

STATEMENTS OF
DR HIROSHI NAKAJIMA
DIRECTOR-GENERAL
TO THE
EXECUTIVE BOARD AND THE
WORLD HEALTH ASSEMBLY



WORLD HEALTH ORGANIZATION

1998

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AT ITS 101st SESSION
Geneva, 19 January 1998

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THE DIRECTOR-GENERAL
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Mr Chairman, distinguished members of the Board, ladies and gentlemen,

WHO will be 50 years old this year. As we celebrate this fiftieth anniversary, we can look back with legitimate pride to the many health gains which together we have achieved for the benefit of all the peoples of the world. At the same time, fully aware of our responsibilities for the present and future generations, we must assess emerging global health challenges and ensure that our policies and structures are well adapted and will enable us to meet the expectations of the peoples whom we exist to serve.

In May 1998, reclaiming the principles and values set out 50 years ago in WHO's Constitution, we will be adopting a new declaration on global health and a new health-for-all policy. These will provide a framework for WHO's activities in the twenty-first century when, in my view, international cooperation will have increasingly to focus on the developmental aspects of health. Our whole reform process, in fact, has been guided by a concern to meet the ever-changing needs of our Member States more efficiently so that health and socioeconomic development reinforce each other.

Fifty years ago, WHO's main priorities included immunization, infectious and parasitic diseases, malnutrition, hygiene and sanitation, basic health infrastructure, education and training for health workers, and the development or reconstruction of health services. To a large extent these remain major areas of concern and activity of the Organization. Yet the scope of the challenges we face, and our approaches to dealing with them, have changed considerably.

In the area of immunization against childhood diseases, we have increased the global coverage rates for children under one year of age from an average of less than 5% in 1974 to about 80% in 1994. In 1980, we were able to declare the eradication of smallpox. We then embarked on other ambitious yet feasible endeavours. We targeted the eradication of poliomyelitis and the elimination of other preventable diseases such as measles and neonatal tetanus. By 1996, the

global incidence of measles was reduced by about 70%. The eradication of poliomyelitis has been achieved in the American Region and is near completion in the Western Pacific Region, while enormous progress is being made in Africa and South-East Asia.

We have effective tools and strategies, and National Immunization Days are being organized regularly in all countries and regions concerned. Our task is now to ensure the sustainability of these efforts and promote the development of multipurpose vaccines that will be both easier to use and affordable to those who need them most. Thus the highly successful Expanded Programme on Immunization has been supplemented by the Children's Vaccine Initiative, mobilizing the joint support of various bodies from both the public and the private sectors. As we extend immunization coverage, we have to find ways to reach populations that remain excluded by poverty and other disadvantages. Here again, the solutions have to be worked out with other sectors.

WHO has supported the development of global coalitions and intersectoral cooperation against several other diseases such as leprosy, dracunculiasis, onchocerciasis, and Chagas disease. The results are impressive. Between 1985 and 1996, the global prevalence of leprosy was reduced by 82%. During roughly the same period, the global prevalence of dracunculiasis fell from 3.5 million cases to only 130 000 cases. Onchocerciasis has been eliminated from 11 countries of Western Africa and 1.5 million previously infected people have been freed from the risk of blindness. Launched in 1991, the elimination of the transmission of Chagas disease is making remarkable progress in Latin America.

For many years now, WHO has been warning the international community that neglecting health needs has disastrous consequences for the human and economic development of countries. We have made the case that a healthy environment is required to attract domestic and foreign investment for socioeconomic development.

WHO alerted public opinion and led the global mobilization against such scourges as HIV/AIDS, malaria and tuberculosis. An active cosponsor of UNAIDS, WHO also provides countries with specific support for epidemiological surveillance, research, control of sexually transmitted diseases, health education and information, blood safety and access to antiretroviral drugs and other health products. The launching of an African initiative based on the revised global malaria strategy, and the successful development of DOTS, the directly observed treatment short course against tuberculosis, are other examples of WHO's continued leadership in the fight against infectious diseases.

Fifty years ago, it seemed self-evident that science and technology meant progress, and that progress was irreversible. Such assumptions have been called into question by the emergence of new infectious agents, new environmental

health hazards, and drug resistance. Outbreaks have occurred of diseases such as plague, cholera, dysentery, *E. coli* O157 infections, viral haemorrhagic fevers of the dengue, Ebola and Hantaan type, yellow fever, Rift Valley fever, bacterial and viral meningitis, transmissible spongiform encephalopathies and, more recently, avian influenza A(H5N1) in humans. They have confronted WHO with additional challenges. We have done a considerable amount of networking to improve global preparedness for epidemics, and successfully built up our capacity to respond to countries' requests for emergency support. The International Health Regulations are also being revised to maximize health protection while minimizing social and economic constraints.

Mother and child health has always ranked high on WHO's agenda. Over the years, significant reductions have been achieved globally in infant and child mortality and morbidity rates. While implementing our commitments at the World Summit for Children, we have moved away from a focus on narrowly defined age groups and diseases to broader community and family health approaches. These have been based on our concern that all people should have ready access to a continuum of essential care and support at all stages of their lives, at home, at school, at work and in their communities.

This integrated approach to issues such as childhood illness, adolescent and women's health, reproductive health, nutrition, substance abuse, noncommunicable diseases, health of older persons and disability, can be traced back to the inclusive definition of health provided by our Constitution. It may also be seen as a direct extension of the WHO primary health care strategy which was defined 20 years ago in Alma-Ata. Much of the terminology used today may remain the same but I believe that there has been a fundamental change in perspective, the consequences of which have yet to be fully recognized. As I see it, in the new approach to developing integrated primary health care, the focus is moving from structures and systems to people. In the future, an even greater effort will have to be made to understand users' needs, their expectations, and their potential to contribute to the definition and implementation of health priorities and interventions.

This change in perspective reflects a growing awareness of the importance of developing an open and mutually respectful dialogue between health professionals and the public. Empowering people in all cultures and segments of society with the necessary information and opportunities for health development is both an ethical and a technical imperative.

Noncommunicable diseases such as cancer, cardiovascular diseases, diabetes and mental health disorders are on the rise everywhere and a major cause of suffering and disability. They are influenced by a combination of factors which include lifestyles, environmental hazards, genetic predisposition and the global ageing of the world's population. A vast amount of epidemiological data on

these diseases has been generated worldwide through research coordinated by WHO. Cost-effective interventions and strategies are available. Our next urgent task must be to help integrate them into national health policies, especially in developing countries, to put in place health promotion and education activities, case-finding, case-management, and rehabilitation and social support services. Success will depend increasingly on our ability to communicate with the public about the need to adopt health-conducive lifestyles.

The link between health, lifestyles and the environment was already made by the Constitution in the context of what was then called “environmental hygiene”. Traditionally, WHO has been particularly strong in areas such as nutrition, sanitation, and vector control, and we remain actively involved in initiatives such as Africa 2000, for the development of basic sanitation, including water supply and waste disposal systems. But, especially during the last two decades of this century, environmental health has become an entirely new area of major concern worldwide, closely related to issues of sustainable development and justice. The WHO Commission on Health and Environment played a decisive role in this regard at the Rio Conference. Today, such issues as air and water pollution, urban and industrial development, occupational hazards, climate change, and chemical and food safety are being hotly debated both by the general public and by governments.

As the nature and scope of environmental and man-made health hazards have changed, WHO has redefined its emergency relief capability. It has placed new emphasis on preparedness to mitigate the health consequences of both natural and man-made disasters, and on providing technical backup for the health aspects of humanitarian and rehabilitation work.

Fifty years after it was founded, WHO’s prime responsibility remains that of fostering access to health for all through international cooperation. It does this by working with countries to formulate sound health policies and strategies, and to establish and manage effective and sustainable health services. Capacity-building is a prerequisite for sustainability. It must include not only human resource development but also the financial and institutional support measures that will ensure that the health services can be fully operational.

At a time of wide-ranging social, political and economic change, practically all countries in the world are having to redefine their development strategy and reform their national health systems. WHO’s new health-for-all policy offers support to our Member States as they strive to ensure the relevance, effectiveness and sustainability of their action for health development. The definition of essential public health functions provides a basis on which national health services can be organized and operated. The health services of the future will continue to carry out disease prevention and control activities using traditional approaches, but they will also include the public health applications of new

knowledge and technology such as genetics, molecular biology, immunology and diagnostic imaging.

It is particularly important in this context to strengthen collaborative research based on actual public health needs and ensure the dissemination of relevant findings to potential users. It is just as important that the development and implementation of research, technology and health services should be carefully assessed and guided by sound technical and ethical principles. Rapidly evolving areas of science and medical practice such as organ transplantation, cloning, genetic engineering and clinical research have major ethical and social implications for our humanity. WHO provides a forum within which international consensus can be built with regard to the many crucial issues that arise in these areas.

Ethical concerns are also at the core of our health-for-all policy. WHO's goal of promoting equitable access for all to health services, including care and essential drugs, is based on the principle of justice and the recognition that all human beings should enjoy equal rights and opportunities. Our new partnerships for health will stimulate innovation and encourage the participation at national and international level of all institutions and sectors concerned, including civil society and nongovernmental organizations.

During 1997, reform in WHO has continued as an ongoing process of change, focusing on further improving accountability and efficiency. In the preparation of the Tenth General Programme of Work, particular care has been given to ensuring consistency with health policy reform and strategic budget orientations. The major elements of reform which the Board will be considering at this session are related to the review of the Constitution and regional arrangements of the World Health Organization as well as the revised proposals for WHO's representation and cooperation mechanisms at country level. Other important items on your agenda include the nomination of the next Director-General and the review of the proposed new declaration on health and new health-for-all policy which the Health Assembly will adopt in May 1998.

Mr Chairman, distinguished members of the Board, colleagues, ladies and gentlemen,

Over its 50 years of existence as a vital part of the United Nations system, WHO has done an impressive amount to promote health and peace worldwide. We should celebrate the anniversary of our Organization with feelings of pride, gratitude and humility. We can be proud of having been able to take part in WHO's inspiring endeavour. We should feel grateful to all those who, today as in the past, have contributed to making our achievements possible. Finally we must recognize, in all humility, that the task ahead of us remains formidable. This must prompt us to act with renewed determination, mobilizing our resources

and efforts for our common goal of making health accessible to all. Fighting disease and alleviating human suffering will continue to require the dedication and cooperation of all of us. It is in this spirit that I invite the Board to proceed with the important work on the agenda for this session.



STATEMENT BY
THE DIRECTOR-GENERAL
TO THE FIFTY-FIRST
WORLD HEALTH ASSEMBLY
Geneva, 11 May 1998

Mr President, excellencies, honourable delegates, ladies and gentlemen,

The Constitution of the World Health Organization came into force on 7 April 1948, with its acceptance by 26 States Members of the United Nations. That was 50 years ago, when the estimated infant mortality rate worldwide was more than 160 per 1000 live births; now it is 57 per 1000. Average life expectancy was about 46 years then, now it is 66. Smallpox was still a dreaded scourge, now it is 20 years since the last person died of that disease. Paralysis from poliomyelitis struck the rich and the poor alike, now this disease is close to being eradicated worldwide. The prospects are also good for eliminating leprosy, measles, dracunculiasis, Chagas disease, neonatal tetanus and micronutrient deficiencies. New initiatives are being launched against onchocerciasis, lymphatic filariasis and trachoma. We have accumulated a large body of knowledge on the relation between health, lifestyles and the environment, which has given us the basis for effective prevention and control strategies. As pointed out in *The world health report 1998*, we can look forward to a future that holds the promise not merely of longer life but also of better quality of life, with less disease and disability.

For the world as a whole, human health has improved more during the last half century than in any other period we know about. This reflects remarkable achievements in the health sector as well as the much wider process of economic and social development. The World Health Organization, with 191 Member States now, is justly proud of the leading role it has played in helping to make these achievements possible through international cooperation.

Fifty years ago, WHO was given the core responsibility, within the United Nations system, of directing and coordinating international health work. Its purpose was to help ensure that all people, in all countries, could have access to the highest attainable standard of health, expressed by our Constitution in terms of physical, mental and social well-being. This asserted the right of all human beings not just to basic health security but to the opportunity of developing their individual potential to the fullest. At the same time, the founders of WHO

recognized the interdependence of the peoples and countries of the world in their struggle for sustainable health, peace and prosperity. In the words of Dr Scheele, Surgeon-General of the United States Public Health Service and President of the Health Assembly in 1951, “The world cannot remain half healthy and half sick and still maintain its economic, moral and spiritual equilibrium”.

In the post-war period, in many countries everything had to be built or rebuilt virtually from scratch: policy, infrastructure, public services, staff and training. During its first 10 years, WHO made an enormous contribution, with the help of the whole scientific community, to this work of reconstruction. Already in the 1960s however, the limitations of an exclusively biomedical approach to public health were becoming obvious. Similarly, it was becoming clear that international cooperation was not a matter of simply transferring technologies and policies that had been designed for other societies and situations.

These perceptions at last found their expression in 1978 with the Alma-Ata Declaration on primary health care as the way to achieve health for all. It marked a turning point in WHO’s history and in health cooperation. It outlined a new approach to health care, especially in developing countries, and drew attention to the much greater social and economic effort which health development required. Sensing the need to move away from traditional aid policies, it emphasized self-reliance and the development of national health systems. It underscored the responsibility of governments in this regard. It stressed the importance of community participation and the need for appropriate technology and access to essential drugs and vaccines.

There was strong commitment by national health ministries to this approach but they had to contend with major obstacles. These included severe shortages of trained human resources, particularly in countries that had recently become independent, lack of baseline data for adequate planning and monitoring of health efforts, and continued overemphasis of hospital care and technology with the escalating costs involved. In addition, both nationally and internationally, most institutions and decision-making processes remained firmly centralized. This left little room and few resources for involving local communities in defining priorities and taking the necessary action. Finally, many countries were faced with great difficulties related to the global economic situation, the debt crisis and the highly negative social effects of structural adjustment measures. WHO itself, since 1986, has had to function with a zero growth budget in real terms although the demands placed upon it have continued to increase steadily.

Thus, at the end of the 1980s, in spite of significant improvements in global health indicators, the situation was one of growing inequities in health status and actual access to care. A new major threat to public health was emerging in the form of HIV/AIDS, and diseases whose strength had been underestimated, such as malaria and tuberculosis, were returning with renewed virulence.

An effective response to problems of such magnitude and complexity could not be provided by health services alone. A broader understanding of the health sector was required, and new partnerships for health had to be established to mobilize and coordinate the efforts of other agencies, the private sector and nongovernmental organizations.

Fostering such partnerships has become a central role for WHO. The Global Tuberculosis Programme, the Intergovernmental Forum on Chemical Safety, and the Global Programme for Vaccines and Immunization are examples of the new partnerships that have been set up during the past 10 years, putting to good use the experience we have gained in such areas as research on cancer, maternal and child health, human reproduction, tropical diseases, food safety and humanitarian assistance. WHO has also put in place innovative networks for epidemiological surveillance and response to emerging diseases, antimicrobial resistance, and epidemics. The role of WHO collaborating centres within such networks and partnerships is proving crucial.

Special campaigns against diseases such as leprosy, poliomyelitis and onchocerciasis have brought together the efforts of national health services, private foundations, local and international organizations and the general public. These campaigns have often provided a first point of contact between health workers and underserved population groups and thus an opportunity to build up mutual understanding and the primary health care approach. Our experience in the Global Programme on AIDS, in particular, has demonstrated the need to recognize the users of the health system as key partners for health development and local empowerment.

Empowering people and local communities on a much larger scale with the necessary information and skills to take care of their own health would contribute significantly to reducing some of the health disparities that still face us. Mortality among children under five years old has been reduced from 21 million in 1955 to 10 million in 1997, but the figure remains unacceptably high. For some countries, representing over 50 million people, average life expectancy is still less than 45 years. About 585 000 women still die each year of pregnancy-related causes, 99% of them in developing countries. The risk of maternal death is one in 1400 in Europe, one in 65 in Asia, and one in 16 in Africa. Between two and three million adults die of tuberculosis every year although an effective and affordable cure for this disease exists. Infectious and parasitic diseases continue to be a major threat for all, especially in developing countries. We welcome the commitment made by the Foreign Ministers of the Group of Eight last week in London to support WHO in developing global surveillance networks and building up the capacity of countries to control these diseases.

Poverty remains a major factor of ill-health and lack of access to health services, but new approaches to health development and cooperation can

significantly reduce this problem by making better use of current resources and human potential. Our analysis of achievements and shortcomings in the implementation of the health-for-all policy has helped us to define some of these approaches. They include: first, the provision of integrated care throughout the life span; second, intersectoral and interdisciplinary collaboration; and third, advocacy for health in social and economic development. New partnerships, at different levels and in different areas of activity, open up the way for all three of these mutually supportive approaches.

(1) The provision of integrated care throughout the life span is necessary to overcome the limitations of a piecemeal approach to diseases, services and age groups. Ensuring a continuum of care to all will enable us to improve not just the figures for selected indicators but the actual health status and well-being of individuals.

Health is multidimensional: problems of infection, nutrition, psychology, allergy or genetic predisposition may coexist and reinforce or trigger other conditions. Health gains can also be reversed at any time in the event of failure to maintain access to essential drugs and adequate care and living conditions. This was shown in the recent past by the actual decrease in life expectancy experienced until 1995 in 16 countries with a total population of about 300 million. Similarly, HIV infection could cancel out some of the major gains achieved in child health over the past 50 years; it is estimated that, last year alone, 590 000 under-15-year-olds became infected with HIV.

In addition, health status is influenced by health events which occurred in the previous generation or at an earlier stage in life. Women's health and their access to reproductive health care and counselling largely determine the health status of their babies. Proper care and nutrition in the first years of life are not only important for resistance to childhood diseases but also prepare the way for improved adolescent and adult health. Substance abuse and other risk-taking behaviour in youth have a far-reaching influence on health status in middle age and later life. For example, because of early and prolonged use of tobacco, lung cancer in women has increased fourfold over the last 30 years in many industrialized countries and is also on the rise in developing countries.

Ageing, changes in lifestyle, and the concomitant worldwide increase in noncommunicable diseases such as cancer, diabetes, cardiovascular diseases and mental disorders, make the need for integrated care and lifelong health promotion more urgently felt in all countries.

Within the next 30 years, increases of up to 300% of the older population are expected in many developing countries, especially in Latin America and Asia. By 2025, there will be more than 800 million people in the world who are over 65 years old - twice as many as today, and two-thirds of them will be in

developing countries. One of the biggest challenges in all countries will be to find out how best to prevent and postpone disease and disability and to maintain the health and autonomy of an ageing population.

Because of these trends, improving efficiency in the financing and delivery of health care has become a major concern of all countries, and many have introduced reforms to their health systems in an effort to ensure that they are functional and sustainable. Containing health care costs is a necessary objective but must not result in the rationing of essential health care and services. Much of the sickness and disablement which consume health budgets can be avoided through rational investment in preventive care. Recent trends in industrialized countries have shown the effectiveness of health promotion activities in preventing, delaying and reducing the severity of chronic diseases and related disability. Disease prevention should be recognized as an essential component of all cost containment strategies.

(2) Regarding our second approach to health development - intersectoral and interdisciplinary collaboration - it reflects the growing recognition that many important health determinants are beyond the direct control of the health sector. Partnerships make it possible to monitor relevant developments in other sectors and disciplines, anticipate related risks and opportunities for health, and provide technical advice on policies and activities accordingly.

Thus WHO's work on environmental health, chemical safety, housing, sanitation, occupational health, and prevention of violence and substance abuse has been done in collaboration with partners in areas such as education, agriculture, engineering, town planning, consumer associations and the media. This has proved indispensable for the control not only of epidemics but also of noncommunicable diseases and the health consequences of natural and man-made disasters.

The incidence of many infectious diseases such as malaria, Ebola-type haemorrhagic fever, schistosomiasis and Rift Valley fever, is closely linked to a variety of factors such as migration, climate, and water and land use patterns. These need to be analysed and tackled in a coordinated fashion. Compartmentalization and communication gaps between experts and institutions can cause major problems as was seen during the outbreaks of bovine spongiform encephalopathy and *E.coli* O157. Last year, the Health Assembly urged WHO to continue to lead and coordinate work on chemical risk assessment, with special attention to persistent organic pollutants (POP), their potential endocrine-related health effects, and their possible causal links with cancer and reproductive, neurological and immunological disorders.

Intersectoral collaboration is also critical for research on health development. The importance of basic biomedical research must be strongly reasserted, but it

is equally indispensable to mobilize other disciplines to take into account the behavioural, social, anthropological, technological, economic and legal aspects of health development.

(3) An important and complementary aspect of WHO's responsibility is to uphold the requirements of health in a rapidly changing global environment. This defines our third approach, of advocacy for health in social and economic development.

In fact, advocacy for health development has always been one of WHO's responsibilities as an intergovernmental body, and has been put into practice in our involvement in research, information exchange, policy-making, technical cooperation, capacity-building and standard-setting. But until recently, WHO's work in this area has been done essentially with the health professions and ministries of health and for their own immediate use and that of their "natural" partners in health-related fields. Aimed mainly at the health community, WHO's advocacy work has been conducted within its own expert committees and governing bodies, and, to some extent, within the internal coordination committees of the United Nations system.

In the past 10 years, approaches to development work and international cooperation have changed tremendously. A mark of this change is the recent series of "summit" conferences on practically the whole spectrum of activities of the United Nations system. These include the environment (Rio), population (Cairo), social and economic development (Copenhagen), women's empowerment (Beijing), food (Rome), and human settlement (Istanbul). It is noteworthy that, whatever their original technical brief, all these meetings ended up dealing with the issue of **sustainable development**, that is development for the whole of humanity, throughout the world, and for future generations. WHO has been actively involved in all these conferences, their preparation, and the follow-up work now in progress.

Another important feature of these world conferences, and a major departure from the past, has been their opening up to the huge body of nongovernmental organizations which has emerged and multiplied worldwide, reflecting a new determination on the part of civil society to be involved not only in local development activities but also in political decision-making at both national and global level. This strongly felt need for increased democratization in health work and development is also shaping WHO's own new policy and partnerships for health. The reforms currently in progress in WHO are aimed at increasing effectiveness at country level precisely through this wider sharing of knowledge and responsibility.

The nature and scope of WHO's work for advocacy and standard-setting are being further redefined by powerful trends such as privatization in the health

sector and globalization in the world economy, financial flows, trade, labour, technology, and information systems. Important international forums and interest groups have emerged at regional and global level, and the decisions they make have far-reaching implications for health and development in our Member States.

It is WHO's responsibility to represent the interests of health - of **all people's** health - in these forums and interest groups, and to uphold the technical and policy requirements for equitable and sustainable health development. WHO has the moral and scientific authority to do so, and the obligation to do so is placed upon it by its Constitution, although the environment in which it must be fulfilled has greatly changed.

Since its inception, the Organization has been involved in setting technical standards and proposing guidelines and codes of practice in many important areas of health, including pharmaceuticals, breast-milk substitutes, organ transplants and biological standards. More recently, countries and regional groupings have been turning to WHO for scientific advice on global standards for safety and quality assurance in the trade of food, health products and services. We have been working on such issues with a large variety of partners, including UNCTAD, the World Trade Organization, the Group of Eight, the Organization of African Unity, the European Union, ASEAN and MERCOSUR. In these activities, WHO's role must be to protect the health of consumers while facilitating trade in the interests of all people worldwide. We have to insist that the pursuit of profitability and resource generation does not overrule the requirements of safety and justice.

For we must always remember that our responsibility is not just technical. Research and health care raise major ethical issues in areas such as clinical trials involving human subjects, cloning, xenotransplantation, patients' rights, genetics, confidentiality of data and intellectual property issues. In all cases, what must prevail is concern for people's health, their safety and their autonomy. In our commitment to health work and international cooperation, respect for the equal worth and dignity of all human beings must be our guiding principle.

The World Health Declaration submitted to you for adoption reaffirms this principle and the values embedded in WHO's Constitution. It reiterates the interdependence of all people and nations and their shared responsibility in working towards health for all. The new health-for-all policy, which you will also be considering for adoption, sets out the main directions for our work in the twenty-first century. It is part of an ongoing planning process and must be seen as a starting point, a flexible framework rather than a fixed programme. Most importantly, it reaffirms our commitment to international cooperation in health development, based on the values of equity, solidarity and respect.

The World Health Organization has achieved a great deal in its 50 years of existence, and has enormous potential to serve the world in the coming century. I have full confidence in its strength and adaptability, and in the wisdom and skill of its future leaders.

Most of my professional life has been dedicated to WHO and to working with our Member States in the pursuit of health for all. I am deeply grateful for these many years of sometimes difficult but always rewarding work. I want to pay special tribute to WHO staff, my colleagues, to the high quality of their work and to their devotion to the goals and values of the Organization. I wish to thank them all for the support they have given me throughout these years.

Mr President,

It has been a very special honour to serve the Member States of the Organization. Their commitment to health - from officials at the highest political level to workers in the most remote communities - has always been and always will be the one essential ingredient of our success. I warmly thank all those of you who, in your different capacities, have worked with us in friendship and determination to improve the health of the peoples of the world, towards peace and prosperity in the twenty-first century.

