead in the coming millennium. The future generations are counting on our commitments and sincerity of intentions.

Dr E.F. Ehtuish (Libyan Arab Jamahiriya), Vice-President, took the presidential chair.
Le Dr E.F. Ehtuish (Jamahiriya arabe libyenne), Vice-Président, assume la présidence.

Dr SUKAROMANA (Thailand):

Mr President, distinguished delegates, ladies and gentlemen, I first express my sincere thanks to you in offering me this great honour to say a few words at this prestigious moment of the Health Assembly. During the past decade this Assembly and the Executive Board of WHO proposed and agreed on several resolutions to improve the efficiency and transparency of WHO. We are waiting to see the results. In this connection, I would like to commend the great effort of our Director-General, Dr Gro Harlem Brundtland, to bring about real changes. From these resolutions, she is indeed making a difference, starting from within the Organization itself, and we appreciate that. I am sure we all agree that the final goal in making a difference is the reduced gap between the health of the better off and the poor. This means particularly the rapid improvement of the physical, mental, social and spiritual well-being of people in the poorer developing countries. This should be the priority of making a difference. All possible obstacles, which may result from globalization, trade liberalization, political conflicts, war, natural disasters, including intellectual and financial imperialism, have to be collectively and effectively tackled and solved. It is thus very clear that in order to achieve this goal, the health sector needs to work very closely with other sectors. This also means that WHO needs to work closer with other international organizations. This may be part of the concept for partnership of health development, which is also a Cabinet project of the Director-General. Nevertheless, this is not enough.

The recent changes in the global political climate and rapid advancement in international communications result in the current regional structure of WHO being somewhat of an antique: our regional structure is definitely outdated. To give you just one example, the 10 Asian countries and the six Mekong-basin countries belong to two regions of WHO, South-East Asia and Western Pacific. It is thus very difficult for these countries with geographical as well as cultural proximities to work together under the current WHO structure. To make a difference means both to reform the structure of WHO headquarters and its relationship with other international organizations and also to restructure its regional configuration. In addition, innovative horizontal mechanisms for countries in different regions of WHO to work together on certain specific health development activities should be promoted. These horizontal mechanisms are like the horizontal threads that are interwoven into the vertical threads to form a strong piece of world health cloth. It is this strong world health cloth that will keep us warm, sheltered and trying to make a difference. Some examples of these horizontal relationships have been initiated, for example, technical cooperation among Asian countries on pharmaceuticals, the Asian Subcommittee on Health and Nutrition, and several Mekong-basin health development projects. I thus would like to see WHO working closely with other international development organizations to support the creation of more of these horizontal mechanisms. The Cabinet project on Partnerships for health development should focus its efforts and budget on supporting and strengthening this horizontal trend.

The second important issue in regard to making the difference is the prioritization of our efforts towards high priority health problems and determinants. I would like to give strong support to the Director-General in focusing her efforts on a few Cabinet projects, for example the Tobacco-Free Initiative and Roll Back Malaria. These are definitely important killers, particularly in the developing world. Nevertheless, I would like to see concrete evidence that shows our real and serious commitment to this priority. The best indicator is the budget that we allocate to these priorities in Thailand. We have just finished formulating our plan of action for the WHO country programme for the year 2000-2001. We decided to create separate plans for these two priorities, which comprise 10% of the WHO country activities budget. We are going to do the same thing in our intercountry programme for the South-East Asia Region, in particular for Roll Back Malaria. We agree totally with the Director-General to focus on the African Region. However, our region also has a high burden of malaria and is the main exporter of multiple drug-resistant malaria. The South-East Asia Region should also be the focus of attention.

Mr President, it is clear from the proposed programme budget of the WHO headquarters that US$ 42 million, or 14% of headquarters' regular budget, is allocated to communicable and noncommunicable diseases, including these two priorities. There is no clear budget allocation specifically for these two Cabinet projects. This of course may not make much difference in bringing about the changes that we aim for. It is also clear evidence that we tend to think and talk more than being prepared to really perform. This is not the first time that we have talked about making a difference. Nevertheless, few results have been achieved so far. I do hope that this Assembly will be the beginning of our pooled efforts to build up our solidarity to make a real difference. I am also quite convinced that under your leadership, and with the solidarity of our Member countries and support of an efficient, transparent and better calibre staff under the Director-General, we will make several great and real differences in bridging the health gap in the new millennium.

M. CIAVATTA (Saint-Marin) (*interprétation de l'italien*) :[1]

Monsieur le Président, Mesdames et Messieurs les Ministres, honorables délégués, je suis particulièrement heureux de m'exprimer au nom de la République de Saint-Marin devant cette Assemblée, dont le rôle est notamment d'examiner le *Rapport sur la santé dans le monde, 1999 - Pour un réel changement*. Tout d'abord, je voudrais présenter au Dr Gro Harlem Brundtland, Directeur général de l'OMS, les salutations de notre Gouvernement et de notre pays tout entier.

Le cadre général de la situation mondiale, spécialement dans les pays les plus industrialisés, montre que la durée de vie augmente de plus en plus, accentuant ainsi les différences par rapport aux pays en développement et entre le Nord et le Sud, où la pauvreté, les guerres et les maladies compromettent gravement l'espérance de vie de millions d'hommes, de femmes et d'enfants.

Le bien-être et le haut niveau de développement qui caractérisent l'économie de Saint-Marin ont certainement contribué à prolonger l'espérance de vie moyenne de la population, et l'on enregistre aujourd'hui un pourcentage de personnes de plus de 65 ans supérieur à celui des jeunes de moins de 15 ans. La conséquence la plus immédiate de ce phénomène est la nécessité de rester en bonne santé le plus longtemps possible.

Grâce à une politique sociale qui insiste depuis bien des années sur les thèmes de la prévention et de l'assistance aux couches sociales les moins favorisées, les recommandations de l'OMS ne prennent pas Saint-Marin au dépourvu. C'est en fait sur ces prémisses que l'on a établi, pour la première fois dans notre pays, le "Plan sanitaire", qui est actuellement soumis à l'approbation des instances politiques. Il s'agit d'un instrument de programmation valable pour les cinq prochaines années et proposant des lignes directrices pour les réformes et les mises à jour qui seront nécessaires dans le domaine de la santé et de la sécurité sociale. L'objectif premier du Plan est la prévention, qui est de la responsabilité de l'Etat, ou bien, conformément aux recommandations de l'OMS, la promotion de modes de vie sains, ce qui exige une meilleure éducation et une information correcte en ce qui concerne la nutrition et l'activité physique, les risques liés à la consommation de tabac et d'alcool, et l'importance de l'application stricte de la législation relative à la sécurité et à l'hygiène sur les lieux de travail. Cela signifie aussi combattre par des actions spécifiques les affections principales qui sont aujourd'hui, selon les relevés les plus récents, les maladies cardio-vasculaires et le cancer, sans oublier les accidents du travail et les maladies professionnelles. Il faut aussi améliorer l'environnement par des interventions spécifiques concernant l'air, l'eau, les aliments, les rayonnements et les déchets et renforcer la protection des sujets les plus faibles par des initiatives destinées à combattre le phénomène de la toxicodépendance, à soutenir les personnes atteintes d'incapacité et à offrir les services nécessaires dans les phases de la vie où l'individu est le plus vulnérable, à savoir l'enfance et la vieillesse. J'aimerais aussi souligner que l'un des projets les plus importants des cinq prochaines années, déjà approuvé par notre Gouvernement, consiste à établir un centre de cancérologie hautement spécialisé, en vue de compléter le cycle des thérapies médicochirurgicales existantes qui font partie de nos services.

Enfin, pour que le système de santé puisse fonctionner de manière satisfaisante, il est nécessaire que l'appareil administratif soit efficace et fonctionnel. Dans ce but, des réformes sont actuellement en cours d'élaboration. En outre, par suite des variations dans les tendances démographiques, la République de Saint-Marin est en train d'affronter le problème d'une réforme du régime de retraite, qui devra poursuivre deux objectifs principaux : garantir les droits déjà acquis par les citoyens en activité et garantir en même temps le droit à la retraite des nouvelles générations.

Nous croyons, tout comme l'OMS, qu'un pays ne peut se permettre de consacrer ses ressources à des interventions de qualité médiocre qui aboutiraient à des activités médiocres. Il ne s'agirait que d'un gaspillage inutile. Le principe de la solidarité, que tout système sanitaire doit respecter et qui prélude à un "nouvel universalisme" dans le domaine de la santé, ne signifie pas "tout donner à n'importe qui", mais diversifier les interventions sur la base des exigences réelles, selon une politique planifiée et clairvoyante.

Nous sommes convaincus que cela est fondamental, même face aux situations sanitaires d'urgence causées par les guerres en cours dans plusieurs parties du monde et qui demandent toute notre attention, en particulier celle des Balkans, où une population tout entière vit une tragédie ethnique que nous n'aurions plus voulu voir après la Seconde Guerre mondiale. Face aux nombreux besoins de la population du Kosovo et compte tenu du contrôle sanitaire imposé par l'arrivée des réfugiés dans les différents pays d'Europe, seuls des systèmes de santé efficaces seront en mesure d'offrir cette solidarité qui ne s'exprime pas par des mots, mais plutôt par des interventions qualifiées. C'est aussi dans cette voie que chaque Etat devra s'engager en priorité absolue.

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[1] Conformément à l'article 89 du Règlement intérieur.

El Dr. TAPIA (México):

Señoras y señores delegados: Antes de iniciar mi intervención quiero felicitar a la Secretaria de Salud de Portugal por su elección como Presidenta de esta Asamblea, y asimismo expreso el reconocimiento a la Dra. Brundtland por el informe que nos ha presentado el día de ayer, el cual es, a la vez, punto de partida de nuevos desafíos.

En nombre del Gobierno de México y del Secretario de Salud, expreso el honor que representa dirigirme desde esta alta tribuna a quienes encabezan el esfuerzo sanitario a nivel mundial. La propuesta de la Dra. Brundtland representa una nueva visión del liderazgo que la Organización Mundial de la Salud está llamada a asumir y a construir para enfrentar con éxito los retos del próximo milenio. Doctora Brundtland: El liderazgo que usted propone, México lo asume, ya que creemos que la única forma legítima de garantizar acciones de salud es fundamentarlas en las necesidades de las comunidades, de los países y de las regiones, reconociendo que en todos los países, independientemente de su nivel de desarrollo, han surgido reivindicaciones de participación y acción colectiva que ya no aceptan recetas verticales, ni de gobiernos ni de organizaciones. Este nuevo liderazgo se construye a partir de redes en la comunidad misma, con los organismos, incluso en los organismos no gubernamentales y en el sector privado, pero que debe de estar dirigido siempre en el ámbito nacional por los gobiernos; y en el internacional por los Estados Miembros.

Doctora Brundtland: Quiero subrayar que México es su socio, no sólo por ser Estado Miembro, sino porque comparte su convicción de impulsar un cambio profundo que ponga a la salud en el centro de las políticas públicas, para alcanzar buenos resultados sanitarios, para tener sistemas de salud con mayor eficacia, y lo más importante, generar un impacto en la salud de los pueblos. Nos parece afortunada la elección de la malaria en el campo de las enfermedades transmisibles y el control del tabaco en el de los padecimientos no transmisibles, como epidemias a contener, como el gran marco de trabajo al que habrá que dirigir los esfuerzos mundiales, pero no debemos olvidar que entre estos dos extremos existe una amplia gama de enfermedades que demandan atención, y por ende de una definición de prioridades. Asimismo, México se suma al esfuerzo global contra la poliomielitis, no sólo de palabra, sino con hechos, y pone a la disposición de la OMS la experiencia acumulada de casi 10 años de haber erradicado este grave padecimiento.

Señoras y señores delegados: Para enfrentar los retos sanitarios que el *Informe sobre la salud en el mundo 1999* destaca es importante recordar que contamos con una estrategia válida y efectiva para todos ellos, que es la promoción de la salud, y que consideramos que es importante ver de manera más explícita en los futuros documentos de esta Organización. Debido a que tenemos una firme convicción en la importancia de la creación de redes de cooperación, proponemos la creación de la Alianza Global de Promoción de la Salud, Alianza que pretende iniciar con un compromiso a nivel ministerial.

Esta Alianza se hará realidad en la Quinta Conferencia Mundial de Promoción de la Salud, que se celebrará en México en junio de 2000 y que es una muestra clara de los cambios que realmente harán la diferencia. Muchas gracias.

Dr HOLCÁT (Czech Republic):

Mr President, distinguished guests, ladies and gentlemen, thank you very much for the invitation to the Fifty-second World Health Assembly. We welcome very much the ongoing WHO reform and fully support your vision of "one WHO". A change in the way of global thinking as well as of working as a team will help us to improve health care management in the Czech Republic.

Preparation for accession to the European Union will dominate Czech politics throughout the forecast period. The main problem is to prepare the changes in the Czech legislation. Key health policy issues for accession process are the following: rationalization of the network of health establishments; substantial improvements of control activities; standardization of technologies, human resources, and diagnostic and therapeutic procedures; strengthening of occupational health services in line with the ILO Convention 161; toughening of drug policy to decrease the influence of the pharmaceutical lobby; strengthening the position of the hygiene services, including occupational health and food industry surveillance; and legislative work for change of our health legislation within the framework of the European Union.

Here are examples of health indicators with international comparisons. Since 1990, life expectancy at birth has risen fast, but is still about four years below the average of the European Union and slightly below its lowest level. The Czech Republic has the second highest value of life expectancy among accession countries. In 1997 life expectancy at birth increased to 70 years for men and to 77 for women. The infant mortality rate has been continuously decreasing in the last years and in 1998 was reported to be 5.2 per 1000 live births. Maternal mortality is close to the average of the European Union and was 2.2 per 100 000 live births.

The leading cause of death is cardiovascular diseases, which account for about 55% of all deaths in the Czech Republic. The standardized death rate for those under 65 years of age for cardiovascular diseases has decreased since 1990, but still far exceeds the worst in the countries of the European Union. Premature mortality caused by cancer has been declining during recent years, but is still well above the worst observed in countries of the European Union. The proportion of deaths from malignant tumours was 24.8%. Lung cancer mortality is decreasing from relatively high levels, with an increasing incidence of colorectal carcinoma, malignant melanoma, as well as mammary carcinoma in women. Mortality from injuries and poisoning has slowly been declining since 1990 and is currently close to the highest observed level for the European Union.

In general, the situation with respect to communicable diseases is similar to countries of the European Union. Vaccine-preventable diseases are well under control. HIV infection and AIDS are still at a very low level as compared with most countries of the Union. Estimates of daily smoking prevalence in the adult population show a decline during recent years to slightly below the average for the European Union. Alcohol consumption increased in 1989 and in 1994 it reached 10 litres of pure alcohol per person per year, being slightly above the European average.

To conclude this very short summary of health of the population of the Czech Republic it is important to report our priorities for future collaboration with WHO. From the beginning of the year 2000 the Czech Republic will start to implement on the national level WHO health-for-all strategy "Health 21", with special focus on integrated health promotion and disease prevention issues, especially for cardiovascular diseases and for malignant tumours.

Mr A. ABDULLAH (Maldives):

Mr President, distinguished delegates, ladies and gentlemen, august Assembly, I wish to take this opportunity to commend the Director-General for her world health report. We strongly support her reform initiatives and look forward to seeing their positive results benefit mankind. She has shown great vision and leadership for practical action, clearly demonstrated in her priority initiatives, particularly the Roll Back Malaria project and the Tobacco Free Initiative, which are of critical importance to our regions where millions of people suffer and die as a direct result of these two scourges. I also thank our Regional Director for his invaluable support and guidance.

The millennium is upon us. When we look around we may be forgiven for believing that we are entering a future full of conflict and strife. Daily we see all manner of woe and catastrophe; such events are more newsworthy and take precedence over the many accomplishments man is recording every day. There is no doubt that the millennium will bring tremendous health-related challenges; the signs are indeed visible. Our obligation is to turn these challenges into triumphs. The role of WHO has become increasingly important in achieving this metamorphosis.

Our challenges have become even more complex. Many remain technical, such as dealing with disease, developing new cures, new ways of integrating man and the environment. These in themselves have become more urgent, acute and costly, but certainly achievable. However the political and commercial challenges are more difficult to address: the equitable distribution of health, dealing with the pressures of multinational commerce, an equitable quality of life, finding the balance between health and commercial interests, ensuring wealth is not created at the expense of poverty. An example of the type of challenge is demonstrated by the Director-General's Tobacco Free Initiative. How do we persuade a commercial interest to cooperate in a campaign, the end result of which may not be in their best interest?

Great achievements have been made during the short lifetime of WHO. Health has generally improved and expectations have risen. But we are far from finished; a great deal more has to be done to achieve even basic health care in many parts of the world, let alone global equity of health care. The disparity between the wealthy and the poor countries has to be bridged; we must get to the point where we understand that health care is a human right not a commodity.

The advocacy and leadership role of WHO must continue, expanding with greater emphasis on prevention, health education and awareness. Advocacy at the policy level will have little benefit without proper knowledge and understanding at the level of implementation. Additionally, a public that is properly informed and with a desire to seek knowledge will provide the single most positive effect on health. The developing countries must seek to reach the awareness position of those more fortunate countries, so that a man chooses not to smoke because he is fully aware of the effect it will have on his health; a yard is kept tidy so that mosquitoes have no place to breed, or a woman prefers not to have a large family because she knows it is not good for her health.

Like everything else in this ever-changing world, we must keep abreast of events or try to stay ahead of the game. This is certainly true in the area of education and knowledge. We need to embrace modern

technology and use it to our advantage in getting the proper messages to the people that need to hear and will react to it. It is a technology that has to be targeted to the young who most need to hear our message. It is with their lives that they will form a healthy future. We must do all we can to ensure that the future does not suffer from their lack of knowledge. We must ensure that our programmes are as glamorous as the advertising campaigns. We must make health trendy, something that people realize can be influenced by decisions they make. There is much more to achieve. We must extend health education and awareness programmes to more effectively target the young, so that they can better assume responsibility for their lives and that of their children and families. At the same time, we must address health-related environmental issues such as water supply, sanitation, the dangerous effects of global warming, all very difficult issues for low-lying island nations like ours.

In conclusion, may I thank you very much for WHO's rewarding cooperation. I look forward to seeing our partnership growing stronger in the able hands of our Director-General. Working together we can make a real difference, and go into the new millennium as a stronger and healthier community.

Professor WHITWORTH (Australia):

Mr President and distinguished delegates, I would like to begin by thanking our Director-General for the breadth and depth of the reforms, which have been initiated in this very short time. The changes now being implemented are embraced wholeheartedly by Australia and we wish to signal our enthusiasm to continue to work with Dr Brundtland to ensure that WHO continues to "make a difference".

The central theme of the Director-General's report is that human health should be placed at the core of the global development agenda. I agree that health underpins all other aspects of human and economic development. In this context, Australia's Minister for Foreign Affairs recently released our policy on health in Australia's aid programme. The policy recognizes the clear evidence that shows poverty and ill health are linked, and that good health is a cost-effective investment in development, and prioritizes action to help break this poverty-ill health cycle.

The generation and application of new knowledge about diseases and their control has been pivotal in the progress we have so far made towards health for all. But we need to take this one step further. The generation and application of knowledge of the determinants of health, not just the causes of disease, is necessary if we are to ensure the most equitable and efficient use of our health resources in the future.

By way of example, I will comment on the experience of Australia in applying the principles of evidence-based policy and decision-making to the funding of health services and products, and more recently, to population health activities. Evidence-based decision-making can be defined as the systematic application of the best available evidence to the evaluation of options and to decision-making in clinical, management and policy settings. It is the best foundation for an effective and efficient health system. Australia has readily embraced this principle. Australia was perhaps one of the first countries in the world to require proof of improved cost-effectiveness before new pharmaceuticals can be eligible for government subsidy, in addition to the usual requirements for safety and efficacy.

We have introduced a systematic approach, with information from economic evaluations, into decisions about whether new drugs should be added to the Government subsidised national pharmaceutical benefits scheme. The process has not immediately reduced Australia's overall expenditure on pharmaceuticals. It has, however, ensured that Government funding is used for the most cost-effective interventions, and has enabled us to guarantee a high level of public safety.

Drawing on the experience gained by evidence-based policy for pharmaceuticals, Australia has also recently established a Medical Services Advisory Committee to provide expert advice on the safety, efficacy and cost-effectiveness of new medical technologies and procedures. A favourable assessment, according to strict criteria, is required before new medical services and technologies can be listed on the medicare benefits schedule, which in turn establishes eligibility for government subsidy.

The process of introducing evidence-based decision-making into Australia's health system, has not been easy. A multidisciplinary approach is required, scientific rigour is essential and perhaps most importantly, not all resource allocation decisions are related to efficiency - equity is also a key consideration.

A health system should have available the best evidence to support decisions at all levels and in all contexts. In Australia we see the next frontier in evidence for population health. In the recent federal budget the Government announced the establishment of a "population health evidence base advisory mechanism". Recognizing that population health is characterized by diverse interventions with varied theoretical underpinnings, this initiative will start with methodological development. We anticipate it will lead to a systematic approach to reviewing evidence and propagating the implementation and uptake of that evidence in policy and practice. The population health evidence base advisory mechanism will target those

areas where the greatest gains in health are likely to be made. Assessment of cost-effectiveness of interventions will ensure best use of available resources.

Australian efforts in tobacco control represent an example of how overwhelming evidence of public health harm has led to comprehensive health interventions. Australia has a strong record of achievement in tobacco control. We have implemented a tobacco advertising ban and a State Government has dedicated a portion of the taxes raised from tobacco products to fund anti-tobacco activities, including replacement of tobacco sponsorships. We have a widespread commitment to tobacco control with a ministerial level council of health and law enforcement ministers, at both state and federal levels, to ensure a coordinated national effort in tobacco control. The Tobacco Free Initiative is crucial. It reflects the magnitude of the evidence requiring concerted global action as well as action by individual countries. Australia is committed to assisting with the implementation of the Tobacco Free Initiative. Discussion of the Tobacco Free Initiative today is also particularly timely as it coincides with the release of the World Bank's report on governments and the economics of tobacco control. The report clearly demonstrates that it is in the economic interests of governments to take action on tobacco as well as the more obvious public health interest. It outlines a number of strategies that can be adopted to overcome the arguments that tobacco control will cost governments in the short and longer term. Australia welcomes the release of the report to assist implementation of comprehensive tobacco control action plans. We emphasize the Western Pacific Region in this context, given the seriousness of the tobacco pandemic in our Region, with two-thirds of the world's smokers estimated to be in Western Pacific Region countries.

Finally, returning to the Director-General's report, Australia particularly commends Dr Brundtland for the introduction into the new organizational structure of the Evidence and information for policy cluster. We all need to follow this lead. By basing our collective efforts on the best available evidence we will have the greatest chance of achieving real and lasting health gains. I know that this is not an easy task, but everything is possible. If we have sufficient will, we have made the first step towards establishing sufficient means.

Dr FARHADI (Islamic Republic of Iran):

In the Name of God, the Compassionate, the Merciful:

I would like, at the outset, to congratulate the President on her well-deserved election as the President of the Fifty-second World Health Assembly. My congratulations also go to other members of the Bureau. I should thank the Director-General and her colleagues for the informative and thought-provoking annual report. We are grateful to the Director-General for her undertakings since coming to office, including the Tobacco Free Initiative, and assure her of our full support.

Since last year, WHO has gone through significant structural changes that in our view will strengthen its capacities to respond to the new and emerging challenges at the turn of the millennium. These changes should be continued and extended to the Organization's country Representatives to ensure attainment of better cooperation for addressing health problems in the field, which in turn would promote global public health. Increasing globalization and enhancement of communications have brought with them participation of non-State actors, including individuals, local communities, nongovernmental organizations and the private sector in decision-making at all levels. The problems of spiritual and material destitution, injustice, poverty, discrimination, unhealthy lifestyle, emerging and re-emerging diseases and insufficient resources cannot entirely be solved without close collaboration and active involvement of all these partners. Moreover, Member States should allocate a larger portion of their GNP to health activities in order to provide more financial resources to address health problems.

The initiative of the President of the Islamic Republic of Iran to mark the year 2001 as the year for dialogue among civilizations was adopted by the Fifty-fourth General Assembly of the United Nations in 1998. The General Assembly resolution on this subject calls on the United Nations system to contribute to the objectives of this initiative through planning of various activities. In this respect, we strongly hold that this dialogue should involve discussions on ethical and human values that contribute to the promotion of health worldwide. Through centuries, positive norms such as justice, caring for other, sharing with others and assisting the poor and needy have enabled societies to cope with health problems. We invite the Director-General to explore ways and means of WHO's participation in this endeavour.

Meeting the country's primary health care needs could be taken as one of the world's successful models. Comprehensive health care services in a new concept integrating prevention and curative services, research and medical education are thus being implemented in three provinces of Iran as a pilot plan with the collaboration of the Regional Office for the Eastern Mediterranean as well as of public and private sectors. We shall soon share our experiences in these areas with other countries.

One of the principles of change in both global and WHO health policies should be priority changes in order to meet new and emerging needs. We believe nutrition and food safety should be considered as

one of the important health priorities. We ourselves have accorded a high priority to this aspect of health in our Third Socioeconomic Development Plan.

At present our globe is suffering from many political and economic problems which threaten the sustainability and promotion of health. I should, in conclusion, make a reference to the ongoing ethnic cleansing in Kosovo, entailing numerous health problems. I need also to call for a substantial increase in international assistance, specially the provision of health care services to alleviate the human suffering of Muslim Kosovars.

Dr DEGUARA (Malta):

Mr President, honourable colleagues, delegates, I am sure I am echoing the view of those present that the election of Dr Bruntland to the post of Director-General of WHO has brought about an innovative perspective and approach to health issues. I am sure that under her strong leadership WHO will continue to affirm itself as the leader in world health matters.

Economic development and advances in medical technology have made it possible to achieve advances in life expectancy and a quality of life never dreamt of by our predecessors. However, these hard won improvements are being threatened by emerging infections, lifestyle-related noncommunicable diseases, demographic shifts and conflicts. In the face of such threats we cannot afford to be complacent. *The world health report 1999: Making a difference* shows us all the way forward to address these issues. My country endorses this vision as we have done with the European Region's Health 21 strategy.

Malta's indicators are among the best in Western Europe. The life expectancy in men is 75 years and that in women 79 years. As a result Malta is facing the same problems being experienced by the most developed countries. Our birth rate is decreasing and by the year 2020 the elderly will constitute 25% of our population. Given this scenario the great challenges facing us over the next decare are, first, to ensure adequate funding for the sustainability of our health systems, and secondly to ensure good quality of life for our elderly. In facing these challenges we have to make certain that basic principles such as ethical consideration, equity and solidarity are respected when drawing up our priorities for action. These in fact were the guiding principles in the drawing up of our national health policy document back in 1994. This document "Health Vision 2000" emphasizes the importance of multisectoral collaboration and healthy alliances as a vital channel to bring about the desired health improvements. In particular, the priorities of combating the tobacco epidemic and health systems reforms and development recognized within *The world health report* have been highlighted as a priority area in our own national health policy.

With regard to tobacco control, in spite of implementing many of the advocated strategies such as public awareness campaigns, the introduction of smoking cessation clinics and drastically increasing the price of cigarettes, not only have we failed to achieve the desired reduction in tobacco consumption but the number of young women smokers continues to increase. Moreover, our lower socioeconomic groups have been shown to be more adversely affected by the tobacco epidemic, a clear confirmation of the link between poverty and ill health. We therefore welcome the wider strategy advocated in the Director-General's report, the Tobacco Free Initiative.

Another priority area which we are actively addressing is health systems development and reform. In Malta our health care system offers universal coverage free at the point of use. Our primary health care system needs strengthening and we are also currently in the process of constructing a new general hospital to replace the existing out-dated facilities. Striking the right balance between investment and preventive and curative services has never been an easy task. While there is consensus on the long-term benefits of investment and preventive services, the public assesses the quality of the service by the high technology curative interventions provided today. On the other hand, the prevailing view amongst many is that increasing health care funding is the only solution. I am convinced that we must not let ourselves be conditioned by these beliefs. The growing concern that the progressive rise in health care expenditure might be reaching unsustainable levels was echoed by many ministers during the round table conferences of yesterday and today. Our reforms are directed towards need-driven, outcome-oriented, evidence-based service provision. This type of approach is essential to ensure that our scarce human and financial resources are utilized to target unmet needs in areas where the greatest health gains are possible to achieve. Strengthening our efforts, from preventing illness and disability to concerted health promotion initiatives, will remain one of our main long-term strategies. We shall continue to improve our primary health care services to serve as the main channel for these reforms. We believe that a useful strategy to adopt is to seek and encourage partnerships with the private health sector. We strongly maintain that this has an important role to play in service provision, but duplication of services has to be avoided. We therefore agree with the philosophy of a new universalism in health care provision as expounded in *The world health report*. It is essential to strive to achieve national consensus amongst all stakeholders in health care, namely the

politicians, health care professionals and the general public. By pursuing the above strategies I am convinced that we shall be translating the report, "Making a difference", into reality.

Finally, it is reassuring to realize that we do not face these issues in isolation, I would like once again to thank Dr Bruntland for bringing to the fore these issues of common concern. We need to be able to support each other in tackling these most challenging issues. There is strength in unity and no doubt it is strength that we require to be able to place health at the top of any nation's agenda where it rightly deserves to be.

El Dr. RODRÍGUEZ OCHOA (Venezuela):

Señor Presidente, señora Directora General, amigas y amigos: Compartimos el documento de nuestra Directora General y los logros y cambios funcionales realizados. Asimismo felicitamos el apreciable aumento de la participación de la mujer en la Organización. Tal como expresó el delegado de la Federación de Rusia, para hablar con propiedad de los sistemas de salud es indispensable tener muy en cuenta las características históricas y socioeconómicas de cada pueblo, porque el perfil de salud de un país con alto desarrollo es muy distinto del de otro con mediano o poco desarrollo, lo que determina que las prioridades a establecer sean muy distintas.

Debemos privilegiar la salud y la vida y no la curación de la enfermedad, particularmente en los países poco desarrollados, para lograr estándares de bienestar que otros países ya lograron. Por tanto, hay que dar prioridad a las actividades de promoción de la salud, prevención de las enfermedades y atención médica de primero y segundo nivel. En consecuencia, se impone establecer como política la atención integral en las redes ambulatorias de salud.

Ningún sistema de salud es perfecto. Pero los mejores, incluyendo a países desarrollados como el Canadá, España e Inglaterra, y otros menos desarrollados como Costa Rica y Cuba, garantizan eficientemente la cobertura universal y no discriminatoria. Para ello, su financiamiento debe ser solidario. En relación a la insuficiente competencia del Estado para prestar todos los servicios y a todas las personas, no creemos aconsejable la transferencia de los recursos públicos ni de los sectores contributivos de la economía formal a administradoras privadas de fondos de salud, porque favorece la privatización de los servicios y las distorsiones que la globalización de los mercados generan en un bien público tan esencial como la salud y la vida. Incluso es bien conocido, por ejemplo, que el propio presidente Bill Clinton planteó a su Congreso la necesidad de reformar el sistema de salud de su país por ser muy costoso, inequitativo y menos eficiente que el de varios países; su Congreso no aprobó esa solicitud.

La globalización de los mercados en materia de salud distorsiona de manera grave e inevitable el derecho a la salud de las poblaciones no desarrolladas, ya que por ser el lucro la principal motivación del modelo privatizador se privilegian las intervenciones curativas y hospitalarias. Ante esa opción proponemos la globalización de la solidaridad entre los pueblos, que en salud significa garantizar a todos los ciudadanos el acceso universal y sin discriminación a los recursos principales que la humanidad ha conquistado en este campo a lo largo de su existencia. Estamos convencidos de que si en materia de salud se globaliza la solidaridad y no el mercado, daremos un paso gigante en la solución de las angustias de nuestros pueblos.

Planteamos la necesidad urgente de invertir en obras de saneamiento básico ambiental a cambio de deuda externa. Ciertamente conviene tanto a los países desarrollados como a los otros tener un mundo sano. Los países más desarrollados han sido los primeros causantes del grave daño ecológico universal. Basta citar que el consumo energético promedio de los habitantes de los países desarrollados es aproximadamente 15 veces superior al de los no desarrollados. Invertir entonces en saneamiento ambiental a cambio de deuda externa es un negocio razonablemente justo.

Es necesario encontrar vías para la disminución de los costos de los medicamentos, particularmente para la diabetes, las enfermedades cardiovasculares, el SIDA, algunos antibióticos y equipos de hemodiálisis. Apoyamos así la resolución EB103. R1 del Consejo Ejecutivo de la OMS, de enero de 1999. En relación con los avances tecnológicos y terapéuticos, la OMS debe ser el organismo que valide oficialmente sus bondades.

Por último, el paludismo: Venezuela tiene experiencia sólida desde 1936. Nuestra escuela internacional de malaria cumplió 56 años. El paludismo es una causa de subdesarrollo, particularmente en países donde no existe una organización idónea para combatirlo. Estamos de acuerdo en que la estrategia más importante hoy día es combatir el parásito, impulsando el diagnóstico y el tratamiento precoz, capacitando al personal de salud y a los residentes de las localidades malarígenas. Sin embargo, también es necesario el control integral del vector, particularmente en áreas hiperendémicas o de alta endemicidad donde no haya existido un sistema eficiente de combate integral del paludismo. Muchas gracias.

Mr HASHMI (Pakistan):

Mr President, the year 2000 holds special significance for WHO. Twenty-one years ago we proclaimed the goal of health for all by the year 2000. Ideally, by now all of us should have reached the happy state of complete physical, mental and social well-being. We have made important strides, smallpox has been eradicated. We are winning the fight against poliomyelitis. Life expectancy and other health indicators have also been moving in the desired directions. Yet, the scale of the task left undone is enormous. As we have overcome old foes like smallpox and poliomyelitis, we face newer, even more deadly ones, such as the HIV/AIDS virus. Even diseases thought to be on the decline such as tuberculosis and malaria have rebounded with renewed resilience and increased resistance to established therapies. We are also confronted with a disturbing paradox. The developing world still suffers from high levels of morbidity and mortality due to the traditional communicable diseases. At the same time the incidence of the so-called rich people's diseases such as heart disease and diabetes are also increasing in the developing countries. The essential issue before us is equity. While a wealthy minority is benefiting from the fruits of new technologies and high cost health care, the majority of the world population is living in distress and misery. This should not be acceptable to us. We are therefore greatly heartened that our Director-General, in her first statement to the Executive Board, said that the developing world carries 90% of the disease burden, yet poor countries benefit from only 10% of resources that go to health. We derive encouragement from her declaration that universal access to quality health care will remain the major principle for the work of WHO.

I would venture to make a few suggestions as our contribution to the debate: (i) base reforms in the health sector on equity. We should endeavour to stop inequalities in income and in access to health care within and amongst nations. WHO must assume its leadership role, and focus more attention on alleviating maldistribution of resources. Health care should be available at affordable cost from any medical institution on a global base. This should be the part of the basic human rights of a sick person; (ii) promote the concept of social responsibility for health: health programmes cannot succeed without a motivated public to make proper use of health services. Moreover, people must promote their health with their own actions and efforts. More emphasis thus has to be laid on public health education and health promotion; (iii) increase investment for health development. Many developing countries are spending too little on health care. WHO should play its role in motivating States to increase their budget for health. Countries should be made to realize that better health is free counsel for economic development; (iv) develop alternate financing of health care. Many countries are looking towards WHO for advice and assistance. WHO must take the initiative and develop models towards this objective. We would also like to place on record our support for the Director-General's request for the adequate financing of WHO and its programme. The zero nominal growth budget should be the least that should be accepted by the WHO Member States. Finally, I would like to register our appreciation of the good work being done by WHO in the context of the Kosovo crisis, particularly with respect to the hundreds of thousands of refugees in Albania and Macedonia.

La Sra. McCOY SÁNCHEZ (Nicaragua):

Distinguido señor Presidente; honorables señores miembros de la Mesa; honorables delegados, señoras y señores: Es un honor para mí poder dirigirme a esta magna 52ª Asamblea Mundial de la Salud en nombre de los hermanos pueblos de Belice, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panamá y la República Dominicana, y en su nombre y representación felicitamos a la señora Presidenta por su nombramiento.

La década de los años ochenta representó para la región latinoamericana la década perdida en lo económico, lo social y lo político. A partir de los años noventa se consolida la democracia en la mayoría de los países latinoamericanos. Durante los últimos años, los países centroamericanos, incluyendo aquellos afectados por conflictos bélicos, han continuado su inversión social, principalmente en el sector salud. Estos esfuerzos se han visto reflejados en logros significativos en el campo de la salud principalmente: reducción de la mortalidad infantil; incremento de la cobertura de inmunizaciones para niños menores de un año de edad, particularmente para sarampión (cabe señalar que debido a esta cobertura nuestra subregión centroamericana será la primera región libre de sarampión en el mundo); erradicación del virus salvaje de la polio; reducción de las muertes por enfermedades infecciosas; incremento del acceso al agua potable; e incremento de la expectativa de vida. Cuando la subregión centroamericana se encontraba inmersa en un proceso sostenido de crecimiento económico, logrando grandes avances en salud, educación, justicia social, saneamiento ambiental, hace su aparición en el mes de octubre pasado el desastre natural más grave de la región centroamericana, afectando directamente a los más pobres y

afectando la buena marcha de los programas de desarrollo. Esto ha obligado a los países centroamericanos a reorientar los recursos destinados al desarrollo humano a atender las necesidades inmediatas de reconstrucción y rehabilitación.

Los países que conforman la región sanitaria de América Central y la República Dominicana tenemos una alianza estratégica desde hace varias décadas, constituyendo así un modelo de solidaridad y esfuerzo conjunto ante el reto de implementar estrategias comunes ante el proceso salud/enfermedad de la población y de apoyar las contingencias sanitarias de los países que conforman esta región. A lo largo de los años hemos fortalecido la gestión conjunta de proyectos de cooperación externa para el desarrollo sanitario y humano de los habitantes de la región. A pesar de las diferencias sanitarias entre nuestros países, hemos trabajado de manera coordinada ante intereses comunes, por lo que el proceso de integración de Centroamérica y la República Dominicana no es circunstancial ante los efectos de los desastres naturales vividos en los últimos meses.

Han pasado casi siete meses desde la catástrofe provocada por el huracán Mitch. En este periodo los países afectados y sus poblaciones han hecho grandes esfuerzos para superar los aspectos más críticos de la emergencia, contando con la valiosa ayuda de la comunidad internacional. El huracán Mitch, junto con las inundaciones y deslizamientos de lodo, costó la vida a unas 10 000 personas y dejó a más de un millón de familias sin hogar; destruyó o produjo daños considerables a 3600 escuelas; arrasó con áreas de cultivo y ganadería vitales para la economía de estos países y devastó la infraestructura básica de la región. Más allá de la pérdida irreparable de vidas humanas, el impacto sobre la producción y la infraestructura que sustenta la misma implica un severo retroceso en el proceso de desarrollo de la región.

Los esfuerzos iniciales de la salud se han orientado a la atención inmediata de las personas afectadas, a la vigilancia epidemiológica, al manejo de residuos sólidos, a la desinfección del agua, la higiene de los alimentos, la salud mental y al control de vectores, entre otros. Gracias a estas intervenciones, producto del esfuerzo propio y la solidaridad internacional, se controlaron los brotes epidémicos. Sin embargo, es importante resaltar que, no obstante nuestra capacidad de respuesta, se hace necesario continuar invirtiendo en salud, y para esto es importante seguir contando con la cooperación internacional. Los países centroamericanos y de la región estamos convencidos que la cultura de prevención y los planes integrales de manejo ambiental que hemos adoptado nos ayudarán a evitar pérdidas de la magnitud de las provocadas por el paso de los huracanes Mitch y Georges y otras contingencias sanitarias en el futuro, dada la variabilidad climática de este año, el fenómeno de La Niña y la amenaza de nuevos huracanes.

Los ministros de salud centroamericanos y de la República Dominicana hemos asumido un importante liderazgo en las comisiones nacionales y en los esfuerzos subregionales. En este sentido, hemos tenido varias reuniones de carácter regional y en la última reunión realizada en Managua, los días 8 y 9 de abril, acordamos presentar dos proyectos subregionales a Estocolmo relacionados con la mitigación y prevención de desastres naturales y otro relacionado con la negociación conjunta para medicamentos especiales.

Se están produciendo progresos en las tareas de reconstrucción, pero aún quedan muchos problemas por resolver. Los gobiernos centroamericanos han elaborado planes nacionales y subregionales para la reconstrucción y transformación social de sus países, con el objetivo de disminuir la vulnerabilidad ante futuras catástrofes y posibilitar un desarrollo sostenible que reditúe en beneficio de la mayoría pobre de la población. Los países centroamericanos y de la región ya hemos iniciado este proceso de reconstrucción con nuestros propios medios, pero dada la magnitud de los efectos necesitamos de la cooperación externa. La próxima reunión en Estocolmo es sólo un comienzo. Durante la misma, los países centroamericanos presentaremos los planes para la reconstrucción y transformación de nuestros países, mientras que las naciones donantes y los organismos multilaterales de cooperación técnica y financiera, o sea nuestros socios en este proceso de desarrollo, tendrán la oportunidad de definir sus aportes. Esperamos que la reunión de Estocolmo resulte en el apoyo necesario en la cooperación que requerimos.

La solidaridad con América Central hasta ahora mostrada por gobiernos, instituciones e individuos de todo el mundo ha sido impresionante. Los países de Centroamérica y la República Dominicana desean en esta Asamblea reiterar su agradecimiento por esta solidaridad. Nada podrá reemplazar las pérdidas humanas que afectaron a incontables familias centroamericanas, pero esta tragedia puede convertirse en un punto decisivo para el desarrollo de la región.

Los representantes de estos países remarcamos también la importancia de proseguir el proceso de integración regional, no sólo en lo que se refiere al comercio y a la salud, sino también a nivel de infraestructuras y medio ambiente, como por ejemplo en la administración y mantenimiento de las cuencas hidrográficas compartidas. Por lo anteriormente descrito, expongo a los distinguidos delegados y a su honorable Presidenta los siguientes considerandos con el objetivo de que los mismos puedan ser reflejados en una resolución de esta Asamblea: 1) que las consecuencias sin precedentes del huracán Mitch afectan a los países centroamericanos y ponen en serio riesgo las condiciones de medio ambiente y desarrollo

humano sostenible en esa parte del mundo; 2) que el efecto económico provocado por el huracán Mitch agrava la situación de desempleo, lo cual puede tener consecuencias sociales negativas, también para la salud y el desarrollo, que tanto preocupan a esta Organización y a nuestros gobiernos; 3) que, dadas las serias limitaciones que afectarán a los países centroamericanos debido a una excesiva reducción en sus recursos económicos y de otro tipo, solicitamos a los hermanos países Miembros de esta Organización que expresen su solidaridad con nuestros pueblos afectados por el huracán Mitch apoyando la solicitud de asistencia inmediata y sustantiva, instando a los Estados Miembros a proporcionar o continuar proporcionando la asistencia y los recursos requeridos por los países centroamericanos, directamente o a través de la Organización Mundial de la Salud y su Oficina Regional para las Américas.

En este contexto solicitamos a ustedes el invaluable apoyo de todos a un proyecto de resolución que presentaremos en la comisión correspondiente. Asimismo, solicitamos a la Directora General que difunda esta resolución dentro del sistema de las Naciones Unidas y otros organismos internacionales apropiados. Que Dios les bendiga. Muchas gracias.

Mr NGEDUP (Bhutan):

Mr President, distinguished delegates, ladies and gentlemen, on behalf of the Bhutanese delegation, and on my own behalf, I would like to extend to you and the members of the Bureau our warmest congratulations upon your election.

Mr President, I feel it a great privilege and honour to represent my country at this Fifty-second World Health Assembly, which is the last one before the next millennium. We can be justly proud that the century we will be leaving behind shortly has been marked by far reaching medical, scientific, and technological advances beyond our wildest dreams. And yet, sadly, these wonders have also failed to touch the lives of a large segment of the world's population. It is in this context that my delegation welcomes *The world health report 1999* which sets clear guidelines and directions for the twenty-first century with a people-centred approach. The visionary report will indeed usher in a new era that will shape health care and management to greater heights. Making a difference is a clarion call to governments and peoples to make collective efforts to strengthen the health and well-being of the citizens of the twenty-first century. The oft-repeated statement that diseases know no political boundaries, and that our world is reducing to a global village, makes us realize how vulnerable we really are. Therefore, I fully agree with Madam Roseira's statement that health is everybody's business. Rich or poor, strong or weak, big or small, the sooner we come to this realization the safer our world will be. According to *The world health report 1999* one billion people have yet to profit from the fast-changing living standards, economic development, lifestyles, and health status. Among these, we must not lose sight of the small least-developed and disadvantaged group of countries. The yardstick of genuine development is when development filters down to the poorest of nations and the poorest of peoples. WHO's reform process must therefore give special attention to these marginalized groups, through strengthening collaborative activities at the country level.

The Director-General and WHO deserve our appreciation for preparing the innovative report. The report raises many ideas and proposals. These proposals will have far-reaching implications and will require time to be absorbed, reflected upon and analysed. They have also to be assessed in the context of national capacities and capabilities. My delegation welcomes the emphasis being placed on the two Cabinet projects: Roll Back Malaria and the Tobacco Free Initiative. My delegation is confident that the same wisdom will prevail in the case of other equally important health problems.

Bhutan too is responding to the call for innovative approaches in the twenty-first century. In this regard, I would like to mention the establishment last year, with the help of WHO, of a health trust fund, which is a cost-sharing mechanism that will seek to ensure sustainable and timely availability of critical vaccines and essential drugs. While there could be many approaches to ensuring sustainability, Bhutan believes that the idea of trust funds deserves support as it represents an effective collaborative effort at a time when resources are shrinking and needs increasing.

I take great pleasure in informing this august Assembly that our nation is celebrating the Silver Jubilee of the King, His Majesty Jigme Singye Wangchuck. Our King has selflessly dedicated his life to the service of his people for the last 25 years. Unprecedented social economic progress during this period has visibly improved the health and the well-being of the Bhutanese people. It is therefore fitting that the country this year is making a determined and collective effort to honour the King by launching various programmes involving all segments of society in order to further promote His Majesty's goal of gross national happiness.

In conclusion I would like to pay tribute to Dr Gro Harlem Brundtland for the many initiatives taken by her to make WHO a vibrant and dynamic organization. I wish her every success in her endeavours and assure her of our country's continued and dedicated support.

Dr NASHER (Yemen):

Mr President, distinguished delegates, ladies and gentlemen, may I first of all thank and congratulate the Director-General, Dr Brundtland, for her excellent report which highlighted great accomplishments, radical reforms, clear and well-defined directions and priorities like Roll Back Malaria and the Tobacco Free Initiative, which we fully support.

Yemen, my country, is one of the least developed in the world. We have many health problems, some of the worst health indicators and the least resources. The Yemen Ministry of Health is doing what it can to tackle health problems by instituting health systems that attempt to make the most efficient use of its limited resources and to expand its resource base, and during the last two years the Ministry of Health has designed and begun implementation of health sector reform. That, we feel, will help us do a better job of tackling some of our health problems. The main elements of the reform are: decentralization of planning, decision-making and financial management; a redefinition of the role of the public sector with a stronger emphasis on policy regulation and public health, and establishment of limits to its role as a service provider; the district health system approach; community co-management of health systems; cost-sharing; reform of the essential drugs policy and realignment of the logistic system for drugs and medical supplies; decentralized outcome-based management system from the central to the community level, with an integrated focus on gender; hospital autonomy and eventual basic health facility autonomy; intersectoral cooperation; encouragement of responsible participation by the private sector and nongovernmental organizations through appropriate policy design and regulation; encouragement of innovation; and a sector-wide approach to donor funding and programming, with a stronger role for the Ministry of Health in coordinating donor assistance.

Among the many health problems the Ministry of Health is tackling, the priorities are as follows: communicable diseases - malaria, tuberculosis, hepatitis and AIDS; noncommunicable diseases such as heart disease and cancer; as well as road traffic accidents, civil violence and arms-related fatalities, smoking, reproductive health, family planning and safe motherhood.

As I stated earlier, Yemen is doing what it can with a very limited resource base, but it cannot fight this battle alone. First, it needs international support for its health sector reform. This is the challenge within Yemen. Secondly, it needs developed countries to recognize the need for globalization of the fight against disease. This is the global challenge. The first aspect of this global challenge has to do with research and development in vaccines and drugs against diseases that affect mostly developing countries. This should be encouraged with the help of the developed countries and other multinational partners. This is good for developing countries like Yemen but also for the developed world. Though many communicable diseases are still confined to poor and developing countries, developed countries can still be inflicted with these same diseases through international travel. In addition, it is legitimate, because the traffic of disease goes in both directions: from the developing to the developed world and vice versa. Thirdly, poverty leads to poor health and to the destruction of the environment which affects the global village in its entirety. Therefore, there must be a global strategy to protect the environment, with the rich helping the poor to overcome poverty, health problems and environmental destruction. They, indirectly, protect themselves from the future hazards of all of the above. And, on the verge of the millennium, you cannot say this does not concern me. Now the globe equals the village, let us save our village for the sake of our future generations.

WHO, under its strong and dedicated leadership, the World Bank, the other world health leaders and other agencies, need to join forces to help the poor reduce poverty, improve health status, reduce environmental destruction in order to make Mother Earth a safe haven for future generations. May I conclude by quoting the Director-General, Dr Gro Harlem Brundtland when she said yesterday: "With cool heads and warm hearts, we can make a difference."

The PRESIDENT: الرئيس:

السيدات والسادة، الساعة الآن الخامسة والنصف وهو موعد انعقاد اللجنة العامة. ستنعقد الجلسة العامة غدا الخميس ٢٠ أيار/ مايو ١٩٩٩ الساعة التاسعة صباحا.

أدعو الدول الأعضاء في اللجنة العامة للذهاب الى القاعة السابعة حيث ستبدأ الآن أعمال اللجنة العامة. ونلتقي معكم غدا ونرفع الجلسة.

رفعت الجلسة الساعة ١٧,٣٠ مساء.

The meeting rose at 17:30.
La séance est levée à 17h30.

SEVENTH PLENARY MEETING

Thursday, 20 May 1999, at 9:00

President: Mrs Maria de Belém ROSEIRA (Portugal)
later: Mr S.U. YUSUF (Bangladesh)

SEPTIEME SEANCE PLENIERE

Jeudi 20 mai 1999, 9 heures

Président: Mme Maria de Belém ROSEIRA (Portugal)
puis: M. S.U. YUSUF (Bangladesh)

LOOKING AHEAD FOR WHO AFTER A YEAR OF CHANGE: REPORT OF THE DIRECTOR-GENERAL (INCLUDING *THE WORLD HEALTH REPORT 1999* (continued)
L'AVENIR DE L'OMS APRES UNE ANNEE DE CHANGEMENT: RAPPORT DU DIRECTEUR GENERAL (Y COMPRIS LE *RAPPORT SUR LA SANTE DANS LE MONDE, 1999* (suite)

The PRESIDENT:

May I begin by thanking Dr Ehtuish and Dr Stamps for having replaced me yesterday afternoon. At 9:30 this morning, I have to hand over the presidence to Mr S.U. Yusuf, the fourth Vice-President, because of an unavoidable engagement. Before we continue with our work, I wish first to report on the discussions at the General Committee which held its second meeting yesterday afternoon. The Committee considered the programme of work of the Assembly until Friday, 21 May, and agreed to make the following proposals to the Assembly: this morning, we can complete the discussion of item 3. Committee A is at present holding its third meeting. On adjournment of this plenary, Committee B will hold its second meeting. This afternoon at 14:30 both Committees A and B will meet. At 17:00 today, the Plenary will hold its eighth meeting to deal with item 8, Awards. On Friday, both Committees A and B will meet in the morning and afternoon, keeping in mind that at an appropriate time, Committee A may meet to consider the appropriation resolution when there is no meeting of Committee B so that all participants may attend the meeting of Committee A. At 17:30 the General Committee will hold its third meeting.

We shall now return to item 3 and continue with the list of speakers. The next two speakers on my list are the delegates of Myanmar and Democratic People's Republic of Korea. I give the floor to the delegate of Myanmar.

Mr KET SEIN (Myanmar):

Madam President, Madam Director-General, honourable ministers, distinguished delegates, on behalf of the Government and the people of the Union of Myanmar, I would like to convey warm greetings to you all. Allow me to join the other delegations in expressing my heartfelt congratulations to the President on her unanimous election to the highest office of the presidency of the Fifty-second World Health Assembly.

The changes at WHO headquarters during 1998 have been remarkable and I would like to express my support for the new organization and management structures initiated by the Director-General. Myanmar's health policy focused on the provision of equitable health care with universal coverage, accessibility, multisectoral and community involvement, appropriate technology and cost effectiveness. To ensure that all citizens are assured of their basic rights to health and health care, reforms have been encouraged, including the development of alternative health care financing.

WHO's inputs, policy guidance and technical assistance have been crucial in enhancing the health status of the population. I would like to express my appreciation to WHO for supporting health programmes in my country. Myanmar is well on its way to achieving its goals of elimination of leprosy, public health problems, and poliomyelitis by the year 2000. Malaria still reigns as a leading cause of mortality and morbidity in Myanmar. As part of the regional framework a Roll Back Malaria initiative was initiated last year. This has mobilized multisectoral involvement and development of partnerships among government sectors, agencies and in communities. However, considerable assistance and technology inputs are needed to sustain the initiatives, strengthen human and institutional resources, expand laboratory information services and tackle the problem of multidrug resistance. In disseminating information, communication and education activities are also required for promotion of personal protection methods.

Myanmar has adopted the Declaration on health development in South-East Asia in the twenty-first century as the basis for the formulation of the next cycle of the national health plan which is to begin in the year 2001. We are all facing the double burden of disease: communicable and noncommunicable diseases; among the noncommunicable diseases, tuberculosis accounts for the major portion of the disease burden. Thus we welcome the Tobacco Free Initiative as an important means for reducing the present and future effect of tobacco on health. Widespread dissemination of information, including education against the use of tobacco, has been provided as an integral part of comprehensive health promotion activities. Much support and cooperation will be necessary to facilitate and implement the Tobacco Free Initiative.

In Myanmar the implementation of the ASEAN programme on essential drugs has ensured the public's access to safe, effective, affordable, easily accessible and good quality drugs. Drugs laws with regard to registration, procurement, storage, distribution and quality assessment have been promulgated, which also cover traditional medicines commonly used in Myanmar. In conclusion, Myanmar will continue to work in collaboration with the health technology and pharmaceutical clusters.

Professor CHOI CHANG SIK (Democratic People's Republic of Korea) *(interpretation from Korean)*:[1]

Mr President, first, I would like to express my congratulations to the President and Vice-Presidents of this Health Assembly. I also extend my warm congratulations to the Director-General for her energetic activities in the development of world health and for her wonderful report presented in this meeting. Taking into account the successes achieved and lessons learned in the past work of WHO, the Director-General analysed in detail the existing and emerging challenges to world health and formulated strategic directions to cope with them in the next century. Recognizing that these directions have reflected the realities of the present world and the regional health situation, my delegation sincerely hopes that they will contribute to the development of health worldwide and in the South-East Asia Region in particular.

Last year the health sector in my country was seriously affected by natural disasters and by the economic difficulties derived from them. These difficulties gave rise to the recurrence of diseases like malaria, which were eradicated long ago in my country, and to an increase in cases of tuberculosis which had been considerably reduced. Furthermore, the status of mother and child health has been seriously threatened. The result has been that the system of universal, complete free medical and advanced home doctor care, under which the State takes full responsibility for the people's health, has been faced with serious challenges. To tackle these challenges, we established a firm partnership with other sectors in the government, as mentioned in the Declaration on health development in South-East Asia in the twenty-first century, and made joint efforts to prevent the transmission of diseases. At the same time, we took active measures to treat emerging diseases in good time. In particular, last year, with the support of WHO, we implemented the epidemiological surveillance of malaria and tuberculosis throughout the country and took preventive measures. Practical measures were also taken to improve the nutritional status of children.

I would like to take this opportunity to express my sincere thanks to WHO for its generous assistance to our health development, in spite of its recent financial difficulties. Through last year's work, we have come to feel more deeply the need for strengthening preventive work and the vital importance of the government's regulatory role in making rational use of a limited health budget and financial resources for the priority areas. This year, we are planning to give priority to the protection of mothers and children, especially those under the age of five, and to concentrate our efforts on them. In the meantime, we will be actively engaged in endeavouring to eliminate many communicable diseases, including malaria and tuberculosis, and will promote an extensive tobacco-free campaign, thus steadily improving the people's health.

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[1] In accordance with Rule 89 of the Rules of Procedure.

الدكتور فتحي عرفات (فلسطين): Dr. ARAFAT (Palestine):

السيدة الرئيسة، السيدة المديرة العامة، السادة نواب الرئيس، أصحاب المعالي، وزراء الصحة، السيدات والسادة، أود قبل كل شيء أن أعرب هنا وباسم دولتنا الفلسطينية عن أصدق تهانينا للسيدة الرئيسة ولنوابها لانتخابهم لادارة شؤون جمعية الصحة العالمية الثانية والخمسين، خاصة وأنها آخر دورة في القرن العشرين، كما أود أن أشكر الدكتور حسين الجزائري المدير الاقليمي على التعاون والدعم المتواصل الذي يقدمه لشعبنا الفلسطيني.

السيدة الرئيسة، لقد مرت ثلاثون عاما وشعبنا يخوض معركة الصحة في ظل ظروف الاحتلال والحرب والتشرد، ثلاثون عاما وأنتم جميعا ممثلي الصحة لكل دول العالم تشاركوننا هذه المعركة طويلة الأمد، وكم بذلتم من مجهود، وكم أخذت هذه القضية من وقتكم الثمين، ولا أنسى أن احدى جلساتكم امتدت لما بعد منتصف الليل. كنا جميعا حريصين أن يستطيع شعبنا، هذا الشعب الصغير، أن يحافظ على أدنى حد من استمرار الحياة وأدنى حد من تقديم الخدمات الصحية. ورغم الاحتلال وقسوته كانت ارادة شعبنا الاستمرار في الحياة ومحاولة اللحاق بركب الحضارة العالمية، وكم تعلمنا منكم جميعا على مدى هذه السنوات، وكم حملنا شعار منظمتكم الموقرة "توفير الصحة للجميع بحلول عام ٢٠٠٠"، ونحن الآن على أبواب هذا التاريخ. استطعنا أن ننشئ أجهزتنا الطبية لأهلنا في أرضنا المحتلة وأهلنا في المخيمات وأماكن النزوح محاولين أن نضرب المثل على أن الشعوب دائما قادرة أيا كان هناك التصميم والعزم. أنشأنا جمعية الهلال الأحمر الفلسطيني لتتولى المسؤولية الصحية عن شعبنا، وأنشأنا المجلس الصحي الأعلى ليأخذ دوره بعد مؤتمر مدريد، ووضعنا الخطة الوطنية الصحية لشعبنا الفلسطيني، ثم كانت اتفاقيات أوسلو والتي أنشئت على أثرها السلطة الوطنية الفلسطينية بما فيها وزارة الصحة، واستمر التعاون بين شعبنا ومنظمتكم الموقرة مستمرين في خوض معركة الحياة. ولقد عملنا جاهدين، بدعمكم المتواصل، على تحسين البنية التحتية لوزارة الصحة الفلسطينية التي دأبت على العمل الجاد لتحسين صحة شعبنا على أساس مبادئ ألما آتا مع ايلاء أهمية خاصة للرعاية الصحية الأولية التي نعتبرها العمود الفقري لجهازنا الصحي، فبذلنا جهدا كبيرا لتحسين مراكز الرعاية الصحية الأولية في كافة الأراضي الفلسطينية، كما أولينا اهتماما خاصا لبرامج صحة المرأة وحقوقها دون أن نهمل تطوير خدمات الرعاية الثنائية والثلاثية، وذلك بالرغم من قسوة الاحتلال الذي طالما حاول وضع العراقيل أمام تقديم خدماتنا، وحاول هدم البنية التحتية لمؤسسات شعبنا، بل حاول القضاء عليها. وكانت ارادة شعبنا أكبر من قسوة الاحتلال وكان دعمكم لنا من خلال منظمتنا الكبيرة ومن خلال التعاون بين وزاراتكم الموقرة مباشرة صرحا قوّى عزيمتنا وصلّب ارادتنا وقررنا أن ننظر فقط الى الأمام. عندما نجد أن شعبا ما يتألم في العالم كنا دائما نشعر معه ونود دائما أن نكون قادرين على الوقوف بجانبه، أقول هذا رغم محنة شعبنا، فشعبنا مع أهالي كوسوفو ولاجئي كوسوفو حيث أرسلنا بعثة رمزية لمعاونته، فنحن مررنا بالتجربة وعرفنا مرارتها ونتمنى أن يقف العالم مع هذا الشعب حتى نخفف من وطأة الكارثة التي لحقت به. والآن، ونحن على أبواب عام ٢٠٠٠، يستكمل شعبنا مسيرة ثورته ونضاله ويتأهب لاعلان دولتنا الفلسطينية لتأخذ دورها ضمن دول العالم، ونكون بتجربتنا المتواضعة تحت تصرف أي شعب في العالم. لقد أراد شعبنا السلام، وعمل الكثير من أجل ارادته هذه، ودائما نرى العالم داعما لأي مسيرة سلام، وقد حققنا الخطوات الكثيرة في هذه المسيرة. تعالوا جميعا لننظر، ونحن على أبواب ألفية جديدة، أن تكون ألفية المحبة والسلام، أن تكون هذه الألفية ألفية المحبة والسلام ولنبني جميعا عالما جديدا يعيش فيه أطفالنا كل أطفالنا أطفال فلسطين وأطفال اسرائيل وأطفال كوسوفو وكل أطفال العالم في محبة وسلام. والسلام عليكم

El Dr. CHIOLA (Paraguay):

Señora Presidenta, Excelencias, distinguidos delegados, señoras y señores: Quiero felicitar a la señora Presidenta y a los Vicepresidentes por su elección para presidir esta magna Asamblea. Hago extensiva la felicitación a la Directora General y a las demás autoridades.

A todos nos afecta esta circunstancia de pasar al siglo XXI y estamos concordando en que esta última Asamblea del siglo nos pone en la perspectiva de una evaluación más profunda de los hechos y circunstancias que afectaron y afectarán a la salud. Sabemos que la pobreza creciente de los países en vías de desarrollo se constituye en el mayor obstáculo para cambiar la situación sanitaria. En el mundo globalizado, el esfuerzo mancomunado de los países ricos y los países pobres en erradicar la pobreza y las enfermedades de sus territorios debe darse en el contexto de un compromiso para el apoyo económico franco y efectivo de los ricos con los pobres, de manera a dar un toque de equidad a la distribución de los recursos en nuestro planeta. Debe prestarse una especial atención a los flagelos de la impunidad y la corrupción, que constantemente atentan contra la utilización efectiva de los recursos, impidiendo llegar a

objetivos trazados y que requieren una lucha sistemática y persistente para su disminución. Otra perspectiva a tener presente es la de dar una mayor eficiencia al uso de los recursos de los organismos internacionales, mediante el direccionamiento de un mayor porcentaje hacia el cambio efectivo de la situación de las poblaciones meta, antes que en procedimientos burocráticos.

Existen muchos desafíos. En el Paraguay, país en vías de desarrollo con una pobreza creciente, se ha definido una política y planes que consideran a la salud como eje fundamental del desarrollo humano sostenible, para sustentar el desarrollo armónico del país. Se han tenido progresos en la situación de salud, pero se hace imperiosa la necesidad de mayores recursos externos para sostener los avances.

Se debe revisar la distribución de los recursos de los programas de salud de los organismos de las Naciones Unidas, buscando mantener los recursos para aquellos países que han logrado mejorar su situación y no premiar la ineficiencia, dando mayores recursos derivados de los primeros para aquellos que no los han sabido utilizar eficazmente.

La Política Nacional de Salud del Paraguay tiene como finalidad impulsar la reforma sanitaria mediante la reorganización de los servicios de salud, el fortalecimiento de la rectoría del Ministerio de Salud, el desarrollo del Sistema Nacional de Salud, la movilización y ejecución de recursos financieros y de nuevos modelos de aseguramiento a la población, la descentralización y el impulso de los procesos de promoción a fin de aumentar la cobertura de los servicios, agua y saneamiento, y de controlar las principales enfermedades transmisibles y no transmisibles. Nuestro gran reto en salud es extender la cobertura de servicios a un tercio de nuestra población, que no tiene acceso a una atención en salud oportuna y de calidad. Por lo tanto, impulsaremos la aplicación de la estrategia de atención primaria que permita llegar a las comunidades con servicios y programas, dando prioridad a la población rural y a la de áreas marginales urbanas.

La atención al control y eliminación de las principales enfermedades transmisibles y no transmisibles como el sarampión, tétanos neonatal, enfermedad de Chagas, rabia humana, dengue, paludismo, cáncer del cuello uterino y mamas, así como las enfermedades cardiovasculares, constituye una meta prioritaria. Se hará mediante el desarrollo de un sistema de vigilancia epidemiológica en el nivel local, con participación de la comunidad organizada, buscando detectar oportunamente los posibles brotes epidémicos e interviniendo rápidamente para controlar su propagación.

Impulsamos la reforma sanitaria para garantizar la sostenibilidad de las acciones de extensión de cobertura y de control de enfermedades. Muchas gracias.

Mr S.U. Yusuf (Bangladesh), Vice-President, took the presidential chair.
M. S.U. Yusuf (Bangladesh), Vice-Président, assume la présidence.

The PRESIDENT:

I continue with pleasure the discussion of item 3 of the agenda, and call upon the delegate of Malaysia.

Mr ALI MOHAMED RUSTAM (Malaysia):

Mr President, distinguished delegates, ladies and gentlemen, I would first of all like to congratulate the President and the officers of the Bureau on their election to these esteemed positions. The Malaysian delegation would also like to join other speakers in thanking and congratulating the Director-General on her enlightening report entitled "Looking ahead for WHO after a year of change".

As we cross the threshold into the twenty-first century, a developing country like Malaysia will have to bear the burden of dealing with infectious diseases and chronic noncommunicable diseases like cancers, cardiovascular diseases, diabetes and tobacco-related ailments. In addition, we are faced with problems that accompany rapid industrialization, and conditions that come with an ageing population. We need to look at the experiences of industrialized countries in responding to these challenges, and WHO will help to facilitate this. It is our fervent hope that the expansion and application of new knowledge about diseases and their control will reduce mortality, morbidity, and disability and enhance the quality of life throughout the entire life span. We wholeheartedly welcome the report's assertion of the need to invest in expanding the knowledge base, as this will provide tools for continued gains in the twenty-first century. However, while looking at the experiences of the developed countries as a reflection of what we might face in the future, Malaysia will not forget the difficulties which we have ourselves faced in the past. Therefore, we are firmly committed to sharing our experiences with other developing countries, especially in the field of health and how it relates to the process of development.

It is aptly remarked in the Director-General's report that limits exist on what a government can finance and on its capacity to deliver services. The government then has to establish its priorities so that the policies and strategies decided upon will ensure maximum benefit to the people within the limited resources available. Our Government has also affirmed its advocacy of health as a social responsibility and health was made an integral part of the national development process. If investment in health has alleviated poverty, let us now find appropriate and effective strategies to save the same people from the clutch of diseases of affluence.

We support the Tobacco Free Initiative that WHO is developing. The dedication of one chapter to this shows WHO's grave concern over the issue, and this is justifiable. Tobacco addiction will probably remain a major public health problem in the next decade. We agree that a global response and global commitment to its control is the answer to this growing menace. Within a country, tobacco control demands multisectoral involvement of both government and nongovernment bodies because the issues involved are complex and sensitive.

It is noted that the fight against infectious diseases in the past had successes and failures. The world has eradicated smallpox and is now almost succeeding in eradicating poliomyelitis, leprosy and measles. However the threats of other diseases like dengue haemorrhagic fever, malaria and cholera are still real. Initiatives like building on current efforts at the local, national, regional and global levels and sharing experiences with countries which have successfully eradicated malaria should be given due emphasis. The same strategy should be adopted for the control of other major infectious diseases. In this connection, as a concrete example of our belief that developing countries can and should help one another, we are willing to share our experiences in the successful control of malaria. We also believe that the need to exert extra vigilance over new and emerging infectious diseases is warranted. In this regard, we are grateful to the rapid response of WHO to our call for assistance during the recent outbreak of a new hendra-like virus in certain areas of Malaysia. The same gratitude goes to other countries that have also rendered invaluable assistance throughout the outbreak.

In conclusion, we reiterate that we support WHO's efforts in reviewing the challenges in world health and in looking at their implications when recommending new approaches, priorities and work in the years to come.

Dr KRAG (Denmark):

Mr President, ministers, Madam Director-General, esteemed colleagues, ladies and gentlemen, after taking office in July last year, the Director-General of WHO, Dr Gro Harlem Brundtland, has led this Organization into a process of profound change. This reform process is difficult and often painful, but it is necessary. Denmark supports and encourages the Director-General to continue to pursue her vision of a future WHO regaining its position as the lead agency in health in cooperation and dialogue with all partners concerned. For this vision to come true, the process of change has to maintain its inclusive character. This process is still ongoing; it will only be brought to full completion if all parts of WHO are able to work towards one common goal. In order to do so, WHO has to develop into one fully unified and coherent entity with clear objectives and priorities. We, too, wish to see one WHO.

Let me briefly comment on some very important issues which are currently being contemplated by a reformed WHO. Denmark fully supports the objective of a WHO working more effectively and supportive for, in and with countries. Denmark would like to see WHO become a more reliable and effective supporter of countries as they reform and restructure their health sectors. We agree that WHO should regain its place at the centre of the health sector development agenda and should become a more effective supporter of the development of health systems.

We are pleased that the Director-General yesterday announced that WHO is ready to join the United Nations Development Group and called for stronger interagency cooperation. Denmark welcomes the active participation of WHO in the process of the United Nations Development Assistance Framework and would like to see WHO fully engaged in the United Nations reform at country level. In 1998 Denmark contributed to the Health Renewal Fund in order to support WHO's reform process. The success of WHO's continued efforts of reform and restructuring will play an important role for the future Danish voluntary contributions.

It is of crucial importance to maintain the focus of WHO on areas where the Organization has its strength, knowledge, skills, comparative advantages and where its leading role is indisputable. The Director-General's summary underlines the important fact that many determinants of better health lie outside the health system itself. Health development is closely associated with achievements in other areas, especially social welfare, environment, housing, education, employment and working conditions. In these areas WHO must take into account responsibilities and capabilities of other partners. In the social area, for example, it is evident that the health sector and the health professionals have an obligation to bring

supportive evidence of the impact on health stemming from poverty, deprivation, loneliness, broken families, lack of network, insecurity and other social problems. On the other hand, WHO and the professionals in the field of health should neither take the lead in, nor the responsibility for, solving social policy problems in our societies. Social policy has its own legitimacy and needs no crutches. In fields like these, outside the health sector itself, WHO intends to serve as active and informed advocates of health-friendly policies. Denmark warmly supports this balanced approach that will indeed consolidate the supportive and collaborating attitude of the Organization, building and concentrating on basics in the field of health.

Dr PIATKIEWICZ (Poland):

Mr President, distinguished delegates, ladies and gentlemen, allow me first of all, on behalf of the delegation of Poland and myself, to congratulate all our colleagues who have been elected to the highest offices of the Fifty-second World Health Assembly, and particularly to Madam Maria de Belém Roseira, the President of the Assembly. Allow me also to extend our congratulations to Dr Brundtland and her staff for the concise but comprehensive report, *The world health report 1999*, as well as her presentation on "Looking ahead for WHO after a year of change".

As we are all aware, many Member States all over the world are engaged more or less intensively in the process of the reform of their health care systems, trying to respond to the growing expectations and demands of their population, as well as to the growing financial constraints in health expenditure. The same applies to WHO, where the process of the reform was also initiated several years ago and was subjected to severe financial constraints. In Poland we have also decided to accelerate the pace of reform and this year we have introduced a new system of health care financing based on health insurance and with elements of a market for providers. We welcome and commend Dr Brundtland's initiative on "making a difference" as indicated clearly in the subtitle of *The world health report 1999*.

We agree that the health problems we Member States and WHO are facing today, and the challenges we will face tomorrow, are enormous, and therefore we all need to focus on priorities. We welcome the Roll Back Malaria project and the Tobacco Free Initiative as major representative elements of the double burden of disease. But the spectrum of health care is very wide and accepting priorities we are all obliged to continue our everyday efforts. This spectrum starts with: (a) pure public goods, for example immunization and other preventive care, health promotion, food handling, sanitation, communicable diseases control, school health and many other public health functions; (b) diseases due to lifestyles and unhealthy behaviour or special risks which, in addition to smoking, include alcohol or drug abuse, pollution of all kinds, injuries and accidents; (c) sociomedical care of the elderly and chronically ill, as we remember for this year especially; (d) diseases in the realm of statistical certainties like those related to age, gender or poverty; (e) all other diseases that happen throughout the whole life of each individual, and may be called chance occurrences. This wide spectrum of health care services indicates clearly that public health functions play an important part in the provision of health care and that health professionals, in determining their current and future obligations, have to consider striking a balance between individual and community health care and between curative and preventive, promotive and restorative care. The importance of appropriate utilization of available resources as the main issue in health care delivery is fully recognized, and we are aware that even with the most effective utilization of resources not all things can be publicly financed. But we are also aware that pressures on public resources to address problems of illness and to support the provision of public health services will not diminish. This is why we look forward to WHO leadership and guidance.

Dr MUBARAK (Iraq): الدكتور أوميد مدحت مبارك (العراق):

بسم الله الرحمن الرحيم،
السيدة الرئيسة، السادة الحضور، يشرفني أن أنقل لكم تحيات سيادة الرئيس صدام حسين، كما يسر وفد بلادي أن يتقدم لكم بخالص التهنئة لانتخابكم لرئاسة جمعية الصحة العالمية الثانية والخمسين. وانني على ثقة بأن ما تتمتعون به من خبرة وحكمة كفيل بانجاح سير أعمال هذه الدورة باتجاه تحقيق الأهداف الانسانية النبيلة التي نعمل جميعا من أجلها.

السيدة الرئيسة، لقد عمل العراق بكل اهتمام وجدية على تنفيذ هذه الأهداف عبر العديد من البرامج الصحية المتطورة لأن الحرب التي شنتها دول التحالف في عام ١٩٩١ وما تلاها من أعمال عدوانية مسلحة والتي دمرت كامل البنية التحتية للعراق، واستمرار الحصار الشامل الظالم المفروض على شعب العراق منذ تسع سنوات تسبب في احداث خلل كبير في تنفيذ الخطط والبرامج الصحية وانعكس بشكل سلبي خطير

على مجتمعنا بكل شرائحه. فقد ارتفع عدد وفيات الأطفال عام ١٩٩٨ الى ٢٧٩ ٧١ وفاة، بينما كان عدد الوفيات عام ١٩٩٠، ٨٩٠٣ فقط للأطفال دون الخامسة من العمر، وكذلك الحال بالنسبة للفئات العمرية أكثر من خمس سنوات، فقد ارتفعت الوفيات لأسباب كان بالامكان السيطرة عليها لو توفرت الأدوية والتجهيزات الطبية الأساسية ومنها أمراض القلب وداء السكري وأمراض الكلى وأمراض الكبد وأمراض ارتفاع ضغط الدم. وقد بلغت عام ١٩٩٨، ٧٦٠ ٨٨ حالة وفاة بينما كانت عام ١٩٩٠، ٥٦١ ٣٢ وفاة فقط. وازدادت نسبة الاصابة بأمراض سوء التغذية والهزال، وارتفعت نسبة المواليد بأوزان ناقصة دون ٢,٥ كيلو غرام من ٤,٥٪ عام ١٩٩٠ الى ٢٣,١٠٪ عام ١٩٩٨. كما عاودت الظهور أمراض سارية سبق أن بُذلت جهود عظيمة للسيطرة عليها. ففي عام ١٩٩٨ بلغ عدد اصابات الملاريا ٦٩٩٦ اصابة وازدادت الاصابات بالأمراض المنقولة بسبب تدهور نوعية مياه الشرب وعدم توفر الصرف الصحي الصحيح مثل مرض التيفود ٨٢٥ ١٩ اصابة ومرض التهاب الكبد الفيروسي ١٤٢ ١٢ اصابة أي بمعدل زيادة ستة أضعاف عما كانت عليه عام ١٩٩٠. كما بلغ عدد الاصابات بمرض الكوليرا ٢٥٦٠ اصابة في عام ١٩٩٨. وقد أكدت وكالات الأمم المتحدة العاملة في العراق وجميع المنظمات الانسانية هذه الحالة الخطيرة في العديد من تقاريرها التي اطلعتم عليها دون شك. وهذه الأرقام تظهر جزءا من حجم المعاناة الانسانية للشعب العراقي جرّاء التدهور الخطير في برامجه الصحية والتردي الكبير في الخدمات البلدية والبيئية. وقد أضافت مشكلة القدرة على تأمين المياه الصالحة للشرب لجميع المواطنين أبعادا خطيرة للمشاكل الصحية التي يعاني منها الشعب العراقي. ففي الوقت الذي كان تأمين المياه الصالحة للشرب عام ١٩٩٠ يغطي نسبة ٩٠٪ من السكان من خلال ١٥٠٠ مجمع مائي وبطاقة انتاجية تبلغ ٧ ملايين متر مكعب في اليوم الواحد أصبحت الكمية المتوفرة الآن ١,٥ مليون متر مكعب فقط يوميا أي أقل من ربع الكمية التي كانت متاحة عام ١٩٩٠.

السيدة الرئيسة، حتى مذكرة التفاهم الموقعة بين العراق والأمم المتحدة بشأن صيغة النفط مقابل الغذاء والدواء التي كان من المفروض أنها تهدف الى تخفيف المعاناة اللاانسانية لأبناء شعب العراق لم تتمكن من الحد من التدهور الخطير في الأوضاع الصحية والتغذوية والبيئية التي يعيشها شعب العراق منذ أكثر من تسع سنوات، وذلك بسبب سعي المندوبين الأمريكي والبريطاني في لجنة ٦٦١ الى افراغ هذه المذكرة من مضمونها الانساني، عبر وضع مختلف أنواع العراقيل والصعوبات أمام التنفيذ السلس للعقود الخاصة بها حيث كانت نسبة التنفيذ لحد الآن المرحلة الأولى ٨٤٪، المرحلة الثانية ٨٧٪، المرحلة الثالثة ٧٠٪، المرحلة الرابعة ١٢٪، المرحلة الخامسة صفر٪. وقد تسببت الآلية التي تعمل بموجبها لجنة ٦٦١ في تأخر وصول مواد طبية هامة وعرقلة اقرار عقود مواد أخرى ضرورية، بغية تكامل توفير الاحتياجات، اضافة الى عرقلة العقود الخاصة باصلاح المنظومات الكهربائية ومشاريع المياه الصالحة للشرب ومشاريع الصرف الصحي، الأمر الذي ضاعف من معاناة السكان المدنيين. ان وفد العراق يتوجه، سيادة الرئيسة، بالنداء الى جمعية الصحة العالمية للاضطلاع بمسؤوليتها الانسانية وانطلاقا من أهدافها ومبادئها السامية من أجل العمل على انهاء الوضع الصحي المأساوي الذي يعيشه أبناء الشعب، والذي يتناقض مع الأهداف الانسانية النبيلة التي تعمل منظمتنا من أجلها وذلك بالدعوة الى تطبيق الفقرة ٢٢ من القرار ٦٨٧ كخطوة أولى نحو رفع الحصار بشكل كامل لتمكين العراق من تلبية احتياجاته الانسانية.

وختاما أرجو أن تتكلل أعمال هذه الدورة بالنجاح التام من اجل تحقيق الأهداف النبيلة لمنظمتنا بتوفير متطلبات الصحة للجميع مع تمنياتنا للسيدة برونتلاند المديرة العامة للمنظمة كل النجاح في مهمتها الصعبة. والسلام عليكم

الدكتور اسحق مرقة (الأردن): Dr MARQA (Jordan):

بسم الله الرحمن الرحيم

أصحاب المعالي والسعادة، سيداتي سادتي، يسعدني أن أتقدم لكم سيادة الرئيسة بأجمل التهاني لانتخابكم لهذا المنصب الرفيع أنتم والسادة نوابكم، وكلنا ثقة من أن هذه الدورة ستقوم بانجاز الأعمال المعروضة عليها على أكمل وجه، وأنتهز هذه الفرصة لأتقدم بالشكر الى سعادة المديرة العامة وجميع مساعديها في الأمانة العامة على جهودهم في تسيير أعمال منظمتنا على أفضل وجه ممكن، وعلى بيان المديرة العامة والتي رسمت به معالم التغيير والخطط المستقبلية لمنظمتنا، وكذلك أتقدم بالتقدير البالغ للتقرير الوافي الذي قدمه المجلس التنفيذي لما احتواه من معلومات هامة وأساسية في عمل المنظمة.

أيها السيدات والسادة، انها لفرصة ثمينة في هذه المناسبة، ونحن نجتمع في آخر دورة لجمعية الصحة العالمية في القرن العشرين، ننتهزها لمراجعة الانجازات والمعوقات التي شهدها هذا القرن، ونتطلع

بثقة وأمل كبيرين لدخول القرن الحادي والعشرين. فبالرغم مما تحقق من انجازات كبيرة في المجال الصحي شمل حقولا كثيرة، الا أن حقوق الانسان مازالت مهددة في أجزاء كثيرة من العالم رغم مرور ما يزيد على خمسين عاما على اعلان حقوق الانسان. ان جميع هذه الأمور تؤثر تأثيرا مباشرا في صحة الناس وتقتضي الحاجة الى مضاعفة الالتزام من قبل الحكومات والقطاعات الأهلية المختلفة والمنظمات الدولية من أجل مجابهتها والتغلب عليها. فلابد من وضع الصحة في صميم خطط التنمية لأي بلد وخاصة في بلدان العالم الثالث، لأن الاستثمار الحكيم في الصحة يعتبر من أنجح الاستراتيجيات لمساعدة البشر على التخلص من الفقر حيث أن التحسن الذي حدث في الصحة في الماضي قد أدى الى حفز التطور الانساني والتقدم العلمي والاقتصادي.

أيها الاخوة والأخوات، ان حكومة المملكة الأردنية الهاشمية قد قطعت شوطا كبيرا في مجال تحسين صحة المواطن الأردني وخاصة خلال الربع الأخير من هذا القرن، وهي تسعى باستمرار الى رفع كفاءة الخدمات الصحية وتسهيل منالها وخفض تكلفتها وخاصة على شرائح الفقراء ومحدودي الدخل، بالرغم من محدودية الموارد المتاحة. ويظهر هذا التقدم الكثير من المؤشرات الصحية كمتوسط العمر المأمول ومعدل وفيات الرضع ومعدل وفيات الأمهات، والخصوبة. ويدرك الأردن جسامة التحديات الواجب التصدي لها، مع دخول القرن الحادي والعشرين وأبرزها ما يلي: التزايد المطرد في شيوع الأمراض غير السارية؛ زيادة شيوع مرض الايدز وعودة بعض الأمراض المسيطر عليها كمرض الملاريا والسل؛ توسيع برامج التطعيم الوطني ليشمل مطاعيم جديدة لأمراض أخرى، اذ ننظر الى برنامج التطعيم بأنه من أكثر البرامج الصحية فعالية ومردودا؛ خفض عبء الأمراض على المواطنين وخاصة الفقراء منهم من خلال المشاركة بين القطاعين العام والخاص وتحسين كفاءة الخدمات الصحية والعدالة في توزيعها وتنظيم عملية التأمين الصحي؛ زيادة نصيب الرعاية الصحية الأولية من الموازنة الخاصة بالصحة؛ الاستثمار في البحوث وتطوير الموارد البشرية ورفع كفاءتها من خلال برنامج التعليم الطبي المستمر؛ الاستمرار في توفير الأدوية الأساسية ذات الجودة العالية والتكلفة البسيطة للمواطنين؛ انتشار وباء التدخين والتصدي الفعال لهذا الوباء وما ينجم عنه من مخاطر صحية كبيرة.

الاخوة والأخوات، ختاما لابد من التنويه بأن الأردن يثمّن الثورة الاصلاحية الكبيرة التي تشهدها منظمة الصحة العالمية حاليا، ويحدوه الأمل بانبلاج عهد جديد يعود بالخير على سكان العالم مع دخول القرن الحادي والعشرين، ويلتزم في الوقت نفسه باستمرار التعاون مع المنظمة ومع جميع الدول والهيئات التي تسعى في سبيل تحسين الصحة للجميع ورفاه الانسان.

سيداتي وسادتي، ان الاستراتيجية العالمية للصحة لن تؤتي ثمارها مع نهايات هذا القرن أو القرن القادم، وواقع الحال يشهد الحرب والدمار والقتل في كثير من بقاع هذا الكون والويلات تلاحق أعدادا كبيرة من بني البشر في مواقع كثيرة وهي من صنع البشر. فالحروب والنزاعات الدولية هي التي تسبب الويلات متمثلة في الفقر والتدهور الصحي والمعاناة بأشكالها كافة خاصة اذا ما آلت افرازاتها ونتائجها الى عزل ومقاطعة وحصار لا تحقق من الهدف شيئا الا ازديادا في عدد الوفيات وانتشارا في الأمراض والأوبئة وتدهورا صحيا واجتماعيا كما هي الحال في العراق وفلسطين والسودان وغيرها من بقاع الأرض.

أيها السيدات والسادة، في الختام لا يسعني الا أن أتقدم بجزيل الشكر والعرفان لمنظمة الصحة العالمية على جهودها الحثيثة والمتواصلة من أجل النهوض بصحة الانسان وتخفيف معاناته أيا كان موقعه من خلال تنسيق جهود جميع الدول ودعمها لتحقيق الأهداف المرجوة.

سيداتي سادتي، أتمنى لاجتماعاتنا هذه كل التوفيق والنجاح ولمداولاتنا نتائج وقرارات مثمرة تؤثر ايجابا على حياة شعوبنا، متمنيا الصحة والعافية للجميع، وأشكركم سيدتي الرئيسة والسادة أعضاء الوفود لحسن الاستماع. والسلام عليكم ورحمة الله وبركاته.

Le Professeur RATSIMBAZAFIMAHEFA (Madagascar) :

Monsieur le Président de séance, Mesdames et Messieurs les délégués, Madame le Directeur général, Mesdames et Messieurs, c'est pour moi un grand honneur de prendre la parole au nom des Ministres de la Santé des pays suivants : Bénin, Burkina Faso, Cameroun, Congo, Côte d'Ivoire, Gabon, Guinée, Mali, Mauritanie, Niger, République centrafricaine, Sénégal, Tchad, Togo et Madagascar.

Monsieur le Président de séance, permettez-moi tout d'abord de féliciter le Président pour son élection à la tête de la présente Assemblée, ainsi que le Directeur général pour le début du processus de changement au sein de l'Organisation ces dix derniers mois.

Nous avons pris connaissance avec intérêt du contenu du rapport annuel 1999 sur la santé dans le monde. Il en ressort que des progrès réels ont été accomplis dans l'amélioration des conditions sanitaires des citoyens de la planète.

Nous voulons cependant insister sur les défis qui nous attendent pour un réel changement, dans l'espoir qu'ensemble nous pourrons trouver les solutions qui nous permettront non seulement de consolider les succès acquis, mais aussi de définir des stratégies pour promouvoir la santé des populations de nos pays.

Comme il est dit dans le *Rapport sur la santé dans le monde 1999*, on assiste à la résurgence de certaines affections et à la progression des maladies non transmissibles, au nombre desquelles les maladies cardio-vasculaires, les troubles mentaux et les pathologies liées au phénomène naturel du vieillissement.

En effet, pendant les dix dernières années, nos pays ont connu, chaque année, des épidémies de maladies transmissibles émergentes ou réémergentes. Pendant ce temps, l'appui des partenaires au développement a permis d'amoindrir les conséquences néfastes de ces situations urgentes, créées notamment par la méningite cérébro-spinale, la rougeole, le choléra, la fièvre hémorragique à virus Ebola, la fièvre de Marburg, la fièvre jaune et le VIH/SIDA.

La coopération sanitaire internationale devrait donc continuer à se développer. Pour ce faire, il apparaît nécessaire de formaliser davantage les procédures d'intervention de manière à systématiser le réflexe de riposte efficace à ces épidémies, parce que la maladie ne connaît pas de frontières. Cette coopération doit mettre particulièrement l'accent sur le VIH/SIDA.

En ce qui concerne le développement cohérent des systèmes de santé, il est essentiel d'optimiser les interventions. Cette optimisation nécessite un réel changement dans la manière de procéder. Ainsi, il sera certainement judicieux - le Directeur général l'a bien souligné - de mettre l'accent sur un nombre limité d'interventions facilitant du coup la possibilité d'obtenir un impact réel et observable sur le développement sanitaire des pays. Je voudrais énumérer quelques-unes de ces mesures : la réduction de la charge de morbidité et de la mortalité subséquente, la mobilisation des moyens de lutte efficace contre les menaces potentielles, la mise au point d'un système garantissant l'équité dans l'accès aux soins de qualité pour donner à chacun selon ses besoins, et une exploitation judicieuse des connaissances acquises dans les domaines de la santé et de la science.

Dans cet esprit, l'OMS doit assurer son rôle de leadership en encourageant une utilisation rationnelle des ressources au lieu d'un emploi par programme, comme c'est le cas maintenant, ce qui a limité les initiatives novatrices de nos pays. La plus grande autonomie prônée par le Directeur général devra s'accompagner d'une plus grande possibilité de négociation dans la planification et l'emploi des ressources pour la santé. En fin de compte, une plus grande exigence quant aux résultats à atteindre sera de rigueur.

Le projet Faire reculer le paludisme donne une occasion concrète de développer cette nouvelle approche par des initiatives de proximité dans la promotion de la santé au bénéfice des plus nécessiteux. Ainsi, nous souhaitons que l'Afrique, qui a déjà lancé son initiative adoptée par les chefs d'Etat et de gouvernement du continent, puisse avoir un programme directement géré par la Région africaine elle-même en termes de moyens matériels et humains et de stratégies, à l'exemple des programmes de lutte en cours contre l'onchocercose et la dracunculose, avec l'aide de la communauté internationale.

La lutte contre le tabagisme est incontestablement un des grands défis à relever. En 1996 est entrée en vigueur une résolution de l'Assemblée mondiale de la Santé préconisant que tous les vols aériens soient des espaces non fumeurs. Il nous semble que ce résultat soit encore loin d'être acquis du fait des profits réalisés par le commerce du tabac et de son effet pervers, qui est la "contribution effective" mobilisée par l'industrie du tabac en faveur de la "promotion du sport". Nos gouvernements apporteront le soutien politique nécessaire à cette lutte, qui sera certainement longue et peut-être plus difficile que celle contre les maladies infectieuses.

Le changement dans la gestion de l'OMS doit également se traduire par l'équité et la responsabilisation des personnels cadres de l'Afrique. Un accent particulier doit être mis sur leur développement adéquat. Sur ce plan, nous demandons que le Directeur général fasse un plaidoyer auprès des autres partenaires pour soutenir nos plans de formation.

Par ailleurs, il faut une équité accrue dans la mise à disposition simultanée des documents dans toutes les langues de travail de notre Organisation et la traduction simultanée s'impose dans toutes les conférences où au moins deux langues statutaires sont représentées.

Enfin, la nouvelle réforme de l'Organisation doit permettre une répartition équitable des ressources financières basée sur les besoins réels des pays de notre Région, pour qu'ensemble nous puissions apporter les changements souhaités.

Dr SONIN (Mongolia):

At the outset, allow me to congratulate the President and Vice-Presidents on their election to those high offices of the Health Assembly.

We are speaking here today, almost at the end of the twentieth century which was the original deadline for achieving our strategic goal: health for all. In these particular circumstances, I am pleased to

acknowledge that the world health status has improved in general, and that significant progress and achievements in the health of the population have occurred in my country. However, we still have some health concerns, and many governments like my own are facing new challenges in health care and are making an effort to respond to them effectively within limited resources. It seems to me that health care reform, which may be described as a process of planned and systematic change to attain well-defined health goals, encompasses common health development features in the different countries. Reform has many objectives, such as improved quality of services, equitable access, consumer satisfaction and financial sustainability. We need to analyse the effects of reform to assess these changes. I think that it is now the time in many countries to look beyond illness and disease to wellness and positive health, and to focus on the responsibility of individuals for their own health and the health of the community.

The Government of Mongolia is strongly committed to providing equitable and good quality health services to all citizens and it is well reflected in the national health policy, pursued during the economic and social reform process over the past several years. Our national health policy provides a vision for comprehensive health reform by defining the following four main policy directions: first, a new philosophy for health system development based on preventive rather than curative medicine; secondly, wide community participation and involvement of individuals and families in improving their health status, as well as improved intersectoral collaboration; thirdly, decentralization and improved health services management targeted at better effectiveness and economic sustainability of the health system; finally, equity in the provision of health services by defining responsibilities at all levels, and by strengthening financial information systems to improve accountability.

We all know that given the right circumstances, people have the potential to make long-term differences in their health. Therefore, it is our role to provide support in achieving this by creating favourable conditions and the right environment and by promoting preventive health measures and health education. In this regard, the Government of Mongolia wishes to thank WHO for the valuable support and assistance it has given in the past within a new framework of health development and the WHO global agenda.

I am pleased to note that our technical collaboration and emphasis are gradually shifting from a disease-centred approach to public and preventive health, while maintaining effectively and adequately a health service delivery system, through rationing the health structure and facilities and training health personnel. I hope that this Fifty-second World Health Assembly will focus on the present health challenges and that WHO will collaborate intensively with the Member States in the areas that are relevant to the needs of the twenty-first century.

Finally, I would like to inform you that the Government of Mongolia highly values and recognizes the vital importance of the Director-General's policy address at the last Executive Board session and of her efforts to reorganize the structures and functions of WHO to improve communication and transparency. We also appreciate the changes that support her policies at regional and country levels, as illustrated by the Regional Director's policy directions for the WHO Western Pacific Region. I wish them all success.

Le Professeur CIOCALTEU (Roumanie) :

Monsieur le Président, Madame la Directrice générale, chers confrères, Mesdames et Messieurs, c'est un grand honneur pour moi et pour la délégation de la Roumanie de transmettre mes sincères félicitations et souhaits de succès à Mme Maria de Belém Roseira pour son élection à la présidence de la Cinquante-Deuxième Assemblée mondiale de la Santé, fonction qui implique une grande responsabilité. De même, je félicite les distingués Vice-Présidents de l'Assemblée et les Présidents des deux commissions, tout en exprimant ma conviction que, sous leur direction compétente, les travaux de notre réunion déboucheront sur des résultats bénéfiques pour l'état de la santé dans le monde. Je voudrais également remercier le Dr Gro Harlem Brundtland, Directrice générale de l'OMS, et son équipe de leur immense effort pour organiser dans de très bonnes conditions la présente Assemblée, qui nous offre un cadre propice à d'amples débats sur des thèmes spécifiques.

J'aimerais commencer par une citation de Rainer Maria Rilke, un poète qui m'est très cher :

"Heure, tu t'éloignes de moi,
ton battement d'ailes me déchire.
Seul : que faire de ma voix ?
de ma nuit ? de mon jour ?"

Ce que je voulais dire par là, c'est que l'amélioration de l'état de santé, en Roumanie comme partout, n'est possible que si vous, les Etats Membres de l'Organisation mondiale de la Santé, restez près de nous. Restons ensemble pour le bien-être commun, pour la santé de nos frères du monde entier. On ne peut pas réussir tout seul. Dieu n'est qu'un, quelle que soit la façon dont nous nous représentons son image ou la langue dont nos prières se servent.

La récente visite en Roumanie du Saint-Père, qui nous a rappelé toutes ces choses, est une preuve - s'il en était encore besoin - de notre ouverture aux valeurs occidentales, au bien, au beau, à la vérité, à Dieu. Nous sommes égaux devant Dieu, soyons-le devant la souffrance et la maladie ! C'est pour cela que je pense, chers confrères, que nous aurions besoin d'un code déontologique médical international, initiative que l'OMS pourrait coordonner.

La délégation de la Roumanie apprécie hautement le rapport présenté par le Dr Brundtland, qui a fait une profonde analyse de la situation particulière où l'on se trouve à présent, c'est-à-dire où, dans presque tous les Etats Membres, se produisent des changements du système de santé.

Des changements se produisent, d'ailleurs, à l'intérieur de l'Organisation elle-même - des changements positifs -, et je tiens à exprimer une fois de plus l'appui de la Roumanie à la réforme dont l'initiative revient à Mme la Directrice générale.

Les efforts de l'OMS pour améliorer l'état de santé sont appréciés dans notre pays aussi; ils se traduisent tant par des actions de caractère général que par des activités visant à la solution des problèmes prioritaires. Ainsi, la réforme du système de santé en Roumanie, en cours d'application, suit les principes que le rapport a mentionnés. Il est méritoire que notre Organisation ait saisi l'importance du moment et que, par son adaptation, elle contribue à l'amélioration de la santé dans le monde entier. C'est pour cela que les quatre thèmes de la stratégie collective proposée sont réalistes et qu'ils vont marquer les actions que nous menons tous.

La nouvelle doctrine de "l'universalisme" mentionnée dans le rapport est favorable à la diversité et à l'implication du secteur privé dans la fourniture de médicaments et de matériels aux prestataires de services. Cette doctrine présente aussi un intérêt particulier pour notre pays en transition, transition économique qui nous fait ressentir plus que jamais la nécessité d'une bonne utilisation des ressources limitées dont nous disposons. A propos des ressources, nous tenons aussi compte de l'expérience nécessaire pour réaliser et gérer convenablement des programmes de santé; l'assistance de l'OMS nous est très utile.

L'approche plus stratégique des activités dans les pays et avec eux se retrouve aussi dans le programme de coopération à moyen terme entre la Roumanie et le Bureau régional OMS de l'Europe, qui représente, lui aussi, un cadre de référence pour nos priorités. On peut dire que les réseaux thématiques organisés par l'OMS nous donnent la possibilité de participer activement au modelage des stratégies sanitaires nationales, et surtout régionales.

Tout récemment, nous avons élaboré des programmes concernant, entre autres, la tuberculose, le cancer, la mortalité infantile et la promotion de la santé. Nous venons aussi d'élaborer une stratégie antitabac, qui - nous l'espérons - produira un impact; elle insiste surtout sur l'interdiction de la publicité et de toute forme de promotion du tabac, mesure qui semblait impossible il y a quelques années.

La réforme et les programmes de santé ont été récemment évalués, remaniés et renforcés conformément à la nouvelle loi relative à la santé publique.

Nous avons aussi établi un programme national intersectoriel de lutte contre l'infection à VIH et le SIDA, programme qui, de concert avec d'autres mesures spécifiques, a conduit à la disparition des contaminations nosocomiales, comme celles qui ont déclenché l'accident épidémiologique des années 1988-1989.

Comme je l'ai déjà dit, dans tous les domaines où nous sommes intervenus pour améliorer la santé de la population, nous avons reçu l'assistance technique et l'appui de l'OMS. De cette manière, le rôle important et l'utilité de notre Organisation ont été démontrés une fois de plus.

En écoutant le rapport de la Directrice générale, nous nous sommes rappelé beaucoup de points qu'elle avait discutés avec les hommes politiques de Roumanie, et je me rends compte que maints problèmes qui se posent à nous vont trouver une solution dans les futurs programmes de l'OMS.

Ces problèmes auxquels la Roumanie doit faire face n'ont pas de caractère spécifique ou singulier; ils ne correspondent pas à des situations isolées. On peut les retrouver, d'une manière ou d'une autre, dans plusieurs pays ou Régions, et c'est pour cette raison que je dois aussi souligner le rôle positif que le Bureau régional de l'Europe a joué et continue à jouer. Dans ce contexte, je pense que le développement de la collaboration entre deux ou plusieurs Etats Membres serait une source commune d'avantages, où l'on peut puiser des solutions adaptées aux besoins de chacun.

Au nom du Gouvernement de la Roumanie, j'exprime le désir et la volonté de notre pays de participer à de tels programmes et d'apporter son concours pour que les moyens les plus efficaces de résoudre les problèmes de santé soient trouvés.

Nous voyons dans la santé l'expression de l'un des droits de l'homme et un élément fondamental pour bâtir une société civile, aussi lui accordons-nous une attention particulière. Et, en pensant à ce qui se passe maintenant sur ce continent, pas tellement loin de nous, je voudrais ajouter ces quelques mots, toujours de Rilke :

"Qu'est-ce donc qui nous empêche de croire
(puisque ainsi nous sommes posés et éparpillés)
que haine et misère et tout ce dont nous sommes la proie
n'ont en nous qu'une demeure temporaire ?"

El Dr. BUSTOS ALONSO (Uruguay):

Es un honor dirigirme a esta 52ª Asamblea Mundial de la Salud, en el marco del *Informe sobre la salud en el mundo 1999*. Quiero felicitar en primer término a la señora Directora General por este informe, donde no sólo se abordan los temas desde una perspectiva sanitaria y técnica, sino que también están contemplados los aspectos humanos. Como el informe lo indica, las circunstancias en el mundo han cambiado los últimos años y lo seguirán haciendo. Por lo tanto debemos abordar los problemas del crecimiento con equidad a largo plazo. Debemos conciliar la eficacia de la economía con la política social. Los problemas sociales están en nuestras agendas de trabajo, pero debemos sumar cada día más gente que comprenda que si no tenemos la capacidad de hacer frente a los aspectos sociales, si no contamos con planes de largo aliento, si no contamos con instituciones sólidas, será difícil asegurar un desarrollo sostenible y equitativo.

En mi país hemos completado la transición epidemiológica y demográfica. Unos de nuestros principales problemas son hoy en día las enfermedades cardiovasculares. El consumo de tabaco es alto. Hay aproximadamente 4800 muertes prematuras por año. Preocupados por esto, el año pasado decidimos realizar una encuesta nacional sobre consumo de tabaco. Un uruguayo de cada cinco fuma. Uno de cada tres es hombre. Uno de cada siete es mujer. Los hombres que más fuman tienen instrucción básica, pero en las mujeres, contrariamente, son las de instrucción superior las afectadas. Conocida la realidad, el Gobierno, a través del Ministerio de Salud Publica, ha preparado un proyecto de ley actualmente en el Parlamento que, entre otras cosas, prohíbe vender tabaco a los menores de 18 años, regula la publicidad, reserva lugares para fumadores en espacios cerrados, etc. No obstante, mientras aguardamos la aprobación de esta ley, el poder ejecutivo ha puesto en vigencia dos decretos: uno vinculado a la prohibición de fumar en las oficinas públicas, y otro al etiquetado de los envases de tabaco en el cual debe lucir que fumar es perjudicial para la salud.

Otro tema que nos preocupa, y mucho, es el VIH/SIDA. Con la promoción de medidas preventivas y con la aplicación del triple plan, hemos logrado detener el crecimiento y mejorado la sobrevida de los pacientes con SIDA. Así como también, tratando a la mujer embarazada, reducir la infestación vertical. A pesar de ser un país con un porcentaje de producto bruto interno destinado a la salud relativamente alto como es 10%, en el año 1985 la mortalidad infantil era de 30,4 por 1000. Que era inaceptable para esa cifra de inversión.

Con el fortalecimiento en el sector público de la estrategia de atención primaria de salud enfocada a la mejora de la calidad de la atención prenatal en el nivel adecuado, el tratamiento precoz de las infecciones respiratorias agudas, la promoción de la lactancia natural, la mortalidad infantil hoy ha descendido a 16 por 1000. Registramos un nivel de cobertura de inmunizaciones que puede definirse como muy bueno: vacunación gratuita contra tuberculosis, poliomielitis, meningitis por *Haemophilus influenzae* tipo B, triple viral, difteria, y tétanos. Hace cuatro años agregamos la vacuna contra la gripe, a la que se añadió este año también la vacuna contra la cepa Sydney. Hemos podido cubrir en este otoño a más del 70% de nuestros mayores de 65 años. Es un país libre de cólera, también libre de transmisión de paludismo, aunque se registran periódicamente casos importados en personas que viajan al exterior, como los contingentes militares en misiones de paz, los cuales están siendo tratados. Pero también tenemos un alto índice de accidentes, especialmente de tránsito, un alto porcentaje de patologías tumorales que traen aparejados altos costos, con decisiones y procedimientos que no son eficientes. Señor Presidente, nos comprometemos a continuar trabajando para contribuir a visualizar y mejorar este lado de la sociedad para, desde una perspectiva global, poder ofrecer a nuestros niños un mundo más deseado y justo: un mundo donde se reduzca la pobreza y la desigualdad. Muchas gracias.

Le Dr RWABUHIHI (Rwanda) :

Monsieur le Président de séance, Madame le Directeur général de l'OMS, Mesdames et Messieurs les Ministres, chers collègues, distingués délégués, Mesdames et Messieurs, c'est un grand privilège pour moi de prendre la parole ici pour remercier la grande famille de l'OMS et ses autorités pour leurs efforts dans la lutte pour la santé de l'humanité, pour leurs efforts dans la lutte pour la vie.

Il y a seulement cinq ans, mon pays, le Rwanda, a vécu la forme la plus extrême de négation de la vie, de négation de la santé : le génocide. Ce qui est déplorable, c'est que la communauté internationale n'a

pas voulu s'opposer au génocide rwandais alors qu'elle en avait les moyens, tous les moyens. Aujourd'hui, le Rwanda est confronté aux innombrables conséquences de cette tragédie : la reconstruction d'un pays et d'une économie anéantis, la protection de la sécurité des populations contre les idéologues du génocide, la réhabilitation des rescapés, la restauration de la justice indispensable pour la réconciliation nationale. Sans être exhaustif, voici le tableau exceptionnel de la situation dans laquelle nous devons en plus affronter les défis que vous avez évoqués, Madame le Directeur général, et que nos services de santé doivent aussi affronter.

Ce contexte exceptionnel a été pour nous l'opportunité de réformer notre système de santé dans le sens de la décentralisation, avec quatre orientations prioritaires : améliorer la qualité des soins de santé, renforcer et organiser la participation de la communauté, assurer l'accessibilité géographique et financière des services de santé, et consolider l'organisation et la gestion des services et de nos maigres ressources. Nous disons modestement "orientations prioritaires", car il est particulièrement difficile pour nous de définir des priorités là où tout, absolument tout, est prioritaire.

Pour ce qui concerne les programmes spécifiques, il faut saluer le projet Faire reculer le paludisme, car il est très ambitieux, vu le poids de cette maladie. Mais il faut reconnaître aussi la sagesse de ce projet : en effet, il s'agit seulement de faire reculer le paludisme et non de l'éradiquer, comme on a pu le prétendre dans les années 60. Cette sagesse est sûrement un gage de bons résultats à venir.

Quant au SIDA, je dois dire que j'ai été surpris d'entendre des délégués dire avec une certaine fierté que, chez eux, cette maladie n'est pas un gros problème de santé publique. J'ai même eu un peu peur, car nous sommes presque tous passés par là. Au Rwanda, le SIDA a bien sûr profité de la guerre, du génocide et des inoubliables déplacements de plus de 7 millions de personnes, sans dire que les programmes de prévention ont été interrompus pendant plus d'un an. Le taux de séroprévalence est passé en quatre ans de 2 à 11% dans les campagnes rwandaises. Devant l'immensité du problème, nous ne pouvons pas grand-chose tout seuls. C'est pour cela qu'avec les Ministres des pays de la région des Grands Lacs, une initiative heureuse vient d'être lancée : GLIAA (Great Lakes Initiative against AIDS), dont la première action, déjà commencée, est la surveillance et la prévention du SIDA le long des grands axes routiers transfrontaliers entre les grands ports et les différentes localités de cette région.

Devant l'énormité des problèmes à affronter, la faiblesse de nos moyens propres, le fardeau de la dette extérieure dont une partie a servi à acheter les armes du génocide, les bailleurs de fonds ont tendance à se décourager et ils nous disent : "On ne peut pas vous aider *ad infinitum*".

Le génocide est un crime contre l'humanité, toute l'humanité, votre humanité aussi. Il ne s'agit pas d'aider le Rwanda, mais il faut avec nous réparer le tort qui vous a été fait en tant qu'humanité. Il ne s'agit pas d'une question de générosité, mais d'un problème moral pour que le Rwanda accède au même niveau que beaucoup d'autres pays dans la lutte contre la maladie, dans la lutte pour la vie, dans la lutte pour la santé.

Le Dr MARQUES DE LIMA (Sao Tomé-et-Principe) :

Monsieur le Président, Madame le Directeur général, illustres délégués, Mesdames et Messieurs, au nom de la délégation de Sao Tomé-et-Principe et en mon nom personnel, permettez-moi de féliciter Mme Maria de Belém Roseira pour son élection à la présidence de cette Cinquante-Deuxième Assemblée mondiale de la Santé. Je suis sûr et certain que, menés sous sa compétente direction, les travaux de cette Assemblée seront couronnés de succès.

Je ne peux pas omettre de féliciter et de remercier Mme le Directeur général pour l'excellent rapport qu'elle nous a présenté sur la situation de la santé dans le monde en 1999. Ce rapport met en relief les progrès considérables accomplis dans le domaine de la santé au cours du XX^{e} siècle, progrès qui constituent un motif d'espérance pour le XXI^{e} siècle qui est à notre porte. Nous avons réussi à éradiquer l'une des maladies les plus mortelles de l'humanité, la variole; certaines maladies infectieuses sembleraient être sous contrôle; nous avons réalisé des avancées notables dans l'amélioration de l'espérance de vie, notamment dans les pays en développement. Mais le rapport nous montre aussi des éléments qui doivent constituer de sérieux motifs d'inquiétude pour l'OMS et les pays Membres. Permettez-moi de m'arrêter sur trois de ces éléments.

Le premier est le paludisme, qui continue à imposer aux populations un lourd fardeau de morts et de souffrances. Son retentissement négatif sur le développement socio-économique des pays les plus touchés est bien connu. Il est important de souligner ici que la majorité, si ce n'est la totalité, d'entre eux sont des pays en développement pour acquérir la notion de la relation intrinsèque entre cette maladie et le sous-développement et pour avoir conscience qu'il n'y a pas de raison plus pressante que celle-là pour que la lutte contre le paludisme soit adoptée comme la priorité des priorités. Nous avons à notre disposition des connaissances, des moyens et des techniques pour faire face de façon satisfaisante à cette calamité. Il devient nécessaire d'agir avec détermination de sorte que ces connaissances, ces moyens et ces techniques

soient mis à la disposition des populations les plus nécessiteuses. Au nom du Gouvernement de Sao Tomé-et-Principe, il me plairait de manifester ici notre total engagement dans l'initiative Faire reculer le paludisme, lancée par le Directeur général de l'OMS.

Le deuxième est l'épidémie d'infection à VIH/SIDA qui poursuit son action dévastatrice, particulièrement en Afrique où le nombre de personnes séropositives et de malades ne cesse d'augmenter. Tandis que des efforts sont déployés pour produire des vaccins qui soient efficaces contre la maladie, nous devons explorer au maximum les possibilités offertes par l'information et l'éducation pour la santé dans le changement d'attitudes et de comportements à risque qui facilitent sa dissémination si nous ne voulons pas compromettre de façon irréversible le processus de développement économique et social du continent.

Le troisième découle de la détérioration de la situation économique et son corollaire, l'augmentation de la pauvreté, problème vraiment préoccupant dans beaucoup de pays. Nous savons que la pauvreté est en même temps génératrice et conséquence du mauvais état de santé des populations, et nous sommes d'avis qu'investir dans la santé des populations les plus pauvres et défavorisées est un des principaux moyens pour atténuer la pauvreté.

L'instabilité politique et la prolifération des conflits régionaux conduisant à la déstabilisation profonde des sociétés et des pays où ils ont lieu constituent aussi des éléments pertubateurs qui, s'ils n'étaient pas jugulés, compromettraient gravement tout l'effort à venir pour améliorer la santé dans le monde. D'où notre idée que le plaidoyer pour la paix devrait aussi être une des actions de l'OMS devant les instances internationales.

Monsieur le Président, rendre possible l'accès à des soins de santé de qualité à toute la population, et particulièrement aux groupes les plus vulnérables, de façon à garantir l'équité dans la prestation des services est un propos qui doit être poursuivi et qui devra nécessairement impliquer notre questionnement sur la manière dont nous gérons nos systèmes de santé. La réforme du secteur sanitaire est indispensable et urgente. Il s'agit d'une action qui doit être dynamisée fondamentalement par les pays eux-mêmes et qui comptera, nous n'en doutons pas, avec tout l'appui de l'OMS.

Dr MANANDHAR (Nepal):

Mr President, your excellencies, ministers of health, Director-General, participants in the World Health Assembly and distinguished guests, I feel honoured to have this excellent opportunity to address this auspicious gathering, a gathering of very distinguished and learned delegates from Member countries of the World Health Organization. I am also happy, because this happens to be the Fifty-second World Health Assembly, the last Assembly of the millennium.

My country, the Kingdom of Nepal, is proud to be a Member of this noble and credible Organization. Nepal became a Member of WHO in 1953. The WHO country office was established in Nepal in 1954 and works closely with the Government of Nepal to implement and strengthen the national health programme. Nepal initiated the expansion of her basic health services during the early 1970s. The Alma-Ata Conference on primary health care provided added impetus. The Government of Nepal also started the integration of the basic minimum needs programme with that of health. In brief, WHO's aims of health for all by the year 2000 is implemented in the true sense as an integral part of total human development.

Our national health policy aims at addressing the priority health problems of the people through the expansion of primary health care facilities, bringing about balanced human development, balanced population growth, poverty alleviation and an equitable distribution of socioeconomic benefits to the people. I am happy to say that in achieving our goals and objectives, Nepal has the full support of WHO. The Government of Nepal appreciates very much the work of WHO and would like to offer our whole-hearted thanks.

As we enter the new millennium, let us take a glance at the past to see what successes we have achieved and what failures we have encountered. Let us look into a new horizon, a new hope for the future. As one of the least developed countries in the world, Nepal could make some progress in the provision of basic health care for her people. The areas of improvement are: in the prevention and control of communicable diseases; in reproductive health care; in the nutritional status of the people; and in other health conditions in general. We participated in the global poliomyelitis eradication campaign, organizing national immunization days with broad participation of the people and nongovernmental organizations. Being a signatory to resolution WHA44.9 and the Regional Committee resolution, Nepal also participated in the attainment of the goal of elimination of leprosy as a public health problem. The leprosy elimination campaign was successfully implemented in 27 districts of the country.

However, challenges for the future are still immense. First, our health systems, as well as infrastructure required for the effective delivery of health services within the country, need to be strengthened. Secondly, as a consequence of economic structural adjustment programmes, the country has

to struggle to fulfill the growing demand in an efficient manner. These reform processes are marred by the growing costs of health services. The everyday increasing need for health care, availability of new technologies in treatments and rising public expectations all exert financial pressures on the government. Therefore, it is urgently required that we review our total health needs, the resources available and plan accordingly.

The maternal mortality, child mortality and in general the mortality and morbidity among the poor is quite high, particularly because of tuberculosis and other communicable diseases. There is still an immense need in investment in the reduction of maternal mortality. Malaria is emerging as a more serious threat to our socioeconomic development, particularly in the Terai and other low altitude areas. Nepal is not spared with the global problem of HIV/AIDS, although its multiple effects have so far been minimal. The potential impact of emerging and new diseases in Nepal can be quite damaging, particularly for the economic development of the country, as it is well known that Nepal is one of the tourist destinations of the world. Risky behaviour and unhealthy environments pose great threats to our people, and even worldwide. Tobacco use is widespread, not only among men but also among women and children, among the population of the cities and urban areas, in villages and even in remote hilly areas. We have already introduced measures to curb the use of tobacco by implementing the banning of advertisements of tobacco and tobacco-related products in all the electronic media of the country.

Taking into consideration the challenges and the limited resources available, priority setting is a must. The Government cannot provide everything and to everybody. Thus, although it is accountable for the health of its people, partnerships and alliances with other players in health care, such as the private sector, community organizations and other social organizations, will have to be encouraged. We also require support from international agencies in this regard. We realize that the present day global economic and political situation also directly influences us, particularly in health care development, intersectoral coordination, and formulation and implementation of overall plan and policies.

May I be allowed to conclude with the remark that WHO has shown itself to be a very reliable source of high quality advice and support. I hope that such support will continue in the days ahead, assisting and enabling us to provide better health services to our people, placing health at the centre of the national development agenda. We believe that together we can make a difference. Together we have to make sure that hope will predominate over uncertainty in centuries to come. Last, I wish the Director-General success in "making a difference" and in the changes in WHO.

Mr NUAMAH DONKOR (Ghana):

Mr President, Vice Presidents, Director-General, distinguished delegates, on behalf of the Assembly of Health Ministers of the West African Health Community (WAHC), I wish to congratulate the President and Vice-Presidents on their election to office and also the Director-General and her staff on a comprehensive report and for steering this great Organization successfully in the past 10 months. It has been a fruitful year of reorganization and restructuring of the Organization to make it more responsive and relevant to the expectations of all peoples globally. The effect of the Director-General's transformation of our Organization has had a far-reaching impact, particularly as regional offices have responded to the change. In-country programmes in the Member countries of WAHC are beginning to respond to the felt needs of their countries. With increased decentralization of authority, programme implementation has taken a positive turn.

Member countries of the West African Health Community continue to respond positively to the call to "roll back malaria" in the West African subregion as a highly commendable initiative of WHO, and have been participating actively in the development of strategic plans initiated by the WHO Regional Office for Africa. It is our intention to cooperate fully with WHO in putting into place well-designed and result-oriented strategies to ensure that we really "roll back malaria". The effects of malaria on the economies and development programmes of our countries are enormous, as will be further revealed by the studies now under way in some of our countries to quantify and document the negative effects of malaria on the social and economic development of our peoples. The subregion has made remarkable progress in surveillance and epidemic control, particularly in averting epidemics of cerebrospinal meningitis and yellow fever. The main challenge is to continue to maintain alertness over time, even when epidemics do not occur. Subregional and intersectoral collaboration are needed to prevent epidemics, as cross-border problems can undermine country level efforts.

The AIDS scourge is still with us in the West African subregion, though programmes are being implemented to stem the tide, using an intersectoral and multidisciplinary approach. Steps are being taken to increase the level of awareness of HIV/AIDS, especially amongst youths, using appropriate health education and social mobilization strategies. We are currently witnessing a resurgence of tuberculosis due

to a number of interrelated factors, such as political strife and its negative effect on the health sector, an increase in HIV/AIDS cases, and malnutrition and poverty. We welcome the interest being shown in tuberculosis in the subregion by some of our development partners and acknowledge the accompanying funding being made available for research. The emphasis on local input and involvement is welcomed, as we do have the relevant manpower and expertise to undertake the required research. Prevention of communicable diseases continues to be our concern as we intensify immunization programmes in a bid to ultimately eradicate diseases such as measles, poliomyelitis, neonatal tetanus, whooping cough and diphtheria. The resurgence of measles in some of our countries needs to be studied and controlled. The potency and effective duration of the vaccines need to be appraised and immunization programmes generally strengthened.

The gains of the WHO Onchocerciasis Control Programme in the West African subregion are being felt in our countries. We congratulate WHO and our other development partners for successfully implementing a programme that will impact positively on the lives of generations to come. It is our hope that the current success will be sustained. Buruli ulcer seems to be appearing over an ever increasing geographical area in the subregion. Epidemiological mapping, treatment facilities and research are important elements of the response that is required.

Whilst gender issues continue to take centre stage in our health sector reforms, human resource development, improved access and quality of health services and involvement of the private sector in health matters are equally being addressed. An appropriate balance between private and public sector involvement must be achieved in order to decrease the huge financial burden of the health sector on the strained economies of our countries. The debt burden of our countries dictates that we look for alternative strategies to finance our health care programmes. Donor response to our health programmes, with its danger of overdependence and risk of unsustainability, is reaching saturation point, and we are therefore being challenged to look inwards to finance the health sector. What we need is supportive collaboration by donor and technical aid agencies, with WHO taking the lead in fostering the right kind of collaborative support.

We are equally aware of the flight of all categories of health professional from the subregion, particularly from the countries just emerging from war, to the developed countries. Unless this haemorrhage of health professionals is addressed the health sector reforms, which must be built on solid human capital, will be meaningless. We are also aware of the serious neglect of hospital and hospital services, and the consequences to the health delivery system. Though an expensive undertaking, hospital and hospital services, development and rehabilitation should nevertheless be properly defined in the context of a well-articulated policy and strategic framework. WHO must again play a leading role in defining the role of hospitals.

We appreciate the role that traditional medicine can play in our health care delivery system, as a large percentage of our peoples, particularly in the rural areas, still patronize traditional medicine practitioners. Steps are being taken to formalize the practice, with the introduction of appropriate controls and legislation, to ensure safety and efficacy of the products used. While the inadequate supply of pharmaceuticals continues to be a major concern, research and development of relevant pharmaceuticals is still limited and their high cost encourages the influx of fake and expired products. Finding ways to ensure the availability of effective and affordable pharmaceuticals and other inputs therefore constitutes a major challenge for the subregion.

Regrettably, political upheavals, civil conflicts and wars, with their attendant negative effects on the health sector, continue to bedevil many countries in the West African subregion. The problems of refugees, orphans, abandoned children and displaced persons have compounded the enormous burden placed on the health services. We pray for lasting peace in the subregion, in the hope that in an atmosphere of peace, appropriate rehabilitation and reconstruction of the health facilities can take place for the benefit of those who did not create the problems in the first place. We call on our development partners to respond positively in complementing our efforts to evolve a new era of peace which would yield great dividends for the health sector.

As we eagerly approach the dawn of the twenty-first century, we are aware of the tremendous gains that could be achieved from the increasing use of the "information superhighway". The demographic and epidemiological changes currently taking place in our countries invite us to fashion responses that will address these changes. Some of these: care of the elderly, new and emerging diseases, noncommunicable diseases and violence as a public health concern, have received relatively little attention in the past, but we need to address them now because of their potential effects on the lives of our peoples.

Being aware of the need for collaboration and cooperation in health matters and to meet the challenges of the new millennium, we in the West African subregion have decided to merge the two existing subregional health organizations for francophones and anglophones in West Africa to form the West African Health Organization. Steps have been taken to implement the relevant protocol signed by

our Heads of State and Government. Disease knows no boundaries. The global trend today is one of collective responsibility and action. Collective action by countries in our subregion would yield higher dividends in addressing certain health problems than for individual countries to keep going it alone. We in the West African subregion do realize that we need each other to tackle the many diverse health problems effectively. Severe economic problems facing all our countries dictate that sharing costs would ease the burden of providing comprehensive, accessible, affordable and quality health care services to all our peoples. We look forward to active collaboration between our two organizations both at the level of the African Region and at headquarters. We in the West African Health Community will continue to subscribe to the fundamental ideals of WHO and wish the Organization, under the distinguished leadership of the Director-General, success in all its undertakings.

Mr MOND (Papua New Guinea):

Mr President, Madam Director-General, excellencies, ladies and gentlemen, I have the honour to represent the island nations of the Pacific: Cook Islands, Federated States of Micronesia, Fiji, Kiribati, Marshall Islands, Nauru, Niue, Palau, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu, in presenting our response to *The world health report 1999: Making a difference*. First, on behalf of the delegations from the Pacific Islands let me congratulate the President and all the elected office bearers at this Fifty-second World Health Assembly which is also the last Health Assembly of the twentieth century. We have every confidence that you will successfully lead our deliberations and we assure you of our support.

We wish to congratulate the Director-General and her staff for the preparation and presentation of *The world health report 1999: Making a difference*. The report is concise, clear and evidence-based as it expounds the lessons to be learned from the past and the challenges to heed for the future. We are especially encouraged by your new directions for WHO leadership in health as we enter the new millennium. In particular, we welcome the emphasis that has been placed on the Roll Back Malaria project and on stemming the tide of tobacco consumption. Nearly half of the Pacific people are still at risk of malaria today and we trust that rolling back malaria will also roll back in its wave the scourge of other vector-borne diseases such as dengue and dengue haemorrhagic fever which, together with malaria, threaten the health and economic development of our island nations.

We are very encouraged that, finally, a global effort of the magnitude of a framework convention is going to be put in place to fight tobacco use head-on. In previous Assemblies we have been among those who have pleaded for assistance in the fight against this product which, much like other instruments of killing, will indeed kill when used as intended and yet is marketed with the strength of billions of dollars, attracting ruin to vulnerable lives and damaging economies through addiction to tobacco. Records show that we in the Pacific region have more than our share of tobacco consumption per capita and more than our share of the ill-health resulting from our addiction to tobacco, both in its smoking and chewing forms. It has been difficult for us to live up to our responsibilities under the Convention on the Rights of the Child, to protect our children from this form of exploitation of their youth, innocence and vulnerability. We resent the targeting of the East Asia and Pacific regions by the multinational tobacco companies as a measure of making up for their losses from current litigation in the United States of America and elsewhere. We resent being forced, through our addiction, to support the tobacco industry's payment of such litigation. We, therefore, welcome the framework convention on tobacco control. We will participate to the fullest extent that we can in its development, to ensure that the usual tactics of tobacco industries to divide and conquer, to diffuse the health message, to sabotage our efforts by funding some aspects of our work through sport, pharmaceuticals or salary supplements and other means, are made known and prevented.

There is one other major issue of concern to the Pacific nations which was not addressed in *The world health report*, perhaps due to limitation of time and space, or perhaps as the Director-General said in her speech, we cannot do everything. This is the issue of global climate change and its impact on the ocean and its life, and in turn its impact on our lives and development. The ocean connects us to each other and provides much of the resources that sustain our daily lives. Its health and sustainability is of utmost importance to us. The *El Niño* and *La Niña* events of last year took a severe toll on the reefs of our islands. The *tsunami* that hit my own country, Papua New Guinea, claimed thousands of lives and devastated several communities. Many of our atoll inhabitants live in constant threat of global warming and excessive tide changes. Global warming and climate changes are "global challenges that demand a global response" and we look forward to WHO to assist us on this.

The Pacific Island nations welcome the reforms made by Dr Brundtland within the WHO structure and with respect to leadership for the days to come. We in the Western Pacific Region also welcome the changes that are being made by our new Regional Director, Dr Omi. Under his leadership the Pacific Island nations are poised to strengthen the resolve for health for all under the conceptual framework of the

Healthy Islands initiative, which was adopted by the ministers and directors of health in 1995, and reviewed and strengthened in 1997 and 1999. In the most recent meeting of ministers and directors of health in March 1999, the Regional Director presented his position for future work in health in the Western Pacific Region, under his leadership. The paper was not unlike *The world health report 1999.* It challenged us to get more done with less, to seek more evidence to support our claims, to develop our own resources, human and otherwise, with technical support from the Regional Office. Based on the review of the Healthy Islands initiative and the Regional Director's vision, the Pacific Island nations health leadership, in a document called "Palau Action Statement", renewed their commitment to make the next millennium healthier for inhabitants of the islands. The "let's get to work" call of the Director-General has been heard and the Pacific Islanders respond together with the Regional Director, "Yes, together we can get the job done".

El Dr. PARDO EVANS (Costa Rica):

Distinguida señora Presidenta, señora Directora General, señores miembros de la Mesa, señores jefes de delegación, señoras y señores: Para mí constituye un verdadero honor presidir la delegación de Costa Rica ante este importante foro y tener la oportunidad de presentar un respetuoso y cordial saludo a todos los presentes en nombre del Gobierno de Costa Rica. Deseo felicitar a la señora Presidenta y demás dignidades electas en esta 52ª Asamblea Mundial de la Salud y felicitar a la Directora General, Dra. Gro Brundtland, por su visión de lo que debe ser la Organización Mundial de la Salud y la forma como está abordando la reestructuración tecnicoadministrativa de esta Organización.

Estamos convencidos de que el liderazgo demostrado durante estos últimos meses por la Dra. Brundtland no sólo ha revitalizado a la Organización sino que ha demostrado que los Estados Miembros debemos jugar un papel activo dentro de la institución. Las metas y la visión de la Directora General responden a la problemática mundial de la salud y llevan a la Organización a jugar un papel fundamental de liderazgo en la transformación de las condiciones de vida y del desarrollo humano en todos los países. El Gobierno recoge con aprecio las reformas que se están dando en el seno de la Organización Mundial de la Salud. Compartimos por convencimiento propio la necesidad de tener una gestión más eficiente, responsable y con una mayor sensibilidad a los cambios en este mundo en constante mutación.

El Estado costarricense es consciente de que para lograr cambios en las condiciones de salud y de desarrollo es necesario hacer profundas transformaciones de carácter político, económico y social, lo cual requiere decisiones y medidas cuyos efectos son en su mayoría visibles en el mediano o en el largo plazo. El estado de salud que Costa Rica ha alcanzado en este momento es producto de decisiones adoptadas y mantenidas durante los últimos 50 años, y eso ha permitido que actualmente tengamos una expectativa de vida al nacer superior a los 76 años, una mortalidad infantil de 12 defunciones por cada 1000 nacidos vivos, que hayamos erradicado el analfabetismo y que tengamos cobertura universal de la seguridad social y de los servicios de salud y educación.

Coincidimos con el planteamiento de la OMS y de la propia OPS en que, aun con este perfil de desarrollo, tenemos, no solamente Costa Rica sino el mundo entero, el reto de la eliminación de la pobreza, de las desigualdades sociales como única forma de lograr un desarrollo pleno y una calidad de vida compatible con los más caros intereses del ser humano. Por lo tanto, apoyamos de manera decidida todos los esfuerzos de la OMS que desde su ámbito de responsabilidades pueda hacer para que las transformaciones sean una realidad.

Costa Rica es un país respetuoso de los derechos humanos. Bien decía la Dra. Brundtland en su intervención ante esta Asamblea que el derecho a la salud es un derecho humano fundamental. En este sentido, Costa Rica ha contribuido con decisión y fraternidad a la salud de América Central al brindar a miles de inmigrantes en situación de ilegalidad migratoria en nuestro país, especialmente a medio millón de nicaragüenses, atención médica gratuita y también educación gratuita con todos los derechos iguales que asisten a los nacionales.

La amnistía migratoria decretada para todos los centroamericanos presentes en Costa Rica antes del 9 de noviembre de 1998 ha permitido que todas estas personas se unan al esfuerzo económico de un servicio social universal por medio de sus cotizaciones. Sin duda alguna estas cuotas contribuirán a mejorar aún más nuestro sistema de salud. Nos comprometemos a apoyar la gestión de la Directora General para la implementación de los mandatos que surjan de esta Asamblea y nos comprometemos también a trabajar firme y solidariamente con los demás países en procura de un mejor futuro para la salud de nuestros pueblos. Muchas gracias.

Dr BARAKZAI (Afghanistan):

Mr President, Madam Director-General, dear colleagues, ladies and gentlemen, I would like to take this opportunity to thank WHO for the efforts made in handling the health problems around the world and especially in Afghanistan. In May the national poliomyelitis campaign started in Afghanistan, with the help of WHO, UNICEF and nongovernmental organizations. This immunization prevents children from being handicapped in their future life. I would like to mention some of the problems in Afghanistan: fighting lasting over 20 years, foreign intervention, destruction of health clinics, hospitals and rural health centres. All these affect the health of the people. Many people were killed by bullets, and a great many by diseases, especially among women, children, and the elderly.

Everyone knows what is going on in Afghanistan. Our problems during and after the collapse of the communist regime; foreign interference, internal conflict, natural disasters, including two recent earthquakes in Takhar and Badakhshan, causing internal migration, and poor socioeconomic conditions are the main causes of health problems. Three generations of our people have not had proper health care, especially the women and children. Women make up more than half of the population, but do not take part in the socioeconomic life of the country. I can say that in some areas they are not even allowed to breathe and be free. At the same time, female medical personnel are not active in the country, and there are no health facilities for females. Our clinics, hospitals and rural health centres are all destroyed. There is no data for establishing statistics of diseases, and no active programme for prevention of disease in Afghanistan. I think it is difficult for us to follow the WHO programme for the eradication of communicable diseases by the second millennium.

Added to this, there are problems of drug-resistance which increase day by day. Drug-resistant cases of malaria are on the increase. At the same time, the incidence of *Plasmodium falciparum* malaria is widespread in the country, causing many deaths among the young and the elderly. Tuberculosis is also drug resistant, due to insufficient therapy and internal migration, as there is no follow-up care. This may become a big concern for us and WHO because of threat of the spread of these drug-resistant diseases to neighbouring countries.

So far for the solving of the problem in Afghanistan, we know that our neighbouring countries can help to solve the problem - especially Pakistan, who has an influence on the Taliban to bring them to a compromise. We hope WHO, UNICEF and nongovernmental organizations and governments will help us in the following: campaign against infections diseases; campaign against diarrhoeal diseases; campaign against acute respiratory infectious diseases; immunization; training of medical personnel at different levels; collection of data and statistics of diseases; supply of drinking-water; reduction of vitamin deficiency diseases, especially blindness, among children and supply of iodized salt to prevent goitre; reduction of poverty and malnutrition; and provision of emergency medical facilities for mine casualties and war injuries.

And last but not least, we are grateful to those who are already helping us, especially WHO, UNICEF and nongovernmental organizations. We hope other governmental organizations will also take part in the reduction of the humanitarian catastrophe in Afghanistan. The new reform by the Director-General will be reflected in the lives and health of our women.

Dr KIYONGA (Uganda):

Mr President, honourable ministers, the Director-General, distinguished delegates, ladies and gentlemen, *The world health report 1999* has ably reviewed the accomplishments and challenges in world health and points to the unfinished agenda being carried forward into the twenty-first century. Most notable, among the items of the unfinished agenda, are the growing inequalities between the developed and developing countries. While the developed world will have less and less of the burden of infectious diseases, the poor developing countries will continue to contend with a double burden of disease arising from both the infectious and noncommunicable diseases. The delegation of Uganda wishes to commend the Director-General's comprehensive but concise and focused report. The vision for the twenty-first century is clear and the innovations for sustaining effective change have been laid before us. Nevertheless, Uganda wishes to propose that the agenda for the developing countries should accord special attention to the areas described below.

HIV-vaccine development: The devastating effects of the AIDS pandemic are most felt in the developing countries, especially in sub-Saharan Africa. Although present efforts in prevention and control of the effects of the disease have shown positive results in Uganda, the most sure way of eradicating the problem lies in research and development of a vaccine against HIV infection. Evidence to date shows that there is very little effort being made to develop an HIV vaccine for developing countries. The impediments

to date are both economic and political. I am glad to announce to this august Assembly that Uganda has this year made a modest start in participating in the testing of an HIV-vaccine candidate. We call upon the rich countries to give this matter greater attention.

Roll Back Malaria: It is gratifying to note that complacency over the leading cause of morbidity and mortality in the tropics has been replaced by a greater determination to combat the problem. In this respect the efforts of the Director-General are commendable, and need the support of all of us. The Organization of African Unity leaders have adopted a resolution, making their commitment to the Roll Back Malaria initiative. In order not to lose momentum, it is urgent that funding for the Roll Back Malaria initiative should be expedited, and should cover increased access to health services by the populations in the developing world.

Increased efforts in general communicable disease control: Despite the epidemiological transition beginning in most developing countries, there is a need to maintain focus on control, prevention or elimination of communicable diseases still prevalent in the poor countries. Uganda is participating fully in the global effort to eradicate poliomyelitis. We are involved in coordinating cross-border efforts to mop up this scourge in our region. Investment in communicable disease control should be maintained and increased to ensure elimination of these diseases globally.

Stronger coordination of development aid: Health development in poor countries will continue to require development aid from several partnerships with both the North and the South. For efficiency and optimal results from such partnerships, there is a need to strengthen and institutionalize mechanisms that would reduce duplication and encourage focused utilization of resources for jointly agreed upon national priorities. The sector-wide approach to health development should be encouraged to bring about change from the projects approach that is still prevalent in most of our countries.

In conclusion, Uganda is committed and determined to strive for better health at the national, regional and global levels in partnership with the Member States of WHO. Uganda recognizes and commends the difference that the new leadership of WHO has already made and looks forward with renewed hope and faith in this important arm of the United Nations system.

Ms AMAHA (Ethiopia):

Mr President, Madam Director-General, distinguished delegates, at the outset allow me to congratulate the President and the other officers of the Bureau on their election. I also wish to express my delegation's appreciation to the Director-General for her dynamic leadership during the last 10 months.

The health policy of my country was launched in September 1993, after receiving Government approval. This policy is based on the following principles: democratization and decentralization of the health system; development of the preventive and promotive components of health care; development of an equitable and acceptable standard of health service that will reach all segments of the population, within the limits of resources available; promotion and strengthening of intersectoral activities; promotion of activities and practices conducive to the strengthening of national self-reliance in health development, by mobilizing and maximally utilizing internal and external resources; working closely with neighbouring countries, and regional and international organizations to share information and strengthen collaboration in all activities contributing to health development, including the control of factors detrimental to health; provision of a scheme of health care for the population according to ability to pay, with special assistance mechanisms for those who cannot afford to pay; and promotion of the participation of the private sector and nongovernmental organizations in health care. This policy framework is a result of careful assessment of the factors behind most of our health problems and the genuine need to resolve them in the shortest possible time.

To make the implementation of these policies easier, health care strategies have been drawn up. A number of other social sector policies designed to complement the health interventions have also been developed. Among these, the education policy, population policy, and Ethiopian women's policy are worth mentioning. A health plan that aims at achieving the goal of universal access to health care in the next two decades has been developed. The first five-year plan is now being implemented. This plan was developed on the principles of the sector-wide approach. It brings together all stakeholders, including the Government, the donors, the private sector, nongovernmental organizations and the community at large, involving them all, right from problem identification through the development of the plan, to implementation, monitoring and evaluation of the programmes.

Ethiopia continues to be affected by epidemic outbreaks. During the past few years malaria outbreaks have claimed many lives. The threat of cerebrospinal meningitis has been great during the past few months, requiring intensive surveillance and preparedness. The HIV/AIDS epidemic and the problem of tuberculosis are in the forefront of our health problems. We are also among the few countries in the world where paralytic poliomyelitis continues to wage war on our young children.

Although we have huge health problems, we believe we are on the right track in terms of policy, strategies and the approach we have adopted towards their resolution. We will continue to need enhanced resource support in our endeavours. This is particularly true for implementing the Roll Back Malaria project, mitigating the effects of HIV/AIDS, treating tuberculosis and preparing for epidemics.

In conclusion, I would like to urge WHO to mobilize the necessary resources to assist our efforts to deal with these huge problems I have attempted to bring to your attention.

Monseñor LOZANO BARRAGÁN (Observador de la Santa Sede):

Señora Directora General de la Organización, Dra. Gro Harlem Brundtland, señora Presidenta de la 52ª Asamblea Mundial de la Salud, Sra. Maria de Belém Roseira: La delegación de la Santa Sede manifiesta su aprecio por los esfuerzos que esta Organización, junto con otros profesionales de la salud públicos o privados, lleva a cabo para que la atención sanitaria básica llegue a todos los habitantes de la Tierra aun en las condiciones extremas de guerra y catástrofes de todo género.

El abismo que separa a las poblaciones ricas de las pobres resulta particularmente profundo y dramático en materia de salud. La asistencia a los enfermos de VIH/SIDA por parte de los agentes de salud católicos, que según una estadística reciente cubre el 24,5% del total de las actividades del sector, alcanza a las regiones más inaccesibles y a los núcleos sociales más marginados. Una vez más se debe repetir el llamado a los políticos y profesionales de la salud para que se empeñen en hacer plenamente accesibles los medicamentos y las terapias más avanzadas a todos los enfermos de SIDA; no sólo a los más pudientes, sino también a los más pobres y desprotegidos.

Además del ingente trabajo realizado por los innumerables agentes de salud vinculados a la Santa Sede, ésta se esfuerza para que todos los miembros de la Iglesia Católica y todas las personas de buena voluntad tomen conciencia de su responsabilidad social universal. Como gesto práctico y símbolo de un compromiso solidario, recientemente ha promovido la iniciativa de «un día sin humo», con la intención de que los fumadores, a la vez que reflexionaban sobre el daño propio y ajeno causado por el tabaco, destinaran el ahorro personal, fruto de la abstención, a ayudar a los enfermos de VIH/SIDA y a sus familias. Tal gesto además se inscribe en la promoción general de los valores espirituales y familiares, que es condición indispensable para lograr estilos de comportamiento solidario en favor del bienestar y salud de todos.

Asimismo, la Santa Sede desea acompañar a la OMS en sus esfuerzos por erradicar las principales enfermedades infecciosas, en especial frente a la tuberculosis y al paludismo, a conseguir modos de vida que disminuyan las incidencias de otras como la depresión, y por aumentar la responsabilidad frente a otras causas de muerte o invalidez, como los accidentes viales.

El servicio de la deuda externa de los países más pobres ocupa los recursos que serían necesarios para una adecuada asistencia sanitaria nacional. La Santa Sede quiere aprovechar esta ocasión para reiterar su constante apelo a la comunidad internacional para que no deje la oportunidad del cierre del segundo milenio sin resolver este grave problema. Interpela a este respecto a los responsables de la política y la economía mundial. Las naciones más industrializadas han anunciado en los últimos meses nuevos planes para ser eficaz, reforzar y ampliar el programa HIPC (países pobres fuertemente endeudados) dando un corte definitivo al grave problema financiero de la deuda externa de los países menos desarrollados.

En pro de una verdadera cultura de la vida y de la salud, la Santa Sede hace votos por que estos planes y propósitos se lleven a cabo de modo eficaz, generoso e inmediato. Muchas gracias.

M. DECAZES (Observateur de l'Ordre de Malte) :

Monsieur le Président, je souhaite tout d'abord adresser au nom de l'Ordre de Malte à Mme de Belém Roseira, Ministre de la Santé du Portugal, mes très sincères félicitations pour son élection à la présidence de la Cinquante-Deuxième Assemblée mondiale de la Santé, ces félicitations étant également formulées à votre intention, Monsieur le Président, et à celle des autres membres du bureau qui ont été élus pour l'assister dans sa tâche si importante. Je salue aussi Mme le Dr Brundtland, Directeur général de l'OMS, ainsi que tous les Ministres de la Santé et autres distingués délégués qui prennent part à ces assises annuelles.

Mesdames, Messieurs, permettez-moi de vous indiquer que l'Ordre souverain de Malte célèbre cette année le neuf centième anniversaire de son activité, qui a débuté à Jérusalem par la création d'un hôpital destiné à accorder des soins, tant à la population locale qu'aux pèlerins de passage dans cette région. Aujourd'hui, sa mission hospitalière demeure et s'étend à tous les continents conformément à sa vocation initiale. Celle-ci est du reste formellement inscrite dans sa Charte constitutionnelle dans les termes suivants : "L'Ordre exerce son activité institutionnelle envers les malades, les pauvres et les réfugiés dans

le domaine hospitalier, y compris l'assistance sociale et sanitaire, sans distinction de religion, de race, d'origine ou d'âge."

Cette longue expérience permet aujourd'hui à l'Ordre d'apprécier à sa juste valeur le plan d'action contenu dans le *Rapport sur la santé dans le monde, 1999 - Pour un réel changement* et précisé par le Directeur général dans son allocution en séance plénière, ici même.

Dans l'accomplissement de ses activités traditionnelles, l'Ordre participe de longue date à la lutte contre la lèpre. Ses programmes dans ce domaine sont conduits par le Comité international de l'Ordre de Malte pour l'Assistance aux Lépreux (CIOMAL), en coordination avec les autorités des pays concernés. Aujourd'hui, nous nous réjouissons qu'une thérapeutique moderne permette enfin d'envisager l'éradication de cette maladie si invalidante.

La coordination de nos efforts est assurée par le CIOMAL, qui, sans s'écarter de sa priorité, la lutte contre la lèpre, a ouvert un nouveau programme de lutte contre la transmission verticale du VIH de la femme enceinte à son enfant, suivant en cela les recommandations de l'ONUSIDA. Dans le cadre de la Fondation de l'Ordre de Malte à Dakar, un programme pilote a été élaboré avec les autorités sénégalaises, lequel, à terme, pourra être étendu à d'autres pays où l'Ordre est présent au travers d'infrastructures et d'activités médicales. Ces mesures nous paraissent correspondre aux différents souhaits exprimés par le Dr Brundtland, à savoir accorder une aide particulière aux femmes en intensifiant les efforts de prévention du SIDA et, à cet effet, développer des liens de partenariat avec les instances concernées.

Une autre activité importante de l'Ordre, consistant en la distribution de dons de médicaments, nous a amenés à participer aux consultations organisées par l'OMS pour en établir les nouveaux principes directeurs. Nous nous félicitons de cette coopération et espérons donc voir l'adoption par cette Assemblée de la résolution EB103.R1 sur la stratégie pharmaceutique révisée.

Monsieur le Président, avant de conclure, permettez-moi de mentionner encore l'actuelle et significative participation de l'Ordre à l'assistance médicale aux populations victimes des tragiques événements se déroulant dans la région des Balkans. En étroite coopération avec les acteurs humanitaires présents dans la région, l'Ordre a mis en place plusieurs hôpitaux et camps de réfugiés, assure une distribution importante de médicaments et de fournitures sanitaires, et dispense des soins de base par l'intermédiaire de ses équipes médicales.

Ainsi, par l'ancienneté de son engagement envers l'humanité souffrante et par l'étendue géographique de ses actuelles activités d'assistance, l'Ordre de Malte s'efforce de rester fidèle à sa vocation initiale, tout en adaptant ses actions aux évolutions des techniques scientifiques et en regrettant que les moyens dont il dispose soient bien modestes au regard des situations de détresse qui l'interpellent.

M. COLLA (Belgique) :[1]

Monsieur le Président de séance, Madame le Directeur général, Mesdames et Messieurs, comme l'on pouvait s'y attendre, cette Cinquante-Deuxième Assemblée mondiale de la Santé est résolument placée sous le signe du bilan. De bilan, il en a été question pendant toute cette année du cinquantième anniversaire de l'OMS, mais aussi, et surtout, dès l'ouverture de notre session, lors de la présentation des rapports du Conseil exécutif et du rapport d'activité du Dr Brundtland et de son équipe.

La question qui se profile dès lors à l'horizon est la suivante : "Et maintenant, quel avenir pour quelle santé publique ?".

Les réaménagements intervenus dernièrement au sein de l'Organisation - et qui, au premier abord, ont parfois été perçus comme retentissants - constituent certainement une bribe de réponse. C'est en effet cette volonté d'anticiper sur l'avenir qui a mené le nouveau Directeur général à se pencher sur le propre fonctionnement de son institution avec l'ambition de bâtir, par le biais d'une réforme administrative progressive, les fondations d'une meilleure gestion et d'une meilleure communication. Ces réformes arrivent en outre à un moment où toute la communauté internationale exprime des attentes et des exigences claires quant aux nombreux enjeux auxquels doit faire face l'Organisation, des enjeux qui sont encore "péniblement" exacerbés par les crises politiques, comme celle du Kosovo. Faut-il rappeler que les violations des droits de l'homme ont des effets graves sur la santé ? Prenons le seul exemple de la violence conjugale, dont le coût social pèse lourdement sur la vie des personnes touchées et sur toute la collectivité. Que dire alors de la violation des droits de l'homme au niveau des nations ? Ce thème a d'ailleurs fait l'objet d'une récente conférence, organisée à Strasbourg par le Conseil de l'Europe.

Bref, si l'on y regarde de plus près, les réformes proposées par le Dr Brundtland coïncident bel et bien avec le développement même du concept de santé publique. La santé publique est un tout qui doit être

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[1] Le texte qui suit a été remis par la délégation de la Belgique pour insertion dans le compte rendu, conformément à la résolution WHA20.2.

considéré en rapport avec ses nombreux déterminants, d'où l'approche transversale des programmes. De par ses impacts tant humains que socio-économiques, la santé publique est un enjeu pour la société tout entière et se doit d'occuper une place centrale dans tous les domaines d'activité, d'où l'intensification des contacts avec les autres partenaires internationaux. La santé publique revêt par essence un caractère international qui nécessite de réels processus de collaboration, d'où la redynamisation des réseaux d'experts et d'institutions.

A travers cinquante ans d'histoire, l'Organisation a subi une évolution durant laquelle le quasi-monopole médical a fait place à des équipes pluridisciplinaires; l'approche a été élargie jusqu'aux concepts des soins de santé primaires et de la santé pour tous. Entre-temps, des succès remarquables ont été obtenus dans la lutte contre les maladies transmissibles.

Un exemple parlant : celui de la tuberculose. La tuberculose est un réel problème de santé publique dont l'importance semblait avoir diminué au cours des dernières décennies. Actuellement, pourtant, son incidence augmente dans les pays développés comme dans les pays en développement, et ce à la suite des mouvements rapides de population, de la marginalisation de certains groupes et de son association fréquente avec le VIH/SIDA. Dans les actions envisagées, il paraît donc de plus en plus indispensable de remonter à la source (exemple d'une action conjointe entre la province d'Anvers et la région de Léningrad). "Il ne sert à rien de combattre sur un seul terrain, en laissant autour de soi des mines prêtes à exploser." Or cette approche globale, seuls les organismes internationaux sont à même de la coordonner. Rappelons-nous les épisodes de l'épidémie de fièvre d'Ebola ou de la crise de la vache folle. Ce sont là quelques moments forts où la communauté internationale a ressenti clairement la nécessité d'une OMS forte, qui s'appuie sur une chaîne d'acteurs allant des centres et experts aux alliés "silencieux" que sont les ministères de la santé publique des Etats Membres.

Ce qui est vrai pour les maladies transmissibles l'est aussi pour les domaines de la santé directement liés aux évolutions de la société. En déclarant l'année 1999 Année internationale des personnes âgées, l'Organisation des Nations Unies a enjoint tous les gouvernements à tenir compte d'une donnée essentielle dans leur politique : l'accroissement du nombre de personnes âgées nécessite une adaptation profonde de toutes les sociétés. Car il est temps de mettre fin ici à deux préjugés par trop ancrés dans nos conceptions : la personne âgée est plus qu'une personne à aider; la problématique du vieillissement touche aussi les pays en développement.

Une belle illustration de ces deux axes est donnée par le cas de la maladie d'Alzheimer : de plus en plus, les liens entre les générations et le suivi des aidants prennent leur importance dans une pathologie lourde de conséquences familiales; plus encore, de nombreux programmes de santé, y compris dans les pays en développement, ont dû intégrer ce paramètre - la prévalence de la maladie d'Alzheimer chez les personnes de plus de 65 ans est estimée à entre 5 et 10%.

Toujours dans le même ordre d'idées, en avril dernier, Bruxelles a accueilli le premier colloque conjoint OMS/Union européenne relatif à la santé mentale. Pour rappel, les troubles mentaux figurent parmi les principales causes de morbidité et d'incapacité dans le monde. Et dans trop de pays, la promotion et les services et soins de santé mentale en sont encore réduits à leur plus simple expression. Lors du colloque, trente-huit pays, en particulier les Etats Membres de l'Union européenne ainsi que la plupart des pays d'Europe centrale et orientale, ont réfléchi à la meilleure manière de concilier les deux axes de la promotion et des soins et sont arrivés à dégager un consensus sur les problèmes de santé mentale en Europe.

Bien évidemment, l'Organisation n'a pas seulement un rôle à jouer en temps de crise. Il est aussi remarquable de voir comment l'OMS parvient à fournir les normes techniques et les modèles qui deviennent la source d'inspiration des Etats Membres, dans divers domaines de la santé publique. En la matière, on peut parler de véritable plus-value.

En effet, s'il est vrai que, mis bout à bout, les efforts nationaux peuvent parfois apporter des débuts de solution, il est aussi et surtout réel qu'aujourd'hui, les problèmes de santé sont - si l'on ose dire - inversement proportionnels aux ressources budgétaires. Quelles que soient les options que nous envisageons dans nos "hémicycles de réflexion", nous devons de toute façon tenir compte des possibilités financières. En ce sens, le développement de modèles pouvant servir à plusieurs pays évite de répéter l'effort, et permet donc à moyen et long terme de faire des économies.

Permettez-moi d'ouvrir ici une succincte parenthèse sur la création, à Bruxelles, du Centre européen pour la Politique sanitaire. Ce Centre, qui est une émanation directe du Bureau régional OMS de l'Europe, revêt une importance capitale pour les futures politiques européennes de santé publique. Il s'agit concrètement d'analyser les politiques de santé appliquées dans les différents pays, d'organiser la consultation des pays demandeurs de bonne politique et de bonne pratique, et de mettre en place des formations à l'intention des décideurs politiques et des formateurs. En somme - et c'est sur cette formule que je fermerai la parenthèse - c'est en mettant en commun les connaissances que l'on pourra aussi mettre en commun les ressources financières.

Et si l'on va plus loin dans cette approche concertée, on peut également soutenir que c'est l'ensemble des politiques et des programmes de santé publique qui doivent être conçus en partenariat. Je citerai ici un exemple que la Belgique a suivi de près : il s'agit de l'accès aux médicaments essentiels en Afrique australe. Un groupe directeur composé de représentants de l'OMS, de l'Afrique du Sud et de la Belgique s'est réuni pour définir les lignes d'une nouvelle politique des médicaments en Afrique, y compris l'amélioration de l'accès de la population, l'échange d'informations et l'élaboration de législations nationales. Outre leur apport personnel dans cette action, les deux Etats impliqués se sont également lancés dans un plaidoyer auprès d'autres Etats européens et africains. Ainsi, par exemple, il a été convenu que la Belgique fournirait une assistance bilatérale au Mozambique, dans le cadre de ce projet. Cette assistance pourrait notamment se concrétiser par l'application de nouvelles techniques d'information telles qu'Internet. Dans la société de l'information dans laquelle nous vivons, tous les pays doivent avoir un minimum d'accès aux données, car c'est cet accès qui empêchera que ne se creuse sans cesse le fossé latent entre pays dits industrialisés et pays en développement.

Ici s'achève le message de la délégation belge devant la Cinquante-Deuxième Assemblée mondiale de la Santé de l'OMS. Nous souhaitons résumer comme suit les axes de réflexion qui permettront d'envisager le devenir de la santé publique et autour desquels nos futurs débats doivent s'articuler : une nouvelle utilisation des structures et des moyens existants, la participation active de la population, le rétablissement des liens entre science et politique, et le recours à l'intersectorialité. Autant d'approches qui visent à replacer la santé au centre des préoccupations et d'en faire une valeur qui prime sur toutes les autres, y compris la propriété intellectuelle, la valorisation personnelle et le mercantilisme aveugle. Certes, tout ceci requiert quelque changement dans les mentalités, mais c'est à ce seul prix que notre santé aura un avenir.

Dr KATZAROV (Bulgaria):[1]

Mr President, Madam Director-General, delegates and guests, ladies and gentlemen, on behalf of the Bulgarian delegation I would like to express our appreciation and support for the statements, ideas and recommendations presented in the working documents of the Fifty-second World Health Assembly. The importance and complexity of the health and health care problems has been indicated in the context of the global economic, political and social processes.

The general spirit of Assembly discussions can be outlined as "optimistic realism". It is true that health problems are extremely serious and nowadays are connected to the very survival of humanity. It is also true that from a political and organizational point of view, the health care sector is one of the most sophisticated sectors in every country. It is true that in a number of countries and regions health care is facing problems generated by other sectors. But it is also true that today humanity has at its disposal knowledge, technologies and resources which can help in finding a solution to the problems through adequate coordination of resources and targeting them to priorities. Thus we come to partnerships for health - a clearly manifested need for the present, and even more important for the future.

In this context I would like to inform you briefly about the current tendencies in Bulgarian health care. Over the last three years, the Bulgarian Government is implementing a programme for sustainable democratic development of the country, stabilization of the market economy and formation of a civil society. This process is carried out in conditions of severe economic difficulties, recently hindered even more by the complicated political situation in the Balkans. However, although working in these restricted circumstances, the country is implementing a radical health care reform, aimed at suspension of the negative tendencies in the health status of the nation, increasing the efficiency of the health care system and implementation of the standards and approaches adopted in the European Region. A number of legislative acts have been adopted, such as the Health Insurance Act, and the Act on Professional Organizations of Physicians and Stomatologists. The Act on Health Care Facilities will be voted soon. Based on the new legislation, radical changes are under way in health care financing, decentralization of management, increasing the autonomy of health care establishments and rationalization of health care structures. A number of programmes targeted at health promotion and disease prevention priorities have been put into force in collaboration with other sectors, nongovernmental organizations and local administrations. Serious attention has been given to the health problems of ethnic minorities, especially to the Roma community. Clear and substantial priorities and goals, definite directions and approaches have been formulated in the new health strategy and policy.

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[1] The text that follows was submitted by the delegation of Bulgaria for inclusion in the verbatim records in accordance with resolution WHA20.2.

In this regard, I would like to express our gratitude to WHO and the Regional Office for Europe, to the European Union and its organs, the World Bank and other international agencies for the support that has been provided, and is still being provided to our country. Along with this, I would like to stress that we consider the "partnership for health" policy to be extremely important both in its international and local aspects. We are interested in regional programmes for collaboration and in the establishment of new effective partnerships. We consider most important the collaboration with WHO, not only in the implementation of the health-for-all policy for the twenty-first century, but also in the context of support to the Bulgarian health care reform and to the process of integration into European structures and harmonization with European Union standards and requirements.

In conclusion, I would like once again to emphasize the clear political will of the Bulgarian Government to implement health care reform in the country for the well-being of the Bulgarian nation.

Mr GUNNARSSON (Iceland):[1]

Mr President, Madam Director-General, distinguished delegates, ladies and gentlemen, allow me to congratulate the President and the officers of the Fifty-second World Health Assembly on their election. Congratulations are also extended to the Vice-Presidents, the Chairmen of the main committees and other officials.

My delegation would like to extend its appreciation to the Director-General, Dr Gro Harlem Brundtland, for her leadership and her eminent work for WHO. I would also like to assure her of the Icelandic delegation's constructive cooperation in the coming years. Allow me also to congratulate the Director-General and her staff on the concise but comprehensive report represented to us, *The world health report 1999*. The report clearly provides a review of the new priorities of the Organization, emphasizing that vision, commitment and global leadership are needed to improve the health situation.

As emphasized in most recent world health reports, the struggle against ill-health must be fought on two main fronts: infectious diseases and chronic, noncommunicable diseases. Our attention should be focused on the fact that current prospects are extremely serious in many developing countries, which will most likely come under greater attack from both types of illnesses. The history of WHO over half a century is indeed a story of successes. Improvements in child health, great emphasis on safe motherhood, family planning programmes, and improvements in public health and health promotion are examples of successes: others are the introduction of the essential drugs concept, improvements in working conditions, increased research, education and training of health personnel, and greater availability of vaccines. Over the years, WHO has positively influenced health policy in Iceland and the development of our health care system. At the beginning of the 1970s Iceland started building up a comprehensive primary health care system. This task was supported by constructive advice from WHO. As demonstrated in our health statistics, this system has undoubtedly led to progressive improvements in health of the entire population. At this Assembly this year's *The world health report 1999: Making a difference* reviews the accomplishments and challenges in world health and emphasizes the tasks and priorities for WHO in the years to come. The world health report is a document of high standard and we are especially pleased to see the emphasis which is now laid on health system development, rolling back malaria, combating the tobacco epidemic and the strong commitment to health as a fundamental human right.

I would like to conclude my address by assuring you, once again, of the commitment of the Government of Iceland to contribute to constructive efforts to fulfil WHO's noble mission to improve health for all people of the world.

Dr DURHAM (New Zealand):[2]

The health of a nation underpins its well-being and standard of living. The role of the government as principal funder of health services continues to be important, because it seems the best way to meet efficiency and equity objectives in securing health gains. In the face of new technology, ageing populations and rising consumer expectations, priority-setting is one of the central challenges facing governments in all countries. Governments do have a responsibility to ensure that priorities are set to ensure the best possible health gains for available resources. Priority-setting is about aligning government priorities for health and disability services and the money it is prepared to spend on these services, with the decisions

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[1] The text that follows was submitted by the delegation of Iceland for inclusion in the verbatim records in accordance with resolution WHA20.2.

[2] The text that follows was submitted by the delegation of New Zealand for inclusion in the verbatim records in accordance with resolution WHA20.2.

that individual health and disability professionals make for individual patients or population groups. This poses a fundamental challenge to the way governments, policy-makers and health professionals work together.

New Zealand has recent experience with its National Health Committee which has been set up under statute to advise the Minister of Health on which health and disability support services should have priority for public funding; who should receive those publicly-funded services first; whether the right services are going to the right people, in the right way and at the right time; and whether they are the most effective services, the best value for money, and going to the people who would most benefit. The National Health Committee advocates that services should be evaluated according to the following principles: evidence of benefit or effectiveness, value for money, fairness, and whether services accord with the values of the communities.

A range of tools is available for evaluating cost-effectiveness, for example, quality-adjusted life years and disease-adjusted life years as used in the World Bank's burden of disease. Systematic evaluation of the evidence is then required, given that yet another challenge arises in turning that information into a format that assists in decision-making at all levels. Clinical practice guidelines and health technology assessment reports have been successful in New Zealand and are being well utilized.

Priority-setting is a dynamic process. Incorporating community values into decision-making is particularly difficult as community values change over time. There will always be difficult trade-offs. Attention should be paid, therefore, to informing the public and health and disability providers, in depth, about any prioritization process, and to improving knowledge and understanding of broad issues involved in determining priorities and specific issues in making particular decisions. In addition, identified priorities need continuous review and renegotiation as evidence emerges or changes.

WHO has undertaken important priority-setting and has decided on Roll Back Malaria and the Tobacco Free Initiative. New Zealand supports WHO in setting these priorities. In particular, the framework convention on tobacco control is close to our hearts, as although New Zealand is recognized by WHO as having a comprehensive tobacco control strategy and has been successful in halving tobacco consumption since 1980, this success has not been shared evenly throughout the community. Fifty per cent of Maori adults smoke, and progress in reducing smoking by women and young people has not been great in recent years. New Zealand looks forward to international protocols for addressing smoking by women, young people and indigenous people. New Zealand enthusiastically supports the proposal to develop a framework convention on tobacco control as part of the Tobacco Free Initiative and intends to play an active role in the working group. New Zealand supports priority-setting for maximizing health status and supports WHO in its priority-setting, particularly the focus on the framework convention on tobacco control.

Le Dr Ponmek DALALOY (République démocratique populaire lao) :[1]

Monsieur le Président de séance, Madame le Directeur général de l'OMS, Excellences, honorables délégués, Mesdames, Messieurs, aujourd'hui, c'est pour nous un honneur et un plaisir de participer de nouveau à cette Assemblée mondiale de la Santé.

Avant tout, je voudrais exprimer nos chaleureuses félicitations au Président et aux Vice-Présidents pour leur élection à leurs postes de haute responsabilité. Nous souhaitons que, sous leur sage et compétente direction, l'Assemblée soit couronnée de succès.

A vrai dire, placée sous le signe d'un réel changement, l'Assemblée de la Santé revêt une importance particulière, car nous sommes au tournant du siècle. C'est aussi un grand défi pour nous. Malgré ce défi, il est clairement démontré que, si nos actions sont menées d'une façon clairvoyante et efficace, l'amélioration de la santé peut être obtenue avec des avantages socio-économiques considérables. Nous y croyons grâce à notre propre expérience.

Malgré les grands changements de contexte qui, d'un côté, nous offrent plus d'opportunités, mais, de l'autre, nous imposent de nouveaux défis, notamment l'impact négatif de la crise économique et financière de l'Asie, notre pays a pu trouver son chemin en définissant et appliquant une politique judicieuse.

La République démocratique populaire lao est un petit pays. Depuis son adhésion à l'ANASE, d'un pays sans littoral, il est devenu un pays de transit. Situé au centre de grands et dynamiques marchés, comme ceux de la Chine, du Viet Nam, du Cambodge, de la Thaïlande et du Myanmar, il est devenu le maillon qui permet l'intégration terrestre des pays du bassin inférieur du Mékong, et est de ce fait nanti d'un potentiel

[1] Le texte qui suit a été remis par la délégation de la République démocratique populaire lao pour insertion dans le compte rendu, conformément à la résolution WHA20.2.

de développement prometteur. Pays montagneux, riche en ressources naturelles encore inexploitées, il demeure sous-développé. Il est peu peuplé (4 800 000 habitants), habité par de multiples ethnies vivant de façon dispersée, et barré par d'énormes obstacles de communication (surtout en saison de pluie). Le niveau général de l'éducation, de la science, de la technique et de la gestion est bas. La différence reste grande entre la ville et les régions rurales d'accès difficile. La fécondité, la natalité, la mortalité générale, infantile et maternelle restent élevées, parmi les plus élevées de la Région du Pacifique occidental. Certaines épidémies persistent et les maladies les plus fréquentes sont les maladies infectieuses et parasitaires, telles que le paludisme, la dengue, les infections aiguës des voies respiratoires, les maladies diarrhéiques, les six maladies infantiles évitables par la vaccination, la tuberculose, la lèpre, les parasitoses intestinales, la schistosomiase, etc.

Et pour comble, nous sommes sous la menace du SIDA, des maladies sexuellement transmissibles, de la drogue, de l'accroissement des accidents de la circulation et de la multiplication des blessures par mines antipersonnel non explosées. Tout en étant menacés par les maladies transmissibles, nous assistons à la montée des maladies non transmissibles, dont le traitement est plus complexe et coûteux, ce qui fait que beaucoup d'entre nous sont allés se faire soigner dans les pays voisins.

Les problèmes de santé sont caractérisés par un grand déséquilibre entre la demande, sans cesse croissante, pressante et immédiate, et l'offre, limitée à tout point de vue (personnel, expérience, fonds, équipements, etc.), déséquilibre qui est exacerbé par le processus de mondialisation.

Soulager les souffrances des plus démunis est l'objectif le plus urgent, le plus juste, le plus humanitaire, le plus louable. La priorité ne peut être que la prévention, la prévention avant tout, à savoir la mise en oeuvre des soins de santé primaires avec leurs huit éléments fondamentaux. Cette politique est inlassablement soulignée et appliquée par l'établissement et l'extension du réseau sanitaire, aussi bien public que privé, et par la réalisation de projets de prévention verticaux d'importance stratégique.

Notre Parti et notre Gouvernement ont toujours prôné une combinaison très étroite - ou organique - entre le préventif et le curatif, comme il prône l'association entre la médecine traditionnelle et la médecine moderne. Pour cela, le pays s'est doté d'un réseau curatif : 2 hôpitaux centraux, 6 centres, 18 hôpitaux provinciaux, 131 hôpitaux de district et près de 600 dispensaires. Ce réseau est appuyé par un réseau de production et de distribution de médicaments tant modernes que traditionnels.

Pour le changement, le changement de qualité, il nous faut créer les moyens : les moyens humains, les moyens financiers et, pour cela, les moyens organisationnels. C'est dans l'optique de cette tâche d'organisation que nous travaillons à renforcer nos capacités de coopération. Nous savons que notre chemin sera long et difficile. Mais nous sommes confiants dans notre avenir, confiants dans les changements réels.

Mrs AHLUWALIA (International Federation of Red Cross and Red Crescent Societies):[1]

The World Health Organization and the International Federation of Red Cross and Red Crescent Societies have recently decided to extend their long collaboration to yet another area, namely injury prevention and management. The focus will be on organizational capacity building and enhancing the ability of individuals, communities, governments and organizations to prevent and manage injury-related problems more effectively and cost-efficiently (particularly through partnerships, in areas as diverse as road use, home and workplace injuries or incidents, urban violence, landmine problems, etc.). *The world health report 1999*, in addressing the double burden of emerging epidemics and persistent problems, states that "injuries are a major public health concern because of their increasing significance within the global disease burden". Not only are deaths, injuries, and disabilities caused by accidents major public health problems, but they are also major social and economic problems. One excellent example that demonstrates the magnitude of this problem is road accidents, affecting all countries, but the poor countries bear a disproportionate burden (nearly 70% of deaths caused by road accidents occur in developing countries). According to World Bank estimates accidents globally cost US$ 500 billion a year, resulting in losses of 1% to 3% of the annual gross domestic product. The cost to developing countries and to those in transition exceeds all multilateral and bilateral loans and aid received by them.

We have highlighted the fact that road traffic accidents are "a worsening global disaster destroying lives and livelihoods, hampering development and leaving millions in greater vulnerability". According to the studies undertaken by Harvard University for the World Bank and the World Health Organization, road accidents are likely to become the third leading cause of the burden of disease by the year 2020, after heart diseases and depression.

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[1] The text that follows was submitted by the International Federation of Red Cross and Red Crescent Societies for inclusion in the verbatim records in accordance with resolution WHA20.2.

Governmental authorities have the primary and ultimate responsibility for public health. However, they need not be alone in this task. Intersectoral and multidisciplinary partnerships are needed between the different actors concerned with health promotion and provision at all levels. The Red Cross and Red Crescent Societies, as the oldest and largest nongovernmental humanitarian organization, is conscious of the significant role that civil society will have to play in the twenty-first century to achieve the ideals of health for all, offering the vast network of our 175 National Societies and more than 100 million volunteers and staff to respond to this call. One of the most significant activities and tools the Red Cross and Red Crescent intends to use for injury and accident prevention management is our global first-aid programme. First-aid training seeks to educate the citizen on accident, injury and disease prevention and to train them in how to react in a helpful way to major or minor emergencies until skilled professional help is available. Helping people to help themselves, or the whole notion of first aid at the community level and by the members of the community, is an extremely effective and efficient tool at the service of health development, whose real value has not been sufficiently recognized and acknowledged. Accordingly, in order to protect and save more lives, permit me to submit to you three suggestions for action:

(1) to include first-aid training in the school curricula for all ages through the necessary legislation;

(2) to provide opportunities for first-aid training for civil and public servants, workers, health professionals and volunteers; and

(3) to form partnerships for injury and accident prevention and management programmes, including road safety, with all concerned parties, governments, business and civil society, in particular with Red Cross and Red Crescent Societies, for the development of relevant emergency preparedness and response services, as well as psychosocial and rehabilitation programmes.

Through their collaboration, WHO and the Red Cross and Red Crescent will, among others, promote these partnerships. Allow me to call on you as ministers of health to do the same with the national Red Cross and Red Crescent Societies in your countries.

Early this year the World Bank took the initiative of bringing together over 80 organizations (from the governmental, civil society, international finance and private sectors) to set up the Global Road Safety Partnership. The aim is to slow down the increase in road accident deaths, injuries and disabilities, and to strengthen and develop professional safety expertise in the developing world, through partnerships that promote collaboration and coordination of road safety activities. The membership is open to all parties committed to the objective of this global partnership. The Red Cross and Red Crescent is hosting the secretariat of this partnership and this is another service that we are offering you.

At the forthcoming International Conference of the Red Cross and Red Crescent which is a forum for discussing issues of common interest between the States and the Red Cross and Red Crescent Movement, we will repeat our appeal to your governments to join us to confront these global problems in partnership. The burden of global health problems on the already overstretched health resources is far too heavy for us not to try to compensate for this pressure with partnerships and feasible cost-effective community services such as first aid. Such global partnerships and advocacy for health are critical ingredients in the formula for making a difference.

This collaboration between WHO and the Red Cross and Red Crescent can be a major instrument put at your disposal for preserving and restoring health, this fundamental right of all human beings.

Together let us keep our promise of health for all in the twenty-first century.

This completes the list of speakers and our review of item 3. I shall now give the floor to the Director-General. Dr Brundtland, you have the floor.

The DIRECTOR-GENERAL:

Thank you. Let me first thank all ministers and delegates for their interventions, which will be studied carefully and taken into consideration as a basis for our future work in many fields. I am, of course, also appreciative of the support that has been expressed for the change and renewal in WHO, and for your reflections and comments based on *The world health report 1999: Making a difference*. It has been good to observe all the positive responses to the innovations that have been introduced at the Health Assembly this year. The ministerial round tables have been generally very well received. Ministers have participated actively and contributed to pointed and lively debates on key issues confronting them. There was a genuine sense of open discussion and an exchange of ideas and practical experience. We will now be looking into and reviewing the experience, and looking at even further improvements based on this year's efforts. I believe that we can all also learn from studying the many important points and observations that were shared between ministers during the round tables, and that they will prove fruitful in our future work.

The PRESIDENT:

Thank you, Dr Brundtland.

After hearing the statements of the delegates, we are now in a position to express an opinion in the name of the Assembly regarding *The world health report 1999*. After hearing the comments of the various delegations, we have the clear impression that the Assembly wishes to express satisfaction with the manner in which the Organization's programme for this year was implemented. Your comments will be duly recorded in the records of the Assembly. We have now concluded our work for today. The next plenary will be held this afternoon at 17:00. Committee B will now hold its second meeting. The meeting is adjourned.

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

EIGHTH PLENARY MEETING

Thursday, 20 May 1999, at 17:00

President: Mrs Maria de Belém ROSEIRA (Portugal)
later: Dr E.F. EHTUISH (Libyan Arab Jamahiriya)

HUITIEME SEANCE PLENIERE

Jeudi 20 mai 1999, 17 heures

Président: Mme Maria de Belém ROSEIRA (Portugal)
puis: Dr E.F. EHTUISH (Jamahiriya arabe libyenne)

AWARDS
DISTINCTIONS

The PRESIDENT:

We shall now take up item 8, "Awards". Excellencies, distinguished delegates, ladies and gentlemen, we are assembled here today for the presentation of the prizes awarded by the Darling Foundation, the Léon Bernard Foundation, the Jacques Parisot Foundation, the Ihsan Dogramaci Family Health Foundation, the Sasakawa Health Prize and the United Arab Emirates Health Foundation.

I have much pleasure in welcoming among us the distinguished winners of these prestigious prizes: Dr Jarbas Barbosa da Silva, representing the late Dr Agostinho Cruz Marques; Dr Vinod Prakash Sharma; Mrs Debbie Emma Choonga; Mr Boinkum Benson Konlaan; Professor Münevver Bertan; Dr Juan Guillermo Ortiz Guier; Dr Ayanda Ntsaluba, representing the Institute of Urban Primary Health Care, South Africa; Professor Ismail A. Sallam; and His Eminence Metropolitan Chrysostomos of Kition and Dr Kyriacos Veresies, representing the Centre for Education about Drugs and Treatment of Drug-addicted Persons, Cyprus.

I am also very pleased to greet Professor Ihsan Dogramaci, the founder of the Ihsan Dogramaci Family Health Foundation, Professor Kenzo Kiikuni, representing the Sasakawa Memorial Health Foundation, and His Excellency Dr Hamad Abdul Rahman Al Madfa, representing the founder of the United Arab Emirates Health Foundation.

Presentation of the Darling Foundation Prize
Remise du Prix de la Fondation Darling

We shall start with the presentation of the Darling Foundation Prize. The Darling Foundation Medal and Prize are presented at the Health Assembly to a person or persons for their outstanding achievements in the pathology, etiology, epidemiology, therapy, prophylaxis or control of malaria. I am pleased to announce that the Executive Board of WHO, having considered the report of the Darling Foundation Committee, awarded the prize to Dr Agostinho Cruz Marques, from Brazil and to Dr Vinod Prakash Sharma from India.

The achievements of the late Dr Agostinho Cruz Marques in combating malaria are remarkable. Over a span of 35 years he worked principally in the poorest and most needy regions in Brazil and held various key positions in the States of Acre, Amazonas, Rondônia, and Roraima. In 1977 he assumed the responsibility for nationwide coordination of all antimalaria activities, successfully dealing with the

challenge of the disease and eventually reducing it to a considerably lower level. Dr Marques was the author of a number of publications on malaria control.

Dr Vinod Prakash Sharma's accomplishments have been of immense value in enhancing the understanding of malaria dynamics, the organization of situation-specific control interventions, and the development of an integrated and ecologically sound cost-effective approach and method for malaria control. His work contributed substantially to the successful implementation of malaria control in several states of India. Dr Sharma is the author of a number of world-acclaimed publications on malaria.

It is now with much pleasure that I invite Dr Barbosa da Silva on behalf of Dr Agostinho Cruz Marques and Dr Sharma to receive the prizes.

Amid applause, the President handed the Darling Foundation Prize to Dr Jarbas Barbosa da Silva, representing Dr Agostinho Cruz Marques, and to Dr Vinod Prakash Sharma.
Le Président remet au Dr Jarbas Barbosa da Silva, qui représente le Dr Agostinho Cruz Marques, et au Dr Vinod Prakash Sharma le Prix de la Fondation Darling. (Applaudissements)

The PRESIDENT:

I now invite Dr Barbosa da Silva to address the Assembly.

Dr BARBOSA DA SILVA:

As the Director of the Brazilian National Centre for Epidemiology, and today also as a representative of the laureate, and of all the Brazilian community of public health professionals, I feel honoured to receive this award presented by the Darling Foundation to Dr Agostinho Cruz Marques.

Dr Marques dedicated his entire life to the control of malaria in Brazil. His work in the fields of epidemiology, medical care, research and teaching will not be forgotten. He has indeed left many followers, perhaps not as brilliant, but all with a strong will and dedication to sustain his struggle against disease, in the pursuit of better living standards for our people. Thank you very much.

The PRESIDENT:

Thank you, Dr Barbosa da Silva. I now invite Dr Sharma to address the Assembly.

Dr SHARMA:

Madam President of the Fifty-second World Health Assembly, Madam Director-General, excellencies, honourable ministers of health, distinguished members of delegations to the Fifty-second World Health Assembly, ladies and gentlemen, I wish to thank the World Health Organization for this high honour given to me by awarding me the Darling Foundation Prize for combating malaria in India. I am deeply indebted to the Indian Council of Medical Research, the Ministry of Health and Family Welfare, and the National Anti-malaria Programme of the Government of India for their unstinting support throughout my research career. The development of the bioenvironmental malaria control strategy has been realized through dedicated hard work and selfless service by the staff at the Malaria Research Centre. Malaria is dreadful. It kills routinely children, pregnant women, nonimmunes; and the sick are especially vulnerable. In poor nations, malaria is a major cause of high mortality and a key element of vicious cycles of poverty and ill-health. A major reduction from malaria had been achieved in many endemic countries; but it has returned with added vigour, entered new territories and has had an adverse impact upon the development and poverty alleviation programmes. In India malaria also adds additional weight to the already over-stretched social and health welfare programmes, effectively crippling local economies. Insecticide spraying to control malaria is harmful and produces diminishing returns. Developments designed to improve the national economy have led to the relentless march of man-made malaria.

Over the past few decades peoples' own perception of fighting malaria has changed, the wisdom of incessant spraying has been questioned; and societies have become more open, democratic and demanding. The return of malaria has become more aggressive and its control requires renewed attack based on local epidemiological determinants. In this context bioenvironmental methods to roll back malaria offer a sustainable, and in my experience, wise alternative. It is indigenous, ingenious, involves local populations in their own health care, and is environmentally sound. It adapts equally well to both nature and changing scenarios of social progress. It is a strategy in which the old and new join hands in a scientific frame, with the common aim of thwarting mosquito-borne misfortunes. This methodology is ideally suited for poor

and developing nations, and offers a platform on which self-reliant and vibrant social structures can be built. Our work offers a more viable alternative to malaria control than complete reliance on insecticide- and drug-based strategies, and I hope it will be applied in countries where malaria remains a killer.

The PRESIDENT:

Thank you, Dr Sharma.

Presentation of the Léon Bernard Foundation Prize
Remise du Prix de la Fondation Léon Bernard

The PRESIDENT:

I shall now proceed to the presentation of the Léon Bernard Foundation Prize. This prize is given to a person having accomplished outstanding service in the field of social medicine. The Léon Bernard Foundation Prize is awarded this year to Mrs Debbie Emma Choongo of Zambia.

Mrs Choongo commenced her career as a registered nurse, then as a public health nurse. In 1989, as Principal Nursing Officer (Research), she was assigned to coordinate a women's project in rural communities of the Mambwa District, Zambia, called "Promoting health through women's functional literacy and intersectoral action". The aim of the project was to assist local communities to find workable solutions to their problems by using available local resources through direct community participation. The main areas of activities were health, functional literacy, and income-generating activities.

Mrs Choongo's personal commitment, creativity and communication skills have been instrumental in the achievement of remarkable successes in all these areas. Under her impetus, the project has been so successful that this community is now regarded as a model for good community health practices, with information on this experience being disseminated to other communities.

For her outstanding accomplishments, I now have great pleasure in presenting Mrs Choongo with the Léon Bernard Foundation Medal and Prize.

Amid applause, the President handed the Léon Bernard Foundation Prize to Mrs Debbie Emma Choongo.
Le Président remet à Mme Debbie Emma Choongo le Prix de la Fondation Léon Bernard. (Applaudissements)

The PRESIDENT:

I invite Mrs Choongo to address the Assembly.

Mrs CHOONGO:

Madam President of the Fifty-second World Health Assembly, distinguished guests, ladies and gentlemen, I feel honoured to be the recipient of the Léon Bernard Foundation Prize in social medicine, the first of its kind to be bestowed upon a Zambian. On behalf of the Zambian Government and indeed on my own behalf, I wish to thank the World Health Organization and the Léon Bernard Foundation Committee for awarding this prize for outstanding service in social medicine. I feel simply overwhelmed by this gesture.

I believe that there are many others out there better than I, but their work has probably not been noticed. I have learned from my experience in social medicine that people's involvement in planning and decision-making is pivotal in achieving desired change in health and quality of life, even during times of crisis. Working in social medicine has helped me to see more objectively some of the problems of vulnerable groups, such as low-income families, and their difficulties in finding alternative solutions.

In a developing and highly indebted poor country like Zambia, implementing and sustaining community health initiatives is always a challenge, the major constraints being lack of a financial base to expand and replicate initiatives. Zambia is spending more than 50% of its foreign exchange earnings on debt-servicing, thereby depriving its citizens of the much needed funds for improving health services. It is in this vein that I join the many Zambians and other countries advocating debt cancellation.

From experience, I have found nothing more satisfying than helping to untie the knots that hold back the health and economic potential of the less privileged people in society. From my work I have fully learned that one cannot succeed by operating from a platform far removed from the daily realities of people.

It is necessary to understand and share their difficult circumstances through discussions, information dissemination and research for effective resource utilization. I would like to pay my special tribute to the communities that I have worked with for opening their doors and permitting this rich mutual sharing of opportunities to improve our health. My message is that community health programmes continue to be important, but nearly every nation is experiencing new health problems that demand fresh approaches to their solutions. I believe that every man, woman and child must have the opportunity and capacity for full health development and productivity. There is a need to empower communities with knowledge of and skills for key actions that may improve their health status. When people participate in health programmes they develop a sense of ownership, and they value the services more, and quickly learn to do more.

This occasion is a driving force for me to work harder and serve as a model. I intend to dedicate myself to building the capacity of my fellow workers and communities through a participatory learning approach, which has a multiplier effect. I thank my Government for creating a conducive working environment, which enabled me to execute my work ably. It is my great pleasure once again to thank the World Health Organization and the Léon Bernard Foundation Committee for bestowing this prize upon me.

Thank you and God bless.

The PRESIDENT:

Thank you, Mrs Choongo.

Presentation of the Jacques Parisot Foundation Medal
Remise de la médaille de la Fondation Jacques Parisot

The PRESIDENT:

I now proceed to the presentation of the Jacques Parisot Foundation Medal. This Foundation was established for the purpose of awarding every two years a fellowship for research in social medicine or public health. The Fellowship was awarded last year to Mr Boinkum Benson Konlaan, from Ghana.

Having gained a diploma in statistics from the University of Ghana, and a Master of Public Health degree at the University of Umeå, Sweden, Mr Konlaan is currently pursuing doctoral studies at Umeå University within an innovative project on cultural stimulation and health. The objective of the research he is undertaking under the Fellowship is to delimit individuals in the normal population who rarely attend cultural events, and to make a randomized, controlled experiment that would encourage them to do so more often. The individuals are being followed up with regard to the health-related effects.

In a few minutes, Mr Konlaan will give us a brief outline of the results of his work. In the meantime, it is a privilege for me to present to him the Jacques Parisot Foundation Medal.

Amid applause, the President handed the Jacques Parisot Foundation Medal to Mr Boinkum Benson Konlaan.
Le Président remet à M. Boinkum Benson Konlaan la médaille de la Fondation Jacques Parisot. (Applaudissements)

The PRESIDENT:

Mr Konlaan, you have the floor.

Mr KONLAAN:

Madam President, ladies and gentlemen, as a Ghanaian working in Sweden, I have come to believe that the participation in the cultural life of any country is important for the well-being of its people. In the studies performed with the support of this fellowship I have come up with rather clear indications on its importance even for the survival of individuals. Secondly, we believe that a widening of intense cultural participation in all social and ethnic groups could attenuate health inequalities between them. Our studies on participation in cultural life thus have the general aim of attenuating health inequalities. The background is an impressive difference in access and use of the cultural offer between socioeconomic and educational groups. If participation in the cultural life has a health impact, a new and important way of promoting equality in health could be to promote equity in the participation in cultural life.

In our first studies we found that attending cultural events had a significant influence on survival for people after we had discounted other health determinants like smoking, income, education, social network,

etc. In order to contribute to the discussion on causation we then carried out an experiment where people were encouraged to increase their participation in cultural events. This was a randomized controlled investigation using a factoral design, where attending cultural events and taking easy physical exercise were tested simultaneously. Participants had responded to a postal questionnaire on their attendance at cultural events. Of these, 21 individuals (11 men, 10 women) were recruited into a two-month long experiment.

The interesting finding was that the two ways of stimulation produced two different responses. A decrease in the levels of stress-related hormones was observed only in those subjects encouraged to attend cultural events. Physical exercise encouragement instead increased the "good" cholesterol. Obviously, there was a specific effect apart from the general response to the attention or being observed. This was in fact to be expected from basic biological research. The way may have been opened to diminishing the health differential between social classes. We have been encouraged to continue the studies and will be happy to report on them in due course.

The PRESIDENT:

Thank you, Mr Konlaan.

Presentation of the Ihsan Dogramaci Family Health Foundation Prize
Remise du Prix de la Fondation Ihsan Dogramaci pour la Santé de la Famille

The PRESIDENT:

I proceed now to the presentation of the Ihsan Dogramaci Family Health Foundation Prize. This prize is given to a person having accomplished service in the field of family health. I have pleasure in announcing that the Ihsan Dogramaci Family Health Foundation Prize has been awarded this year to Professor Münevver Bertan from Turkey.

Professor Bertan has devoted her whole career to the promotion of family health. Included among her many exemplary achievements is the 1985 national immunization campaign of Turkey, which Professor Bertan was responsible for organizing, as technical adviser to the Minister of Health. This programme not only achieved high coverage, but also established a system for sustaining immunization, and became the model for the creation of the Turkish Intersectoral Committee on Child Survival and Development. Other notable achievements of Professor Bertan include the project on "Strengthening Clinical Family Planning Training in Medical Schools in Turkey" and the "Community Health Workers Project in a rural area of Turkey". In addition, she has also participated as principal investigator in several national and international collaborative research studies on diarrhoeal diseases, acute respiratory infections and other projects related to family health.

Before presenting the prize to Professor Bertan, I invite Professor Ihsan Dogramaci, the distinguished founder of the prize, to address the Assembly.

Professor DOGRAMACI:

Madam President, Madam Director-General, distinguished delegates, ladies and gentlemen, on behalf of the Foundation Committee, I would like to congratulate Professor Münevver Bertan, who has been singled out among many distinguished candidates as this year's recipient of the Ihsan Dogramaci Family Health Prize. Professor Bertan is Professor of Paediatrics and Public Health in the University of Hacettepe in Turkey. This is the first time in 19 years, since the establishment of the prize, that a Turkish national has been awarded this prize.

Professor Bertan's work at the national and international level to improve the health and well-being of women, adolescents and children makes her richly deserving of this recognition. She is an academic, a researcher, a teacher, social mobilizer, a supporter of nongovernmental organizations, a leader for the rights of children, a pioneer in the movement updating knowledge in paediatrics in the republics of Central Asia, a strong voice for adolescent health. Indeed, she is truly multisectoral. She has worked as a senior adviser with the Ministry of Health of Turkey on immunization policies, while keeping up her duties on the Faculty Board of the School of Medicine and the University Council. She has been President of the European Society of Social Paediatrics, and Coordinator of the International Pediatric Association; she serves as Secretary-General of the Turkish National Committee for UNICEF, and she was until recently a member of the Executive Board of WHO. Professor Bertan continues to serve on the scientific advisory boards of many institutions.

She has been recognized by the Foundation Committee as an impressive team leader and an innovative capacity builder in public health, a strong advocate of children's and women's health and rights. Professor Bertan is awarded this prize for her active involvement in and contribution to health and development at the national and international level. It is my pleasure to congratulate Professor Bertan on behalf of the Foundation Committee.

The PRESIDENT:

In recognition of her outstanding achievements, I have pleasure in presenting Professor Bertan with the Ihsan Dogramaci Family Health Foundation Prize.

Amid applause, the President handed the Ihsan Dogramaci Family Health Foundation Prize to Professor Münevver Bertan.
Le Président remet au Professeur Münevver Bertan le Prix de la Fondation Ihsan Dogramaci pour la Santé de la Famille. (Applaudissements)

The PRESIDENT:

I now invite Professor Bertan to address the Assembly.

Professor BERTAN:

Madam President, Madam Director-General, distinguished delegates, ladies and gentlemen, it is a great honour and privilege for me to be present at this Health Assembly to receive the Ihsan Dogramaci Family Health Foundation Prize. This honour is not mine alone. I share it with the grass-roots service providers who work so hard to improve family and child health, and also with my colleagues who conduct studies in the community. This prize has a special meaning for me. In the first place, I have worked with WHO since 1972 as an adviser, principal investigator for many child health and family planning projects, as a member of the Scientific and Advisory Group of the Special Programme of Research, Development, and Research Training in Human Reproduction and most recently as Executive Board member from 1993 to 1996. Closer to home, I have the privilege of working in the university and children's hospital established by Professor Dogramaci who is an internationally known figure in child health and higher education and who was among the signatories of the WHO Constitution in 1946.

I would like to take this opportunity to underline some of the anticipated challenges for the next millennium. The dramatic shift from rural to urban life styles will create more crowded settlements without safe sanitation, access to essential basic social services, adequate shelter and secure livelihoods. Economic and political crises will continue to give rise to millions of poor and vulnerable families, who depend most directly on public services and who long for a future with no war, violence or starvation, free from preventable acute and chronic diseases, including a healthy environment.

As a paediatrician and public health person, I see that the human development agenda should focus on education, prevention and health promotion, especially in the three critical periods of life: pregnancy, infancy and early childhood and adolescence. Every child has the right to reach the age of six, healthy and able to learn. This is an investment that all countries, rich and poor, must be able to make. Although a lot still remains to be done for them, infants and children have traditionally received more attention, so I would like to focus on older children, especially adolescents, those who will influence the health patterns and life styles of future generations. Just as a healthy intrauterine life is important to produce a healthy newborn, a successful adolescence is vital for a healthy and fruitful adulthood. Wide implementation of the Convention on the Rights of the Child, and a firm commitment to women's rights and human rights are also necessary to achieve better health and welfare in the next millennium. And we must not forget that violence spawns further violence, whereas peace brings peace. Child-friendly environments and adolescent-friendly communities will help to bring about a spirit of understanding, peace, tolerance, and equality of the sexes among the world's peoples.

Another important challenge will be genetics and ethics. Technological advances can help give us the power to solve problems, but we must be conscious of the fact that the same advances can raise serious ethical issues which must be tackled by the international community.

It is my firm belief that a public health approach to the challenges facing us will serve to combat poverty and inequalities as well as poor health. Each country must bring together its policy-makers and researchers in a cross-disciplinary approach to identify priorities for development in an ethical context. They must take into account how globalization affects human welfare. Their goal must be to develop

policies aimed at reducing poverty, eliminating socioeconomic inequalities, and reforming the health and education sectors.

The goal for the next millennium should be to strengthen the knowledge and practice of a public health approach to primary health care. In that way we can attain health for all, and we can marshal all for health, throughout the world.

The PRESIDENT:

Thank you, Professor Bertan.

Presentation of the Sasakawa Health Prize
Remise du Prix Sasakawa pour la Santé

The PRESIDENT:

Distinguished delegates, ladies and gentlemen, I now come to the presentation of the Sasakawa Health Prize. This prize is awarded to individuals or institutions for outstanding innovative work in health development, and aims at encouraging the further development of such work.

It is with pleasure that I announce that the 1999 Sasakawa Health Prize has been awarded to Dr Juan Guillermo Ortiz Guier, of Costa Rica, and to the Institute of Urban Primary Health Care, Bergvlei, South Africa.

During a career that spans over 30 years, Dr Ortiz Guier's contribution to primary health care has been exemplary, both in terms of his accomplishments at country level and in fostering the primary health care movement worldwide. Having been involved in the development of a community hospital in the rural region of San Ramon since its inception in 1955, Dr Ortiz began in the early 1960s to organize home care for aged people in the same area, building up teams of physicians, nurses and other auxiliary personnel including social workers, to serve this programme. The programme, designed to provide access to appropriate health care for all, was later to become known as "Hospital without Walls". In 1974, the programme was expanded to include the establishment of 300 health posts throughout the country, and a year later the Social Security Fund created 400 primary health care teams to cover the whole country. At international level, Dr Ortiz was involved in the preparation of the Alma-Ata Conference in 1978 and has frequently been called upon to present his experience in many countries of the world. The prize money will be used in part to support a subprogramme of "Hospital without Walls" for aged people, entitled *Hogar de Ancianos de San Ramon*. It will also be used to support the creation and organization of health development committees in primary and high schools throughout Costa Rica.

The Institute of Urban Primary Health Care, Bergvlei was established in 1990, initiated by the Alexandra Health Centre to carry out primary health care research and training activities. In 1997 it became and independent trust. The work of the Institute has helped to build the capacity and numbers of health service personnel able to work in primary health care. Since 1994 its activities have extended beyond provincial and country boundaries to include neighbouring provinces and countries. The prize money will be used to expand the Institute's work through its local branch in Kwa Zulu, Natal Province. The Institute also intends to develop courses for other categories of health personnel involved in rehabilitation in Kwa Zulu. The aim is to ensure that rehabilitation is truly regarded as one of the cornerstones of primary health care.

Before presenting the prize, I invite Professor Kiikuni to address the Assembly on behalf of the Sasakawa Memorial Health Foundation.

Professor KIIKUNI:

Madam President, distinguished winners of this year's different health prizes, Madam Director-General, distinguished delegates and friends, first of all let me express my most sincere esteem and appreciation to all my colleagues gathered here today for your tireless effort for the advancement of health and welfare of the people of the world. On behalf of the Nippon Foundation and Sasakawa Memorial Health Foundation, I would like to congratulate Dr Juan Guillermo Ortiz Guier of Costa Rica and the Institute of Urban Primary Health Care of South Africa, the recipients of this year's Sasakawa Health Prize, for their innovative effort and leadership which have inspired all of us whose concern is enhancement of health of the people of the world.

The Sasakawa Health Prize was established in 1984 by a complete agreement between two unique leaders in health: Dr Halfdan Mahler, the then Director-General of WHO, and the late Mr Ryoichi Sasakawa, the founder of the prize and the then Chairman of the Nippon Foundation. Creation

of this prize was to demonstrate the strong commitment by the two leaders for betterment of health of people through individual and group efforts in primary health care.

It was in the mid-1970s when Mr Ryoichi Sasakawa decided to support WHO's effort in leprosy elimination. Leprosy is a disease which had been generally forgotten, but Mr Ryoichi Sasakawa was different. He had a special concern and sympathy toward the sufferers of the disease. In those days, it was a disease with grave social consequences. Patients suffered not only physically but also socially and mentally. No other disease brings such agony and distress to its afflicted and their families as leprosy. WHO's definition of health being the physical, mental and social and now spiritual well-being of people, elimination of leprosy will no doubt have a significant meaning in human history.

Eliminating an age-old disease, however, requires tremendous effort by every sector of society. Maintaining political commitment, ensuring financial resources and planning and implementing the programme from the top to grass-roots levels is a formidable challenge. I must truly praise the Director-General for her determination and leadership, soon after she took office, in calling for an intensified strategy to strengthen and accelerate leprosy elimination, in accordance with resolution WHA44.9 adopted in 1991. I would like to acknowledge the outstanding results which the global effort has achieved to date. The use of multidrug therapy to treat and cure leprosy patients has already reduced the global prevalence of leprosy by 85%: from five million registered patients in 1985 to 800 000 today. The Nippon Foundation and Sasakawa Memorial Health Foundation are very pleased to be a part of this successful operation of the multidrug therapy drug delivery system, with our annual contribution of US$ 14 million.

I am happy to inform the award recipients, and everyone else participating in primary health care in the world, that we have come near to the elimination of leprosy. But, we say in a Japanese proverb that when climbing Mount Fuji, even if we arrive at the ninth station, out of 10, we have only come half way. The final ascent demands the hardest work. Unless we intensify our efforts the abominable times may return. We must therefore be steadfast, as the achievement of our goal is in sight. Once we attain the goal, then we can turn our attention to strengthening primary health care in order to sustain the elimination and also to control and eliminate other public health threats. This is a unique opportunity and a challenge to mankind. Let us reaffirm our commitment to unite our efforts towards the elimination of leprosy, as a concrete and important element of the achievement of health for all.

The PRESIDENT:

Thank you, Professor Kiikuni.

It is now my privilege to present the Sasakawa Health Prize to Dr Juan Guillermo Ortiz Guier, and to Dr Ayanda Ntsaluba, representing the Institute of Urban Primary Health Care.

Amid applause, the President handed the Sasakawa Health Prize to Dr Ortiz Guier and Dr Ntsaluba.
Le Président remet le Prix Sasakawa pour la Santé au Dr Ortiz Guier et au Dr Ntsaluba. (Applaudissements)

The PRESIDENT:

I now invite Dr Ortiz Guier to address the Assembly.

Dr ORTIZ GUIER:

Madam President, Madam Director-General, distinguished delegates, ladies and gentlemen, to obtain the Sasakawa Health Prize for primary health care is a great honour for my country, because in Costa Rica the communities have taken part in primary health care. We have created the well-known programme called "Hospital without Walls". This meant that the hospital projected its influence throughout the whole area, with all the professional staff, technicians and other staff in different departments, who take part in preventive and curative medicine, education and community development, such as water supplies, obtaining small pieces of land for peasants to work, creating housing and cooperative milk societies for small producers, loans for agriculture in the programme zone with money from the Inter-American Development Bank, because we went to them and asked for it, and the establishment of the "Regional Productive Projects Association".

The community constructed health posts with their own resources and some help from the Government. Intersectoral and interinstitutional actions were carried out for the health organization and development of patients. In primary and high schools we created committees for health and development, which took part in the programme. Later we did the same through social security, covering the whole

country. The results of all this were that the incidence of infectious diseases and parasitoses were lowered completely, and that infantile mortality and other health indexes were excellent. Our hospital was a community hospital working through a board of trustees with great hopes for the future. Later, in 1974, the Health Minister of my country created 300 health posts for the rest of the country, and following this obtained wonderful health indexes. My country thus became one of the first countries in Latin America with good health indexes.

Later, when the Health Ministry became Health Rector, and when social security assumed preventive, curative and rehabilitation as a whole, the health posts became basic teams called "*ebais*" and we now have more than 800 in our country. This has resulted in a wonderful improvement in the standard of care given to citizens in rural areas and periurban cities. Now, in 1998, Costa Rica has an infant mortality rate of 12.1/1000.

I believe that hospitals in the rest of the world, and particularly those in first line care must follow the example of the "Hospital without Walls" programme if they want to obtain a very active, excellent, vigorous and effective primary health care service. I believe that primary health care services can achieve the highest goals if the hospitals support them with the facilities they have in all their areas of influence. I wish that God's will would be done on our planet Earth, that total harmony may reign, with health development and justice for all mankind. We must from now on talk about globalization of health, justice and development, and not only about economic globalization.

In our programme "Hospital without Walls", the achievements were made possible because all the team members and the organized community worked together with unified ideas and goals that were able to be transformed into actions. I have worked for 49 years in communities and in rural areas, and if I had the opportunity of another life, I would work again in primary health care.

I would now like to tell you in my own language something about "Hospital without Walls" that I felt in my own soul, and which is expressed in a poem which goes like this:

> En la profunda hondura humanitaria de la mente y del espíritu
> se forjaron las corrientes sociales en forma natural
> y así se expresaron como el sol, como el aire y como el agua
> que aclaran, iluminan y dan vida,
> porque todos vivimos en el mundo común.
> Así también de nuestro íntimo torrente surgieron mis ideales
> vigorosos y firmes como tanques de paz
> a romper las paredes del clásico hospital,
> abrazando en su amor toda el área rural
> y quedaron sembradas enfermeras en toda su extensión.
> Como trombas de amor corrieron el mensaje,
> cambiando la actitud pasiva y conformista de nuestro campesino
> por la lucha constante de energía sin desmayo
> con la frente despierta e incisiva como llama encendida en noche oscura. Y toda la niñez se protegió
> contra los monstruos vivos de la enfermedad infecciosa,
> la parasitosis intestinal y la desnutrición. Es la nueva actitud comunitaria
> que sigue la mujer desde su cuna
> y la prepara para ser la madre responsable,
> y vigila a su hijo desde que fue en el vientre
> pensando en un futuro ciudadano más feliz
> y al completo desarrollo tu campesino luchador se organizó
> en tu pueblo con todo su derecho a respirar salud.

Madam, I thank you for allowing me to quote, in Spanish, and in my own words, this poem on the occasion of this award.

The PRESIDENT:

Thank you, Dr Ortiz. I now invite Dr Ntsaluba to address the Assembly on behalf of the Institute of Urban Primary Health Care.

Dr NTSALUBA:

Madam President, Madam Director-General, distinguished delegates, it is indeed a great pleasure for me to receive this prestigious Sasakawa Health Prize on behalf of the Institute of Urban Primary Health

Care. This is particularly so since one of my colleagues, Ms Rose Mazibuko, was a recipient of the same prize last year. It is indeed reassuring to realize that as South Africans labouring in the difficult conditions of our health systems transformation that we are not alone and that others recognize the value of what we are attempting to do. That it is the World Health Organization that has recognized us by awarding us this prize is of high regard and a notable achievement in our history. This is indeed the highlight of the year for the Institute. The Institute of Urban Primary Health Care was formed in 1990 as a unit of the Alexandra Health Centre, based in Johannesburg, to carry out research and training activities related to primary health care in Alexandra and to gather information on the development of services and systems at the centre. Subsequently, the Alexandra Health Centre has been noted both in South Africa and abroad for its pioneering work in the establishment of comprehensive primary health care services and is regarded as a model for the country. The Institute has also been engaged in training primary health care nurses and mentors, committee-based rehabilitation facilitators, supervisors and managers, health advisers and home-based care givers. They have engaged in lobbying for the inclusion of community-based rehabilitation in national policy and for the recognition of community-based rehabilitation facilitators. With this award we hope to attract those persons or organizations that are interested in pioneering development initiatives for empowering communities to help interventions, to engage us in discussion, partnership and joint ventures for research and implementation, so that the Institute would continue to be relevant to the people of South Africa and our region.

The Institute is grateful to the World Health Organization for this award and expresses its thanks not only on its behalf as an institute but also on behalf of the Alexandra Health Centre, from which the Institute emerged, the institutions and donors who have supported it and also to the people in the Government of South Africa. The funds associated with this award are needed, but we also look forward to working with this Organization on programmes with common objectives. Madam President, once more many thanks for this award.

Dr E.F. Ehtuish (Libyan Arab Jamahiriya), Vice-President, took the presidential chair.
Le Dr E.F. Ehtuish (Jamahiriya arabe libyenne), Vice-Président, assume la présidence.

The PRESIDENT: الرئيس:

شكرا للدكتور شالوبا.

Presentation of the United Arab Emirates Health Foundation Prize
Remise du Prix de la Fondation des Emirats arabes unis pour la Santé

The PRESIDENT: الرئيس:

سيداتي سادتي، نمضي الآن الى تقديم جائزة مؤسسة الامارات العربية المتحدة للصحة، وتمنح هذه الجائزة مكافأة على المساهمة الجليلة في مجال التنمية الصحية وقد منحت هذا العام مناصفة لكل من الأستاذ الدكتور اسماعيل سلام من مصر ومركز التثقيف بشأن المخدرات وعلاج المدمنين عليها في قبرص.

لقد كانت مساهمة الأستاذ الدكتور سلام في التنمية الصحية خلال حياته المهنية الناجحة نجاحا باهرا على مدى ثلاثة عقود من الزمن مساهمة جليلة. وقد ذاع صيت الأستاذ الدكتور سلام كجراح للقلب على المستوى الدولي، سواء في المجال الأكاديمي أو الممارسة الطبية، فمن انجازات الأستاذ الدكتور سلام في المجال الأكاديمي أنه أوصل الرعاية المتخصصة الى عدة مناطق ينقص فيها تقديم هذه الخدمات في مصر، وأدخل خدمات تشريح محسنة الى عدة مستشفيات في مناطق في نواح نائية في الصعيد المصري، وأبدى اهتمامه بخدمات نقل الدم الى انشاء منظمة غير حكومية تعنى ببناء الخدمات الوظيفية للتبرع بالدم للمستشفيات الحكومية. وقدم في حياته السياسية مساهمات جليلة، فالسياسة الصحية الجديدة التي أدخلت بقيادته كوزير للصحة والسكان أدت الى اصلاحات عديدة بعيدة المدى لبعث الحيوية والنشاط في الخدمات الصحية. كما نتج عن التزامه بتطوير نظام الرعاية الصحية الأولية تعزيز برامج مكافحة الأمراض وتحسين خدمات صحة الأسرة، وشجع الأستاذ الدكتور سلام كذلك المناهج الجديدة الخاصة بصحة المرأة مما أسفر عن زيادة الخدمات المقدمة للمرأة ومن ثم تقليص أمراض ووفيات الأمومة. وكان الأستاذ سلام شخصية بارزة لأمد طويل في مجال التعاون الدولي أيضا. ذلك أن مساهماته في برامج المساعدة الانسانية حظيت بقبول حسن في بلدان شرق المتوسط وأفريقيا.

أما مركز التثقيف بشأن المخدرات وعلاج المدمنين عليها، فهو منظمة غير حكومية، وقد أنشئ في عام ١٩٩٤ لتلبية الحاجة الى منظمة قبرصية يمكنها جمع معلومات عن مبادرات مختلف المنظمات المشتركة في الصراع ضد المخدرات بهدف تنسيق الجهود. وينتمي الأعضاء في المركز الى عدة قطاعات مختلفة من المجتمع كما أن المركز يعمل بالتعاون الوثيق مع المنظمات المحلية والدولية. ومنذ انشاء مركز التثقيف بشأن المخدرات وعلاج المدمنين عليها نجح هذا المركز، في فترة وجيزة، في تدعيم برنامج الوقاية الأولية من خلال تعزيز مشاركة ومساهمة المجتمع بأثره على نحو فعال ولاسيما المجموعات المعنية بتثقيف الشباب. ويتمثل هدف ذلك المركز فيما يتعلق بمواصلة التطور في ايجاد برنامج يعني بالوقاية من الدرجتين الثانية والثالثة.

السيدات والسادة، قبل تقديم الجائزة الى الفائزين بها الموقرين أدعو ممثل الامارات العربية المتحدة للصحة سعادة الدكتور حمد عبد الرحمن المدفع الى التحدث الى الجمعية فليتفضل.

الدكتور حمد عبد الرحمن المدفع (الامارات العربية المتحدة): Dr AL-MADFA (United Arab Emirates):

سعادة الأخ الزميل رئيس جمعية الصحة العالمية الموقر، السيدة الدكتورة المديرة العامة للمنظمة، السيدات والسادة، السلام عليكم ورحمة الله وبركاته.

يطيب لي أن أرحب بكم جميعا أجمل ترحيب في هذا الاحتفال السنوي الكبير والمتميز والذي تقيمه منظمة الصحة العالمية لتكريم الأطباء الأجلاء والعلماء والباحثين الذين تترسم خطاهم منظمتنا هذه دائما على طريق التقدم والازدهار. كما يسعدني، في هذا المقام الطيب، أن أتوجه بالشكر، باسم مؤسسة الامارات العربية المتحدة للصحة، الى جمعكم هذا والى المجلس التنفيذي للمنظمة على الجهود الطيبة التي يبذلها أعضاء المجلس للاعداد لتكريم الفائزين بهذه الجائزة السنوية تعبيرا عن الشكر والعرفان لهؤلاء العلماء والأطباء الأفاضل لسعيهم المتواصل في اثراء هذه الجمعية بخلاصة أفكارهم ونتائج درساتهم وأبحاثهم لاسعاد البشرية في بقاع العالم المختلفة. ان مؤسسة الامارات العربية المتحدة للصحة والتي أنشئت بتوجيه كريم لصاحب السمو الشيخ زايد بن سلطان آل نهيان رئيس الدولة حفظه الله، وبمبادرة من صاحب السمو الشيخ خليفة بن زايد آل نهيان نائب القائد الأعلى للقوات المسلحة ولي عهد أبو ظبي، جاءت مكملة للجهود والانجازات المتعددة في مجال الخدمات الصحية بدولة الامارات والتي تحققت خلال العقدين الماضيين وشملت جميع القطاعات مما كان له كبير الأثر في توسيع قاعدة الخدمات الصحية لتصل الى كل ركن من أركان الدولة مرتكزة في ذلك على مفهوم الرعاية الصحية الأولية كمدخل للرعاية الطبية المرجعية التخصصية اضافة الى البرامج الوقائية والأنشطة التعزيزية والتأهيلية، تعكسها مؤشرات التنمية الصحية حيث ارتفع معدل العمر المأمول عند الميلاد ليصل الى ٦٧ عاما للاناث و٧٤ عاما للذكور بنهاية عام ١٩٩٨. كما انخفض معدل وفيات الأطفال الرضّع الى أقل من تسعة في الألف والأطفال دون الخامسة الى حوالى ١ لكل ألف مولود حي، كل ذلك دلالة واضحة على ما تحقق بمستوى متميز من الخدمات الصحية الشاملة ذات النوعية العالية.

أيها السيدات والسادة، لقد اعتمدت دولة الامارات هذه المؤشرات اضافة الى مؤشرات صحية أخرى كالحد من حدوث معظم الأمراض السارية، واستئصال بعض أمراض الطفولة كشلل الأطفال والكزاز الوليدي والحصبة للاهتداء بها في رسم السياسات الصحية المستقبلية. ومع التغيير الواضح الذي طرأ على اتجاهات حدوث الأمراض برزت أهمية الأمراض المزمنة كأولويات تتطلب تدخلا سريعا لمواجهتها. فقد أثبتت المعلومات الاحصائية المتوفرة محليا أن أمراض القلب والأوعية الدموية والسرطان والحوادث تشكل أهم أسباب الوفيات في الدولة. ونظرا للارتباط الوثيق بين هذه المشاكل والعوامل البيئية والسلوكيات والممارسات الحياتية السائدة برزت أهمية تطوير الخطط التي من شأنها أن تحد منها ومن مضاعفاتها. فمع التطور السريع في التقنيات الحديثة المتاحة أصبحت هذه الأمراض تشكل عبئا اضافيا على الموارد المالية مما يؤكد مرة أخرى على أهمية ايجاد الحلول والبدائل المناسبة للحفاظ على مستوى ونوعية الخدمات الصحية المقدمة.

السيدات والسادة، يشرفني، في هذا المقام، اعلام الحضور الكرام بأن المؤسسة، وبموافقة المجلس التنفيذي لمنظمة الصحة العالمية، قد قررت منح جائزة هذا العام مناصفة الى كل من أولا، معالي الأستاذ الدكتور اسماعيل سلام الذي يشغل حاليا منصب وزير الصحة في جمهورية مصر العربية. فالى جانب تخصصه وعمله في جراحة القلب ساهم الدكتور سلام، باخلاص وكفاءة نادرة، في شتى المجالات الأكاديمية والاجتماعية والسياسية ليس فقط في وطنه الأم بل على نطاق العالم العربي والأفريقي، حيث كان لمبادراته العديدة أثر كبير وفعال في بلورة السياسات الصحية في جمهورية مصر العربية الشقيقة. والفائز الثاني بالجائزة هو مركز التثقيف بشأن المخدرات وعلاج المدمنين عليها في جمهورية قبرص فقد تقرر

منحه الجائزة نظرا لدوره ومشاركته الفاعلة منذ أن تأسس عام ١٩٩٤ في تفعيل وتنشيط عمل المنظمات والجمعيات ذات النفع العام للتعاون من أجل مواجهة الاستعمال الخاص للأدوية والمخدرات والادمان عليها. ان هذا المركز قد قام بتطوير ومتابعة وتقييم برامج أثبتت فعاليتها الكبيرة في الحد من هذه الظاهرة في بلاده وصار بذلك مثالا يحتذى به في التعامل مع الادمان على المخدرات والتي تمثل مشكلة صحية ملحة في كثير من بلدان العالم.

ان عالمنا أحوج اليوم ما يكون لايجاد حلول جذرية للمشكلات الصحية التي يواجهها واننا اذ نأمل أن تكون هذه الجائزة، خاصة ونحن على مشارف الألفية الثالثة، بمثابة نقلة مباركة وحافزة للأطباء والعلماء لبذل المزيد من الجهد واجراء المزيد من البحوث والدراسات الطبية التي تساهم في رفع مستوى الرعاية الصحية لمجتمعاتنا نكون قد ساهمنا ايجابا في المحاولات الجادة في تطوير الخدمات الصحية وتوفير استراتيجيات منظمتنا منظمة الصحة العالمية.

وأخيرا، أؤكد أننا على أتم الاستعداد لمواصلة سعينا نحو تقديم كل ما من شأنه أن يعود بالخير والفائدة للبشرية جمعاء. وفقنا الله عز وجل لكل ما فيه خير ومنفعة للبشرية جمعاء والسلام عليكم ورحمة الله وبركاته.

الرئيس: The PRESIDENT:

شكرا للدكتور حمد المدفع.

وادعو الآن وبكل سرور أخي الأستاذ الدكتور اسماعيل سلام وممثلي مركز التثقيف بشأن المخدرات وعلاج المدمنين عليها صاحب النيافة المتروبوليت خريسوستوموس كيتيون والدكتور كيرياكوس فيريسياس الى تسلم الجوائز.

Amid applause, the President handed the United Arab Emirates Health Foundation Prize to Professor Sallam, to His Eminence Metropolitan Chrysostomos of Kition, and to Dr Veresies.
Le Président remet le Prix de la Fondation des Emirats arabes unis pour la Santé au Professeur Sallam, à Son Eminence le Métropolite Chrysostomos de Kition et au Dr Veresies.
(Applaudissements)

الرئيس: The PRESIDENT:

أدعو الآن الأستاذ الدكتور اسماعيل سلام الى التحدث الى الجمعية فليتفضل.

الأستاذ الدكتور اسماعيل سلام (مصر): Professor SALLAM:

سعادة الرئيس، السيدة مديرة منظمة الصحة العالمية، السادة رؤساء وأعضاء الوفود الموقرين، السيدات والسادة، انني أشعر بالأسف لبقاء السادة المندوبين حتى الساعة السادسة مساء. ونحن نشكر لكم هذا الصبر وهذا التقدير الذي أعرب عنه أعضاء ورؤساء الوفود الذين يحضرون معنا هذه الجلسة. ان سعادتي بالغة للتقدير الذي أولتني اياه منظمة الصحة العالمية، كما لا يفوتني أن أحيي دولة الامارات التي رصدت هذه الجائزة وأيضا الجهات الأخرى التي وضعت تقديرا للتميز والتفوق. وهذه الجائزة هي جائزة لفريق العمل بوزارة الصحة بمصر التي وضعت استراتيجية متكاملة للصحة ودخلت في برامج غير تقليدية، وأنا أريد أن أقول ان هناك أيضا برنامجا طموحا للرعاية الصحية وتنمية الموارد البشرية. ولقد راعينا في هذا أن يكون للمرأة شأن كبير في داخل الرعاية الصحية سياسيا وثقافيا واجتماعيا في مفهوم شامل. أدخلنا مبادئ الجودة في داخل القطاعات المختلفة وشعرنا بأن المحك الحقيقي هو أن نصل الى المناطق النائية والى القرى والنجوع وأن مسؤوليتنا الأولى هي الفئات المحرومة. ولقد شعرنا دائما بأن مفاهيم الصحة يجب أن تمتد الى مشاركة حقيقية خارج مصر لترسي مبدأ هاما وهو أن العمل الانساني لا حدود له وأن الشرايين الانسانية النابضة يجب أن تفتح لمن يختلف أو يتفق معنا. ولقد سنحت لي الفرصة لزيارة العديد من المواقع في العالم ودعوني أوضح أنني في بلاد مختلفة لم أشعر فرقا بين طفل أفريقيا وطفل العراق وطفل فلسطين وطفل كوسوفا وطفل مصر. شعرت وتمنيت دائما أن يتدفق البعد الانساني من كل المهتمين في الرعاية الصحية في العالم وأن تكون منظمة الصحة العالمية هي طوق النجاة للذين أتعستهم الظروف ووقعوا فريسة للخلافات السياسية وأصبحوا مجنيا عليهم دون أن يقترفوا أي اثم أو ذنب. ان الذين ينادون بحقوق الانسان يجب أن يولوا له الأولوية ذاتها في الرعاية والاحتضان.

السيد الرئيس، اذا كان الغرض من منحي هذه الجائزة هو المكافأة على انجازات بارزة، فانني أقول ان كثيرين ممن يجلسون هنا يستحقون أيضا مثل هذه الجائزة وأنا أعتبر نفسي ممثلا لأحدهم ممن يقودون العمل الصحي في كثير من المواقع. انني أكرر شكري وامتناني لكل من منظمة الصحة العالمية ودولة الامارات العربية المتحدة ولا يفوتني أن أخص بالشكر أيضا المجلس التنفيذي للمنظمة الذي شرفني بهذا الاختيار وكذلك أولئك الذين رشحوني لهذه الجائزة وأملي أن أكون دائما عند حسن ظنهم، أشكركم والسلام عليكم.

The PRESIDENT: الرئيس:

شكرا للأستاذ الدكتور سلام، والآن أدعو صاحب النيافة المتروبوليت خريسوستوموس كيتيون الى التحدث الى الجمعية نيابة عن مركز التثقيف بشأن المخدرات وعلاج المدمنين عليها فليتفضل.

His Eminence Metropolitan CHRYSOSTOMOS OF KITION:

We warmly thank you for your decision to present KENTHEA with the United Arab Emirates Health Foundation Prize. This decision constitutes a great honour, not only for the Cyprus Ministry of Health and all members of KENTHEA, but also for all the people of Cyprus.

I would like to stress that this honour reflects on the entire population of Cyprus, because KENTHEA has managed in the space of five years to bring together under the same roof 32 volunteer organizations which are working hard to combat drugs and all kinds of narcotic substances, in close collaboration with the Orthodox Church of Cyprus, the Ministry of Health, the Ministry of Education, the Ministry of Labour and Social Insurance and the Ministry of Justice, Cyprus University, youth organizations, educational organizations and the Parents' Association for Elementary and Secondary Education, as well as with all the municipalities and communities in the free part of Cyprus.

The endeavours and efforts of KENTHEA are focused mainly on collecting information and localizing the extent and nature of the problems associated with narcotic substances, organizing suitable programmes to prevent these substances spreading, and also providing the necessary treatment and support for drug-addicted persons.

For me, personally, and for all members of KENTHEA, this award is nothing more than a reminder of our obligations and the additional heavy duty to offer our help to our society, thus achieving the well-bring and health of those in need. We will exert all our efforts in the cause of minimizing the use of narcotic substances. It is in this sense and with these thoughts that we accept this award.

Once again we express our thanks and gratitude to the World Health Organization for honouring KENTHEA with the United Arab Emirates 1999 award. We regard this action as a great encouragement to our efforts and we promise you that we shall never give up and we will continue giving all our love and help to all those in need. A love that will, undoubtedly, lead to a healthy and happy life for all the people.

Thank you and God bless you.

The PRESIDENT: الرئيس:

شكرا لصاحب النيافة.

Francesco Pocchiari Fellowship
Bourse Francesco Pocchiari

The PRESIDENT: الرئيس:

أخيرا أود أن أدلي ببيان بخصوص منحة فرانشيسكو بوكياري الدراسية، لقد استحدثت منحة فرانشيسكو بوكياري الدراسية لتخليد ذكرى الأستاذ فرانشيسكو بوكياري المدير العام الأسبق للمعهد العالي للصحة في روما، وعضو المجلس التنفيذي للمنظمة سابقا، والغرض منها هو تقديم منحة دراسية أو منحتين دراسيتين كل سنتين لتمكين الباحثين الشباب من زيارة بلدان أخرى لكي يكتسبوا خبرات جديدة ذات صلة بأبحاثهم وبأولوياتهم الوطنية، ويجري التشديد الخاص على المواضيع التي تتعلق بالعلوم الصحية وما يتصل بها من القضايا المنهجية ذات الصلة الوثيقة الخاصة بالتنمية الصحية ومن دواعي سروري أن أعلن أن المجلس التنفيذي لمنظمة الصحة العالمية بعد أن نظر في تقرير اللجنة المعنية بمنح منحة فرانشيسكو بوكياري الدراسية قرر تقديم منحة فرانشيسكو بوكياري الدراسية لعام ١٩٩٩ الى الدكتورة السيدة رايموندا ليلو توتوني من ألبانيا.

والدكتورة توتوني تخرجت في كلية العلوم الطبيعية بجامعة تيرانا الحكومية ثم تابعت الدراسات العليا في مجال الكيمياء التحليلية مع التركيز بصفة خاصة على تقنيات وصف تلون الغازات وذلك لتحديد ثمالات مبيدات الهوام في مياه الشرب. وتلقت تدريبا رسميا في مجال الصحة البيئية في تيرانا واليونان وهي الآن عضو في ادارة الكيمياء التحليلية بجامعة تيرانا الحكومية وتعمل باحثة في معهد الصحة العمومية، وهي مسؤولة بوصفها مسؤولة اتصال عن المحافل أو عن المحفل الحكومي الدولي للسلامة الكيميائية في ألبانيا، مع الاهتمام بوجه خاص بالفلزات الثقيلة. وهذا المشروع يدعمه مدير معهد الصحة العمومية الذي يعتبر أن الفلزات الثقيلة في البيئة تشكل أحد عوامل الاختطار الهامة داخل البلد وأحد مجالات الدراسة الرئيسية بالنسبة للمعهد.

السيدات والسادة، لقد انتهينا الآن من تناول البند الثامن. وأفيدكم وأعلمكم بأن الجلسة العامة التالية في يوم الاثنين ٢٤ أيار/ مايو ستفتتح في الساعة التاسعة صباحا. ترفع الجلسة.

The meeting rose at 18:25.
La séance est levée à 18h25.

NINTH PLENARY MEETING

Monday, 24 May 1999, at 14:30

President: Mrs Maria de Belém ROSEIRA (Portugal)

NEUVIEME SEANCE PLENIERE

Lundi 24 mai 1999, 14h30

Président: Mme Maria de Belém ROSEIRA (Portugal)

1. FIRST REPORT OF COMMITTEE B[1]
PREMIER RAPPORT DE LA COMMISSION B[1]

The PRESIDENT:

You have before you the first report of Committee B, contained in document A52/33. Please disregard the word "(Draft)" as the Committee approved the report without any amendments. The report contains five resolutions which we shall proceed to adopt one by one.

Let us now consider the first resolution entitled "Status of collection of assessed contributions". Is the Assembly willing to adopt this resolution? I see no objections, the resolution is therefore adopted.

The second resolution is entitled "Arrears in payment of contributions: Latvia". Is the Assembly willing to adopt this resolution? I see no objections, the resolution is therefore adopted.

The third resolution is entitled "Arrears in payment of contributions: Liberia". Is the Assembly willing to adopt this resolution? I see no objections, the resolution is therefore adopted.

The fourth resolution is entitled "Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution". Is the Assembly willing to adopt this resolution? I see no objections, the resolution is therefore adopted.

The fifth resolution is entitled "Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine". Is the Assembly willing to adopt this resolution?

I call upon the delegate of the United States of America.

Mr BOYER (United States of America):

Thank you Madam President. The United States of America voted against this resolution in Committee B. Although we will not call for another vote in the plenary, we remain strongly opposed to this text. We would have no objection if this resolution were limited to the subject of the health of the Palestinian people. The United States shares the concerns of others that the health status of the Palestinian people must be improved. To this end the United States has provided more than US$ 50 million in assistance to the Palestinians for child survival and maternal health programmes, and we are continuing this assistance. But this resolution goes far beyond health matters. At this Assembly we have had solid substantive discussions on poliomyelitis, malaria, smallpox, tobacco and many other technical issues. In contrast, this resolution takes up inappropriate political issues. More than that, this resolution seems to poke a finger in the eye of the new Israeli Government. An approach such as this cannot hope to advance

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[1] See reports of committees in document WHA52/1999/REC/3.
[1] Voir les rapports des commissions dans le document WHA52/1999/REC/3.

the bilateral discussions between Israel and the Palestinians, and it seems to run counter to the best interests of everyone. This is very strange indeed, and it is entirely inappropriate for this Assembly. The United States remains opposed to this text. Thank you Madam President.

The PRESIDENT:

I thank the delegate of the United States, and I now call on the delegate of Israel.

Mr PELEG (Israel):

Madam President, on 17 May this year, the people of Israel elected a new prime minister, Mr Ehud Barak. In the course of his victory speech, on 18 May at 2.30 a.m. Mr Barak said and I am quoting: "We know that it is imperative for our generation that fought Israel's war to do everything to strengthen the security of the State by progressing towards peace agreement." This Fifty-second World Health Assembly is the first meeting of a United Nations organization after the Israeli elections, and what was the reaction of the Health Assembly to this reaffirmation of Israel's dedication to peace? It is, unfortunately, another irrelevant exercise in the singling out and bashing of Israel and the politization of the specialized agencies. Israel has considered asking for a vote on the resolution adopted on 20 May in Committee B, but has decided not to do so in view of the professional nature of this Assembly under the able leadership of the Director-General and in view of our hope that the progress which will be achieved in the coming year in the peace process will encourage the Palestinians, our partners in this long march towards peace and conciliation, not to raise this political draft resolution at the next Health Assembly. Israel has decided not to ask for a vote in spite of the unfortunate adoption of the resolution in Committee B. However, I want to make it very clear that Israel is opposed to the resolution, voted against it in the Committee, and therefore it was not accepted unanimously or by consensus. Progress for peace in the Middle East has always come as a result of direct negotiations. United Nations resolutions which aim to substitute for direct negotiations, or to prejudge them, can only damage the peace process. Let us all rededicate ourselves to the support of the peace process and not waste our energies on political and one-sided resolutions like the one before us. Thank you very much.

The PRESIDENT:

I thank the delegate of Israel. I now give the floor to the observer from Palestine.

Dr KHOURI (Palestine):

السيد رفيق الخوري (فلسطين):

السيدة الرئيسة، أود قبل كل شيء أن أشكرك على اعطائي الكلمة، كما أود أن أعرب عن شكر وفد فلسطين لجمعية الصحة العالمية الثانية والخمسين لاعتمادها قرار "الأحوال الصحية للسكان العرب في الأراضي العربية المحتلة بما فيها فلسطين ومساعدتهم"، اننا نعتبر اعتماد هذا القرار تعبيرا اضافيا عن تفهم العالم لمأساة شعبنا الناتجة عن تعثر العملية السلمية وعن استمرار الاحتلال الاسرائيلي لمعظم الأراضي الفلسطينية بما فيها القدس الشرقية. ان لاستمرار هذا الوضع نتائج خطيرة على أوضاع شعبنا الاجتماعية والاقتصادية بشكل عام وعلى أوضاعه الصحية بشكل خاص. وقد جاء القرار المعتمد ليؤكد على هذه الحقيقة.

السيدة الرئيسة، ان وفد فلسطين يأمل في أن ما أسفرت به الانتخابات من تغييرات في الحكومة الاسرائيلية سيؤدي الى تقدم ملموس وسريع في مسيرة السلام، هذا السلام الذي يتمناه كلا الشعبين الفلسطيني والاسرائيلي. كما أود أن أعرب عن أمل بلادي في أن تكون دولة فلسطين وعاصمتها القدس العربية عضوا كامل العضوية في منظمة الصحة العالمية خلال الدورة القادمة لهذه الجمعية الموقرة. وشكرا لاصغائكم.

The PRESIDENT:

I thank the observer from Palestine. I see no more delegates wishing to speak. Is the Assembly prepared to adopt this resolution? I see no objections. The resolution is adopted and the first report of Committee B is therefore approved.

2. SECOND REPORT OF COMMITTEE B[1]
DEUXIEME RAPPORT DE LA COMMISSION B[1]

The PRESIDENT:

Let us now consider the second report of Committee B, document A52/34 refers; please delete the word "(Draft)" as the Committee approved the report without amendments. The report contains three resolutions and one decision: We shall start with the first resolution entitled "Agreement between the World Health Organization and the Universal Postal Union". Is the Assembly willing to adopt this resolution? I see no objections, the resolution is adopted.

The second resolution is entitled "Active ageing". Is the Assembly willing to adopt this resolution? I see no objections, the resolution is therefore adopted.

The third resolution is entitled "Appointment of the External Auditor". Is the Assembly willing to adopt this resolution? I see no objections, the resolution is therefore adopted.

Under agenda item 18, "Collaboration within the United Nations system and with other intergovernmental organizations", the Committee decided to request the Director-General to draw up an analytical report on WHO's participation in the United Nations Development Assistance Framework (UNDAF) exercise for consideration by the Executive Board at its 105th session in January 2000. Does the Assembly agree with this decision? I see no objections. It is so decided. The second report of Committee B is therefore approved.

3. FIRST REPORT OF COMMITTEE A[1]
PREMIER RAPPORT DE LA COMMISSION A[1]

The PRESIDENT:

We shall now consider the first report of Committee A contained in document A52/36; please disregard the word "(Draft)" as the Committee approved the report without amendments. The report contains three resolutions which we shall proceed to adopt one by one.

The first resolution is entitled "Reimbursement of travel expenses for attendance at regional committees". Is the Assembly willing to adopt this resolution? I see no objections, the resolution is therefore adopted.

The second resolution is entitled "Smallpox eradication: destruction of variola virus stocks". Is the Assembly willing to adopt this resolution? I see no objections, the resolution is therefore adopted.

The third resolution is entitled "Roll Back Malaria". Is the Assembly willing to adopt this resolution? I see no objections, the resolution is therefore adopted, and the first report of Committee A is therefore approved.

4. THIRD REPORT OF COMMITTEE B[1]
TROISIEME RAPPORT DE LA COMMISSION B[1]

The PRESIDENT:

We can now consider the third report of Committee B. You have received document A52/37. Please disregard the word "(Draft)" as the report was approved by the Committee without amendments. The report contains six resolutions and one decision which we shall proceed to adopt one by one.

The first resolution is entitled "Support to Central American countries affected by Hurricane Mitch". Is the Assembly willing to adopt this resolution? I see no objections, the resolution is therefore adopted.

The second resolution is entitled "Salaries of staff in ungraded posts and of the Director-General". Is the Assembly willing to adopt this resolution? I see no objections, the resolution is therefore adopted.

Under item 15, "Management and financial matters: Appointment of representatives to the WHO Staff Pension Committee", the Committee decided to appoint Dr L. Malolo, delegate of Tonga, as a member of the WHO Staff Pension Committee, and Dr J.K.M. Mulwa, delegate of Botswana, as an

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[1] See reports of committees in document WHA52/1999/REC/3.
[1] Voir les rapports des commissions dans le document WHA52/1999/REC/3.

alternate member of the Committee, the appointments being for a period of three years. Does the Assembly agree with this decision? I see no objections. It is so decided.

The third resolution is entitled "Unaudited interim financial report on the accounts of WHO for 1998; report of the External Auditor; report of the Internal Auditor". Is the Assembly willing to adopt this resolution? I see no objections, the resolution is therefore adopted.

The fourth resolution is entitled "Real Estate Fund". Is the Assembly willing to adopt this resolution? I see no objections, the resolution is therefore adopted.

The fifth resolution is entitled "Amendments to Financial Regulations and Rules". Is the Assembly willing to adopt this resolution? I see no objections, the resolution is adopted.

The sixth resolution is entitled "Scale of assessments for the financial period 2000-2001". Is the Assembly willing to adopt this resolution? I see no objections, the resolution is adopted, and the third report of Committee B is therefore approved.

5. SECOND REPORT OF COMMITTEE A[1]
DEUXIEME RAPPORT DE LA COMMISSION A[1]

The PRESIDENT:

We shall now consider the Second report of Committee A. This is contained in A52/38. Please disregard the word "(Draft)" as the Committee approved the report without amendments. The report contains two resolutions which we shall proceed to adopt one by one.

The first resolution is entitled "Towards a WHO framework convention on tobacco control". Is the Assembly willing to adopt this resolution? I see no objections, the resolution is adopted.

The second resolution is entitled "Revised drug strategy". Is the Assembly willing to adopt this resolution? I see no objections, the resolution is adopted, and the second report of Committee A is therefore approved.

6. THIRD REPORT OF COMMITTEE A[1]
TROISIEME RAPPORT DE LA COMMISSION A[1]

The PRESIDENT:

We can now consider the third report of Committee A (document A52/39) which contains one resolution: "Appropriation resolution for the financial period 2000-2001". Is the Assembly willing to adopt the resolution? I see no objections, the resolution is adopted, and the third report of Committee A is therefore approved.

7. EXECUTIVE BOARD: ELECTION [OF MEMBERS ENTITLED TO DESIGNATE A PERSON TO SERVE ON]
ELECTION DE MEMBRES HABILITES A DESIGNER UN REPRESENTANT AU CONSEIL EXECUTIF

The PRESIDENT:

Let us now consider item 7, "Executive Board: election". I draw your attention to the list of 10 Members, contained in document A52/35, drawn up by the General Committee in accordance with Rule 102 of the Rules of Procedure.[1] In the General Committee's opinion these 10 Members would provide, if elected, a balanced distribution of the Board as a whole. These Members are, in the English alphabetical order: Belgium, Chad, Comoros, Congo, Côte d'Ivoire, Guatemala, India, Lebanon, Switzerland, Vanuatu.

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[1] See reports of committees in document WHA52/1999/REC/3.

[1] Voir les rapports des commissions dans le document WHA52/1999/REC/3.

Is the Assembly prepared, in accordance with Rule 80 of the Rules of Procedure, to elect these 10 Members as proposed by General Committee? I see no objections. I therefore declare the 10 Members elected. This election will be duly recorded in the records of the 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.

8. REPORTS OF THE MINISTERIAL ROUND TABLES
RAPPORTS DES TABLES RONDES MINISTERIELLES

The PRESIDENT:

We can now proceed to agenda item 5, "Round tables: lessons learned in world health". The chairmen of these round tables will now present oral reports on the four topics of the round tables. I give the floor to Mr Telefoni Retzlaff, First Vice-President, to present reports on one of the round tables on the theme "Priority-setting in the health sector: challenges to ministers", and on the round table dealing with the theme: HIV/AIDS: strategies for sustaining an adequate response to the epidemic. You have the floor Mr Telefoni Retzlaff.

Mr TELEFONI RETZLAFF (Samoa):

Thank you Madam President. It was a privilege and pleasure to chair these round tables and I believe we are all in agreement that the initiative of the Director-General has been fully justified in that so much was learnt from these discussions.

I have the pleasure to report first on one of the round tables on "Priority-setting in the health sector: challenges to ministers". The first conclusion of the round table was that priority-setting is a very complex, political process. The starting point for the discussion was the importance of focusing on the fundamentals of good public health and ensuring equity of access. However, the dominant theme thereafter was that priority-setting is a complex and primarily political process. Whilst all participants recognized the need for more systematic, rational and transparent approaches, ministers have to cope with competing demands from different constituencies. There is a need to pay greater attention to what makes priority-setting difficult in the real world. In many countries ministers have to respond to individuals demanding special treatment, sometimes on a case-by-case basis. It is also difficult to insist on government priorities, if, at the same time, people are being required to pay for previously free services. The problem, of course, is that if ministers are pressurized into responding to individuals and special interest groups, priority-setting will lack transparency. In these circumstances, those who cannot articulate their needs are likely to lose out. The public judges government performance not by the health status of the population in five years' time but by how they are treated when they are admitted to hospital today. One cannot ignore the hospital sector just because primary care is a priority. The meeting heard many telling examples of the close correlation between closing hospitals and losing parliamentary seats. Furthermore, it is equally predictable that more wealthy groups will demand access to more sophisticated services and a wider range of treatments. Ministers need to respond to these demands if they wish to remain in office. The challenge is to ensure that private provision for the few does not divert resources or undermine systems that are designed to serve the rest of the population. Ideally, however, equal access to all services should be available to all peoples in all countries. An assumption underlying the discussion was that ministers of health are able to set spending priorities but it was recognized that they are far from being the only actors. In countries with a heavy debt burden, for example, the overall level of resources for the social sector may be constrained. In addition, conditionalities imposed by lenders often influence how funds are spent within the health sector. It was also noted that in many countries the minister of finance is the main arbiter of how national funds are spent, and that ministries of health have limited room to manoeuvre. There is a need to market health priorities in terms that will appeal to ministers of finance and others, and I would like to stress this very important need to market.

I think it is very important that Dr Brundtland invited Dr Sen to give one of our opening addresses. Dr Sen's message is very important here, in that good health is not just a part of economic development, but in fact is fundamental to economic development. Priorities are often based on explicit values such as universal access to health care. The problem arises when resources are insufficient to fund those values. Countries then have to start thinking about priorities within priorities. It is important not to forget that stated priorities have to be matched by actual patterns of spending. This is often more difficult in decentralized systems where central government has less control over local authorities. The second

important section that was dealt with by the round table was that changing circumstances make the task of priority-setting even harder. In the developing world, not only are resources scarce but circumstances are also unpredictable. It is hard to stick to agreed priorities for government spending when emergencies arise through man-made or natural causes. Sometimes these emergencies are acute, for instance a major flood. In other cases they are more insidious, as in the case of HIV/AIDS. The HIV/AIDS pandemic in Africa has had a significant impact on patterns of spending. In countries affected by conflict, better health care may only be a priority for governments when peace has returned. Whilst government plans are for the long term - five to 10 years - short-term needs are often more pressing and determine actual resource allocations. For example, if in a small country the main national hospital is in disrepair it is hard not to divert funds in order to address the problem, even if the funds have to come from primary services. Only a few countries acknowledge the need for continuing systematic review of priorities. The financial crisis that has affected East Asia has not only made national priority-setting more complex, for some countries it has also meant a closer relationship with donors, many of whom bring their own sense of priorities to the table. In the countries of the former Soviet Union, the change has been even more dramatic. It is difficult to think about priorities at all when your health budget has declined from US$ 150 per person to just US$ 0.40 per person. It was suggested that in former command economies the first task is to change the attitude of the public and professionals who have previously been used to the State providing everything for free. Priority-setting requires that everyone recognizes that they have a responsibility to participate in difficult decisions about how scarce resources should be used. Some lessons from different national experiences: nothing succeeds like success. Having the capacity to demonstrate that government policies and priorities lead to better health indicators makes it easier to stick to those priorities when they are opposed. Health needs vary in most countries. National-led priority-setting must allow for local decision-making. The issue is whether decisions should be made by clinicians and managers alone. An increasing body of experience suggests that public consultation is essential. Some of the countries said that they in fact had national health consortiums or meetings once a year to fully consult the public.

Building consensus around national priorities is critical, but so is leadership. It is part of the task of politicians to explain and defend spending decisions. Priority-setting must be geared to national circumstances but it is important to take on board international standards, particularly as a way of changing entrenched medical practices and, in some countries, overcoming a tendency towards national isolationism. Turning to the process of priority-setting, the suggestion in the background paper that there needs to be a shift in thinking in favour of processes, ensuring procedural rights rather than focusing exclusively on defining the precise nature of entitlements, was confirmed by the discussions. Priority-setting does not work without effective consultation. The question, however, is what makes consultation effective? One participant pointed out that if you ask superficial questions, you will get superficial answers. Consultation processes need to be well designed. Furthermore, consultation should not be used just to rubber-stamp decisions that have already been made. The question was also raised as to how frequently consultation should take place, particularly when national circumstances are changing.

Lastly, the round table discussed the role of donors. Are donors part of the problem or part of the solution? It was squarely recognized that donors influenced priority-setting in important ways. Two difficulties were identified. First, donors bring their own agenda to the table, which may run counter to national priorities. Second, donor funding is concentrated on particular types of spending, making overall national decision-making more difficult. Perhaps the dilemma could somehow be resolved by donors focusing on preventive or public health spending, as this allows the country to put its resources in providing health care. It was encouraging that most ministers thought that these problems could be overcome through longer-term and more robust partnership arrangements. Some ministers spoke explicitly about sector-wide approaches, but many others talked about the need for joint and negotiated priorities. A further way of increasing the effectiveness of development assistance is to ensure that it is provided not on an *ad hoc* basis but as part of an overall public expenditure plan, which identifies health as a priority sector.

Finally, I would like to thank all the ministers who participated in this round table. You were committed, you contributed frankly, and you made the round table an unequivocal success.

I also had the privilege of chairing the round table on "HIV/AIDS: strategies for sustaining an adequate response to the epidemic". The situation in one southern African country, where a state of emergency has been declared in relation to HIV/AIDS, was presented to illustrate the challenges faced by governments and the health sector. High-level government commitment to HIV/AIDS was identified as a prerequisite for an effective and sustainable national response. Other essential elements include community-based activities, a multisectoral approach and extensive public education. Denial and complacency have seriously impeded timely and effective action. A key government responsibility is to be the leading advocate of open and accepting attitudes towards HIV/AIDS at all levels of the community.

Certain participants recognized that their countries responded for extraneous reasons far too late and this delay was costly in terms of the impact of the disease on their countries. The existence of two categories of citizens in relation to access to proven treatments should not be tolerated. The *Fonds de Solidarité thérapeutique international* has been established as a first step towards addressing equity of access to treatments.

Countries require assistance from international organizations in negotiating lower prizes with industry. Industry involvement is necessary to broaden access to drugs for HIV/AIDS. In fact some of the more sophisticated treatments are so expensive they are only proving extremely frustrating to many of the countries in the developing world. Their citizens are learning about them but countries can never afford to provide them. There is both a moral obligation and direct self-interest in supporting the development of a vaccine applicable to all viral strains. However, there was agreement that the hope of a vaccine should never stall positive action which needs to be taken now. Funds made available from the global HIV/AIDS effort from both national and international sources are insufficient to meet the growing demand in HIV prevention, care and research. The round table also discussed the prevention of mother-to-child transmission of HIV, which is seen by many as the priority intervention that should benefit from access to anti-retroviral drugs. Countries requested assistance in providing the full support required for mother-to-child transmission interventions.

Notification of partners, with the agreement from the patient, is part of counselling procedures in certain countries. Guidelines have been issued on conditions that must be met for notification of partners by health professionals when explicit consent cannot be obtained. However, it was agreed that although the diseased person had his right to confidentiality, that person should be warned that any knowing infection of innocent third parties from that point on could result in prosecution for manslaughter. Indeed manslaughter prosecutions have been successfully brought in many countries for such offences. Shared confidentiality in which a close friend or relative is involved with the consent of the person concerned in counselling was cited as an approach to increasing acceptance of disclosures to others, particularly innocent victims who may be infected. The involvement of people living with HIV/AIDS in advocacy and public education is important. Concern was expressed that the right to privacy of a person with HIV infection may supersede the rights of other people to be informed. The key to this issue lies in good counselling, leading to voluntary notification, and in fighting discrimination and stigma. Lastly, some ministers expressed concern that although increased efforts should be made to increase the total amount of spending on HIV/AIDS strategies, we should never lose sight of the need to continuously monitor the use of available funds. The "how" should be of as much importance and concern as the "how much".

I would like to thank the Director-General for this initiative. I believe that this Assembly has resolved that the round tables should be continued and reinforced in future and I am fully in support of this. I would like also to thank all the participants of this particular ministerial round table for an extremely lively, constructive, and no-holds-barred, debate on a very important issue. I appreciated being able to chair this meeting and I thank you, Madam President, for the opportunity to make these oral reports.

The PRESIDENT:

Thank you, Mr Telefoni Retzlaff. I now give the floor to Dr Abudajaja, who is reporting on behalf of the Second Vice-President, Dr Ehtuish, who chaired the other round table on "Priority-setting in the health sector: challenges to ministers" but who has unfortunately had to leave Geneva. You have the floor, Dr Abudajaja.

Dr ABUDAJAJA (Libyan Arab Jamahiriya): الدكتور أبو دجاجة (الجماهيرية العربية الليبية):

شكرا السيدة الرئيسة، سيداتي سادتي رؤساء وأعضاء الوفود الكرام، السيدة المديرة العامة، أسعد الله يومكم. يسعدني نيابة عن الدكتور احتيوش فرج احتيوش أمين الصحة بالجماهيرية والذي اضطر الى السفر لأمر خارج عن ارادته أن أطرح، نيابة عنه، ملخصا لما دار من نقاش حول المائدة المستديرة، ولقد كان الموضوع هو تحديد الأولويات في قطاع الصحة. وقبل أن أطرح عليكم الملخص فانني أثمّن عاليا ثلاث نقاط، النقطة الأولى: فكرة الموائد المستديرة، وأرجو أن تستمر والمساهمة الفعالة لأصحاب المعالي الوزراء ودور المنشط في اثراء النقاش. لقد تابعت المتحدث الأول ولاحظت أن الموضوع ليس فيه أي تكرار ممل لكم فقد كانت المائدتان منفصلتين، ولذا فانني أتلو عليكم خمس نقاط لخصت في هذا الموضوع. كانت النقطة الأولى التي انطلق منها النقاش هي أهمية التركيز على أساسيات الصحة العامة الجيدة وضمان العدالة في الحصول عليها. بيد أن الموضوع الأهم الذي برز بعد ذلك كان تحديد الأولويات في اطار عملية معقدة وسياسية في المقام الأول، فالوزراء مضطرون الى الاستجابة لمطالب مختلف الجهات والجماعات والتحدي

هنا هو ضمان ألا تؤدي احتياجات القلة التي ترفع صوتها الى تحويل الموارد أو تقويض النظم المعدة لخدمة باقي السكان. النقطة الثانية، في العديد من أرجاء العالم لا يقتصر الأمر على ندرة الموارد فحسب بل يتعذر التنبؤ بالظروف والأوضاع أيضا. ومن الصعب التمسك بأولويات متفق عليها فيما يتعلق بالانفاق الحكومي عندما تنشأ حالات طارئة نتيجة للأزمات المالية أو السياسية أو الطبيعية. وفي حين أن الخطط الحكومية غالبا ما تكون طويلة الأمد، فان الاحتياجات القصيرة الأجل تصبح أشد الحاحا في كثير من الأحيان، وبالتالي فانها تحدد عملية تخصيص الموارد الفعلية. ولا تعترف سوى قلة من البلدان بضرورة استعراض الأولويات على نحو متواصل ومنتظم. النقطة الثالثة، لابد من تكييف تحديد الأولويات مع الظروف السائدة على الصعيد الوطني، غير أن من المهم الأخذ بالمعايير الدولية ويتعين من جهة أخرى، أن يصبح تحديد الأولويات على الصعيد الوطني باتخاذ القرارات محليا. وهذا يفضي الى تحديين اثنين: التحدي الأول أن هناك ضرورة لقيام آليات تكفل تقيّد السلطات المحلية بالمبادئ التوجيهية الوطنية العامة. أما التحدي الثاني فيتمثل في طرح تساؤل عما اذا كان يتعين اتخاذ قرار من جانب الأطباء السريريين والمديرين. وفي هذا الصدد تبين أن هناك توافقا في الآراء حول المائدة المستديرة فحواه أن عملية التشاور الرسمي الجيدة التنظيم أمر أساسي الأهمية. النقطة الرابعة، ان الرأي الوارد في ورقة المعلومات الأساسية يشير الى وجود حاجة للتغيير في الآراء لصالح العمليات ضمان الحقوق الاجرائية بدلا من التركيز بصورة حصرية على تحديد الطبيعة الدقيقة للاستحقاقات الأمر الذي أكدته المناقشات. ويعتبر التوصل الى توافق في الآراء حول الأولوية الوطنية أمرا حاسم الأهمية، ولكن الريادة لا تقل عنه أهمية. وان شرح القرارات المتصلة بالانفاق والدفاع عنها يشكلان جزءا من مهمة السياسيين، غير أنه يربح الجولة مثل النجاح. فالتمتع بالقدرة على الاثبات بأن سياسة الحكومات وأولوياتها تؤدي الى تحسين المؤشرات الصحية يسهل التمسك بهذه الأولويات عندما تتعرض للانتقاد أو الصدمات الخارجية. النقطة الأخيرة الخامسة، من المسلم به أن الجهات المانحة تمارس نفوذها على تحديد الأولويات بعدة سبل. فهي أولا تطرح بجداول أعمالها الى مائدة المفاوضات التي قد تتعارض في بعض الأحيان مع الأولويات الوطنية، وثانيا، كثيرا ما يتركز التمويل من الجهات المانحة على أنواع معينة من الانفاق، مما يجعل اتخاذ القرارات على الصعيد الوطني بمجملها أشد صعوبة. وكان رأي معظم الوزراء أن بالامكان التغلب على هذه المشكلات من خلال اقامة ترتيبات شراكة أطول أمدا وأشد متانة وتماسكا. وتحدث بعض الوزراء صراحة عن المناهج المتبعة في قطاعات بأكملها لكن الكثير غيرهم تحدثوا عن ضرورة تحديد الأولويات على نحو مشترك. انتهى التلخيص.

The PRESIDENT:

Thank you, Dr Abudajaja. I now give the floor to Dr Stamps, Third Vice-President, who chaired the round table on "Investment in hospitals: dilemmas faced by ministers". You have the floor, Dr Stamps.

Dr STAMPS (Zimbabwe):

Madam President, Madam Director-General, ladies and gentlemen, colleagues and friends. It was my privilege to chair the meeting on "Investment in hospitals: dilemmas facing ministers".

Among the multitude of issues raised, the ministers discussed whether governments should divest themselves of service provision and alternately develop contractual arrangements with public and private providers. Optimal planning and management of hospitals and hospital resources, the government's role and responsibilities in ensuring appropriate public and private balance, intercountry and regional cooperation in specialized service provision were also examined. The critical importance of explicit hospital policy in health sector reform was strongly emphasized, as well as the need for balanced development of a health facilities network to reach remote and rural populations, and to improve the interface between hospitals and primary health care. It became apparent that there is no single package of solutions, and that simple replication of foreign approaches may result in additional burdens. Countries must be prepared to build on what they actually have, and restructuring of services should respond to country priority needs occurring within the framework of national capabilities and resources to ensure sustainability.

Throughout the deliberations it was emphasized that governments have a responsibility to provide quality health care to all their people which cannot be delegated, abdicated or avoided. Access to hospital care therefore has to be universal, equitable and affordable. Ministries should not divest themselves of this responsibility, even while they use the most relevant mechanisms, including the private for-profit and private not-for-profit agencies in civil society. A large proportion of health care delivery is provided by the private sector, and especially not-for-profit providers, in many countries. Ministers were of the view that ministries should coordinate the overall national health policy and provide a framework for the private

sector to participate in and positively contribute to the delivery of care for the entire population. The challenge identified by the ministers for achieving optimal health care delivery is to ensure a complementarity between public and private sectors, for-profit and private not-for-profit institutions and personal contributions. It was mentioned that regulation is necessary but it should not stifle innovation, and a system of appropriate incentives needs to be found.

The issue of providing, versus purchasing, hospital services was deliberated and certain common issues were identified. It was stated that, where private providers are available and contracting is possible, it may be possible to curb costs and improve quality. However, concerns regarding equity and accessibility for the poor persist, and relevance of this particular issue for countries with a limited private sector is marginal. Key factors in making contracts work, both with private for-profit and private not-for-profit institutions, are institutional capacity, political determination and real competition in awarding contracts. Ministries also must have mechanisms to ensure quality and assess performance, and use appropriate methods and policies to improve equity and accessibility for all those who need hospital services.

Unanimity was expressed that the investment in hospitals is very significant, and examining investment strategies is imperative today to limit the extent of burden in the future. Hospital planning, management and sustainable operation had however not received sufficient attention, especially in recent years, and an average assessment shows that annual costs of running hospitals correspond to about 30% of their capital cost. With regard to the question of who should manage hospitals, especially in view of the trend to increased autonomy, most ministers argued that a professional health-related background is preferable; however, the essential point is to have specific management training and good management skills. In general, it was felt that good management should be guided by ethics, technical and administrative competence, and professionalism. Involvement of the community served in managing their hospitals is a critically important factor.

A number of factors impeding efficient operation of hospitals were mentioned by ministers. These included the loss of skilled personnel due to poor career opportunities and insufficient remuneration, and the burden of maintaining physical assets and health care technology. The need for rational planning, acquisition and utilization of technology, especially with regard to expensive and sophisticated equipment, and provision of adequate maintenance services was emphasized. Several speakers presented innovative mechanisms for improved sustainability of hospitals, including cost-recovery schemes, revolving and special funds, and earmarked taxes, the overall effectiveness of which has not yet been fully assessed. New concepts, approaches, techniques and methodologies should be supported by evidence, so the voids in hospital research should be urgently filled. Ministers indicated that further studies should address the complexity of different types of hospital systems in a changing sociopolitical environment, including new financing mechanisms and advances in health technology. Challenges of globalization, redistribution and regulation will need urgent focused attention. Mechanisms and skills to cope with these challenges in the field of hospital investment and management urgently need to be developed. WHO should collaborate with countries in exchanging ideas and experiences, and distilling lessons from successes and failures. A concerted international effort is required to support countries in this critical area. Regrettably, too little time was available to discuss these topics meaningfully, and the political fallout of inefficient or unavailable hospital services was not discussed at all.

I add my thanks and of my group to the Director-General for her initiative in this area, and while some refinement has to be made to enable more interaction between ministers when the Moderator assumes the roles of commentator and chairperson as well as his primary functions.

The PRESIDENT:

Thank you, Dr Stamps. I now give the floor to Mr Salah Uddin Yusuf, Fourth Vice-President, who chaired the round table on "Finding the money: dilemmas faced by ministers". You have the floor, Mr Yusuf.

Mr YUSUF (Bangladesh):

I am pleased to be able to report to the plenary the results of the round table that I had the privilege to chair. Both sessions of "Finding the money: dilemmas facing ministers" covered similar critical issues. During the extensive and lively debate, a number of major points were stressed.

Finding the money is only one side of the coin. Of equal importance is the management of that money to get the best results. It was clear that there is no universal blueprint for either finding more money or managing the money you have in the best way. It depends on the economic, political and demographic situation in the country. Nevertheless, there are many interesting and innovative strategies being deployed

in different countries. WHO should analyse the evidence of those experiences in order to provide policy options to countries. In reality, policy needs in health are constantly moving targets, because of, for example, emergencies, new diseases and ageing populations. This makes finding the right balance between raising and spending the money much harder to achieve. Furthermore, ministers have to balance both political and technical priorities. External funding is important in many developing countries but cannot be a substitute for government finance. Several ministers reported innovative government-donor partnerships such as sectoral assistance and health trust funds. The case was also made for richer countries recognizing their responsibilities to poorer ones because of the resource problems generated by globalization. Several sources of funds and mechanisms for collection were described. These included governments, social security agencies, insurance funds. Out-of-pocket payments were said to be the least desirable but not always avoidable. Options that share risks such as social insurance are more desirable but not always feasible. Ministers need to be able to defend the case that health spending is an investment when competing for their share of the government budget. User fees are one of the most difficult issues ministers have to deal with. Both poorer and richer countries have found that fees involve a conflict between the need to mobilize additional revenues and the need to ensure access to care by the poor. Exemptions for the poor have not worked well in practice.

Many different ways were described for trying to manage the money better. These included provider-side reforms such as greater hospital autonomy and performance contracts. Some ministries of health are moving towards a more regulatory role and away from direct provision. Some are also moving from subsidizing the supply to subsidizing the demand for services, for example through patient vouchers. Other strategies include introducing new employment and incentive arrangements for health workers; cutting costs where possible, for example by using more generic drugs; and by investing more in preventive and primary-level care. Partnerships are being created to better use resources. There are examples of increasing regional cooperation between small countries, and attempts to generate partnerships between the public and private sectors.

Thank you, Madam President, for allowing me to present the report of the round tables. I thank the Director-General for introducing the round tables, which I support, and I thank the delegates for their attention.

The PRESIDENT:

Thank you, Mr Yusuf. The Assembly has now heard summary reports of the discussions on the round tables, and these will be included in the records of this Assembly.

I wish to thank all the Vice-Presidents for their assistance on this very interesting and stimulating innovation. It is gratifying to note that this initiative will continue in future Assemblies with any necessary modifications as recommended for the reform of the Health Assembly.

This completes our work for today. Immediately on adjournment of this meeting, Committees A and B will meet. The next plenary will be held tomorrow at 11:30. The meeting is adjourned.

The meeting rose at 15:45.
La séance est levée à 15h45.

TENTH PLENARY MEETING

Tuesday, 25 May 1999, at 11:30

President: Mrs Maria de Belém ROSEIRA (Portugal)

DIXIEME SEANCE PLENIERE

Mardi 25 mai 1999, 11h30

Président: Mme Maria de Belém ROSEIRA (Portugal)

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

The PRESIDENT:

We shall start by considering the second report of the Committee on Credentials. You have before you document A52/42 which contains this report. Does the Assembly have any comments? I see none. The report is therefore adopted.

2. FOURTH REPORT OF COMMITTEE B[1] QUATRIEME RAPPORT DE LA COMMISSION B[1]

The PRESIDENT:

Let us now continue with approval of the report from the main committees. We shall start with the fourth report of Committee B. It is contained in document A52/40 and deals with one resolution. Please disregard the word "Draft" as the Committee agreed to the report without amendments. The resolution is entitled "Reform of the Health Assembly". Is the Assembly willing to adopt this resolution? I see no objection. The resolution is adopted and the fourth report of Committee B is therefore approved.

3. FOURTH REPORT OF COMMITTEE A[1] QUATRIEME RAPPORT DE LA COMMISSION A[1]

The PRESIDENT:

Let us continue with the fourth report of Committee A which is contained in document A52/41. Please disregard the word "Draft" as the Committee adopted the report without any amendments. The report contains three resolutions which we shall proceed to adopt one by one. The first resolution is entitled "Poliomyelitis eradication". Is the Assembly willing to adopt this resolution? In the absence of any objections, the resolution is adopted.

[1] See reports of committees in document WHA52/1999/REC/3.
[1] Voir les rapports des commissions dans le document WHA52/1999/REC/3.

The second resolution is entitled "Strengthening health systems in developing countries". Is the Assembly willing to adopt this resolution? I see no objection. The resolution is adopted.

The third resolution is entitled "Prevention and control of iodine deficiency disorders". Is the Assembly willing to adopt this resolution? In the absence of any objections, the resolution is adopted and the fourth report of Committee A is therefore approved.

4. A YEAR OF CHANGE: REPORTS OF THE EXECUTIVE BOARD ON ITS 102nd AND 103rd SESSIONS (continued)
UNE ANNEE DE CHANGEMENT: RAPPORTS DU CONSEIL EXECUTIF SUR SES CENT DEUXIEME ET CENT TROISIEME SESSIONS (suite)

The PRESIDENT:

We now come to the conclusion of item 2, "A year of change: reports of the Executive Board on its 102nd and 103rd sessions".

Now that the main committees have finished their consideration of the Executive Board's reports, we are in a position to formally take note of these reports. From the comments which have been made, I take it that the 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 tasks entrusted to it. In the absence of any comments, it is so decided.

5. SELECTION OF THE COUNTRY IN WHICH THE FIFTY-THIRD WORLD HEALTH ASSEMBLY WILL BE HELD
CHOIX DU PAYS OU SE TIENDRA LA CINQUANTE-TROISIEME ASSEMBLEE MONDIALE DE LA SANTE

The PRESIDENT:

I should like to draw the Assembly's 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 interest 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 Assembly decides that the Fifty-third World Health Assembly will be held in Switzerland. In the absence of any objections, it is therefore so decided.

6. ANNOUNCEMENT
COMMUNICATION

The PRESIDENT:

Before adjourning the meeting, I would like to mention that a seminar on "Year 2000 computer problem" will be held today at 14:30 in Room A at WHO headquarters. I shall now adjourn the meeting for a few minutes. Please remain in your seats. The closing plenary will be held in a few minutes.

The meeting rose at 11:45.
La séance est levée à 11h45.

ELEVENTH PLENARY MEETING

Tuesday, 25 May 1999, at 11:45

President: Mrs Maria de Belém ROSEIRA (Portugal)

ONZIEME SEANCE PLENIERE

Mardi 25 mai 1999, 11h45

Président: Mme Maria de Belém ROSEIRA (Portugal)

CLOSURE OF THE SESSION
CLOTURE DE LA SESSION

The PRESIDENT:

I invite Dr Sulaiman, Chairman of Committee A, to come to the rostrum and address the Assembly to give us an overview of the work of Committee A.

Dr SULAIMAN (Oman) (Chairman, Committee A): الدكتور على جعفر محمد سليمان (عُمان) (رئيس، اللجنة "أ"):

بسم الله الرحمن الرحيم، والسلام عليكم ورحمة الله وبركاته، تقرير اللجنة "أ" للجلسة العامة لجمعية الصحة العالمية الثانية والخمسين.

السيدة الرئيسة، السيدة المديرة العامة، زملائي المندوبين، سيداتي سادتي، يشرفني تقديم ملاحظاتي عن المناقشات التي دارت في اللجنة "أ" حيث تناولنا جدول أعمال مكثفا شاملا لاستعراض ميزانية المنظمة البرمجية المقترحة للسنتين ٢٠٠٠-٢٠٠١ والموافقة عليها. وقد جرى الاجتماع في ظل روح عالية من المشاركة والتعاون فيما بين المندوبين الذين سعوا طوال المداولات الى ايجاد السبل الكفيلة باعداد المنظمة لمواجهات تحديات القرن المقبل. وأعرب المندوبون عن دعمهم الثابت والمتحمس لاصلاح المنظمة والقيادة الجديدة ووافقوا على التحدي الذي أعلنت عنه مديرتنا العامة والمتمثل في دراسة كيفية تمكين المنظمة ككل في البلدان والأقاليم والمقر الرئيسي من احداث أكبر أثر ممكن على حياة الناس. لقد بدأنا نقاشنا بمناقشة عامة للميزانية البرمجية وتناول الكلمة في هذه المناقشات مندوبون من ثلاثة وعشرين بلدا للاعراب عن اقرارهم الراسخ لاعادة الهيكلة الجارية بالمنظمة على النحو الوارد في الميزانية، وتم الاعراب عن التقدير الخاص على وضوح الأهداف وحذو الأقاليم حذو الهيكلة الجديدة للدوائر في المقر الرئيسي ودمج الميزانية العادية والاعتمادات الخارجة عن الميزانية لاظهار أساس اجمالي للموارد وقدر كبير من الالتزام بمبدأ المساعدة. وأعرب المندوبون كذلك عن سرورهم بالمستوى غير المسبوق للتمويل المخصص لدعم البرامج ذات الأولوية في البلدان. ومن ثم انتقل نقاشنا لبحث الدوائر التسع والمهام التنفيذية في المقر الرئيسي وفي الأقاليم وقد أدركنا من خلال تبادل حيوي للرؤى والتجارب ما تنتظره الدول الأعضاء من المنظمة والسبل للمنظمة لتعد أحسن الاعداد لتلبية ذلك. وسمعنا تأكيدا على مواطن قوة المنظمة التقليدية في وضع المعايير الدولية وتزعّم الكفاح ضد المشاكل الدائمة مثل الأمراض السارية وسوء التغذية، كما سمعنا دعوات لمساعدة المنظمة في معالجة الصور البيانية للأمراض المتغيرة بشكل جذري والمتميزة بظهور أوبئة جديدة وتفاقم في الأمراض المزمنة مع تغير أنماط الحياة وتقدم الناس في السن وهو ما نشهده حاليا في

مختلف أنحاء العالم. وخلال هذه المناقشات، وتمشيا مع التوجه لتخصيص مزيد من الاعتمادات للبرامج ذات الأولوية اعتمد قرار عن استرداد نفقات السفر لحضور اللجان الاقليمية بتوافق الآراء. وبعد ساعات طويلة من المفاوضات وبيانات كثيرة مفادها أن المنظمة، وهي تمر باصلاحات سريعة تلقى الترحاب وتستحق كل الدعم المالي، تمت صياغة قرار ملائم اعتمد بتوافق الآراء بروح الحلول التوافقية الابتكارية. وبينما أشار عدة مندوبين الى مناخ التقشف المالي العالمي والأزمات الاقتصادية في بعض أنحاء من العالم لم يوجد بلد واحد يرغب في رؤية زخم هذه الموجة الاصلاحية يتباطأ بسبب النقص في الموارد المناسبة. وأعرب عدة مندوبين عن ثقتهم في أن استمرار الاصلاحات من شأنه أن يُبرز طرقا لزيادة ترشيد العمليات الجارية واستقطاب شركاء ماليين جدد ومن ثم الحفاظ على الأنشطة الحيوية للمنظمة في مستوياتها الحالية على الأقل. وقد تضمن البند الرئيسي الثاني في جدول أعمالنا، أي المسائل التقنية والصحية، تسعة بنود فرعية وسبعة قرارات وتناولنا من بين هذه الأمور القضية التي قد تكون الأكثر اثارة للجدل وهي الاستراتيجية الدوائية المنقحة التي كانت موضع مناقشات محتدمة لأكثر من عام.

سيدتي الرئيسة، انني سعيد أشد السعادة لاعتماد هذا القرار الهام بتوافق الآراء وبروح الحلول التوافقية الابتكارية التي سادت طيلة مناقشات اللجنة. وبالمثل تم بتوافق الآراء اعتماد قرار يعيد التأكيد على تدمير ما تبقى من مستودعات فيروس الجدري تدميرا نهائيا على النحو الذي تم تعديله به وكان ذلك بعد جهود جبارة داخل فريق الصياغة ومناقشتها بعد ذلك. وفي هذه المناسبة كما هو الشأن في مناسبات أخرى عديدة رأينا مدى الحاجة الى قيادة المنظمة ومدى التقدير الذي تحظى به هذه القيادة. وكما أمكن توقعه فان المشروعين الجديدين للهيئة الادارية للمديرة العامة أي دحر الملاريا ومبادرة التحرر من التبغ استأثرا بمناقشات مفعمة بالحيوية والحماس بصفة خاصة. وقد أعطيت الكلمة لأربعة وأربعين وفدا للاعراب عن التأييد للمشروع الخاص بالملاريا وذكر بعضهم منظمتنا بالحاجة الى اتباع نهج متكامل بشأن مكافحة الملاريا يقوم على المشاركة المجتمعية، وذكر البعض الآخر أن مبادرة المنظمة جعلت الملاريا تحتل موقعا متقدما بالفعل في جدول العمل السياسي وأذكت الوعي الدولي بضرورة اتخاذ اجراءات متسقة عاجلة وأثارت اهتمام المانحين. وتم بتوافق الآراء اعتماد القرار الخاص بدحر الملاريا. وفيما يتعلق بمبادرة التحرر من التبغ أعطيت الكلمة لخمسين متحدثا للاعراب عن موافقتهم القوية على هذا المشروع وعلى العمل من أجل وضع اتفاقية اطارية لمنظمة الصحة العالمية بشأن مكافحة التبغ. وحيث أنه لا يوجد بلد بمأمن في عالم لا تعرف فيه الأمراض حدودا فقد علّق المندوبون بأنه لا يوجد بلد يستطيع حماية سكانه من التهديد الذي يشكله التبغ في عالم يمكن فيه أن تنقل وسائل الاتصالات السلكية واللاسلكية الحديثة الرسائل الاعلانية عبر الحدود. ومرة أخرى تم تأكيد الترابط بين البلدان في مجال المسائل الصحية وأهمية القيادة التي توفرها المنظمة على الصعيد العالمي. وتم بتوافق الآراء اعتماد القرار الخاص بوضع اتفاقية اطارية لمنظمة الصحة العالمية بشأن مكافحة التبغ الذي يمهد الطريق لاعداد أول اتفاقية عالمية ملزمة قانونا في تاريخ المنظمة بالصيغة التي عدل بها. وكما هو متوقع في لجنة تقنية كهذه، ناقش ما يزيد على خمسة وأربعين متحدثا التقدم المحرز فيما يتعلق باستئصال شلل الأطفال من العالم وهو أمر وثيق الصلة بهدفها، حيث تجادلوا بخصوص الالتزام السياسي والتمويل اللذين سيتيحان الانتقال الى القرن القادم بعالم خال الى الأبد من هذا الداء المشلّ. كما أشار كثيرون الى الكيفية التي أدى بها نجاح هذه الحملة الى تعزيز جميع الجهود الخاصة بالتمنيع في البلدان، والكيفية التي وفر بها هذا النجاح دروسا بالغة الأهمية بشأن طرق توسيع نطاق الرعاية ليشمل جميع الأطفال. ومرة أخرى تم الاعتماد، بتوافق الآراء، القرار الخاص بشلل الأطفال بالصيغة التي عدّل بها. لقد ناقشت لجنتنا قرارين آخرين وأعرب المندوبون عن تأييدهم الكبير لقرار اقترحته مجموعة كبيرة من البلدان بشأن النظم الصحية في البلدان النامية، واعتمد بتوافق الآراء، وحظي القرار الخاص بالوقاية من اضطرابات عوز اليود ومكافحتها بتأييد كبير مماثل اعتمد بتوافق الآراء بالصيغة التي عدّل بها. وقد شمل بحثنا للمسائل التقنية والصحية أيضا مناقشة التقرير المرحلي عن مراجعة وتحديث اللوائح الصحية الدولية والتقرير المرحلي عن الاستنساخ في مجال الصحة البشرية.

في الختام أود، سيدتي الرئيسة، أن أشكر المندوبين الموقرين على روح التعاون التي أظهروها طيلة مناقشتنا لهذه القضايا الهامة والصعبة في بعض الأحيان. وعلى الرغم من أن مناقشتنا كانت مفعمة بالحيوية ومن تعدد الآراء المعرب عنها، فان الأمر لم يقتض اجراء أي تصويت للتغلب على هذه الصعوبات. أود كذلك أن أشكر كلا من نائبي رئيس اللجنة ومقررها وأمانتها على دعمهم الدؤوب.

وأخيرا أود أن أذكر أن ترؤسي لهذه اللجنة كان تشريفا لي ولبلدي. والسلام عليكم ورحمة الله وبركاته.

The PRESIDENT:

Thank you, Dr Sulaiman. I should like to congratulate you very warmly for your excellent presentation and also for the outstanding way in which you presided over the Committee.

The next speaker will be the Vice-Chairman of Committee B, Mr Eskola, whom I invite to the rostrum to report on the work of Committee B.

Mr ESKOLA (Finland) (Vice-Chairman of Committee B):

Madam President, distinguished delegates, Dr Brundtland, ladies and gentlemen, it is a pleasure for me to present you with a report of the work of Committee B during this year's Health Assembly. I shall try to be brief and concentrate my remarks on the highlights of the Committee's work, as the details can be found in the reports.

As usual, the emphasis in the work of Committee B was on management and financial matters - agenda item 15. Many subitems were dealt with under this main agenda item. One of the noteworthy issues discussed was the Appointment of the External Auditor. This resulted in the approval of a resolution reappointing South Africa as External Auditor of the accounts of the World Health Organization for the financial periods 2000-2001 and 2002-2003.

Other subitems included personnel matters. Dr Malolo (Tonga), previously alternate member, WHO Staff Pension Committee, replaced Professor Agboton as member, and Dr Mulwa (Botswana) was appointed as an alternate member. The Committee noted the report on Employment and participation of women in the work of WHO and congratulated in particular the new Director-General, Dr Brundtland, and her staff on the progress made since she took office. Amendments to the Staff Regulations and Rules and to the Financial Regulations were approved, as was the Executive Board resolution on the Real Estate Fund.

A resolution on health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine, was approved.

Discussion of the item on Collaboration within the United Nations system and with other intergovernmental organizations resulted in the following resolutions, namely: Agreement between the World Health Organization and the Universal Postal Union; active ageing; support to the Central American countries affected by Hurricane Mitch; and a decision on WHO's participation in the United Nations Development Assistance Framework (UNDAF) exercise.

Under the item on reform of the Health Assembly, a resolution was adopted requesting the Director-Genera, *inter alia*, to submit proposals for the themes and procedures for the conduct of high-level discussions at the next Health Assembly.

The supplementary agenda item on the use of official languages in WHO and in its publications was the last item on Committee B's agenda. The draft resolution was cosponsored by some 50 Member States. This agenda item elicited an intense and lively debate; over 40 delegations took the floor. The proposed resolution was not approved, but it was agreed by consensus to put the item on the agenda of the 105th session of the Executive Board, with an accompanying overview of the financial resources necessary to implement such a resolution.

Madam President, distinguished delegates, Director-General and staff of WHO, it has been an honour and a privilege for me to serve as Vice-Chairman of Committee B. Vitally important management and financial matters were settled in the spirit of conciliation and consensus. I should like to thank warmly all the delegations who contributed to settling our differences in such a spirit. Deliberations were made possible thanks to the unfailing support and cooperation of the Secretariat of Committee B.

Finally, I extend my thanks to you, Madam President, and to the Vice-Presidents and the Director-General for taking such a strong interest in our work. We leave soon for our respective homes, and I should like to take this opportunity to wish you, Madam, and all other officers and delegates, your families, and indeed your countries, continued good health during the coming year. The YK2000 problem was briefly alluded to by the External Auditor. Let us hope that we all survive the YK2000 and meet again for the Fifty-third World Health Assembly.

Safe journey home - *bon voyage, adios y buen viaje*!

The PRESIDENT:

Thank you, Mr Eskola. I wish to thank you for your comprehensive report and thank also the Chairman, Dr Tapia, for conducting so well the work of Committee B. Dr Brundtland would like to say a few words. Dr Brundtland, you have the floor.

The DIRECTOR-GENERAL:

Madam President, distinguished delegates, as we are about to finish my first Health Assembly as Director-General, I move on with very positive impressions and memories. I am grateful that the round tables have so actively and so fully engaged so many ministers. I believe they will prove to be important for our future work and we will draw on their inspiration and the lessons learned when preparing for the Assembly next year. We will all need to further reflect on Professor Sen's presentation a week ago. Health and development are indeed inextricably linked. It is not always a simple relationship, but I believe a greater understanding of it will help decision-makers make the right choices. Placing health at the core of the development agenda remains a key priority for me, and we will be working hard to pursue this ambition in the years to come. I was greatly encouraged by your support for the changes that are taking place throughout WHO. The year that has passed since I identified the projects on Roll Back Malaria and the Tobacco Free Initiative has helped us move ahead so that we can really make a difference. I thank you also for the strong support for the poliomyelitis eradication campaign. We are all aware of the momentum that we need to give it on the final home stretch. The adoption of the budget by consensus after lengthy negotiations was an important achievement. Now it is our challenge to deliver the programme that you have agreed to finance, working hard to achieve the necessary efficiency. Let us not forget that this programme budget was not only about a specific amount of money, it was also a choice of strategic direction for WHO.

This Health Assembly has truly been a global health conference, with very broad participation in all of the debates and in the reaching of conclusions. I would like to thank you personally, Madam President, for guiding us through so skilfully. The Vice-Presidents and the Chairmen of committees have also played, as we all know, a critical role in making this Assembly a success. Let me thank every delegate for contributing so actively to 10 days of very solid work, and I thank all my staff who have worked so hard to support our important discussions. Thank you all and have a safe journey home.

The PRESIDENT:

Distinguished delegates, Madam Director-General, ladies and gentlemen, what is really important can be said in few words. Throughout the Fifty-second World Health Assembly, four aspects became evident: first, we now have a very clear and well-focused health agenda; secondly, we have experienced a participatory, informative and intellectually stimulating Health Assembly; thirdly, there is a better organized, cohesive and firmly led World Health Organization; and fourthly, there is a strengthened WHO, as reflected in the adoption of the appropriation resolution by consensus.

(The President continued in French.)
(Le Président poursuit en français.)

Un programme d'action sanitaire mieux ciblé : qui vise des problèmes de santé majeurs, tels qu'une diminution de 50% de la mortalité liée au paludisme en dix ans, mais aussi la tuberculose et d'autres maladies à forte prévalence; qui s'attaque résolument à des risques imputables à l'homme, tels que le tabagisme; qui s'efforce de contribuer à l'instauration de systèmes de santé plus équitables, plus efficaces et plus efficients; qui reconnaît le rôle central de la connaissance.

Une meilleure Assemblée mondiale de la Santé. Afin que notre programme d'action sanitaire apporte un réel changement, il doit être débattu, adopté, suivi et révisé. Au cours de l'Assemblée de la Santé, des mesures importantes ont été prises dans le bon sens. Nous nous sommes écoutés les uns les autres attentivement, avons participé ou assisté à des tables rondes - nouvelle initiative très bien accueillie - et avons pu suivre des séances d'information très bien préparées : fixation des priorités dans le secteur de la santé : les ministres face à une entreprise ardue; investissements dans les hôpitaux : les ministres face à des dilemmes; trouver de l'argent : les ministres face à des dilemmes; VIH/SIDA : stratégies propices à une réaction adéquate et durable face à l'épidémie.

Une Organisation mondiale de la Santé plus forte. Une seule OMS qui tire pleinement parti de sa structure régionale, en agissant là où il le faut - dans les grandes villes, les petites communautés rurales, les écoles, les lieux de travail, la famille - là où son action est le plus nécessaire. Ceci exige une vision claire. Nous avons cette vision prospective, mais il fallait aussi une véritable direction et nous avons à présent cette direction à l'OMS.

(The President continued in English.)
(Le Président poursuit en anglais.)

It is time to depart. To return to our countries, to renew in many practical and tangible ways our commitment to health for all. We will gather again, at the dawn of a new millennium, strengthened by our achievements in improving the health of our nations, touched by an even stronger sense of solidarity towards all nations.

Madam Director-General, we thank you wholeheartedly for everything you have already done in this first year of your mandate for our health organization. We wish you an equally successful second year. Rest assured, we are all firmly behind you. I thank you all very much for making this experience of mine as President of the Fifty-second World Health Assembly a very pleasant and rewarding one. I appreciated indeed your kind support, and above all your warm friendship. I would also like to thank all those who have worked behind the scenes and who have facilitated the work of the Assembly, particularly the interpreters who have been very understanding in the use of their time to allow us to complete our work on time.

I wish you a safe journey home and now just allow me only one word in my own language, Portuguese, which is spoken by more than 200 million people throughout the world. I could not use it in dealing with the Assembly, as it is not an official language of the Organization, except in the Americas. So, just to thank you all very warmly: *obrigada.*

And now, already missing your presence, I formally declare the Fifty-second World Health Assembly closed.

The session closed at 12:20.
La session est close à 12h20.

COMPOSITION DE L'ASSEMBLÉE DE LA SANTÉ
MEMBERSHIP OF THE HEALTH ASSEMBLY

LISTE DES DÉLÉGUÉS ET AUTRES PARTICIPANTS
LIST OF DELEGATES AND OTHER PARTICIPANTS

DÉLÉGATIONS DES ETATS MEMBRES

DELEGATIONS OF MEMBER STATES

AFGHANISTAN - AFGHANISTAN

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Ministre de la Santé publique

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Minister of Health

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Director of the Institute of Public Health and Adviser of the Minister of Health

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Professeur Y. Guidoum
Ministre de la Santé et de la Population

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Professeur J.-P. Grangaud
Directeur de la Prévention, Ministère de la Santé et de la Population

Dr A. Guennar
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Professeur D. Larbaoui
Président, Comité national de la Lutte contre la Tuberculose

Professeur Z. Mentouri
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M. M. Snoussi
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M. A. Chaouche
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Consejero, Misión Permanente, Ginebra

Sra. M. Gabrieloni
Consejero, Misión Permanente, Ginebra

Sra. A. Repetti
Tercer Secretario, Misión Permanente, Ginebra

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(Chef de délégation du 18 au 19 mai)

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