WHA63/2010/REC/2

WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTÉ

SIXTY-THIRD WORLD HEALTH ASSEMBLY

GENEVA, 17–21 MAY 2010

**VERBATIM RECORDS
OF PLENARY MEETINGS
AND LIST OF PARTICIPANTS**

SOIXANTE-TROISIÈME ASSEMBLÉE MONDIALE DE LA SANTÉ

GENÈVE, 17–21 MAI 2010

***COMPTES RENDUS IN EXTENS0
DES SÉANCES PLÉNIÈRES
ET LISTE DES PARTICIPANTS***

GENEVA
GENÈVE
2010

PREFACE

The Sixty-third World Health Assembly was held at the Palais des Nations, Geneva, from 17 to 21 May 2010, in accordance with the decision of the Executive Board at its 126th session. Its proceedings are issued in three volumes, containing, in addition to other relevant material:

Resolutions, decisions and annexes – document WHA63/2010/REC/1

Verbatim records of plenary meetings, list of participants – document WHA63/2010/REC/2

Summary records of committees, reports of committees – document WHA63/2010/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 WHA63/2010/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 29 October 2010, the cut-off date announced in the provisional version, and are thus regarded as final.

AVANT-PROPOS

La Soixante-Troisième Assemblée mondiale de la Santé s'est tenue au Palais des Nations à Genève du 17 au 21 mai 2010, conformément à la décision adoptée par le Conseil exécutif à sa cent vingt-sixième session. Ses actes paraissent dans trois volumes contenant notamment :

les résolutions et décisions et les annexes qui s'y rapportent – document WHA63/2010/REC/1

les comptes rendus in extenso des séances plénières et la liste des participants – document WHA63/2010/REC/2

les procès-verbaux et les rapports des commissions – document WHA63/2010/REC/3.

On trouvera dans les pages préliminaires du document WHA63/2010/REC/1 une liste des abréviations employées dans la documentation de l'OMS, l'ordre du jour et la liste des documents de la session ainsi que la présidence et le secrétariat de l'Assemblée de la Santé et la composition de ses commissions.

Les présents comptes rendus in extenso reproduisent dans la langue utilisée par l'orateur les discours prononcés en anglais, arabe, chinois, espagnol, français ou russe, et dans leur interprétation anglaise ou française les discours prononcés dans d'autres langues. Ces comptes rendus comprennent les rectifications reçues jusqu'au 29 octobre 2010, date limite annoncée dans leur version provisoire, et sont donc considérés comme finals.

ПРЕДИСЛОВИЕ

Шестьдесят третья сессия Всемирной ассамблеи здравоохранения проходила во Дворце Наций в Женеве с 17 по 21 мая 2010 г. в соответствии с резолюцией, принятой Исполнительным комитетом на своей Сто двадцать шестой сессии. Материалы сессии публикуются в трех томах, в которых, помимо других документов, содержатся:

Резолюции, решения и приложения – документ WHA63/2010/REC/1

Стенографический отчет о пленарных заседаниях, список участников – документ WHA63/2010/REC/2

Протоколы заседаний комитетов, доклады комитетов – документ WHA63/2010/REC/3

Список сокращений, используемых в этих изданиях, перечень должностных лиц Ассамблеи здравоохранения, а также членский состав комитетов, повестка дня и список документов для данной сессии, приводятся в начале документа WHA63/2010/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 29 октября 2010 г., как о том было объявлено в предварительных протоколах, и потому настоящая редакция считается окончательной.

INTRODUCCIÓN

La 63.ª Asamblea Mundial de la Salud se celebró en el Palais des Nations, Ginebra, del 17 al 21 de mayo de 2010, de acuerdo con la decisión adoptada por el Consejo Ejecutivo en su 126.ª reunión. Sus debates se publican en tres volúmenes que contienen, entre otras cosas, el material siguiente:

Resoluciones y decisiones, y anexos: documento WHA63/2010/REC/1

Actas taquigráficas de las sesiones plenarias y lista de participantes:
documento WHA63/2010/REC/2

Actas resumidas de las comisiones e informes de las comisiones: documento WHA63/2010/REC/3.

En las páginas preliminares del documento WHA63/2010/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 29 de octubre de 2010, fecha límite anunciada en la versión provisional, y por consiguiente se consideran definitivas.

مقدمة

انعقدت جمعية الصحة العالمية الثالثة والستون في قصر الأمم بجنيف في الفترة من 17 إلى 21 أيار/ مايو 2010، طبقاً لما قرره المجلس التنفيذي في دورته السادسة والعشرين بعد المائة. وتنشر محاضرها في ثلاثة مجلدات تتضمن، بالإضافة إلى بعض المواد الأخرى ذات الصلة، ما يلي:

القرارات والمقررات الإجرائية والملاحق – الوثيقة ج ص ع63/2010/ سجلات/1

المحاضر الحرفية للجلسات العامة وقائمة بأسماء المشاركين – الوثيقة ج ص ع63/2010/ سجلات/2

المحاضر الموجزة للجان وتقارير اللجان – الوثيقة ج ص ع63/2010/ سجلات/3

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 ع63/2010/ سجلات/1.

وترد الكلمات التي أُلقيت بالعربية أو الصينية أو الإنكليزية أو الفرنسية أو الروسية أو الأسبانية في هذه المحاضر الحرفية باللغة التي تكلم بها المتحدث، أما الكلمات التي أُلقيت بلغات أخرى فترد ترجمتها الإنكليزية والفرنسية. وتتضمن النصوص التصويبات التي تم تلقيها حتى 29 تشرين الأول/ أكتوبر 2010، وهو الموعد النهائي المعلن في النسخة المؤقتة، وهي بالتالي تعتبر نهائية.

序 言

根据执行委员会第126届会议的决定，第六十三届世界卫生大会于2010年5月17日至21日在日内瓦万国宫举行。会议记录分为三卷出版。除刊载其它有关材料外，还刊载：

决议、决定和附件 — 文件WHA63/2010/REC/1

全体会议逐字记录、与会人员名单 — 文件WHA63/2010/REC/2

各委员会摘要记录、委员会报告— 文件WHA63/2010/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WHA63/2010/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2010年10月29日以前收到的更正，这是临时文本中宣布的截止日期，因而它们是最后的文本。

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FIRST PLENARY MEETING

Monday, 17 May 2010, at 09:40

President: Mr N.S. DE SILVA (Sri Lanka)
later: Mr Mondher ZENAIDI (Tunisia)

PREMIÈRE SÉANCE PLÉNIÈRE

Lundi 17 mai 2010, 9h40

Président: M. N.S. DE SILVA (Sri Lanka)
puis: M. Mondher ZENAIDI (Tunisie)

1. OPENING OF THE HEALTH ASSEMBLY
OUVERTURE DE L'ASSEMBLÉE DE LA SANTÉ

The PRESIDENT:

Distinguished delegates, ladies and gentlemen, in my capacity as President of the Sixty-second World Health Assembly, I have the honour to open the Sixty-third World Health Assembly.

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

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

The PRESIDENT:

I now give the floor to Mr Serguei Ordzhonikidze, Director-General of the United Nations Office at Geneva.

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

Mr President, Madam Director-General, *Conseiller fédéral, Conseiller d'État*, excellencies, ladies and gentlemen, it is a great pleasure to welcome you to the Palais des Nations for the opening of the Sixty-third World Health Assembly. It is my privilege to convey to you the best wishes of the Secretary-General, Mr Ban Ki-moon, for a productive Health Assembly, building on the important achievements in global public health over the past year.

You come together five years before the deadline for the realization of the United Nations Millennium Development Goals. Your focus on the health-related Goals is indeed timely, and will provide a most valuable contribution to the high-level plenary meeting of the General Assembly, which will take place in September and which is aimed at strengthening the collective efforts to enable us to meet the Goals within the deadline.

Since the adoption of the Goals 10 years ago, the world has witnessed significant successes in combating extreme poverty and hunger, expanding school enrolment, improving child health, increasing access to clean water and treatment of HIV/AIDS, and in controlling malaria, tuberculosis and neglected tropical diseases. The health-related Goals are not only key objectives in their own right, they are multipliers that hold the potential to help accelerate progress across all the Goals.

Nevertheless, progress has been uneven – across individual Goals and across regions – and if current trends continue, there is a real risk that several of the Goals will be missed. We have made strides in addressing child mortality, but we still fall short of the target of a two-thirds reduction compared with 1990. Maternal mortality figures have barely changed since the adoption of the Goals and are a stain on our collective consciousness. After gains in the fight against HIV/AIDS at the beginning of this century, there are now worrying signs of a lessening of the commitment to this devastating threat to development and security. Donors currently give about US$ 10 000 million a year. Yet, it is estimated that controlling the epidemic would cost US$ 27 000 million annually. And for every two people starting on antiretroviral treatment, there are five new infections. These figures are simply not acceptable.

While we may not have made as much progress as we would have wished for, we can still draw valuable lessons to guide our reinforced efforts. This Health Assembly is a most welcome opportunity for the international community to review these lessons and work to operationalize them so that we may scale up the efforts to meet the health-related Millennium Development Goals.

Inequalities continue to pose major barriers to preventive measures and access to health care and medicines. Fellow human beings in developing countries are at the greatest risk, are the hardest hit, have the least resilience and the fewest tools to address health-related challenges. This is often compounded by a considerable exposure to natural disasters and to the impact of climate change. The dramatic divergence in health status within and across countries continues to grow. The diagnosis is clear: unless we place justice and equality at the heart of the public health agenda, we will simply not meet the Millennium Development Goals.

The challenges in the different areas of health are diverse, but the key elements of treatments are similar. We need national ownership and effective government leadership that strives to enhance the quantity, quality and focus on investments in the health sector. This has to be financed through a combination of domestic resources and international development assistance. There is also a clear

need to develop institutional capacity to deliver quality health services equitably on a national scale, with adequate facilities, competent staff, appropriate supplies and effective monitoring.

In our efforts to improve access and affordability of global public health, we need to maintain a strong focus on Millennium Goal 3 on achieving gender equality. As we this year mark the tenth anniversary of the landmark Security Council Resolution 1325 and the fifteenth anniversary of the Beijing Declaration and Platform for Action, we must face the fact that redressing gender inequality remains difficult and, in some areas, elusive. Yet, it has implications across all Goals. We cannot hope to achieve any of them – not least in the area of public health – if we do not step up efforts to empower women. They are drivers of progress and of lasting change.

Our collective challenge is to radically increase the pace of change on the ground so that we can translate the promises of the Millennium Development Goals into real progress for the world's poorest. We do have the knowledge, we do have the technology and we do have the resources, so we have a duty and a responsibility to employ them effectively in the service of vulnerable fellow human beings and for a better future for all. In that spirit, I wish you a successful Sixty-third World Health Assembly. Thank you very much.

3. ADDRESS BY THE REPRESENTATIVE OF THE CONSEIL D'ÉTAT OF THE REPUBLIC AND CANTON OF GENEVA
ALLOCUTION DU REPRÉSENTANT DU CONSEIL D'ÉTAT DE LA RÉPUBLIQUE ET CANTON DE GENÈVE

The PRESIDENT:

Thank you; we wish to extend our thanks to the United Nations for your traditional hospitality.

I now give the floor to Mr Pierre-François Unger, Counsellor of State, Department of Social Action and Health, of the Republic and Canton of Geneva.

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

Monsieur le Président, Madame le Directeur général de l'OMS, Monsieur le Directeur général de l'Office des Nations Unies à Genève, Monsieur le Conseiller fédéral, Excellences, Mesdames et Messieurs les Ministres, Ambassadeurs, Ambassadrices, Mesdames et Messieurs les délégués, Mesdames et Messieurs, à l'occasion de la Soixante-Troisième Assemblée mondiale de la Santé, j'ai le plaisir et l'honneur de vous souhaiter, au nom des autorités fédérales, des autorités cantonales et des autorités communales, une très cordiale bienvenue à Genève.

Au cours de vos travaux, vous allez vous pencher sur les objectifs du Millénaire pour le développement liés à la santé, une question absolument essentielle alors que le droit à la santé, ou tout du moins à sa protection, est un bien fondamental. Les inégalités de santé, vous le savez, continuent à se creuser autour du globe et à l'intérieur même de chacun des pays qui l'habitent. Même si le Canton de Genève est attentif aux besoins sociaux et sanitaires de ses habitants, pour paradoxal que cela puisse paraître, il n'est pas épargné. Garantir un système de santé équitable mais surtout accessible à toutes et à tous, en évitant l'écueil d'une médecine rationnée et donc à deux vitesses, constitue l'une de mes préoccupations en tant que Ministre de la Santé.

Ce matin, j'aimerais également rappeler que cette dernière année a une fois de plus montré à toutes et à tous l'importance de l'OMS dans la gestion des crises sanitaires. La pandémie du virus A (H1N1) que nous avons vécue en 2009 nous a fondamentalement tous rapprochés. À travers le Directeur général de l'OMS et grâce à son équipe, le monde entier fut à l'écoute de tout ce que nous pouvions apprendre au jour le jour dans cette pandémie. La précision et le sérieux dont ils ont fait preuve nous ont été fort utiles. Je tiens à vous remercier, Docteur Chan ; vous avez fait de Genève et de la Suisse le centre dépositaire mondial de la globalisation de nos préoccupations face à une menace qui fut prise partout très au sérieux. D'aucuns ont dit qu'on l'avait prise trop au sérieux, mais une seule réflexion Mesdames et Messieurs : quand un virus de la grippe est suspect d'être pandémique sur

de bons fondements, quand il se répand six fois plus vite que la grippe saisonnière, quand il ne tue pas les mêmes personnes puisque 60 % des personnes décédées ont moins de 20 ans ou sont des enfants, alors il faut prendre les choses au sérieux. Cette pandémie a montré à nouveau l'importance de notre coopération internationale, d'une communication ouverte et transparente, mais aussi et peut-être surtout la nécessité d'un leadership mondial au niveau tant de la communication que des opérations. L'OMS s'est montrée en mesure de répondre aux attentes des États et elle est prête à soutenir tous ceux qui faisaient appel à elle. Elle a confirmé qu'elle jouait un rôle central dans l'architecture internationale du système de santé. La santé mondiale continue à se construire chaque jour et l'Organisation mondiale de la Santé reste l'un de ses piliers importants.

L'OMS, vous le savez, est au centre d'un réseau très dense d'institutions qui participent ensemble aux efforts de protection de la santé mondiale. Genève, porte d'entrée de ce réseau, est devenue une véritable capitale internationale de la santé : les autorités suisses et genevoises sont bien décidées à renforcer cette position centrale. Actuellement, près de 4000 personnes – soit 2 % de plus qu'en 2008 – travaillent dans la région genevoise au service de la santé internationale dans près d'une centaine d'institutions fonctionnant dans les systèmes de la santé. Il s'agit d'un capital intellectuel de recherche, de développement, d'analyse, bref d'un capital humain sans pareil dont le monde entier doit et peut bénéficier. Très naturellement, au pourtour de ses compétences, Genève est au centre d'une région très dynamique dans les secteurs de la médecine de pointe et des biotechnologies. Il y a, que ce soit dans toute la Suisse occidentale ou dans la France voisine, une richesse impressionnante de centres de recherche qui travaillent dans le secteur des sciences de la vie et des technologies médicales ; ils rassemblent plus de 25 000 personnes. C'est la plus grande concentration du monde dans ce domaine qui a un taux de croissance extrêmement important et qui ouvre des perspectives dont chacune et chacun d'entre nous ne peuvent que bénéficier tant à travers les institutions sises à Genève qu'à travers les accords entre nations.

Cette année, à Genève comme à New York et partout dans le monde, le suivi de la réalisation des objectifs du Millénaire pour le développement est au centre de nos préoccupations. Trois des huit objectifs du Millénaire concernent directement la santé : l'objectif 4 (Réduction de la mortalité infantile), l'objectif 5 (Amélioration de la santé maternelle) et l'objectif 6 (Lutte contre le VIH/sida, le paludisme et d'autres maladies). Genève et la Suisse ont décidé de contribuer activement à la réalisation de ces objectifs particuliers, en menant divers projets visant au renforcement des systèmes de santé, à la promotion de la santé reproductive et à la maîtrise des maladies transmissibles : par exemple, dans plusieurs pays d'Afrique et d'Asie centrale, sur le plan bilatéral en complément des nombreux programmes d'organisations internationales, telles que l'UNICEF, le FNUAP, la Banque mondiale et le Fonds mondial auxquels la Suisse participe.

Je ne peux que me féliciter de la qualité et de l'utilité des rapports que l'OMS publie chaque année sur les avancées globales en matière d'objectifs du Millénaire pour le développement liés à la santé. Cette contribution permet aux États Membres de faire le point sur les réalisations, mais aussi sur les défis à venir. Le rapport de suivi de l'OMS est une contribution essentielle en vue du Sommet sur le suivi des objectifs du Millénaire qui se tiendra à New York en septembre prochain. D'innombrables autres sujets importants sont à l'ordre du jour de l'Assemblée de la Santé : citons notamment l'accès aux soins et aux services médicaux, les conséquences pratiques de la grippe pandémique, les rapports entre la santé et les questions de propriété intellectuelle ainsi que le recrutement international des personnels de santé. Nous ne pouvons que souhaiter que vos travaux se déroulent sereinement loin des débats politiques ou plus ou moins politiciens que l'on connaît parfois dans d'autres enceintes, et surtout que vous parveniez aux résultats concrets que le monde attend impatiemment de vous.

Madame le Directeur général, Mesdames et Messieurs, chers hôtes, vous le voyez, Genève est très fière de vous accueillir une nouvelle fois pour l'Assemblée mondiale de la Santé. Genève tient à la santé du monde et œuvre à son amélioration constante quels que soient les aléas de la conjoncture ou des relations internationales. Sachez que vous aurez du côté des autorités qui vous accueillent le soutien constant que mérite votre remarquable mission. Je souhaite mes meilleurs vœux à chacune et à chacun d'entre vous pour la réussite de vos travaux et vous remercie de votre attention.

4. ADDRESS BY THE PRESIDENT OF THE SIXTY-SECOND WORLD HEALTH ASSEMBLY
ALLOCUTION DU PRÉSIDENT DE LA SOIXANTE-DEUXIÈME ASSEMBLÉE MONDIALE DE LA SANTÉ

The PRESIDENT:[1]

Vice-Presidents of the Health Assembly, Director-General, Dr Margaret Chan. Fellow ministers of health, excellencies, distinguished delegates, WHO staff members, ladies and gentlemen, it has been a great honour and privilege for me to be the President of this august Health Assembly during the past year. It was certainly not merely a personal tribute. More significantly, it was an honour accorded to my country, Sri Lanka, and to my Region, South-East Asia, by the distinguished delegates to this Health Assembly.

I have had the privilege of being very closely associated with the work of WHO at the global and regional level for over 10 years. Having been a member of the Executive Board for two terms, I had the honour of chairing the Board in my second term – just prior to being elected the President at the last Health Assembly. Hence WHO is an organization that I deeply love and respect.

Excellencies and distinguished delegates, during my term of office, we witnessed a number of unprecedented challenges to global health. I recall that just before I assumed office, Dr Chan convened a high-level consultation to discuss the implication of the financial crisis that has struck the world like a gale force wind. I was requested by her to chair the session.

I must commend the proactive role of WHO during these extremely difficult times on health systems and on poor and disadvantaged people. One reason why the countries in South Asia have been protected against the full impact of the crisis is their traditionally cautious economic and financial policies. Associated with this of course is the prominent role of government, including management of market forces. This approach has been subject to some criticism in the past, and reforms in these areas have improved conditions for access to development assistance and international markets.

We have learnt that in times of crisis it is important not to forget the many other threats to health security. Preparing countries to cope with pandemics, food insecurity, war and conflicts and the impact of adverse weather events requires effective surveillance systems. In this connection we need to applaud the work of the Director-General and WHO and the development partners. It is important to ensure that these systems do not fall victim to the economic turndown.

Indeed, if the advent of the crisis provided the necessary stimulus to initiate reform, it was very opportune that a few years ago, we had commemorated 30 years after Alma-Ata, and adopted primary health-care reforms. These had the central objective of moving towards universal coverage. In fact, we have witnessed with a great deal of interest the recent health-care reforms of President Obama, who very courageously introduced some radical measures to make health care accessible and affordable to all Americans.

Pandemic (H1N1) 2009 was another major challenge that we had to face in the past year. Unlike some of the earliest threats to global health, where most of the epidemics started in the developing countries, Pandemic (H1N1) 2009 started and first spread in the developed world. It proved to us yet again diseases are no respecters of man-made boundaries nor economic status, and that everyone is equally vulnerable. However, we must draw inspiration from the fact that our collective global efforts enabled us to counter this pandemic quite successfully. We also commend WHO for efficiently coordinating the distribution of the pandemic influenza vaccines to 95 countries; and the decision of the Director-General to continue to monitor the situation closely, particularly with respect to virus behaviour and to inform Member States accordingly.

Health and disease profiles in the developing world are rapidly changing and the epidemic of noncommunicable diseases has already taken a foothold in the developing world. The evidence is mounting regarding the global burden of noncommunicable diseases and their intimate connection with the increase in poverty and erosion of economic growth. Some have referred to it as the "silent

[1] The following is the full text of the speech delivered by Mr Siripala de Silva in shortened form.

tsunami". Health systems in these countries are overburdened in trying to cope with the cost of treating noncommunicable diseases, while at the same time they are fighting communicable diseases and maternal and child health issues.

In this situation, I believe that the high cost of taking care of complications from noncommunicable diseases could be avoided if such diseases were addressed through a primary health care approach. We are thankful to WHO for defining a set of essential interventions to manage noncommunicable diseases through primary health care and we are informed that these are good investments in health of populations in the long term. I am happy that WHO has selected my country, Sri Lanka, as one of the pilot countries to introduce this model.

The time has come to include noncommunicable diseases in the development domain, together with infectious diseases and health-systems strengthening. These three issues are not in conflict. They do not represent a set of "either/or" options. It is the opposite. They can, and should, be mutually reinforcing. We need to place all three – communicable diseases, noncommunicable diseases and health systems – on the development agenda. Failure to do so will derail international efforts to improve health and reduce poverty. The work of international development agencies in poverty alleviation and in the control of infectious diseases is indeed essential for the world's "bottom billion", the people living in extreme poverty. These agencies also have a key role in promoting balanced investment for healthy development and noncommunicable diseases must be a part of such investment. The developed world, unless it responds to the epidemic of such diseases today, risks failing a considerable proportion of its intended beneficiaries.

The Commission on Social Determinants of Health established clearly that the economic and social features of society are closely linked to the distribution of health within and between countries. The social determinants of health are the circumstances of daily life: the way in which people are born, grow, live, work, and grow old. They also include the structural drivers of those conditions, such as the distribution of power, money and resources.

Sri Lanka has been proud to be strongly associated with the work of the Commission on Social Determinants of Health, led by Sir Michael Marmot. Sri Lanka was a country partner and a sponsor of the Health Assembly resolution on reducing health inequities through action on the social determinants of health. We hosted the first Regional Consultation on Social Determinants of Health during the course of last year. We are fully aware that the successes in health that Sri Lanka has achieved have been possible because for 50 years we gave pride of place to a multisectoral approach to health development, where education, nutrition and social welfare policies complemented the health policies in a judicious manner.

The challenge now is to maintain the momentum of the Commission and implement the main recommendations in the resolution, building concrete action in Member States to reduce health inequities. Member States need to examine their own contexts and see what will work best for them. This means building capacity to measure and monitor health inequities, making health services and programmes more equitable, and seeing how governments can implement an approach that considers health equity in all policies. It is my fervent hope that WHO will continue to provide strong support and leadership to achieve this.

Sri Lanka is working with WHO to improve the capacity of our public-health programmes to work together to reduce health inequities. Addressing the social determinants will be vital to our efforts to address this. We also see opportunities in increasing intersectoral action at the local level. We hope to share this experience with other countries, and I also hope that other Member States will take up the challenge of the Commission so that there can be a global exchange of experiences of reducing health inequities.

Climate change has become a significant and emerging threat to public health, and it changes the way we must look at protecting vulnerable populations. The impact of climate on human health will not be evenly distributed around the world. Developing country populations, particularly in Small island States, arid and high mountain zones, and in densely populated coastal areas, are considered to be particularly vulnerable. Our own Region, South-East Asia, is particularly vulnerable.

In my Region, the main adverse health outcomes that are predicted are varied: mountain countries like Bhutan and Nepal could face disasters of flash floods resulting from glacier melting and

the spread of vector-borne diseases at high altitude. Maldives will face a very fundamental problem of existence as a result of global warming. No country will be spared one way or another.

We are pleased that WHO has helped most South-East Asia Region countries to set up national bodies to study their national vulnerability and assess the potential impacts from climate change. We need much more support and technical advice. Areas with weak health infrastructure – mostly in developing countries – will be the least able to cope without assistance to prepare and respond. Another important response needed to minimize the health impacts of climate change is to build community capacity to help people to adapt to climate change, as a social response to extreme weather conditions and disasters.

We have discussed the issue of migration of health workers at different fora, the Regional Committee, the Executive Board and even at the Health Assembly. We have stressed that effective and efficient management of the existing health workforce would lead to effective programme delivery and significant improvements in health services. We have noted with concern the continued international migration of health personnel, which has contributed to unacceptable shortages, and geographical and skill-mix imbalances in health workforce in many countries of the Region. Most of our developing countries are not yet technically equipped to assess adequately the magnitude and characteristics of the outflow of their health personnel, nor are they able to increase the salaries and allowances to match those of the receiving countries.

I am pleased to see that an international code of practice has been formulated to address these issues and wish that this be adopted and implemented diligently and seriously. However my own contention is that the code does not go far enough. Considering the magnitude of the problem I feel that we should make the code more binding on both the countries of origin and the recipient countries if it is to be truly effective.

We would also seek WHO support for our efforts by facilitating dialogue and raising awareness at the highest national and international levels and between different stakeholders about this important issue.

In many countries we have had medical systems that have proved effective and reliable for over thousands of years. I believe it is high time we place more emphasis and draw from these Eastern effective methods to deliver health care to millions at lower cost. Ayurveda, homeopathy and other alternative and traditional systems of medicine, while reducing costs of care, can increase coverage to the entire population. Recently I was interested to read an interesting discussion in American medical journals proposing to include "complementary and alternative medicine systems" in medical school teaching. The quantity and quality of research in complementary and integrative health care is still a frontier science but is growing rapidly and WHO should take a leadership role to help countries make evidence-based decisions regarding these practices.

Health of migrants, most of whom are in foreign countries for economic reasons, has been another important matter of concern for the distinguished delegates of this global Health Assembly. If we subscribe to the principle that health is a basic human right, leaving aside humanitarian considerations, this is a very unsatisfactory situation that needs to be redressed urgently. We need to ensure that the appropriate provision of adequate quality health care is an essential requirement for recruitment of labour to these countries.

Better health is central to the achievement of the Millennium Development Goals, both as an end in itself and as a major contributor to the overall goal of reducing poverty. Reporting on progress towards the Goals has underscored the importance of working with countries to generate more reliable and timely data and to improve health information systems. In the poorest countries, however, achieving the health-related Millennium Development Goals represents one of the greatest challenges in international development. Currently available data show that while some countries have made impressive gains in achieving health-related targets, others are falling behind. We are also aware that often the countries making the least progress are those affected by high levels of HIV/AIDS, economic hardship or conflict. To this we have to add the steep declines required in child and maternal mortality, where progress lags far behind aspirations.

It is increasingly evident that improving health outcomes to reach the Millennium Development Goals will not be possible without major improvements in health-care delivery systems. Progress will also depend of increasing the availability of resources and the effectiveness and equity of spending

these resources. Escalating health-care costs, a growing number of pharmaceutical treatments, and increasing resistance to antibiotics are just three of the factors that make therapeutically sound and cost-effective use of medicines by health workers and consumers more and more necessary. Therefore rational use of medicines is an urgent need today. Irrational use of medicines by prescribers and consumers is a very complex problem, depending on a number of various and interrelated factors which influence the use of medicines. A well-respected Sri Lankan, Professor Senaka Bibile, promulgated the concept of essential drugs 50 years ago. Due to the subsequent work of WHO, this triggered interest worldwide in the adoption of essential medicines policies. We need to revisit these policies and once again actively promote the rational use of medicines. For this, the cooperation of the medical community is essential. It calls for the implementation of several different interventions at the same time and should also cover the use of traditional and herbal medicines.

A media person in Geneva asked me soon after I took over the Presidency last year, how we might measure our success. I mentioned then that, unlike a company that always determines its success by its profits, WHO and the health sector could not use a similar yardstick in assessing our success or failure. To do so would unacceptably negate the principles of equity and social justice that we cherish so much. Our success can only be measured by the manner in which we support and guide all Member States to provide quality, affordable and socially-acceptable health care to all of their people irrespective of all other considerations. It is up to the Member countries to build their own health systems through innovative approaches, taking into consideration their ground realities. It is the duty of the developed world to support developing and least-developed countries to achieve the goal of equity in health. Thank you for your attention.

Before dealing with the first two items on our provisional agenda, I would like to briefly suspend the plenary and ask our delegates to kindly remain seated while the Director-General and I bid farewell to our special guests.

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

The PRESIDENT:

We will start with provisional agenda item 1.1, Appointment of the Committee on Credentials. The Health Assembly is required to appoint a Committee on Credentials in accordance with Rule 23 of the Rules of Procedure of the Health Assembly. In conformity with this Rule, I propose for your approval the following 12 Member States: Angola, Austria, Bangladesh, Eritrea, Israel, Nauru, Nicaragua, Singapore, Oman, The former Yugoslav Republic of Macedonia, Trinidad and Tobago and Zambia. Is this proposal acceptable? As I see no comments, I declare the Committee on Credentials, as proposed by me, appointed by the Health Assembly.

6. ELECTION OF THE PRESIDENT
ÉLECTION DU PRÉSIDENT

The PRESIDENT:

We shall now proceed with item 1.2, Election of the President. In accordance with Rule 24 of the Rules of Procedure, at each regular session, the Health Assembly shall elect a President and five Vice-Presidents, who shall hold office until their successors are elected. You have before you a white paper which contains names of delegates proposed for consideration following consultations within their respective regions, as well as their respective countries. To consider the nomination for the office of the President of the Sixty-third World Health Assembly, I recall that, in accordance with the practice of regional rotation which the Health Assembly has followed for many years in this regard,

the President of the Sixty-third World Health Assembly should be chosen from among delegates of Members of the Eastern Mediterranean Region. I understand that Mr Mondher Zenaidi of Tunisia is proposed for the office of President of the Sixty-third World Health Assembly. Is this proposal acceptable?

In the absence of any observations, and as it appears that there are no other proposals, I suggest, in accordance with Rule 78 of the Rules of Procedure, that the Health Assembly approves the nomination and elects its President by acclamation.

(Applause/Applaudissements)

Mr Mondher Zenaidi is thereby elected President of the Sixty-third World Health Assembly and I invite him to take his seat on the rostrum.

Mr Mondher Zenaidi (Tunisia) took the presidential chair.
M. Mondher Zenaidi (Tunisie) prend place au fauteuil présidentiel.

The PRESIDENT: الرئيس:

أعلن افتتاح الجلسة،

أصحاب السعادة، معالي السادة الوزراء، السادة السفراء والمندوبين، سيادة المديرة العامة أود أن أشكر هذا الجمع الكريم على الثقة التي أولانيها بانتخابي رئيساً لجمعية الصحة العالمية الثالثة والستين. وأود أن أعرب عن تقديري للسيد نيمال سيريبالا دي سلفا، سلفي في هذا المنصب، لمساهمته في جمعية الصحة العالمية الماضية.

وجرياً على العادة سألقي خطاب الرئيس في وقت لاحق اليوم أما الآن فسنواصل أعمالنا.

7. ELECTION OF THE FIVE VICE-PRESIDENTS, THE CHAIRMEN OF THE MAIN COMMITTEES, AND ESTABLISHMENT OF THE GENERAL COMMITTEE
ÉLECTION DES CINQ VICE-PRÉSIDENTS, DES PRÉSIDENTS DES COMMISSIONS PRINCIPALES ET CONSTITUTION DU BUREAU

The PRESIDENT: الرئيس:

نتطرق الآن إلى تعيين نواب رئيس جمعية الصحة.

Election of the five Vice-Presidents
Élection des cinq vice-présidents

وأود أن أذكّر بأن من الإنصاف، نظراً لأن منصب الرئيس يشغله أحد المنتسبين إلى إقليم شرق المتوسط، اختيار نواب الرئيس من ضمن المندوبين المنتسبين إلى أقاليم المنظمة الخمسة الأخرى. وفي هذا الصدد وردت الاقتراحات التالية:

(L'orateur poursuit en français.) **(يواصل المتحدث كلامه بالفرنسية)**

Professeur Mya Oo (Myanmar), Docteur Maria Isabel Rodriguez (El Salvador), Docteur Richard Sezibera (Rwanda), Mme Gatoloaifaana Amataga Alesana Gidlow (Samoa), Professeur Recep Akdağ (Turquie).

(L'orateur poursuit en arabe.) **(يواصل المتحدث كلامه بالعربية)**

هل هذه الاقتراحات مقبولة لدى الجمعية؟ في حالة عدم وجود أي اعتراضات، أعتبر أن جمعية الصحة ترغب في انتخاب المندوبين الخمسة لمناصب نواب رئيس جمعية الصحة العالمية الثالثة والستين.

(Applause/Applaudissements)

سأتولى الآن، عن طريق القرعة، تحديد الترتيب الذي سيطلب، وفقاً له، من نواب الرئيس شغل منصب الرئيس إذا تعذر عليه أداء دوره في الفترات الفاصلة بين الجلسات.

لقد دونت أسماء نواب الرئيس الخمسة على خمس ورقات منفصلة وسأختار من بينها بالقرعة.

(L'orateur poursuit en français.) **(يواصل المتحدث كلامه بالفرنسية)**

Docteur Maria Isabel Rodriguez (El Salvador), Docteur Richard Sezibera (Rwanda), Professeur Recep Akdağ (Turquie), Mme Gatoloaifaana Amataga Alesana Gidlow (Samoa), Professeur Mya Oo (Myanmar).

(L'orateur poursuit en arabe.) **(يواصل المتحدث كلامه بالعربية)**

ستتخذ بعض الترتيبات فيما يتعلق بجلوس السادة نواب الرئيس هنا إلى يمين المنصة. وأود أن أقترح أن يأخذ السادة نواب الرئيس مقاعدهم هنا في الجلسة العامة الثانية بعد اجتماع اللجنة العامة الأول الذي سينعقد صباح هذا اليوم مباشرة بعد أن نختم الجلسة العامة الأولى.

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

The PRESIDENT: الرئيس:

نتطرق الآن إلى انتخاب رئيسي اللجنتين الرئيسيتين.

لقد اقترح الدكتور ماساتو موجيتاني من اليابان لشغل منصب رئيس اللجنة "أ".

هل يحظى هذا الاقتراح بالقبول؟ وعليه انتخب الدكتور موجيتاني رئيساً للجنة "أ".

(Applause/Applaudissements)

لقد اقترح الدكتور ويمال جاينتا، من سري لانكا، منصب رئيس اللجنة "ب". هل يحظى هذا الاقتراح بالقبول؟

نظراً لعدم وجود أي اعتراضات أعتبر أن جمعية الصحة ترغب في انتخاب الدكتور جاينتا رئيساً للجنة "ب".

(Applause/Applaudissements)

Establishment of the General Committee
Constitution du Bureau

The PRESIDENT: الرئيس:

نمضي الآن إلى انتخاب أعضاء اللجنة العامة السبعة عشر وفقاً للمادة 29 من النظام الداخلي.
تتألف اللجنة العامة من الرئيس ونواب الرئيس ورئيسي اللجنتين الرئيسيتين، و17 مندوباً تتولى الجمعية انتخابهم. ولتحقيق توازن جغرافي عادل ضمن اللجنة العامة، أقترح أن تنتخب الجمعية أعضاء اللجنة العامة المتبقين على النحو التالي: 5 دول أعضاء من الإقليم الأفريقي؛ 4 دول أعضاء من إقليم الأمريكتين؛ دولتان عضوان من إقليم شرق المتوسط؛ 5 دول أعضاء من الإقليم الأوروبي؛ دولة عضو واحدة من إقليم غرب المحيط الهادئ
هناك ورقة بيضاء مطروحة عليكم وتورد اقتراحات بتعيين أعضاء اللجنة العامة السبعة عشر الآخرين. وسأعيد ذكر هذه الاقتراحات بحسب الإقليم.

(L'orateur poursuit en français.) **(يواصل المتحدث كلامه بالفرنسية)**

Région de l'Afrique : Burkina Faso, Cap-Vert, République démocratique du Congo, République-Unie de Tanzanie, Tchad ; Région des Amériques : Chili, Cuba, États-Unis d'Amérique, Jamaïque ; Région de la Méditerranée orientale : Jamahiriya arabe libyenne ; Jordanie ; Région de l'Europe : Espagne, Estonie, France, Fédération de Russie, Royaume-Uni de Grande-Bretagne et d'Irlande du Nord ; Région du Pacifique occidental : Chine.

(L'orateur poursuit en arabe.) **(يواصل المتحدث كلامه بالعربية)**

هل توافق الجمعية على هذه الاقتراحات السبعة عشر؟ لا أرى أي اعتراض وعليه أعتبر أن الجمعية ترغب في انتخاب هذه الدول الأعضاء لعضوية اللجنة العامة. وقد تقرر ذلك. لقد جئنا الآن إلى نهاية أعمالنا فاسمحوا لي بان أعرب عن شكري لجميعكم على تعاونكم.
ستعقد اللجنة العامة أول جلساتها بمجرد رفع هذه الجلسة، وينبغي للسادة أعضاء اللجنة المضي إلى القاعة 12 التي تقع في هذا الطابق من هذا المبنى، في الممر المؤدي إلى المبنى الجديد. وهل لي أن أذكّر حضراتكم بأن المادة 30 من النظام الداخلي تقصر حضور اللجنة العامة على أعضائها وعلى ما لا يتجاوز أكثر من عضو واحد من كل وفد إلى جمعية الصحة من غير الممثلين في اللجنة.
وستعقد الجلسة العامة القادمة هنا في هذه القاعة صباح هذا اليوم في تمام الساعة الحادية عشرة أو مباشرة بعد الانتهاء من اللجنة العامة. رفعت الجلسة.

(Applause/Applaudissements)

The meeting rose at 10:25.
La séance est levée à 10h25.

SECOND PLENARY MEETING

Monday, 17 May 2010, at 11:50

President: Mr Mondher ZENAIDI (Tunisia)

DEUXIÈME SÉANCE PLÉNIÈRE

Lundi 17 mai 2010, 11h50

Président: M. Mondher ZENAIDI (Tunisie)

1. PRESIDENTIAL ADDRESS
DISCOURS DU PRÉSIDENT DE L'ASSEMBLÉE

The PRESIDENT: الرئيس:

أعلن افتتاح الجلسة

بسم الله الرحمن الرحيم،

السادة والسيدات نواب رئيس جمعية الصحة العالمية، السيدة مارغريت تشان المديرة العامة لمنظمة الصحة العالمية، أصحاب المعالي الوزراء، أصحاب السعادة، السادة المندوبين، السيدات والسادة،

يُسعدني في مستهلِ هذه الكلمة أن أتوجه إليكم بفائق التقدير والامتنان على الثقة الغالية التي أوليتموها لبلدي تونس بانتخابها رئيساً لجمعية الصحة العالمية الثالثة والستين وهو شرف كبير يتجاوز تونس ليشمل كامل إقليم شرق المتوسط.

كما لا يفوتني أن أتوجه بخالص التهنئة إلى نظيري معالي السيد نيمال سريبالا دي سيلفا على رئاسته الحكيمة للجمعية خلال الدورة المنقضية والجهود القيّمة التي بذلها من أجل توطيد عُرى التعاون بين البلدان الأعضاء.

ولا يسعني، في نفس الإطار، إلا أن أجدد فائق التقدير إلى معالي السيدة مارغريت تشان، المديرة العامة لمنظمة الصحة العالمية، والسادة المديرين الإقليميين على جهودهم الحثيثة من أجل دعم مقومات الرفاه الصحي لكافة شعوب المعمورة ورفع التحديات الصحية الجسيمة التي يشهدها عالمنا اليوم والتي زادت حدة بفعل تواتر الأزمات وآخرها الأزمة الاقتصادية والمالية العالمية، إلى جانب تكاثر المخاطر الصحية وآخرها أنفلونزا A (H1N1)، فضلاً عن تزايد وطأة التغيرات المناخية على عديد القطاعات وفي مقدمتها القطاع الصحي.

السيدة المديرة العامة، أصحاب المعالي والسعادة، السيدات والسادة، إن اعتزاز تونس برئاسة هذه الدورة ينبع من الأهمية البالغة التي مافتئت توليها بهدي من سيادة الرئيس زين العابدين بن علي لصحة المواطن وذلك انطلاقاً من الوعي بأن الاستثمار في رأس المال البشري يظل الاستثمار الأفضل والرصيد الأبقى لاستحثاث نسق التنمية الشاملة.

وقد مكنت هذه المقاربة الرائدة من إحداث نقلة هامة في واقع القطاع الصحي في تونس على مدى العقدين الأخيرين يجسمها بالخصوص المستوى المتميز الذي بلغته مختلف المؤشرات الصحية على غرار مؤمل الحياة عند الولادة الذي أصبح يناهز 75 عاماً، ومُعدل وفيات الأطفال والأمهات، وتسهيل نفاذ كافة المواطنين إلى الخدمات الصحية، فضلاً عن مواكبة الطب المتطور والقضاء على عديد الأمراض والأوبئة.

وقد كانت هذه المكاسب محل إشادة متواصلة على الساحة الدولية ومن ذلك إحراز سيادة الرئيس زين العابدين بن علي على الميدالية الذهبية لمنظمة الصحة العالمية منذ سنة 1996، فضلاً عن تبوؤ تونس مرتبة مرموقة على الصعيد العالمي بالنسبة إلى مؤشر جودة الحياة، وكذلك نجاحها في تحقيق أسرع نسق للتنمية البشرية على مدى العشرية الأخيرة.

وإذ أشيد بالجهود القيّمة والسياسات التي تنتهجها مختلف البلدان الأعضاء لدعم مقومات الرفاه الصحي لشعوبها، فإني أود أن أؤكد بهذه المناسبة على أهمية تضافر جهودنا من أجل تسريع وتعميق التوجهات الإصلاحية التي تم إرساؤها على مدى الدورات السابقة لتحقيق هدف الصحة الشاملة بما يتطلبه ذلك من تغيير وتجديد للآليات المنتهجة، وتعميق البعد الإستراتيجي لمنظمتنا، وتوحيد جهود سائر الأطراف المتدخلة، وتكريس تضامن دولي حقيقي وفاعل يمكّن من رأب الهوة الصحية المتعاظمة بين بلدان بلغت مراحل متقدمة من التحول الديمغرافي والوبائي وتواجه تحديات جديدة تتمثل أساساً في الكلفة المتنامية للنفقات الصحية، وبلدان أخرى تمثل ثقلاً ديمغرافياً هاماً مازالت ترزح تحت الفقر والجوع وندرة المياه الصالحة للشراب والافتقار إلى أبسط المرافق الضرورية كالصرف الصحي وصعوبة النفاذ إلى الخدمات الصحية الدُنيا.

كما يجدر التذكير في نفس الإطار بالأوضاع الصحية والإنسانية المؤلمة التي يعيشها العديد من شعوب المعمورة ومنهم شطر كبير من سكان إقليم شرق المتوسط لاسيما بسبب الاحتلال الإسرائيلي للأراضي الفلسطينية والأراضي العربية في الجولان السوري مما حرم هذه الشعوب الشقيقة من حقها المشروع في الصحة بما يتعارض مع المواثيق الدولية وقرارات منظمتنا ذات الصلة.

ولاشك أن تواصل هذه الإشكاليات كان له أسوأ الأثر على الوضع الصحي لكثير من الدول وعلى تحقيق الأهداف الإنمائية للألفية التي تمثل موضوعاً رئيسياً لدورتنا هذه حيث، على سبيل المثال، مازالت كثير من الشعوب تعاني، كما تعلمون، من ارتفاع معدلات وفيات الأطفال والأمهات.

وانطلاقاً من موقف تونس الثابت بشأن ضرورة تفعيل التضامن الدولي خدمة للرفاه والسلم والازدهار لكافة شعوب المعمورة، فإني أدعو بهذه المناسبة إلى تضافر جهود الدول الأعضاء من أجل تفعيل التضامن الصحي بوصفه جزءاً لا يتجزأ من التضامن الدولي في مفهومه الشامل.

وهنا أريد التذكير بأن المجموعة الدولية أقرت بالإجماع سنة 2000 إحداث صندوق عالمي للتضامن بصفته آلية أممية تُسهم في تحقيق أهداف الألفية وخاصة تقليص نسبة الفقر بـ50٪ في أُفق 2015.

ولاشك أن إحداث نقلة جديدة في التعاون جنوب – جنوب بما يتطلبه ذلك من دور أكبر وأكثر فاعلية للجهات المانحة، من شأنه أن يُسهم في الحد من الهوة الصحية وضمان العدالة والمساواة في الاستفادة من التكنولوجيا الطبية الحديثة وتطوير الصناعة الدوائية وميدان البحوث العلمية، مع التذكير في هذا الصدد بعراقة تجربة تونس في مجال التعاون الثلاثي مع الجهات المانحة وعدد من البلدان الشقيقة لاسيما في ميادين الصحة الإنجابية وصحة الأم والطفل.

ويُسعدني، من جهة أخرى، أن ألتمس من معاليكم النظر في إمكانية إرساء آلية في مستوى منظمة الصحة العالمية لتقييم آثار الأزمة الاقتصادية العالمية وتشخيص السبل المثلى لتطويقها والحد من وطأتها على قطاع الصحة في مختلف أنحاء العالم.

وتجدر الإشارة من جهة أخرى إلى أهمية التعمق في دراسة تداعيات العولمة وتقدم مسار تحرير التجارة العالمية على التنمية الصحية بمختلف جوانبها بما في ذلك حق كافة شعوب العالم في الصحة وفي الاستفادة من التكنولوجيا الصحية والطبية الآمنتين وبتكاليف معقولة، مع التذكير في هذا الصدد بالصعوبات التي واجهت بلدان الجنوب في الحصول على اللقاحات الضرورية إبان الجائحة الأخيرة لأنفلونزا A (H1N1)، وهو ما أدى إلى تعميق الشعور بعد توفر مقتضيات العدالة الصحية.

السيدة المديرة العامة، أصحاب المعالي والسعادة، السيدات والسادة، إن المكاسب التي تحققت على مدى ثلاثة عقود على درب النهوض بالرعاية الصحية الأولية لا تحجب عنا الحاجة الماسة إلى تقوية النُظم

الصحية في كثير من البلدان، وذلك من خلال مساعدتها على إرساء نُظم فاعلة تقوم على التسيير والتخطيط الجيد وتسهيل النفاذ للخدمات الصحية وتوفير الإمكانيات والموارد البشرية الملائمة.

وإذ أشيد في هذا الصدد بالتوصيات الواردة في التقرير الخاص بالصحة في العالم، لعام 2008، فإنه من الضروري أن تبادر منظمة الصحة العالمية بدعم البلدان المعنية ومساعدتها على تنفيذ هذه التوصيات خاصة من خلال إعداد دلائل استرشادية واضحة تُسهم في تحقيق التغطية الصحية الشاملة ووضع السياسات الصحية الملائمة حيز التنفيذ.

وتجدر الإشارة من جهة أخرى إلى أهمية التفكير العميق في سبل حماية مجتمعاتنا من الخطر المتنامي للأمراض غير السارية التي باتت تشكل تهديداً رئيسياً للصحة العامة ولمقتضيات التنمية المستدامة وذلك في ضوء الانتشار السريع لهذه الأمراض الذي يعود، كما تعلمون، إلى العديد من عوامل الاختطار وفي مقدمتها تعاطي التبغ، والنظام الغذائي غير الصحي، والخمول البدني، وتعاطي الكحول على نحو ضار.

وللأسف، فإن هذه العوامل في تزايد سريع في مختلف البلدان. وما لم يتم التصدي لها، فإن عبء المراضة والوفيات سيتعاظم خلال الأعوام القادمة حيث تشير التقديرات إلى أن الوفيات الناجمة عن هذه الأمراض ستتطور بنحو 17٪ خلال العشرية القادمة، علماً وأن أكبر زيادة ستكون في الإقليم الأفريقي وإقليم شرق المتوسط.

واعتباراً لتبني المجموعة الدولية لمقترح سيادة الرئيس زين العابدين بن علي بجعل 2010 سنة دولية للشباب والتي سوف تتوج بمؤتمر دولي ينتظم تحت رعاية الأمم المتحدة، فإنه يسعدني أن أقترح على معاليكم النظر في إمكانية عقد دورة استثنائية للجمعية العامة تتطرق إلى موضوع "الشباب والصحة" وتكون مناسبة للتفكير العميق والاستراتيجي وتبني رؤية شاملة حول السبل المثلى والآليات الملائمة لحماية الأجيال الناشئة من مختلف أشكال المخاطر الصحية، أو جعل هذا الموضوع شعاراً للدورة القادمة للجمعية العامة.

وسعياً إلى تحقيق تطلعاتنا المشتركة على درب الارتقاء بالوضع الصحي العالمي، أود الإشارة إلى أنه بالتوازي مع ضرورة تقديم مزيد من الدعم للبلدان الأقل نمواً، ينبغي التفكير في الآليات الملائمة لمساعدة البلدان الصاعدة أو ذات الدخل المتوسط التي باتت تواجه تحديات صحية جسيمة نتيجة لبلوغها مراحل متقدمة من التحول الوبائي والديمغرافي.

السيدة المديرة العامة، أصحاب المعالي والسعادة، السيدات والسادة، أشكر لكم جميعاً حسن استماعكم متطلعاً إلى مساعدتكم لي على أداء مهمتي على أكمل وجه ومجدداً اعتزاز بلادي تونس برئاسة هذه الدورة وعزمها على بذل الجهود الملائمة لإنجاح فعالياتها بما يُسهم في توطيد مقومات الرفاه الصحي لكافة شعوب المعمورة.

والسلام عليكم ورحمة الله وبركاته.

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

The PRESIDENT:

The next item to be considered is item 1.4, Adoption of the agenda and allocation of items to the main committees, which was examined by the General Committee at its first meeting. The General Committee examined the provisional agenda for the Sixty-third World Health Assembly (document A63/1), as prepared by the Executive Board and sent to all Member States. The General Committee recommended to delete the following four items from the provisional agenda as there are no corresponding items of business to deal with under them: item 5, Admission of new Members and Associate Members, as no new applications have been received; item 15.3, Special arrangements for settlement of arrears; item 15.5, Assessment of new Members and Associate Members; and item 17.5,

Report of the United Nations Joint Staff Pension Board. Am I correct in assuming it is agreed to delete these items?

I see no objections; it is so decided. May I therefore assume that the Health Assembly agrees to adopt the provisional agenda as contained in document A63/1, as amended? It is so decided.

Document A63/1 Rev.1, reflecting the changes in the agenda will be distributed tomorrow morning. The General Committee also decided to recommend to the plenary that the Sixty-third World Health Assembly should close on Friday, 21 May. Does the plenary agree to this proposal? I see no objection, it is so decided.

The provisional agenda of the Health Assembly was prepared by the Executive Board in such a way as to indicate a proposed allocation of items to Committees A and B, on the basis of the terms of reference of the main committees. The General Committee has decided to recommend to the plenary that agenda item 13 concerning health conditions in the occupied Palestinian territory, including East Jerusalem and in the occupied Syrian Golan – which is normally allocated to Committee B – be allocated this year to Committee A and be taken up by Committee A during the afternoon of Tuesday, 18 May. This recommendation is based on the General Committee's view that the change in timing will facilitate a more effective debate involving all interested parties. This recommendation is premised on the following understanding: that this change is without precedent to the future allocation and scheduling of this item; that the proposed draft resolution for this matter will be available in all languages, fully respecting the principle of multilingualism, as soon as possible in advance of Tuesday afternoon; that Committee A will take into account both the need for coordination among and between regional and other groups, and for ensuring adequate time for debate of the other items allocated to it. With these understandings in mind does the Health Assembly agree with the recommendation of the General Committee? As I see no objection, it is so decided.

It is understood that, later in the session, it may become necessary to transfer items from one committee to the other, depending on each main committee's workload. The General Committee will meet again on Wednesday, 19 May, to review progress on dealing with the agenda and to make any adjustments to allocation of items to Committees, or to the timetable that are necessary. Does the Health Assembly agree with these proposals? As I see no objection, it is so decided.

Returning now to the meetings of the plenary, in order to facilitate the organization of the week, I should like to propose, and this is a procedure followed on previous occasions, that the order of the list of speakers for the discussion under agenda item 3 should be strictly adhered to, and that further inscriptions should be taken in the order in which they are made. These inscriptions should be handed in to the Office of the Assistant to the Secretary of the Health Assembly, or during the plenary to the officer responsible for the list of speakers, on the rostrum. I propose that the speakers list should be closed tomorrow, Tuesday, at 10:00 hours. I assume these proposals are acceptable to everyone.

3. REPORT OF THE EXECUTIVE BOARD ON ITS 125TH AND 126TH SESSIONS RAPPORT DU CONSEIL EXÉCUTIF SUR SES CENT VINGT-CINQUIÈME ET CENT VINGT-SIXIÈME SESSIONS

The PRESIDENT:

We shall now move on to item 2, Report of the Executive Board on its 125th and 126th sessions. 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 rationale and nature of recommendations made by the Board for the Health Assembly's consideration. 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 Sam Zaramba, Chairman of the Board.

Dr ZARAMBA (Chairman of the Executive Board):

Mr President, Vice-Presidents, Dr Margaret Chan, Director-General of the World Health Organization, honourable ministers, excellencies, distinguished delegates, ladies and gentlemen, good afternoon to you all. First of all, I would like to congratulate you, Mr President, and the other office-bearers on your election, and wish you every success in chairing this session of the Health Assembly, which has a very full and interesting agenda. As a detailed report of the work of the Executive Board is available in document A63/2, I will focus my statement on summarizing the highlights of the 125th session of the Executive Board, held in May 2009 and on the 126th session, in January 2010.

During the 125th session of the Executive Board in May 2009, the Board confirmed that elimination of measles was feasible and the Secretariat undertook to report on assessing the feasibility of elimination to the Health Assembly in 2010. The Board also noted the report on availability, safety and quality of blood products, and considered a draft resolution submitted by a number of Member States but agreed to postpone further discussion to the 126th session. The Board similarly decided to defer further discussion on the proposed revision of the guidelines on the WHO review of psychoactive substances for international control to the 126th session in order to allow for technical input. After discussion of the report on birth defects and of a draft resolution submitted by several Member States, it was agreed that the Secretariat would revise the report which, with the proposed draft resolution, would be reconsidered at the 126th session in January 2010. The Board established an Independent Expert Oversight Advisory Committee and approved its terms of reference.

The 126th session of the Board in January 2010 agreed to include three supplementary items: the health consequences of the earthquake in Haiti, treatment and prevention of pneumonia, and leprosy.

Following an update on the current situation on the pandemic (H1N1) 2009, members agreed that the pandemic had demonstrated the effectiveness of the International Health Regulations (2005) for the first time. There were lessons to be learnt, for instance in the area of communications and zoonoses, and the need to strengthen core capacities in surveillance and response had been identified. The Board agreed that the Director-General should activate the IHR Review Committee to examine the global response to the pandemic, which would submit an interim report to the Sixty-third World Health Assembly.

The Board discussed the global strategy and plan of action on public health, innovation and intellectual property, and agreed that the full report of the Expert Working Group on Research and Development Financing in all the official languages of WHO would be circulated in time for an informal meeting with Member States on 13 May 2010.

The Board agreed that an open-ended working group of Member States should be convened to reach agreement on the final elements under the pandemic influenza preparedness framework for sharing of influenza viruses and access to vaccines and other benefits. The group met on 10–12 May 2010 and its report has been submitted to the Sixty-third World Health Assembly.

In order to give impetus to the process of monitoring annual progress towards achieving the health-related Millennium Development Goals, a multi-sponsored resolution has been recommended to the Health Assembly for adoption.

The Board agreed that the draft code of practice for international recruitment of health personnel, which reflected the outcomes of regional discussions, would be submitted to the Health Assembly for consideration, with any comments or amendments submitted by Member States forwarded separately.

Following its discussion of the report on infant and young child nutrition, the Board has recommended to the Health Assembly a resolution which, among other things, requests the Director-General to develop a comprehensive implementation plan on infant and young child nutrition. The

Board discussed the items on birth defects and availability, safety and quality of blood products, and adopted the draft resolutions deferred from the 125th session.

On food safety, the Board recommended a resolution to the Health Assembly on advancing food safety initiatives, which focused on greater international engagement.

Several Board members called for more resources to be allocated to the prevention and control of noncommunicable diseases. It was emphasized that all stakeholders had a role to play, including Member States. The Board also discussed reports on tuberculosis control, leishmaniasis control, smallpox eradication: destruction of variola virus stocks, and the global eradication of measles. The Board recognized the growing public health burden due to viral hepatitis and proposed a resolution to the Health Assembly which, among various actions to improve prevention, control, diagnosis and treatment, designates a World Hepatitis Day.

Consultations over the past year, together with informal discussions during the 126th session, on strategies to reduce the harmful use of alcohol resulted in the Board's adoption of resolution EB126.R11, to which a revised draft global strategy was annexed. The Board recommended the Health Assembly to endorse that global strategy.

The item on Strategic Approach to International Chemical Management had been deferred from the Sixty-second World Health Assembly and the Board adopted two resolutions submitted by several Member States. The two texts focused on different ways to improve health: through safe and environmentally sound waste management, and through sound management of obsolete pesticides and other obsolete chemicals.

Considering anew the proposed revision of the guidelines on the WHO review of psychoactive substances for international control, the Board made a few modifications to the texts and approved the revised guidelines.

In its consideration of the treatment and prevention of pneumonia, the Board recommended a resolution for adoption by the Health Assembly on accelerating progress towards achievement of Millennium Development Goal 4 to reduce child mortality through the prevention and treatment of pneumonia.

In addition to the discussion of technical and health matters, the Board noted the report on the Eleventh General Programme of Work, 2006–2015, which was considered as remaining relevant to the work of the Organization. The Board also reappointed Dr Luis Gomes Sambo as Regional Director for Africa and appointed Ms Zsuzsanna Jakab as Regional Director for Europe. The Board recommended adoption of the scale of assessments by the Health Assembly, and took note of the request by the Programme, Budget and Administration Committee in its discussion of safety and security of staff and premises and the Capital Master Plan for further elaboration of the financing options for capital expenditure and recurrent costs, to be submitted to the Sixty-third World Health Assembly. The Board appointed the candidates proposed by the Director-General as members of the Independent Expert Advisory Oversight Committee, established by the Board at its 125th session.

Mr President, the other Executive Board Representatives and I would like to assure you that we will be available during the discussions in the Committees of the Health Assembly. We stand ready to lend our full support and to provide additional information as required on how the Board dealt with certain items under consideration and in doing so to facilitate the work of the Health Assembly.

The PRESIDENT:

Thank you, Dr Zaramba, for your excellent report. I should like to take this opportunity of paying tribute to the work of the Executive Board, and in particular to express our appreciation and our warm thanks to the outgoing members who have contributed very actively to the work of the Board. This concludes our review of item 2 of our agenda.

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

THIRD PLENARY MEETING

Monday, 17 May 2010, at 14:40

President: Mr Mondher ZENAIDI (Tunisia)
later: Mrs G.A.A. GIDLOW (Samoa)
and Dr R. SEZIBERA (Rwanda)

TROISIÈME SÉANCE PLÉNIÈRE

Lundi 17 mai 2010, 14h40

Président: M. Mondher ZENAIDI (Tunisie)
puis: Mme G.A.A. GIDLOW (Samoa)
et Dr R. SEZIBERA (Rwanda)

1. ADDRESS BY THE DIRECTOR-GENERAL
ALLOCUTION DU DIRECTEUR GÉNÉRAL

The PRESIDENT: الرئيس:

أعلن افتتاح الجلسة،
نتناول الآن البند 3 من جدول الأعمال، وهو بعنوان كلمة الدكتورة مارغريت تشان، المديرة العامة. وأعطي الكلمة للدكتورة مارغريت تشان المديرة العامة. سيدتي، تفضلي بإلقاء الكلمة.

The DIRECTOR-GENERAL:

Mr President, honourable ministers, excellencies, distinguished delegates, Dr Mahler, ladies and gentlemen, good afternoon.

Public health must never cease to learn from its successes, and its failures. Thirty years ago, the World Health Assembly declared that "the world and all its people have won freedom from smallpox". That official death certificate for an ancient scourge marked an unprecedented achievement in the history of public health. It provided dramatic proof of the power of collective action to improve the human condition in a permanent way. This is worth remembering at a time when the international community is engaged in the most ambitious attack on human misery in history, with just five years left until 2015.

Smallpox eradication was a single-disease initiative. That killing, blinding, disfiguring disease never had a cure. The cornerstone of that campaign was prevention at a time when most health systems around the world were designed to deliver curative care. An initiative that broke every single chain of virus transmission in every corner of the world was the ultimate example of universal coverage. This tells us what collective action for a common cause can achieve. Among its many legacies, the eradication campaign spawned the Expanded Programme on Immunization at a time when less than 20% of children in the developing world were covered by immunization programmes.

Throughout the 1980s, the so-called "lost decade for development", the expansion of childhood immunization was a robust and inspiring success story in the midst of an oil crisis, a recession, a crushing debt crisis, and structural adjustment programmes that slashed national spending for social services, including health. Doesn't that sound familiar? This reminds us of how greatly health can suffer from policies made in other sectors.

The point I want to make is this. As we enter the second decade of the 21st century, and the home stretch for reaching the Millennium Development Goals, we need to draw on every lesson, every approach, instrument, and innovative way of raising funds or collaborating together, from Heads of State to civil society. We have very little time left, with little space for unproductive debates. We need to move forward very fast. We need horizontal and we need vertical approaches. We need to scale up the delivery of commodities, and we need to strengthen the fundamental capacities that allow us to do so. We need coherence in policies, within and beyond the health sector, and we need complementarity of efforts.

Reaching the health-related Goals is not about national averages. It is about reaching the poor, who are almost invariably the hardest to reach. This is the challenge, and the measure of success. The Millennium Development Goals promote health as part of an overarching strategy for poverty reduction. Let me put it bluntly: if we miss the poor, we miss the point. We have a long way to go, especially for maternal and newborn mortality, and we welcome the efforts being made, on multiple fronts, to accelerate progress in this area. But let us take heart from what has been achieved so far. Success in public health nearly always saves lives. But it also has symbolic value. Recent progress tells us that when the international community is fully committed to a goal, creative solutions can be found and obstacles, including financial ones, can be overcome.

Since the start of this century, the number of under-five childhood deaths dropped below the 10 million mark for the first time in nearly six decades, and then dropped again to below 9 million. The number of people in low- and middle-income countries receiving antiretroviral therapy for AIDS moved from under 200 000 in late 2002, to 3 million, then beyond 4 million, an achievement unthinkable a decade ago. The rate of people newly ill with tuberculosis peaked and then began a slow but steady decline. For the first time in decades, we are seeing signs that the steadily deteriorating malaria situation might be turned around. Progress in controlling the neglected tropical diseases continued to make impressive progress. By the end of 2008, some 670 million people had been reached with preventive chemotherapy for at least one of these diseases. Cases of guinea-worm disease are at their lowest level ever, now confined to only four countries. I think we can conclude: increased investment for health development is working.

Like the smallpox eradication campaign, the drive to reach the Millennium Development Goals has left some legacies that benefit public health across the board. Let me mention a few. First, the Millennium Declaration and its Goals turned our thinking about development upside down. What do I mean by that? For a long time, factors such as access to safe water and sanitation, literacy rates, infant and young child mortality, and maternal mortality were considered as indicators of a country's level of socioeconomic development. According to the logic at that time, living conditions and health status would gradually improve as economies developed and prosperity increased. That happened, of course, but frequently not to the benefit of society's poorest and most marginalized people. Also, too often, economic growth has meant wealth creation for some, and increased poverty for others. The Millennium Development Goals turned this thinking around. Instead of waiting for living conditions and health status to gradually improve, the Goals called for a direct attack on the conditions and diseases that anchor people in poverty. This was put forward as the best, and probably the fastest, route to equitable and more balanced progress. Indicators of development became engines for development. A quest for economic development became a quest for social development. The report of the Commission on Social Determinants of Health has taken this thinking a few more steps forwards.

Secondly, the Millennium Development Goals changed thinking about aid effectiveness, as reflected in the Paris Declaration and the Accra Agenda for Action. An almost fashionable scepticism about the value of aid, with blame placed on weak capacities and governance in recipient countries, was replaced by recognition that the policies and behaviours of donors could also be at fault. Accountability for results must be mutual. Good aid honours the priorities, capacities and

responsibilities of recipient countries to their citizens. Good aid aims to eliminate the very need for aid. It does so by investing in the capacities and the infrastructures needed to move forward towards self-reliance. If aid does not explicitly aim for self-reliance, the need for aid will never end. For obvious reasons, breaking the cycle of dependence on aid contributes to equity among nations in a fundamental way.

Thirdly, the drive to reach the health-related Goals unleashed the best of human creativity, bringing a host of innovations for improving health, especially among the poorest. The list is long: the GAVI Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNITAID, new partnerships to develop medicines and vaccines for diseases of the poor, advance market commitments as an incentive for industry, a finance facility for immunization, a facility to reduce the costs of malaria drugs, and the International Health Partnership as a new way of working within countries. We have all contributed in some way to these innovations for international health cooperation.

The trend continues. Earlier this year, the Bill & Melinda Gates Foundation launched the Decade of Vaccines by pledging US$ 10 000 million over the next 10 years to help deliver existing vaccines and develop new ones. This commitment is most welcome. Vaccines are one of the best life-saving buys on offer, preventing an estimated 2 to 3 million deaths each year. WHO and UNICEF, in close collaboration with the Bill & Melinda Gates Foundation, countries, and partners, are initiating a process to define the ambitions and scope of this Decade of Vaccines. The momentum that has been growing since the start of this century must continue. Last month, WHO launched simultaneous immunization weeks in more than 100 countries. These events are building public and professional awareness of the value of immunization as well as saving lives.

You will be aware of the setbacks that occur when people decide that vaccines are risky, unnecessary, or even part of a conspiracy. This has been a problem for measles, for the uptake of pandemic vaccines, and most especially for poliomyelitis. Vaccines touch your agenda at several points. You will be considering accelerated action to reduce deaths from pneumonia, the feasibility of measles eradication, and the prevention of hepatitis B virus infection through immunization of infants.

As requested by the Sixty-first World Health Assembly, you will also be considering an aggressive new strategic plan to complete poliomyelitis eradication. The plan incorporates several new strategies that respond to different transmission dynamics in different settings, make use of a new bivalent vaccine, and address head-on the problem of international spread that has made progress so fragile. Significantly, the plan maps out a more systematic engagement of the initiative in the broader effort to strengthen immunization systems. This is a most welcome emphasis. The Polio Initiative knows how to deliver interventions to hard-to-reach populations. This know-how becomes broadly beneficial in the homestretch to 2015, where the greatest challenge lies in reaching underserved populations. Last month's poliomyelitis outbreak in Tajikistan, in a region certified as poliomyelitis-free since 2002, is a stark reminder that finishing eradication is the only viable option for responding to this disease. A resurgence of poliomyelitis, of deaths, and childhood paralysis is the predictable consequence if we fail to stay the course. Collectively, countries and partners have a moral duty to finish the job. Good news for public health usually arises from factors like political commitment, sufficient resources, strong interventions and implementation capacity, equitable delivery, and alignment with national priorities and capacities. Sometimes, though, we are just plain lucky. This has been the case with the pandemic (H1N1) 2009. The virus did not mutate to a more lethal form. Cases of resistance to oseltamivir remained few and isolated. The vaccine closely matched circulating viruses and showed an excellent safety record. Emergency wards and intensive care units were often strained, but few health systems were overwhelmed and the effects were usually short-lived. Schools closed, but borders remained open, and disruptions to travel and trade were far less severe than feared. Had things gone wrong in any of these areas, we would have a very different agenda before us today. This has been the most closely watched and carefully scrutinized pandemic in history. It is normal that every decision and action, especially on the part of WHO, will likewise be closely scrutinized and critically assessed. We welcome this approach. The pandemic has also been the first major test of the functioning of the revised International Health Regulations, which entered into force in 2007. During the January session of the Executive Board, I proposed that a previously scheduled review of the functioning of the Regulations could also be used to assess the international response to the influenza pandemic. The Board agreed to this proposal. A report of the Review Committee's first meeting is

before you. When I opened that meeting, I stressed the need for a frank and critical assessment of performance, including WHO's performance, in a process that is independent, credible, and transparent. We want to know what worked well. We want to know what went wrong and, ideally, why. We want to know what can be done better and, ideally, how. We are seeking lessons, about how the International Health Regulations (2005) have functioned, about how WHO and the international community responded to the pandemic, that can help the management of future public health emergencies of international concern. And I can assure you: there will be more. The report of the Review Committee's first meeting summarizes issues and questions repeatedly raised and likely to guide the review. The Committee further agreed to look into criticisms that have been levelled at WHO for its management of the pandemic. As I said, we welcome this review.

We have some solid evidence that aid for health development is working. But it needs to work much better. The drive to reach the health-related Millennium Development Goals has taught us a major lesson, and this is a lesson about failure. For decades, we have collectively failed to invest adequately in basic health systems, infrastructures, training of staff, information systems, regulatory capacity, and systems for social protection. This is an absolute barrier, and trying to bypass it by building separate single-purpose systems is not the answer. International donors, partners, and governments themselves have failed to rally around national health policies, strategies, and priorities. This contributes to fragmentation, duplication, and added demands and costs, and defeats national ownership. We have learnt this. How can we scale up interventions or aim for universal coverage when the health systems in so many countries are on the verge of collapse? Or when the world faces a shortage of four million doctors, nurses and other health personnel? Weak health systems blunt the power of global health initiatives to reach their goals. Weak health systems are wasteful. They waste money and dilute the return on investments. They waste money when regulatory systems fail to control the price and quality of medicines or the costs of care in the private sector. They waste training when workers are lured away by better working conditions or better pay. They waste efficiency when needless procedures are performed, or when essential procedures are precluded by interruptions in the supply chain. They waste opportunities for poverty reduction when poor people are driven even deeper into poverty by the costs of care or the failure of preventive services. Above all, weak health systems waste lives. This problem is now recognized by countries and donors alike, and it is being addressed by a range of new and existing initiatives, including several global health initiatives. Though designed to deliver specific health outcomes, these initiatives now recognize that meeting their goals and their objectives and their targets depends on a well-functioning health system. In my view, this shift of attention is nothing short of revolutionary. Equity and social justice are at the heart of the Millennium Development Goals. They were always at the heart of the primary health care approach. As last year's resolution on primary health care noted, principles such as universal access to services, multisectoral action, and community participation form a solid basis for strengthening health systems. Efforts to reduce maternal and newborn deaths have shown the slowest progress of all the Millennium Development Goals in all regions. This should come as no surprise, as reducing these deaths depends absolutely on a well-functioning health system.

In preparation for the September United Nations summit on the Millennium Development Goals, the Secretary-General's office is finalizing a Joint Action Plan to accelerate progress in reaching the health-related Goals, with a special focus on maternal and child health. I encourage you to participate in the technical briefings on the Goals on Tuesday, Wednesday and Thursday afternoon, as your views will be decisive in shaping the development of this Joint Action Plan.

Health systems are an issue for other items on your agenda. Drug-resistant forms of tuberculosis arise because of shortcomings in general health services, including years of neglect of laboratory services, inadequate regulatory capacity to ensure the supply and quality of medicines, and a dire shortage of health personnel. In the so-called virus importation belt in sub-Saharan Africa, the spread of poliomyelitis has become predictable, because the virus travels by exploiting weaknesses in health systems. Strong regulatory capacity underpins efforts to reduce the harmful use of alcohol, to control tobacco, to protect children from harmful marketing practices, and to assure the safety and quality of medical and blood products. Some 85 countries, representing 65% of the world's population, do not have reliable cause-of-death statistics. This means that causes of death are neither known nor recorded, and health programmes are left to base their strategies on very crude and sometimes imprecise

estimates. However, on the positive side, work to improve facility-based health care, which is critical for reducing maternal and newborn deaths, will increase the capacity to respond to the vast new challenges that come with the rise of chronic noncommunicable diseases. These are some of the issues you will be discussing this week. Improving fundamental capacities helps reach international commitments, increases efficiency as well as fairness, improves health outcomes in sustainable ways, and moves countries towards greater self-reliance. We have failed to do this job properly in the past. As we enter the home stretch to 2015, we must get back on the right track. On that, I thank you.

2. ANNOUNCEMENTS COMMUNICATIONS

The PRESIDENT: الرئيس:

شكراً للدكتورة تشان.

قبل أن نواصل النظر في البند 3، أود أن أذكركم بما نصت عليه المادة 99 من نظامنا الداخلي، وهو: "في بداية كل دورة عادية من دورات جمعية الصحة يطلب الرئيس من الدول الأعضاء التي ترغب في التقدم باقتراحات تتعلق بالانتخاب السنوي للدول الأعضاء التي يخول لها حق تعيين شخص للعمل عضواً في المجلس أن تقدم اقتراحاتها إلى اللجنة العامة. ويجب أن تصل هذه الاقتراحات إلى رئيس اللجنة العامة في موعد لا يتجاوز أربع وعشرين ساعة من قيام الرئيس بالإعلان عن ذلك وفقاً لهذه المادة." وبهذه المناسبة أود أن أسترعي انتباهكم إلى أن المجلس يتكون طبقاً للمادتين 24 و25 من دستور المنظمة من 34 شخصاً تعينهم 34 دولة عضواً.

والمقاعد الشاغرة في المجلس في هذه السنة 12 مقعداً يتعين ملؤها على النحو التالي: الإقليم الأفريقي، مقعدان؛ إقليم الأمريكتين، ثلاثة مقاعد؛ إقليم شرق المتوسط، مقعدان؛ الإقليم الأوروبي، مقعدان؛ إقليم جنوب شرق آسيا، مقعد واحد؛ إقليم غرب المحيط الهادئ، مقعدان.

والآن أدعو السادة المندوبين الراغبين في تقديم اقتراحات بشأن هذه الانتخابات أن يسلموها إلى مساعد أمين الجمعية في موعد لا يتجاوز الساعة الرابعة من بعد ظهر الثلاثاء 18 أيار/ مايو، حتى يتسنى للجنة العامة أن تجتمع وتقدم توصياتها إلى الجمعية بشأن هذه الانتخابات. وأود أن أخبركم بأن اللجنة "أ" ستبدأ الآن عقد جلستها الأولى في القاعة 18 بالتزامن مع انعقاد هذه الجلسة العامة. والآن نستأنف النظر في البند 3.

موضوع المناقشة العامة في هذه السنة هو المرامي الإنمائية للألفية المتعلقة بالصحة. وبوسع السادة المندوبين الراغبين في تقديم النصوص الخطية لبياناتهم لإدراجها في محضر الجلسة، طبقاً للقرار ج ص ع20-2، أن يتفضلوا بتسليمها. وأود أن أسترعي انتباهكم أيضاً إلى أن القرار ج ص ع50-18 قد أوصى السادة المندوبين بأن يقصروا مدة إلقاء بياناتهم الشفوية على خمس دقائق. ولذلك فإني أناشد جميع أصحاب المعالي الوزراء والسادة المندوبين أن يلتزموا بذلك وإلا فإن ذلك سيؤدي إلى تأخير البدء بأعمال اللجنة "ب" وسيؤثر في سير عملنا بشكل منظم. قائمة المتحدثين ترد في الجريدة.

على السادة المندوبين أن يتحدثوا من على المنصة ولتوفير الوقت وكلما دُعي مندوب إلى إلقاء بيانه ستتم أيضاً المناداة على المندوب الذي يليه في قائمة المتحدثين للقدوم إلى المنظمة حيث يجلس هناك حتى يحين موعد أخذه الكلمة.

ولتذكير السادة المتحدثين باستصواب عدم تجاوز مدة إلقائهم لبياناتهم الخمس دقائق فقد تم تركيب نظام للإضاءة يتحول الضوء الأخضر فيه إلى الأصفر في الدقيقة الرابعة وأخيراً إلى اللون الأحمر في الدقيقة الخامسة.

وإذا ما رغب أحد المندوبين، توفيراً للوقت، في تقديم بيان معد سلفاً لإدراجه كما هو في المحاضر الحرفية (وهو أمر لا يسمح به إلا في إطار هذا البند الثالث من جدول الأعمال)، أو كلما كان هناك نص

مكتوب لخطاب ينوي أي مندوب إلقاءه، فينبغي تسليم نُسخ منه إلى الشخص المسؤول عن وضع قائمة المتحدثين وذلك لتيسير الترجمة الفورية واستنساخ المداولات. وينطبق هذا الإجراء أيضاً على السادة المندوبين الذين يضطرون إلى مغادرة جنيف ويتعذر عليهم إلقاء خطاباتهم في إطار هذا البند من جدول الأعمال قبل المغادرة. فبإمكانهم أن يطلبوا نشر نصوصهم في محاضر الجمعية.

3. ADDRESS BY THE DIRECTOR-GENERAL (resumed)
ALLOCUTION DU DIRECTEUR GÉNÉRAL (reprise)

The PRESIDENT: الرئيس:

وأعلن الآن فتح باب مناقشة البند 3.

أول المتحدثين على القائمة هما مندوب رواندا الذي سيتحدث بالنيابة عن الدول الأعضاء في الإقليم الأفريقي ومندوب أسبانيا، الذي سيتحدث نيابة عن الدول الأعضاء في الاتحاد الأوروبي. فهل لي أن أدعوهما إلى القدوم إلى المنصة. أعطي الكلمة إلى مندوب رواندا المحترم.

Dr SEZIBERA (Rwanda):

Mr President, Vice-Presidents, Chairmen of the main committees, Director-General, honourable ministers and heads of delegation, distinguished guests, ladies and gentlemen, on behalf of the WHO Regional Committee for Africa allow me first of all to congratulate you, Mr President, on your presidency of this Sixty-third World Health Assembly. We believe that the wisdom and counsel you bring to this august house will lead us to reach fruitful deliberations.

Madam Director-General, on behalf of the Ministers of Health of the African Region, I wish to congratulate you on your brilliant and invigorating speech. As usual, you have done us proud and you have brought issues of equity and justice to the centre of health in the world. The African Region would also like to thank you for the commitment and determination that you have exhibited leading WHO, and especially your unwavering support to the African Region. This is exemplified, inter alia, by your personal attendance at several key meetings in our Region, including the Fifty-ninth Regional Committee in Kigali in August 2009, and the WHO Global Policy Group in Johannesburg in April 2010. We thank you for your tireless support and energy in fighting and combating epidemics and pandemics that afflict our Region, including, in particular, the recent global outbreak of pandemic (H1N1) 2009. We salute your leadership and that of your team in this and in other areas.

The theme for this session aims at achieving the health-related Millennium Development Goals. The African Region would invite you not to lose sight of the fact that poverty exacerbates the consequences of devastating epidemics, and that rapid progress to achieve the health-related Millennium Development Goals in Africa is mainly hampered by weak health systems, as the Director-General has said, particularly at the operational level.

This debate comes at an opportune time, because the report of the Fifty-ninth session of the Regional Committee for Africa noted that most countries in our Region have not made sufficient progress. Only a few countries are on track for Goal 4, while the Region has made very little progress towards achieving Goal 5. At the midway in the countdown to 2015, the target here for achieving the United Nations Millennium Development Goals, several examples of success in Africa can however be cited. Although we do have these, huge disparities still exist within and between countries. The Commission on the Social Determinants of Health has reminded us of this fact.

Therefore, greater efforts are needed at national and international levels for many countries in the African region to meet the Millennium Development Goal targets. The estimated number of women dying during pregnancy and childbirth remains unacceptably high in our Region, and progress

towards Goal 5 lags behind all other Millennium Development Goal targets. Only 13 countries have maternal mortality ratios below 550 deaths per 100 000 live births in the Region.

Behind the figures, however, behind the projections, we must constantly remember that there are individuals such as women who lose their lives resulting in destroyed families, and that for the poorest of the poor, the death of a mother during childbirth pushes the family into destitution and affects an entire generation. This clearly is unacceptable. We must therefore make every mother and child count, and to be able to do this, we must be able to count every mother and child. And this is why our Region has launched the Commission on Women's Health in the African Region, which was established in Monrovia, Liberia during April 2010.

Strengthening Africa's health systems is critical. Investment in human resources for health can not be considered a recurrent cost. It must be treated as a capital investment if we are to make progress towards Millennium Development Goal 5 because it enables us to make priority interventions that the Region needs to improve maternal and newborn health. Mr President, we are happy to report progress on Goal 6 in the sub-Saharan region; estimated coverage of antiretroviral therapy is at 44%, an appreciable increase from a few years ago but still far below the universal coverage target of 80%. We have seen success in combating malaria. Countries have shown that it is possible, with investment, to reduce the burden of malaria to over 50%. Eight African countries have documented reductions of more than 50% during the last decade. However, we still see challenges in reducing and reversing the incidence of tuberculosis, and we are seeing the emergence of drug-resistant tuberculosis and only nine countries are on track for Goal 7C: access to safe drinking-water.

At a time of global financial difficulty, therefore, the gains we have seen on the African continent risk being reversed, and we would say that this is the time to ring-fence and indeed scale up spending on health. We know that bailing out failing banks may bring temporary relief. Africa has demonstrated that increasing spending on health, as well as rigorous and prudent management of available resources, brings about dramatic and long-lasting success and saves lives. The work of WHO, the Global Fund, the GAVI Alliance and other international health actors bears ample witness to this.

This therefore is a time for innovation. It is a time to demonstrate that global health is a public good and not a market commodity; that it is a fundamental human right that should not be dependent on the movements of the stock exchange. We know what the challenges are and we know that we need to achieve a budget target of at least US$ 34 per capita on health spending, as recommended by the Commission on Macroeconomics and Health, for a basic package of essential health interventions, and we on the continent are ready and willing to do this.

We are grateful for WHO's continued normative leadership role as well as its commitment to guaranteeing provision of appropriate emergency technical support in times of epidemics and disasters, in this globalized environment. And that is why we, the Ministers of Health of the African Region, laud the proactive and effective leadership of Dr Margaret Chan during this period of the financial global crisis and pandemic (H1N1) 2009.

As President Paul Kagame, President of Rwanda, has said time and time again, Africa is not poor. It is a continent of innovation and progress. In Rwanda, leadership, ownership and country-led health strategies have a demonstrable effect on the health of the poor. Life expectancy is up. Malaria morbidity and mortality have seen a 60% reduction in three years, partly through community-based and facility-based audits and investments, with an obligation to report. Maternal death has dropped thirteenfold in one year alone from 2875 deaths a year to 224 last year. Insurance coverage is at 92% and vaccination rates are above 95%. Health indicators are part of the performance contracts local authorities sign with the Head of State and health workers, including community health workers, are not merely given salaries but are remunerated based on their performance through results-based financing, with a dramatic improvement in the quality of service.

Mr President, what is happening in my country can be and is being replicated elsewhere on our continent. It simply requires clarity of purpose and sustained engagement of national and international partners. There is no doubt in my mind that with your leadership, the leadership of the Director-General of WHO and her team, we will be able to have this clarity of purpose and this sustained engagement. I thank you for your kind attention.

La Sra. JIMÉNEZ GARCÍA-HERRERA (España):

Tengo el placer de tomar la palabra en nombre de la Unión Europea. En primer lugar, quisiera felicitar al Dr. Zenaidi por su elección como Presidente de esta 63.ª Asamblea, así como a los directores regionales recientemente nombrados o confirmados en sus puestos, en particular a la Sra. Zsuzsanna Jakab como nueva Directora Regional para Europa. Nos gustaría expresarle nuestros mejores deseos y confirmarle nuestro total apoyo para los retos futuros.

Señora Directora General: la Unión Europea acoge con satisfacción que la Asamblea Mundial de la Salud de este año se centre en los Objetivos de Desarrollo del Milenio relacionados con la salud. Esto resulta especialmente oportuno en vista de la próxima reunión plenaria de alto nivel de la Asamblea General de las Naciones Unidas sobre los Objetivos de Desarrollo del Milenio de 2010. Al mismo tiempo, existen otras cuestiones que merecen ser debatidas y meditadas, y la Unión Europea las abordará en los puntos del orden del día correspondientes.

La Unión Europea reconoce que se ha producido un relativo progreso mundial en los Objetivos del Milenio relacionados con salud. No obstante, este progreso ha sido desigual y particularmente escaso para la salud infantil y materna, incluida la salud sexual y reproductiva como lo señalaba la Directora General. El año pasado, cerca de nueve millones de niños fallecieron antes de cumplir cinco años, y casi 400 000 mujeres fallecieron durante el embarazo y el parto, la mayoría por carecer de la prevención y la atención básicas. La Unión Europea confirma y reafirma su sólido apoyo y su compromiso para la plena aplicación del Programa de Acción de El Cairo, así como para las acciones clave consagradas a continuar la aplicación del Programa de Acción de la Conferencia Internacional sobre la Población y el Desarrollo acordado en el CIPD+5, y para la Declaración y el Programa de Acción de Copenhague. Asimismo, la Unión Europea mantiene su pleno convencimiento de que, para la consecución de estos Objetivos de Desarrollo del Milenio, se debe otorgar prioridad al desarrollo y a la sostenibilidad de unos sistemas de salud que funcionen adecuadamente, de calidad, y que sean equitativos y accesibles.

Por otra parte, la crisis mundial repercute gravemente en la atención sanitaria y en todas las cuestiones relativas a la salud. Debemos prestar especial atención a los grupos vulnerables y evitar un incremento de las desigualdades en salud en gran número de países. La Unión Europea desea hacer hincapié en la necesidad de luchar contra la pobreza y las desigualdades sociales, especialmente en este Año Europeo de la Lucha contra la Pobreza y la Exclusión Social. En esta línea, la Unión Europea apoya la consecución de los Objetivos de Desarrollo del Milenio 1 y 3, estrechamente relacionados con la salud.

Somos conscientes de que tenemos que trabajar aún más y optimizar los recursos que tenemos a nuestra disposición para proporcionar la mejor atención sanitaria a nuestros ciudadanos. La arquitectura sanitaria es muy compleja, tanto en lo que respecta a nuestros países como a las numerosas iniciativas mundiales que abordan retos específicos de salud mundial, y continúa siendo complicado abordar las necesidades en su totalidad.

En este sentido, la Unión Europea es un socio activo de los países en desarrollo y constituye uno de los mayores contribuyentes a la ayuda oficial al desarrollo. Mantenemos la intención de cumplir nuestras promesas de ayuda al desarrollo, y de continuar apoyando a los países en desarrollo en sus esfuerzos por alcanzar los Objetivos de Desarrollo del Milenio.

Recientemente, la Unión Europea ha adoptado algunas conclusiones sobre salud global, con renovada atención a los Objetivos de Desarrollo del Milenio relacionados con la salud, destinados a apoyar la cobertura universal de servicios de salud integrales y acciones políticas multisectoriales. Este nuevo marco político de la Unión Europea demuestra nuestro compromiso de aplicar los Principios de París y la Agenda para la Acción de Accra en el ámbito de la salud. Destaca la prioridad que todos deberíamos otorgar al fortalecimiento de sistemas de salud nacionales e integrales, evitando trabajar en programas de enfermedades aislados. En nuestras políticas de desarrollo, esto se traduce en un compromiso por incrementar la eficacia de la ayuda en el sector de la salud y para alentar a todos los socios a aplicar los principios acordados en la Alianza Sanitaria Internacional en el sentido de trabajar desde una estrategia nacional, a través de un proceso presupuestario y de un marco de seguimiento.

La Unión Europea cree en el liderazgo de la OMS en esta tarea, y apoya plenamente las deliberaciones en curso para explorar junto con los Estados Miembros y otros socios el papel y la naturaleza de la actividad principal de la OMS en el entorno sometido a constantes cambios que rodea a la salud mundial. En este sentido, la Unión Europea quisiera además subrayar la necesidad de los Estados Miembros de aportar financiación de un modo que permita a la OMS desempeñar este papel de una manera eficaz y sólida.

La Unión Europea está convencida de que uniendo esfuerzos podremos superar las dificultades actuales, de las que tendremos que salir fortalecidos y con una perspectiva más previsora, lo que nos permitirá lograr las metas que hemos establecido: mantener y mejorar la salud de nuestros ciudadanos.

Por lo tanto, señora Directora General, tenga la certeza de que puede contar con el apoyo de la Unión Europea no solo en el curso de los trabajos que hayan de ser asumidos por esta Asamblea durante los próximos días, sino también para el difícil y complicado trabajo del futuro. Muchísimas gracias señor Presidente.

Ms SEBELIUS (United States of America):

Mr President, Madam Director-General Chan, whose friendship I value and whose leadership we admire, and fellow delegates, it is my honour and privilege to again represent the United States at the Health Assembly. Today, on behalf of the entire United States Government, I can tell you we are committed to working with everyone in this room to expand access to health care, to reduce health disparities, advance social justice and improve the health of all nations.

Last year, at this time when we were together, many of us were focused on a dangerous pandemic that threatened communities around the world, especially our children. Pandemic (H1N1) 2009 challenged our global health response and we met that challenge. Thanks to the efforts of people in this room, and under the leadership of Director-General Chan, we avoided the worst predictions. While some have questioned the actions taken by the international community, the outcomes speak for themselves. I believe we made the right decisions at the right time. Our H1N1 response reflected a growing understanding around the world that global health is a shared responsibility, that we all have an obligation and an interest in promoting the health of all people. The highest expressions of that commitment are the Millennium Development Goals.

This year, two-thirds of the way to 2015, we have an important milestone for those Goals. Over the last decade, we have had some notable successes. For the United States, they have included programmes like the President's Emergency Plan for AIDS Relief and the President's Malaria Initiative and we feel privileged to have contributed through these programmes towards the world's great progress on Millennium Development Goal 6. While much remains to be done in the fight against killer infections like HIV/AIDS, tuberculosis and malaria, we can all be encouraged by the gains we have made.

But we cannot be complacent. That is why President Obama has launched an historic six-year Global Health Initiative that meets and expands our existing commitments to programmes that promote health in some of the poorest countries around the world. The Initiative builds on our successes while also accelerating progress towards the Millennium Development Goals, where we are lagging behind, and I am speaking specifically on reducing child mortality and improving maternal health. While some gains have been made in this area, mothers and children, as the previous speaker from Spain noted, continue to die at disturbingly high rates. It is not that we do not know how to save those lives: we have proven evidence-based interventions that we know can improve maternal and child health. That is why our Global Health Initiative will expand our efforts to make pregnancy and childbirth safer, increase the availability of family planning and other reproductive health services and strengthen health systems to respond better to the needs of women and girls.

Earlier this year, we marked the fifteenth anniversary of the United Nations Fourth World Conference on Women and together we drew the important connection between the Beijing Platform for Action and the achievement of the Millennium Development Goals. We understand today that these goals are tied together and that the empowerment of women and girls is important for meeting any of them, particularly when it comes to health. Because of women's role in child-rearing, providing and seeking care and managing household resources, the ability of women to access health-related

knowledge and services also affects the health and stability of the entire community. By taking a woman- and girl-centred approach in our Global Health Initiative, we expect the benefits to ripple through societies.

Over the last year, we have also learnt that progress can bring new challenges. We have made great strides for example in reducing undernutrition around the world, but in some of the same countries where we worry about hunger, obesity and chronic diseases, such as diabetes and heart disease, are now a growing concern. I commend the Health Assembly for taking up issues on noncommunicable diseases during this meeting and look forward to working with all of you to promote better health in these areas.

As our busy agendas this week demonstrate there is much work left to be done, but today at my second Health Assembly, I can tell you that the United States is more committed than ever to following through on our shared commitments on global health and building a healthier world for all people. Thank you.

Dr ALQASSIM (United Arab Emirates): الدكتور القاسيم (الإمارات العربية المتحدة):

السيد الرئيس، سيادة المديرة العامة لمنظمة الصحة العالمية، أصحاب المعالي وزراء الصحة، السيدات والسادة،

بداية، أهنئكم سيادة الرئيس، باسم زملائي السادة وزراء الصحة العرب وبالأصالة عن نفسي، على انتخابكم رئيساً لجمعية الصحة العالمية الثالثة والستين، كما يشرفني أن أعرب باسم المجموعة العربية عن الشكر والتقدير للدكتورة مارغريت تشان، لجهودها وتفاعلها مع كافة القضايا الصحية التي أضحت قضايا واحدة ومشتركة في ظل العولمة التي نعيشها.

كما ترحب المجموعة العربية بعقد جمعية الصحة العالمية الثالثة والستين تحت شعار "تحقيق المرامي الإنمائية للألفية" التي تم تبنيها من قبل قادة وزعماء دول العالم منذ عشر سنوات، في إطار روح التضامن الدولي، وقد قطعت الدول العربية شوطاً كبيراً نحو تحقيق مرامي الألفية، ونأمل أن تحقق المزيد خاصة للدول الأقل نمواً في منطقتنا العربية، ونتطلع إلى نقاشات هامة في هذه الدورة خاصة ونحن مشرفون على عقد قمة لمراجعة تحقيق المرامي الإنمائية للألفية في أيلول/ سبتمبر المقبل بنيويورك.

لقد تابعت المجموعة العربية باهتمام بالغ تطور الجهود التي بذلت لمواجهة جائحة الأنفلونزا A (H1N1)، وتنفيذاً لما دعا إليه إعلان الرياض في 5 أيار/ مايو 2009، تم إعداد خطة عربية موحدة لمواجهة انتشار هذا المرض، والتركيز على أهمية التقييم المستمر لمدى استجابة النظام الصحي الدولي والوطني على حد سواء، للجوائح والأوبئة والطوارئ الصحية العمومية ذات الأبعاد الدولية. وفي هذا السياق، تدعو المجموعة العربية منظمة الصحة العالمية إلى إيجاد آلية تسمح للدول الأعضاء التأهب لمواجهة الجوائح والأوبئة بطريقة أكثر فاعلية وشفافية.

كما ترحب المجموعة العربية برئاسة جمهورية مصر العربية للاجتماع الوزاري الثالث لوزراء صحة دول حركة عدم الانحياز الذي سيعقد يوم 18 أيار/ مايو على هامش أعمال هذه الدورة بمشاركة أكثر من 140 دولة ومنظمة دولية وإقليمية تحت عنوان "تقوية النظام الصحي الدولي وتعزيز التضامن العالمي إزاء الأوبئة العالمية والتحديات الصحية الدولية الأخرى".

الحضور الكريم، في ضوء ما يواجه العالم الآن من مخاطر تفشي الأوبئة والكوارث الطبيعية، وتداعيات التغيرات المناخية المتوقعة على حياة البشر، تبرز أهمية دعم الالتزام القوي والمتجدد لدول المجموعة العربية بالرعاية الصحية الأولية، والتي تمثل الآن، أحد أبرز الأهداف الصحية على مستوى دول المجموعة، بما يتطلبه ذلك، من حرص على تحديد وتوفير الاحتياجات الراهنة والمستقبلية لتوفير الصحة للجميع. وحتى تنجح هذه الخطط الإقليمية في تحقيق أهدافها، لابد من الإشارة إلى أهمية التزام الدول الكبرى بمسؤولياتها، في بذل أقصى الجهود، والعمل على إزالة الخلافات فيما بينها، لحماية حياة البشر، وتحسين نوعية المعيشة، في كافة ربوع العالم.

وفي هذا الإطار، تأتي أيضاً الكوارث الطبيعية، لتشكل مصدر قلق حقيقياً لدول العالم كافة، وذلك لصعوبة توقع حدوثها أحياناً وعدم جاهزية التعامل معها حال وقوعها، في أحيان كثيرة، فبالرغم من أن الألفية الثالثة لم يمر منها سوى عشر سنوات، إلا أن العالم شهد خلالها مجموعة من الكوارث المدمرة في مختلف أنحاء العالم بما فيها المنطقة العربية، تستدعي السعي لإنشاء جهاز دولي، للتدريب على التعامل مع المشاكل الصحية المرتبطة بالكوارث، وإقامة شراكات فعالة، على المستوى الدولي، لإدارة حالات الطوارئ، وضمان التنسيق بين الجهات العاملة في هذا المجال. كما أن علينا، جميعاً، العمل على تعزيز إمكانات النُظم الصحية في كل دولة، ونشر الوعي بمخاطر الكوارث، ومطالبة الجهات المعنية في الدول مراعاة الالتزام بقواعد السلامة العامة خاصة في المناطق المعرضة للكوارث.

وأشير أيضاً إلى العبء الذي يقع على مجتمعاتنا، والناجم عن الأمراض غير السارية، وما تشكله من تحد كبير لجهود التنمية في بلداننا حيث تأتي أمراض القلب والشرايين في مقدمة أسباب الوفيات، كما أن انتشار داء السكري، وأمراض السرطان، وارتفاع ضغط الدم، تشكل خطراً يهدد صحة الفرد والمجتمع. وانتهز هذه المناسبة كي أؤكد على التزامنا الكامل في المنطقة العربية بالاستراتيجية العالمية للوقاية من الأمراض غير السارية ومكافحتها على نحو شامل وفعال، وبالشراكة مع المجتمع الدولي.

ومن هذا المنبر، فإنني أدعو الدول الأعضاء، إلى المشاركة الفاعلة في "المنتدى العالمي لقيادات السكري" والمزمع عقده في مدينة دبي خلال الفترة من 12-13 كانون الأول/ ديسمبر 2010، والذي نعتبره مجالاً مهماً للحوار وتبادل الرأي، وإعداد الاستراتيجيات والخطط اللازمة للتصدي لهذا المرض.

السيد الرئيس، السيدات والسادة،

لقد مضى اثنان وستون عاماً على الاحتلال الإسرائيلي للأراضي الفلسطينية ومازالت الممارسات غير القانونية من قبل الاحتلال الإسرائيلي والتي تنتهك كافة الحقوق الأساسية والمشروعة للشعب الفلسطيني في كافة الأراضي الفلسطينية المحتلة بما فيها القدس الشرقية، ونشهد اليوم بشكل خاص آثار العدوان الوحشي الغاشم على قطاع غزة، والذي أودى بحياة العديد من الأطفال والنساء والشيوخ من الشهداء – هذا العدوان، الذي خلف آلاف الضحايا والمصابين والمشردين، وأحدث دماراً شاملاً في المباني والمرافق العامة، من دور تعليم ودور عبادة ومدارس ومستشفيات ومؤسسات اقتصادية واجتماعية، بالإضافة إلى الدمار الكبير الذي لحق بمرافق ومكاتب وكالة الأونروا. إن تقارير لجان تقصي الحقائق، وفي مقدمتها تقرير السيد غولدستون، وتقرير القاضي جون دوجر، وتقارير دورية أخرى تعكس، بوضوح وصدق، مدى ما أصاب الشعب الفلسطيني في غزة من معاناة، وما تعرضت له مرافقه الأساسية من دمار وتخريب، كما أن الأمور حتى الآن لازالت تسير نحو الأسوأ، فلازال الحصار الخانق يحاصر مليون ونصف المليون إنسان في القطاع للعام الرابع على التوالي، الأمر الذي حوّل قطاع غزة إلى معسكر اعتقال كبير، يعاني من نقص في الغذاء، والمياه النظيفة، والدواء، ومصادر الطاقة، ولازال أطفال غزة يعانون من سوء التغذية التي فاقت نسبة انتشارها بينهم 70٪، وكذلك انتشار الأمراض النفسية بين هؤلاء الأطفال، جراء تجريدهم من طفولتهم، وما يشاهدونه من أحداث دموية ومعاناة يومية. كما أن الحظر مازال مفروضاً على دخول مواد البناء لإصلاح المنشآت الآيلة للسقوط، بما في ذلك مؤسسات الرعاية الصحية.

إن مجلس وزراء الصحة العرب، يدق ناقوس الخطر، مرة أخرى، ويحذر من كارثة إنسانية كبرى، في قطاع غزة، ويناشد منظمة الصحة العالمية، وجميع الدول الأعضاء، التدخل الفوري للاضطلاع بمسؤولياتها، والعمل على رفع الحصار، وتوجيه الدعم والمساندة الطبية للسكان في غزة، وإعادة بناء القطاع الصحي فيها. إننا ندعو منظمة الصحة العالمية إلى إرسال بعثات استقصاء طبية إلى قطاع غزة، لتقييم الوضع الصحي هناك، وتقديم تقارير إلى المدير العام للمنظمة لتوزيعها على الدول الأعضاء، واتخاذ الإجراءات اللازمة، للتعامل مع هذا الوضع الصعب.

كما أشير إلى معاناة المواطنين العرب السوريين في الجولان السوري المحتل الذين يتعرضون لمشاكل عديدة تتعلق بأوضاعهم الصحية. فهم لا يحصلون على الرعاية الصحية اللازمة، بسبب انتمائهم لموطنهم الأم سورية، ورفضهم للهوية الإسرائيلية. كما أن القرى العربية السورية تعاني من نقص حاد في المراكز الصحية والعيادات الطبية ومراكز الإسعاف الأولي إضافة إلى النقص في الأطباء والعاملين الصحيين

هناك. كما ترفق سلطات الاحتلال الإسرائيلي إقامة أي مراكز صحية أو مستشفيات أو تقديم أي مساعدة من قبل حكومة الجمهورية العربية السورية لمواطنيها السوريين في الجولان السوري المحتل.

ولا يفوتني كذلك أن أشير إلى سوء الأوضاع الصحية في إقليم دارفور في السودان وفي الصومال وجيبوتي وجزر القمر– الأمر الذي يحتاج إلى جهود منظمتكم ودولها الأعضاء في تحسين الأحوال الصحية السيئة التي يعاني منها سكان هذه البلاد.

سعادة المديرة العامة، في الختام أود أن أؤكد على أن المجموعة العربية تتطلع إلى المزيد من التعاون وبناء شراكة أكثر قوة ومتانة مع المنظمة ومع كل دول العالم لتحقيق حياة أفضل للشعوب في كافة أنحاء المعمورة.

أشكركم، والسلام عليكم ورحمة الله وبركاته.

Professor CHEN Zhu (China):

尊敬的主席先生、尊敬的总干事女士，各位部长、各位同事：

首先请允许我对主席先生的当选表示祝贺。我相信在您的有力领导下，本届大会一定能够取得圆满成功。我也对总干事陈冯富珍女士表示祝贺，感谢您的精彩讲演，感谢您在过去一年中带领世界卫生组织秘书处，帮助全球各国抗击甲型H1N1流感大流行，并克服金融危机带来的资金短缺等挑战，在全球卫生改革和发展工作中发挥的领导和协调作用。

一个月前，4月14日，中国青海省玉树藏族自治州发生了强烈地震，给当地人民群众生命财产造成了严重损失。已经有2千多人失去了生命。震后，中国政府和各族人民迅速行动起来，展开抗震救灾工作。国家主席胡锦涛、国务院总理温家宝等领导人亲赴第一线指挥救援工作。在克服高海拔等诸多挑战的基础上，我们在较短的时间内完成了紧急救援工作，所有伤员全部得到救治，生活秩序和公共服务基本恢复。目前灾区已进入恢复重建的新阶段。在此，我谨代表中国政府，感谢国际社会所给予的各方面支持和慰问。

主席先生、各位同事，

目前，我们距离实现千年发展目标只剩下5年时间并面临巨大挑战的关键时刻，国际社会必须增强使命感和紧迫感，凝聚共识，协调行动，加快推进。

2009年，中国5岁以下儿童死亡率为17.2‰，比1990年降低了71.8%，提前实现了千年发展目标；孕产妇死亡率为31.9/10万，比1990年降低了66.4%，有望如期实现千年发展目标；中国艾滋病疫情处于总体低流行、特定人群和局部地区高流行的态势，疫情扩展速度有所减缓；疟疾发病率自1995年以来一致保持在5/10万以下，发病率降低一半的目标已经提前实现；对结核患者的现代结核病控制策略（DOTS），覆盖率达到100%，治愈率近年来一直保持在85%以上的水平。

中国在全面实现千年发展目标方面依然面临诸多挑战。城乡、区域之间健康状况存在较大差距，西部省份的指标依然落后；人口老龄化与疾病模式的转变使中国正面

临着控制传染性疾病与慢性非传染性疾病的双重负担；中国城市化进程的加快对公共卫生提出了更高要求。城市中工作的流动人口数量达到了1.4亿，给医疗卫生服务带来了新的挑战。2009年4月，中国政府全面启动深化医药卫生体制改革，加强投入，建设覆盖城乡居民的基本医疗卫生制度，促进千年发展目标的全面、均衡实现。

主席先生、各位同事，

从全球角度，尽管国际社会不懈努力，千年发展目标中的妇女儿童健康指标改善进展缓慢，形势不容乐观。中国认为，妇女儿童健康是国家基本卫生保健制度的重要内容，体现社会经济发展的水平。实现千年发展目标将是人类发展历史上的里程碑，是国际社会的共同责任，必须采取更加有力的措施，加快实现千年发展目标。我愿提出如下建议：

第一，进一步推动千年发展目标的实现。应将妇女和儿童健康议题纳入社会经济发展的核心内容。社会和经济发展的最终目标就是让人们生活得更加美好，让未来更加美好，而健康是其中最重要的内容。

第二，加强卫生系统能力建设。没有完备的卫生服务提供和保障系统，不可能改善人群健康水平。一个强有力的卫生系统也是应对自然灾害、突发公共卫生事件、气候变化的关键。各国应重视卫生体系建设，加大政治承诺，把加强卫生系统建设放在更为重要的位置，强化初级卫生保健，加大对卫生体系的投入力度，并动员全社会多个方面支持和参与卫生改革和发展

第三，控制慢性非传染性疾病对于健康和社会、经济的损害。慢性非传染性疾病正在消耗大量卫生资源，成为不断蔓延的社会经济风险。国际社会应当从健康和社会经济可持续发展的战略高度，研究并采取更为有效的应对措施。

第四，加大对发展中国家的支持。发达国家应兑现承诺，增加发展援助力度。发展中国家应加强南南合作，分享经验，相互支持。世界卫生组织、全球抗击艾滋病、结核病和疟疾基金等国际组织应在协调整合国际资源，形成伙伴关系，为实现千年发展目标、加强卫生体系建设等方面发挥重要作用。中国愿在力所能及的范围内支持发展中国家实现千年发展目标的努力。

主席先生、各位同事，

健康是人类永恒的主题，实现千年发展目标是我们共同的追求。希望各国更加紧密地团结起来，互相帮助，共同抵御疾病威胁，建设我们健康和谐的美好家园。

谢谢大家。

Mr AZAD (India):

Mr President, Dr Margaret Chan, Director-General of WHO, excellencies, distinguished delegates, it is an honour to address this august gathering of the world leaders in health.

To each of you, I bring with me greetings from the people of India. On behalf of the Government of India and on my own behalf, I would like to extend my heartiest congratulations to you, Mr President, on your election as President of the Health Assembly for the year 2010. I would also like to take this opportunity to compliment the Director-General of WHO on her untiring efforts to place the public health agenda high on the list of global priorities for development.

The Millennium Development Goals have influenced all bilateral and multilateral dialogue and influenced the domestic policies of many countries. Over the years, India has revised its own policies and strategies with the aim of achieving the Goals related to health. I am happy to inform you that, as acknowledged in the recent article of the well known international journal, *The Lancet*, India has been showing a systematic decline of 4% per year in maternal mortality. With the rapid expansion in access to institution delivery due to a conditional cash transfer programme, we expect a dramatic reduction in the maternal mortality ratio in the near future.

I am happy to state that, under the infectious disease control programme, we have been able to avert more than two million deaths on account of tuberculosis with the scaling-up of the DOTS programme throughout the country.

Against the Millennium Development Goal target of mortality reduction by 50% by 2015, we have already achieved a 68% reduction. We are now concentrating our energies on those districts that have yet to achieve the international benchmarks of 70% case detection and 85% cure rate. DOTS-Plus for the management of multi-drug resistant tuberculosis has now been rolled out in the country.

The HIV/AIDS programme has done extremely well in my country. India is showing a downward trend in the incidence of new infections due to the multi-pronged strategy of scaled-up access to critical services, behavioural change among the high-risk groups and treatment for AIDS patients. I am happy to inform your excellencies that India's prevention strategy is now universally acknowledged as being the most cost-effective.

Preliminary reports of a recent study on the impact of our strategy shows that we may have averted 50% of all potential infections. This is indeed a very noteworthy development. One of the major initiatives is the federal support to strengthening public health systems in the state governments through the National Rural Health Mission. This year, the thrust has been on health equity with an emphasis on poor-performing districts and a wide-ranging set of programmes of skilled human resources in these districts. There has been substantial addition to health human resources. Some 700 000 community health workers and over 100 000 doctors, nurses and paramedics have been added during the last five years in rural health care.

While we are doing our best to achieve the Millennium Development Goals, we also look forward to proactive measures from WHO. We need to provide our people with access to low-cost and good-quality vaccines and drugs and to drive down prices aggressively. The Indian vaccine industry is producing high-quality vaccines at an affordable price for the domestic and global markets. It is important that the WHO prequalification process should be expedited to further facilitate Indian vaccine manufacturers in playing a wider role in assuring the global security of vaccines. Similarly, low-cost, good-quality generic drugs make medical treatment a viable option for many countries, particularly the poor countries. We need to steer clear of commercially motivated debates over "counterfeit" drugs that have only hampered public health by preventing access to good-quality, low-cost generic drugs. We also need to urgently resolve the deadlock over sharing virus vaccines and other benefits. We firmly believe that virus-sharing and benefit-sharing must be on an equal footing.

I would like to conclude by saying that the promotion of good health values and of low-cost, good-quality generic drugs and vaccines is key to achieving the Millennium Development Goals within the stipulated timelines. With concerted action and a focused approach, we need to strive towards achieving the Millennium Development Goals to which we are committed. Thank you for your kind attention.

Dr MOTSOALEDI (South Africa):

Mr President, Director-General, Dr Margaret Chan, honourable members, colleagues, on behalf of the South African delegation, I wish to congratulate you on your election and wish you all the best

for the duration of your tenure. I also wish to congratulate the Director-General, Dr Margaret Chan, for the inspiring speech she delivered today.

This year is a historic year for Africa. In 25 days, the first ever FIFA Soccer World Cup on the African continent will kick off in South Africa. South Africa is ready to welcome the world. We wish those who will be joining us an enjoyable stay. The health sector has been preparing for years for this event and we have worked with WHO and other partners.

I want to allay fears regarding concerns that have been raised regarding Rift Valley fever. There was a case about a German tourist which started pandemonium within some media circles, especially in Europe, which was just one of the many false alarms that are recently being raised about the continent of Africa. Both the Bernhard Nocht Institute for Tropical Medicine in Germany and our own National Institute for Communicable Diseases in South Africa have confirmed that it was not a Rift Valley fever viral infection. However, we are continually and effectively monitoring all diseases, including Rift Valley fever. This is what any health system in any part of the world is expected to do anyway.

The Health Assembly this year will review progress made towards the Millennium Development Goals. Independent reviews have clearly shown that in sub-Saharan Africa, the goals will never be achieved by 2015. My country is one of those which were found to be lagging behind. I am committed to changing this situation and I wish to share my hope and conviction with all my colleagues who have to meet this target that this situation can be reversed. We are hopeful that this will be within the five years that we have until 2015. We intend to introduce simpler basic interventions to bring down the disgracefully high mortality rates. We will learn from the experience of those countries and Member States that brought down maternal mortality ratios from around 250–450 in the 1960s, to around 25 in 1990. The simple measures we are referring to are mainly about doing the right things, at the right place and at the right time. These interventions are well documented.

Our commitment is also to the number of children under five who die each year. Sadly, most of them die from conditions which can be prevented and which are treatable. Every one of these children deserves an equal chance of survival. We all have a responsibility to act and we are doing so in South Africa. That is why massive child immunization campaigns in my country were launched last month.

As a country, we also know that the main causes of maternal and child mortality are associated with HIV/AIDS and tuberculosis. It is for this reason that our response to improve maternal and child mortality rates includes effective measures to fight HIV/AIDS. We are determined to launch a new trajectory in this regard. HIV/AIDS is the most complex and devastating infection that humanity has ever been confronted with. South Africa is responding aggressively to the HIV/AIDS pandemic, and as with many of the most successful public health interventions in the world, we are certain that it is the simple, sensible things that will bring good results.

World AIDS Day 2009 was a historic day for South Africa in the fight against HIV/AIDS. On this day, which was also attended by the Executive Director of UNAIDS, Mr Michel Sidibé, President Zuma made far-reaching announcements whereby treatment was to be upgraded for certain categories of vulnerable people consistent with WHO guidelines. He also announced that massive prevention strategies would be undertaken within society. I am happy to announce that from 1 April, we have actually implemented the new treatment regimens in South Africa. The history of HIV/AIDS response has been one of demanding action. It has changed the frontiers of public health. It is for this reason that the effectiveness and success of our response are underpinned by the deployment of South African society itself, led by President Jacob Zuma, and with leadership from all the sectors: political, social and economic. This bold and ambitious programme was launched in my country on 25 April; under it 15 million South Africans will be tested for HIV/AIDS by 2011. We have decided to include other noncommunicable diseases in this programme so these 15 million South Africans will also be tested for blood sugar, blood pressure, haemoglobin and tuberculosis. In addition, we are offering pap smears for every woman who tests positive and we hope this will be extended to other women in due course. We have further started massive male medical circumcision, ending a history of 200 years of non-circumcision in one of the biggest tribal groups in South Africa, the Zulu Nation.

Mr President, in conclusion, permit me to thank the WHO Director-General and other United Nations agencies and our development partners for their support in the past year. We will work in partnership with other countries in the African Region and beyond to improve the lives of our people.

Ms STRØM-ERICHSEN (Norway):

President, Director-General, excellences, ladies and gentlemen, in September the world's leaders will meet in New York to discuss the Millennium Development Goals. Improved health reduces both poverty and security threats. We need to constantly remind ourselves that the poor especially women and children, are the most vulnerable. Health is the key to the attainment of the Millennium Development Goals. To succeed, all stakeholders must make concrete contributions. WHO has a special role to play. It must be in the forefront in promoting the health-related Millennium Development Goals. My Government has made a firm commitment to promoting women's and children's health as reflected in Goals 4 and 5. WHO should strengthen its engagement in the inherent health challenges of climate change. Poverty and hunger will increase. Access to clean drinking-water be reduced, the impact on global health is severe.

Many of us are facing huge demographic changes. Our population is ageing posing challenges to our health systems. Not only is there a global lack of health personnel, but the need for health personnel is increasing in many parts of the world. The peak of this crisis is still to be seen. It is obvious that committed international cooperation is essential. Agreement on a voluntary code of practice, as presented to this Health Assembly, is urgent.

The rise in noncommunicable diseases also increases the importance of the principle of health in all policies as public health must be reflected in all sectors of government. More structural measures need to be put in place. Norway warmly welcomes the proposal for a strategy to reduce the harmful use of alcohol. Norway would also like to propose a resolution to accompany the proposed recommendations on marketing of unhealthy food and beverages to children. This is a vital tool in our efforts to prevent obesity. To provide the right health services at the right level and at the right cost is a challenge to all of us. Health services founded on a good primary health care are the best and most cost-effective approach. An increased focus of WHO on health systems strengthening is overdue, and I warmly welcome it. Our health systems also face a change in the burden of disease. While communicable diseases have traditionally contributed most of the burden of diseases, noncommunicable diseases today account for around 60% of the total burden, and their share of the disease burden is expected to increase in the years to come.

I also welcome the strategy on WHO's role and responsibility in health research. We need to obtain knowledge that ensures that the policies adopted and measures taken are evidence-based. A clearly defined role for WHO is of crucial importance. Norway is providing support for health systems research to make health systems more effective.

In order to deliver on their mandate, the United Nations organizations, including WHO, need to strengthen their cooperation at all levels. In particular, WHO and other United Nations organizations have to strengthen their efforts to ensure a United Nations that "delivers as one" at the country level. I am also happy to note the collaboration established between the seven countries in the foreign policy and global health initiative. The seven Foreign Ministers have taken a special interest in making foreign policies responsive to health. We appreciate the working relationship with the Director-General and WHO in this respect, reflecting our excellent cooperation.

Norway has submitted a candidate for the Executive Board this week, with the aim of being an active contributor to the Board's discussions if elected. I highly welcome the initiative taken by the Director-General to discuss the future financing and priorities of the Organization. Norway supports a strong WHO. Norway looks forward to working with Member States to strengthen the role of WHO in promoting the health of the peoples of the world.

El Sr. CÓRDOVA VILLALOBOS (México):

Señora Directora General de la Organización Mundial de la Salud, distinguidos delegados de los países, señoras y señores: Reciban ustedes un saludo del Gobierno y del pueblo de México. Hoy,

hace poco más de un año, muchos de los países aquí reunidos enfrentamos la pandemia de influenza A H1N1. Las acciones realizadas en cada país permitieron su contención y su control. Todos estaremos de acuerdo que el liderazgo de la Dra. Margaret Chan al frente de la Organización Mundial de la Salud contribuyó para el control mundial de la pandemia de influenza. Haremos un reconocimiento a la Dra. Margaret Chan y a su equipo de la OMS por el esfuerzo realizado en esta pandemia.

Todos los que tenemos el privilegio de participar en el sector salud de nuestros países reconocemos que durante el desarrollo de la pandemia se aprendieron diversas lecciones, hubo resistencias, recibimos elogios y hasta descalificaciones, pero aplicamos conforme a las bases técnico-científicas las diversas acciones de control y contención. Mejoramos nuestra capacidad de respuesta en todos los niveles del sistema de salud y logramos rescatar en la sociedad una costumbre del lavado de manos. Resalta por su importancia la campaña de vacunación contra influenza A H1N1 que se dirigió a los diversos grupos de riesgo que, conforme a la historia natural de la enfermedad, juntos fuimos construyendo. Había que proteger a la población y fue todo un éxito. Hemos aplicado poco más del 95% de los 30 millones de dosis que como país requeríamos, prácticamente sin efectos secundarios, lo que da cuenta de la inocuidad del biológico desarrollado.

Durante la pandemia no se descuidaron otras acciones relevantes para mantener y atender la salud y bienestar de la población, es así que, en México, seguimos impulsando acciones para lograr la cobertura universal a través de los diversos esquemas de aseguramiento, tanto por derechos laborales a través de la seguridad social como por aseguramiento público a través del seguro popular. A través de este último esquema avanzamos en la focalización de acciones y recursos económicos para garantizar atención médica integral a todas las mujeres embarazadas con el programa embarazo saludable; a todos los niños recién nacidos y hasta los cinco años de edad con el seguro médico para una nueva generación; la atención del cáncer a todos los menores de 18 años y la atención integral de la mujer con cáncer cervicouterino y cáncer mamario, por mencionar algunos. Mantuvimos nuestras campañas de vacunación con 15 inmunógenos gratuitos y continuamos proporcionando los esquemas de tratamiento de antirretroviral, también gratuito, a todos los pacientes VIH-positivos, seguimos combatiendo al dengue en diversas regiones del país, avanzamos en la instrumentación de estrategias para atacar otras epidemias como la de tabaquismo, la de los accidentes viales, diabetes mellitus y la del sobrepeso y obesidad.

Para México, el sobrepeso y la obesidad representan una gran carga de enfermedad. Somos una de las naciones con mayor rapidez en el crecimiento de este problema de salud pública por sus complicaciones. Por ello, el Presidente de la República, Lic. Felipe Calderón, promovió la suscripción del Acuerdo Nacional para la Salud Alimentaria como una estrategia contra el sobrepeso y la obesidad. En este acuerdo participaron todos los niveles y órdenes de gobierno con los sectores público, social y privado, además de la sociedad mexicana; se cuenta con un decálogo de objetivos por cumplir que busca, entre otras acciones, como ejemplo, promover la actividad física en todos los entornos, aumentar la disponibilidad, accesibilidad y el consumo de agua simple potable, disminuir el consumo de azúcar y grasa en bebidas, aumentar el consumo de verduras y frutas, legumbres, granos enteros y fibras en la dieta, disminuir el consumo de grasas saturadas y eliminar el consumo y producción de grasas trans de origen industrial y también disminuir los tamaños de las porciones en restaurantes y expendios de alimentos preparados y en alimentos industrializados.

Por último, me quiero referir a los compromisos pendientes a nivel mundial. Me refiero con ello al cumplimiento de los Objetivos de Desarrollo del Milenio. Sabemos del esfuerzo que desarrolla la Organización Mundial de la Salud, pero consideramos que se debe acelerar el paso impulsando las acciones necesarias en todos y cada uno de los países para lograr su cumplimiento. Por ello, y si me lo permite el Presidente de esta 63.ª Asamblea Mundial de la Salud y la Directora General de la Organización Mundial de la Salud, me permito proponer la construcción de un observatorio de cuenta regresiva del avance de los Objetivos de Desarrollo del Milenio donde podamos visualizar estos avances.

El Presidente de México, Felipe Calderón Hinojosa, por mi conducto les envía un salud y reitera, en esta alta tribuna, el compromiso de nuestro país, México, para continuar trabajando para garantizar y otorgar las mejores herramientas, intervenciones, de atención y control necesarias para conseguir que la población bajo nuestra tutela mejore su nivel de salud y de esta manera contribuir en

el logro de una aspiración por demás sentida para poder vivir mejor. Por ello, antes de finalizar la presente administración lograremos la cobertura universal en salud en nuestro país.

Externo y comparto con todos ustedes mi aspiración y deseo para que en la construcción de la salud mundial se potencialicen todos nuestros esfuerzos en el logro de las metas que como Organización nos hemos impuesto. Muchas gracias.

Ms AGLUKKAQ (Canada):

President, distinguished delegates, Canada is pleased to be a part of the Sixty-third World Health Assembly. Canada recognizes that there are many global health issues that need to be addressed. And the solutions will come only through international collaboration and mutual support.

Regardless of the distance between us, all of the nations of the world are increasingly linked: whether preparing for or responding to infectious diseases, or whether dealing with the global supply of food, medicines and products, or confronting a catastrophic disaster or noncommunicable disease, we benefit from working together.

We need to share our knowledge and best practices in order to find innovative solutions; the spread of the pandemic (H1N1) 2009 virus has served as a reminder that the transmission of infections does not respect borders. That is why international collaboration and regulations are critical in responding to emerging health challenges. As you know, Canada was among the first countries affected by H1N1. We recognized how important it was to quickly share information and specimens with other Member States through work done at the Public Health Agency of Canada's National Microbiology Laboratory. Information-sharing and collaboration in laboratory diagnosis were instrumental in the early recognition of the outbreak, and we welcome the opportunity to address lessons learnt. Canada was able to deliver on its International Health Regulations obligations through the initial H1N1 response, including notifying WHO within 24 hours of our first laboratory confirmed cases. We continued to share information with PAHO/WHO throughout the H1N1 response.

Canada looks forward to working with the WHO Secretariat and Member States to share the lessons we have learnt in order to better prepare for, and respond to, future threats to global public health. We were especially gratified by the number of Canadians immunized and the ability of provincial governments at all levels that provided an effective response in remote and isolated populations. International collaboration also gives us a chance to share best practices we can use to respond to the health issues that we have in common. For example, we can share our experiences in delivering health services to indigenous peoples and in rural and remote settings. Canada welcomes the collaboration with other countries on this very important issue.

Canada has also been very active in the international response to the devastating earthquake in Haiti. We will continue to support the Haitian people by helping with humanitarian relief in the short-term and the long-term reconstruction of the country. To that end, Canada has cancelled Haiti's bilateral debts, so those financial resources can instead be put directly towards reconstruction. At a meeting of the G7 hosted in Canada's Arctic and my home territory of Nunavut, Canada also led a consensus to forgive all Haitian debt to international financial institutions.

A decade has passed since the signing of the United Nations Millennium Declaration. A great deal has already been achieved towards meeting the Millennium Development Goals, but much more has to be done if we are to meet our deadlines of 2015. Holding this year's G8 Presidency, Canada is championing a major initiative to improve maternal, newborn and under-five child health in developing countries. Canada will be making this a priority at the G8 Muskoka Summit in June. Our preparations for the G8 Summit are being done in consultation with the WHO and many other partners. Dr Chan, I would like to thank you and your staff for your ongoing support and advice to the Government of Canada in the development of this initiative.

As I conclude, I am happy to indicate that Canada is very pleased to be sponsoring a resolution at this Health Assembly – on advancing food safety. I believe that it is timely to advance this resolution as there is a requirement for greater global attention and recognition in this area. I wish to assure you that Canada is committed to the strategic priority set out by the WHO. I believe our deliberations at this Health Assembly will make a difference, and I am confident that together we can achieve health outcomes that will benefit us all.

Dr NELSON (Australia):

Director-General, President and Vice-Presidents of the Health Assembly, honourable ministers, distinguished guests, excellencies, ladies and gentlemen, the Millennium Development Goals have served to focus international efforts to address the health challenges faced by the world's poorest countries. Australia is strongly committed to the achievement of these Goals, and in our 2010–2011 financial year, we will provide AS$ 555 million in aid, or 14% of our total overseas development aid – our largest ever investment in reducing poverty and achieving sustainable development. We are committed to increasing our development assistance to 0.5% of gross national income by 2015–2016. We are also expanding the geographical scope of our support to, for example, Africa in areas such as maternal and child health.

In our own region, the Asia-Pacific, we are working closely with partner countries to move towards achievement of Millennium Development Goals 4, 5 and 6, through making health systems work better and targeting specific interventions. The fruits of our investments are clear. For example, in the Solomon Islands and Vanuatu, malaria-control activities such as the distribution of insecticide-treated bednets have resulted in large decreases in malaria incidence. Maternal mortality, Goal 5, remains the area where progress is weakest. We know what works, and countries such as Nepal, the Solomon Islands, Sri Lanka and Thailand, which have instituted measures to increase access to emergency obstetric care, skilled birth attendants and family planning, have been successful in reducing maternal deaths.

Australia is helping partner countries scale up these approaches through both specific activities, such as training of midwives and other health workers, and approaches that boost the ability of the entire health system to provide high-quality accessible services. We are starting to see progress. For example, in one pilot district in Bangladesh, maternal mortality has decreased from 256 per 100 000 live births in 2007 to 171 only two years later, in 2009.

These successes show that achievement of the health-related Millennium Development Goals is within reach. More resources are needed but equally critical is an increased emphasis on effectiveness, efficiency and impact. Development partners must continue to better harmonize and align their efforts with country priorities. We also call on WHO to enhance timely dissemination of information with all Member States on "what works and what does not work" and how to translate this into "policy and action" in order to achieve the health-related Goals by 2015.

In turning to our own health-care system and measures we are taking to improve women's and children's health in Australia, improving the health and well-being of all women in our country, especially those with the highest risk of poor health, is a priority for the Australian Government. Indeed it is developing a new National Women's Health Policy to encourage specific health services for women to encourage participation in health decision-making and management and promote health equity between women. The Policy will focus on prevention, health inequalities in our societies and the social determinants of those inequalities, and is due for release this year.

In 2009, after a comprehensive review of maternity services, our Government announced measures in improving choice and access to maternity services for pregnant women and new mothers. The package also recognizes the important role played by qualified midwives in the birthing experience of women. A comprehensive plan for maternity services in the future is also being developed. To improve indigenous maternal and child health outcomes, our Government is investing in targeted initiatives such as expanded mothers and babies services and the Australian Nurse–Family Partnership Program of home visits. The health-related Millennium Development Goals are key to our regional and global health objectives, and Australia will continue to work closely with our regional partners and global community to help achieve them. You can rely on Australia. Thank you.

Mr JURIN LAKSANAWISIT (Thailand):

Mr President, Madam Director-General, honourable ministers, ladies and gentlemen, I know that all of you are concerned about the events now unfolding in Thailand. I wish to assure you that the Thai Government is determined to do all it can to deter further violence and bring the country back to normal as soon as possible based on internationally accepted measures.

Mr President, Thailand achieved the Millennium Development Goals well before 2015. Poverty incidence dropped from 27.2% in 1990 to 9.8% in 2002. The prevalence of underweight children dropped from 18.6% to 8.5% between 1990 and 2000. Annual new HIV infections have dropped by over 80% since 1991.

Three important political commitments allowed us to achieve the health-related Millennium Development Goals. First, continuous investment in health; we have achieved universal coverage of essential health infrastructure since the mid-1980s. Second, sustainable investment in human resources, this includes the continuous and intensive scaling-up of production of community health workers and rural health nurses complemented by compulsory rural services for all medical and nursing graduates as well as extensive recruitment and support to around one million village health volunteers in the last three decades. Third, extension of our financial risk protection; Thailand has achieved universal coverage of health interims since 2001, through step-wise gradual coverage.

The current Government further commits to health investments through the following: first, maintaining adequate resources for health. In spite of the 2009 financial crisis, the 2010 budget for universal coverage increased by 9%, while overall the Government budget decreased by 12%. And for 2011, the health budget will increase by 6% over 2010. Second, expanding coverage to "stateless people". In March this year, the Cabinet approved the additional budget of US$ 14 million for essential health care to half a million stateless people. This is to underscore our policy of ensuring the right to health and basic health-care services for all, regardless of nationality. Third, next year the Government will invest more than US$ 700 million to upgrade 10 000 rural health centres to health-promoting hospitals, as well as strengthening secondary and tertiary care.

In January 2011 the Thai Ministry of Public Health, together with the Prince Mahidol Award Foundation, WHO and partners will jointly host the Fifth International Award Conference under the theme "Reviewing progress, renewing commitment to health workers towards the MDGs and beyond". We believe that this Conference will serve as one of the important global movements to tackle the health workforce crisis.

Mr President, we are very glad and would like to sincerely commend WHO, led by the Director-General, Dr Margaret Chan, for its decision to publish *The World Health Report 2010* on the theme of universal access to essential health services. In conclusion, Thailand is ready to learn from, and share information with, other countries on experiences in promoting public health.

Dr MADZORERA (Zimbabwe):

Mr President, Director-General, distinguished delegates, ladies and gentlemen, let me begin by congratulating you, Mr President, on being elected to lead our deliberations.

I stood before this august house at about the same time last year, and shared with you the state of health in Zimbabwe at the inception of our inclusive Government. I feel duty bound today to update this same house on the situation as it relates to our country after a whole year of hard work and cohesive action in matters relating to health. At this time last year, Zimbabwe was in the middle of a pervasive cholera outbreak that started in August 2008, infecting nearly 100 000 people and causing close to 4300 deaths. With the help of local, regional and international partners largely coordinated by the WHO Country Office in Harare, this outbreak was eventually declared over in July 2009. Let me use this opportunity to thank all our friends and partners who gave a helping hand in our time of need. I am happy to announce that the continued alertness, intense health education campaigns and prompt and appropriate responses to reported outbreaks have seen us prevent another potential catastrophe, in spite of the fact that most of the risk factors predisposing us to such outbreaks have not yet been adequately addressed.

I also indicated to you last year that we were likely going to see, in the foreseeable future, the negative effects of a decade of economic regression. Indeed, the outbreak of measles that we currently face, although generally a regional challenge, has been made worse in our country by the poor routine immunization coverage over the last decade. We are sparing no effort to control this outbreak, with the involvement of our leadership at the highest level, and we expect to be on top of the situation soon.

I shared with you last year the difficult situation we were in regarding our human resources for health. I am glad to report that there has been massive improvement in that area. Health professionals

are back to work thanks to the staff retention scheme supported initially by some partners and now by the Global Fund to Fight AIDS, Tuberculosis and Malaria. Indeed we have even been able to attract back some of the health workers who had joined the diaspora. This effort, added to current health worker training outputs, has seen us actually fill all available posts in the categories of general nurses, laboratory technicians and pharmacy technicians among others. We still need, however, to build up post-basic specialization in areas such as midwifery, nurse anaesthetists, mental health, theatre nurses and others, and to beef up our complement of midwifery tutors, doctors, specialists and university lecturers. It is sad to note the loss of the more experienced staff to other countries in the region and beyond. This continues unabated, albeit at a lower pace. We therefore eagerly anticipate the finalization and immediate implementation of the draft code of practice on the international recruitment of health personnel for the mutual benefit of all countries and for the creation of a globe suitable for human habitation.

All of our over 1500 public health institutions are now open and offering services at various levels from primary care to tertiary level. We have come up with a partner-supported primary care package of drugs and sundries to cover common ailments. This package is made available through an informed push system to all our primary health care institutions. As a result of this intervention, the availability of vital drugs now averages 60% and continues to improve.

The Government of Zimbabwe has embarked on a health infrastructure rehabilitation programme. This is a targeted approach to health institution rehabilitation to ensure that our infrastructure is supportive of health service delivery. The Government has prioritized health care and is doing everything possible to ensure that health care is funded. However, although a significant proportion of the overall funding to the health sector is still provided by donors, this funding is not coming directly through Government institutions, leading to a certain lack of flexibility in the use of funds, and creating structures parallel to Government ones. In fact these nongovernmental structures often end up stronger and more capacitated than the custodians of public health delivery in the country. Earlier in the year, we finalized and commissioned our Five-year National Strategic Plan, which details our vision for health in Zimbabwe, and we implore our partners to operate within this strategic framework.

We recently completed building an Investment Case for Zimbabwe using the Marginal Budgeting for Bottlenecks tool with the assistance of UNICEF and the World Bank. The tool showed that we need to invest an additional US$ 700 million over the next three years to make significant progress towards attaining our Millennium Development Goals. We are definitely back on track, and we look forward to rapid acceleration of those high-impact interventions that we have identified. The Plan is currently being considered by the Cabinet, and we hope to host a health-sector investment conference soon.

Lastly, Mr President, let me acknowledge with thanks the assistance we are receiving from WHO towards preparedness against pandemic (H1N1) 2009. We have finalized our pandemic (H1N1) 2009 epidemic preparedness plan, vaccine deployment plan and communication strategy. As a country we are ready to deploy the vaccine as soon as it arrives.

We remain resolute to deliver the highest possible quality of health to our citizens to continue strengthening our primary health-care approach and to involve communities in defining their health priorities and giving them a full mandate for local decision-making in managing their own resources for health and the future is very bright.

Mme BACHELOT-NARQUIN (France):

Monsieur le Président, Madame le Directeur général, Mesdames et Messieurs les Ministres, Excellences, Mesdames et Messieurs, le Sommet de septembre à New York constituera une étape essentielle pour le suivi des progrès réalisés vers les objectifs du Millénaire pour le développement et pour mobiliser les énergies de tous vers l'échéance de 2015. Le temps presse et une nouvelle impulsion politique est nécessaire. Il s'agit aussi d'encourager les Etats à « sanctuariser » les budgets dédiés à la santé des plus fragiles. Un développement économique et social pérenne suppose un renforcement des systèmes de santé sur le long terme.

Si trois objectifs sur huit concernent des problématiques de santé, la réussite de chaque objectif reste étroitement liée à celle des autres. La réduction de la pauvreté, l'autonomisation des femmes, l'éducation, l'accès à l'eau potable constituent des objectifs communs. L'ensemble des politiques menées doivent être engagées de front. Le bilan de réalisation d'un des objectifs est tout particulièrement préoccupant : il s'agit de l'objectif 5 – l'amélioration de la santé maternelle. En matière de santé, comme en matière d'éducation ou d'emploi, ce sont encore les femmes qui paient le plus lourd tribut. La réalisation de cet objectif ne doit donc pas être envisagée sous un angle uniquement sanitaire mais suppose une approche plus large touchant à la condition des femmes, à leur éducation, à la lutte contre les discriminations qu'elles subissent, à la lutte contre les mariages précoces et donc contre les grossesses précoces.

Parmi les nombreuses décisions qui seront prises lors de cette Soixante-Troisième Assemblée mondiale de la Santé, le Code de pratique mondial pour le recrutement international des personnels de santé me tient particulièrement à cœur. Alors qu'il manquerait environ 4,2 millions de professionnels de santé dans le monde, la préservation des ressources humaines en santé et leur répartition équitable sont capitales. La France réaffirme son soutien à ce projet essentiel pour le renforcement des systèmes de santé et donc pour la pérennisation des objectifs du Millénaire.

Je souhaite à ce stade revenir sur l'épisode de la grippe A (H1N1) qui a placé l'OMS sous les feux de l'actualité. Je veux exprimer, au nom de la France, notre solidarité avec l'OMS, prise à partie de façon injuste. Le véritable enjeu d'un nécessaire retour d'expérience devrait être de savoir si nous avons pris collectivement les bonnes décisions, au bon moment, avec les éléments dont nous disposions au printemps et au début de l'été 2009. Il devrait s'agir également de savoir comment nous réagirions – à l'avenir – face à une alerte sanitaire majeure, à l'aune de l'expérience de l'année dernière. À la lumière de cette interrogation, je souhaite revenir sur trois éléments clés de la crise que nous venons de traverser : le premier point est la remise en cause de l'évaluation de la gravité de la menace par l'OMS. En début d'alerte, au moment où nous avons dû prendre la plupart des décisions importantes, notre connaissance de la gravité était imparfaite. Mais la prochaine fois aussi nous aurons besoin de temps pour bien identifier la gravité réelle d'un virus. Nous ne pourrons nous contenter de parier ou d'espérer qu'il se comportera comme le virus de 2009 ! Il est crucial que la crise que nous venons de traverser ne nous induise pas en erreur pour une prochaine crise plus grave, lorsque celle-ci arrivera. Le deuxième point porte sur la perception du risque par nos concitoyens. C'est l'élément le plus perturbant. En effet, nous avons assisté à une véritable inversion des valeurs où le risque a été nié et où les réponses de protection furent identifiées comme menaçantes. Des gens jeunes, sans aucun facteur de risque, sont décédés ou ont passé de longues semaines en service de réanimation alors même qu'un vaccin était disponible et aurait pu les protéger. Ce risque n'a pas été perçu à sa juste mesure. Par contraste, le vaccin, qui était la réponse au danger véritable, s'est mué dans la perception collective en une source de risque. Aujourd'hui encore, cette confusion persiste alors que les vaccins et les adjuvants ont très largement fait la preuve de leur sécurité et de leur efficacité. Le troisième élément est l'attitude de remise en cause systématique de l'expertise à laquelle nous avons assisté. C'est le cas au niveau de l'OMS où le manque de transparence dans l'identité des experts et leurs possibles liens avec l'industrie sont mis en avant. C'est le cas également en France, mais pour des raisons différentes. Le mode de gestion des liens d'intérêt n'est pas suffisamment clair pour les citoyens et les médias. Les effets de cette campagne de dénigrement sont potentiellement dévastateurs : désaffection de certains experts, réserve lorsqu'il faudra rendre des avis difficiles lors des alertes à venir.

Ces polémiques antivaccinales ne doivent pas nous démobiliser. Car ce sont bien les politiques de prévention dont les vaccins sont le cœur qui nous permettront d'atteindre avec vous les objectifs du Millénaire pour le développement liés à la santé.

Dr TEMPORÃO (Brazil) (*interpretation from the Portuguese*):[1]

Mr President, Madam Director-General, ministers, heads of delegation, ladies and gentlemen, health promotion requires a whole series of measures to tackle causes comprehensively and help treat diseases. This being so, all of the Millennium Development Goals are related to health. If hunger and poverty are not eliminated, if education is not improved, if gender equality is not promoted, if environmental sustainability is not attained, if there is no international cooperation, if peace is not achieved – all of which are objectives that Brazil is resolutely pursuing – our efforts will be in vain.

In Brazil, we have been able to take two large steps towards the achievement of these Goals. Between 1990 and 2008, we reduced infant mortality rates by 58%, and the country will accomplish Millennium Development Goal 4 before 2015 even though regional disparities remain to be addressed. Maternal mortality in 2007 had already decreased by half in comparison with 1990 rates. The consistent decrease in vertical transmission of HIV and the significant reduction in the number of cases of malaria and tuberculosis reflect the success of governmental policies related to Goal 6 in Brazil. This holistic view demands bold action on the social determinants of health. In Alma-Ata in 1978, we took a significant step as we signed the Universal Commitment to Health for All with primary health care as its main strategy. Now, it is time to once again honour the pledge and advance towards the achievement of broad consensus about results of the Commission on the Social Determinants of Health, in line with resolution WHA62.14. With this in mind, Brazil will have the honour of hosting the World Conference on the Social Determinants of Health in Rio de Janeiro in October 2011. We should reach the necessary agreements that will turn health, the most basic aspiration of every human being, into a fundamental part of all state policies, thereby making it truly universal.

Our common path towards the achievement of the Millennium Development Goals is winding and full of obstacles, including those of a financial nature which are especially harmful during the ongoing economic crisis. One year ago, during the Sixty-second World Health Assembly, we were facing the great challenge of pandemic (H1N1) 2009, which was rightly considered a pandemic by WHO. Today, we have before us an even greater challenge: to learn the lessons of this recent past and pave our way towards the Millennium Development Goals. On the brink of the influenza pandemic in 2009, our countries rapidly shared the virus, inspired by the commitment to cooperate in the struggle against a common evil. Regrettably, however, the solidarity in sharing the viruses gave way to a slow and insufficient sharing of benefits. This is a structural imbalance we members of WHO have to rectify. The increase in the capacity of developing countries to produce vaccines, antivirals and diagnosis kits is essential to correct this distortion and to ensure that public health will prevail over any other interests or purposes. In spite of these challenges, Brazil has been making substantial efforts to reduce the impact of this pandemic, and in the next few weeks we will conclude the largest vaccination strategy ever undertaken, which aims at vaccinating 90 million people from the most vulnerable groups.

Disease treatment and prevention depend on one key element: health workers. Without them we will never reach our objectives, including the Millennium Development Goals. Emigration of these professionals from poor countries without any control or compensation weakens social policies and condemns developing countries to a permanent setback in the area of health. The draft resolution on the code of practice for the international recruitment of health workers before this Health Assembly should constitute a tool to enhance international solidarity and offer fair solutions to enable the most vulnerable countries to address this complex challenge. The importance of the issue inspired the group on foreign policy and global health to consider it a priority, as reflected by its inclusion as one of the main themes of the United Nations General Assembly resolution presented to the group in 2009.

The participation of civil society in the efforts to promote public health is essential. Brazil has benefitted greatly from its involvement. The National Health Council, on which civil society is represented, will organize a first world conference on the development of universal social security systems in December 2010, an event to which I have the pleasure to invite you all.

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

The attainment of the Millennium Development Goals, in particular Goal 6, demands coordinated action to prevent and treat specific diseases. WHO must engage in the development of a global strategy 2011–2015 to combat HIV/AIDS that will reinforce actions related to viral hepatitis and publicize information and promote its prevention and cure. Furthermore, it is essential to implement the new global strategy 2011–2015 to combat Hansen's disease, approved in New Delhi by 44 endemic countries with an emphasis on reduction of new cases. This strategy should be a starting point for the expert meeting to take place in the second semester, as agreed at the last session of the Executive Board.

Noncommunicable diseases are the most lethal illnesses today. It is our urgent duty to promote prevention and treatment of these diseases, which lead to 60% of deaths worldwide and 80% in the developing world. The recent adoption by the United Nations General Assembly of a resolution in this respect is an important step towards enhancing visibility of these diseases, which are as lethal as they are neglected. The Millennium Development Goals are more than objectives. They are challenges that stimulate us to collaborate for a better future. They inspire solidarity and joint efforts. This is the spirit that ought to guide us all.

Access to safe, efficient and quality medicines is crucial to guarantee a well-structured health system. Generic medicines, which are more accessible, constitute an essential instrument for achieving the Millennium Development Goals. It is the responsibility of WHO to promote access to health products and strengthen regulatory national authorities. The merits of the Brazilian regulatory system were recently recognized by the Pan American Health Organization, which certified Anvisa as a reference authority. Combating falsified medicines, which is our common endeavour, cannot serve as an excuse to allow commercial interests to prevail over public health. Intellectual property rights have nothing to do with falsified medicines. Victims of intellectual property right violations are enterprises. Victims of falsified medicines are patients, and these patients are the ones who require the protection of WHO.

Mr President, as the deadline for the achievement of the Millennium Development Goals approaches, it becomes ever more urgent to effectively implement the global strategy and plan of action on public health, intervention and intellectual property. The greatest challenges to the attainment of the Goals are in the developing world, and it is to the benefit of the developing world that the global strategies should be orientated. South America is setting an example in this respect. Prior to this Health Assembly, we, health ministers of the Union of South American Nations, gathered in Ecuador to discuss the efforts to achieve the Millennium Development Goals through universal access to medication as well as universal access to good quality health systems, capacity building of human resources, action on the social determinants of health, and the enhancement of innovative financing mechanisms for research and development in health.

Mrs G.A.A. Gidlow (Samoa), Vice-President, took the presidential chair.
Mme G.A.A. Gidlow (Samoa), Vice-Président, assume la présidence.

Dr VAHID-DASTJERDI (Islamic Republic of Iran):

Bismillah ar-rahman arrahim. Madam Vice-President, Madam Director-General, excellencies, honourable delegates, ladies and gentlemen, congratulations to you, Madam President, and to the Bureau on your deserved election. I wish you every success in steering the work of this Health Assembly. My word of appreciation also goes to the Director-General and her capable staff for all the preparations.

Indeed pressing needs have compelled us to convene and engage in a high-level dialogue on the health-related Millennium Development Goals. WHO's report on the status of progress towards the Goals suggests that implementation has been slow and uneven across and within Goals and regions. While progress in some regions is recognizable, in many parts of our world, the health-related Goals seem to be hard to reach. Overall, we lag behind achieving the Millennium Development Goals by 2015, and this should be truly alarming.

The Islamic Republic of Iran, while facing challenges, has made considerable progress on the health-related Goals. On under-five and infant mortality rates as well as on the proportion of one-year-old children immunized against measles, we are close to achieving the targets. The same applies to

maternal mortality rates, the proportion of births attended by skilled health personnel, as well as neonatal and postnatal care coverage. Iran is among the pioneer countries with a Multisectoral National Strategic Plan on HIV/AIDS, which includes application of the "Three Ones" principle. On tuberculosis, Iran has already achieved the goal of 100% coverage of DOTS. On malaria, and in spite of our significant achievements, there are still concerns over the situation in just three south-eastern border provinces. We, like many countries, still suffer from uneven progress.

Shortfalls in achieving the Millennium Development Goals are, to a large extent, due to the absence of an enabling international environment. Global imbalances and inequities, coupled with multiple global economic, financial and food crises, further impoverish the poorest. The developing countries are faced with growing vulnerability, due to actions originating in the developed countries. We are deeply concerned over the risk of diversion of attention from achieving the Goals, during recovery from the current economic crisis. Foreign occupation and application of political conditionalities and unilateral sanctions against developing countries, continue to hamper their efforts to achieve the Millennium Development Goals. I wish, in particular, to mention the politically motivated impediments to developing countries' access to peaceful nuclear energy for, among others, public health purposes.

To achieve the health-related 2015 targets, we require a renewed global partnership on the following areas: to eliminate global systemic inequities and their inherent risks through concerted efforts; to provide developing countries with policy space to develop their own strategies tailored to their requirements and ensure their meaningful participation in global economic governance; to address the Millennium Development Goals, mobilization of substantial resources, in addition to what can be generated domestically, is required; commitments made at United Nations conferences, in particular on flows of official development assistance, should be honoured; developed partners should adhere to good governance by subjecting themselves to the same standards of transparency and coherence as they expect from developing countries; technology, knowledge and information are public goods and global assets – relaxing protective measures and providing an unimpeded and universal access to them are absolute requirements; the United Nations system, including WHO, should be enabled to provide effective coordination and policy coherence and monitor implementation of the Millennium Development Goals.

Madam Vice-President, honourable delegates, in conclusion we need to move beyond formalities. The Health Assembly should make its real impact on speeding up the process of realization of the health-related Goals.

Dr LIOW Tiong Lai (Malaysia):

Honourable Chairperson, excellencies, ladies and gentlemen, first and foremost, the Government of Malaysia would like to thank Dr Margaret Chan, the WHO Director-General, for having visited Malaysia in November 2009 and also for officially opening the WHO Global Service Centre in Putrajaya, Malaysia. Malaysia would also like to record its thanks to the Director-General for WHO's contribution of 20 064 doses of Tamiflu® during the outbreak of pandemic (HINI) 2009 last year.

Malaysia has made progress towards achieving its Millennium Development Goal targets, political stability, strong political will, commitment by health-care providers and policymakers contributed to this remarkable achievement in the health status of the population. In line with Goals 4 and 5, the achievements thus far are shown by the marked decline in the under-five mortality rate from 16.8 per 1000 live births in 1990 to 8.1 in 2008 and in the infant mortality rate from 13 to 6.4 per 1000 live births for the same period of time. Similarly, the maternal mortality ratio has declined from 44 maternal deaths per 100 000 live births in 1991 to 28.9 in 2008. The coverage for primary immunization is above 90% of the target population and for measles given in combination with mumps and rubella at one year reached 94.3% in 2008. Deliveries conducted by trained personnel have increased from 92.8% in 1990 to 98.6% in 2008, while the adolescent birth rate declined from 28 per 1000 women in 1991 to 13 in 2007.

The other factors that have contributed to the decline in mortality include provision of trained delivery attendants to manage pregnancy and delivery complications, a comprehensive childhood

immunization programme and establishing the child malnutrition programme. The challenges in achieving the targets for Millennium Development Goals 4 and 5 will require greater effort and focus on strengthening the referral feedback and retrieval system at primary care level; improving knowledge and skills of health-care providers at all levels of care; advocacy on breastfeeding and complementary feeding practices; family planning for high-risk mothers, especially for those with medical conditions; expanding the Integrated Management of Childhood Illness programme to more areas; and prevention of childhood injuries. Other areas that require attention include increasing coverage of maternal and child health services to marginalized groups such as the aborigines, urban poor and unmarried mothers.

Pertaining to Goal 6, Malaysia's response to HIV/AIDS was characterized by high political commitment and our policy of openness about the epidemic that enhanced dialogue at the programme development and also implementation levels. Malaysia has made significant progress by halting and reversing the trend of HIV/AIDS. The number of reported HIV/AIDS cases has declined from 6978 cases in 2002 to 3080 cases in 2009. Since 1986, a total of 87 710 HIV cases have been reported, of which 15 317 have been diagnosed to have AIDS, while there were 13 394 deaths. Malaysia achieved the Millennium Development Goal target for malaria by halving malaria incidence from 29 per 10 000 in 1990 to 2.5 in 2009. We are now moving towards the Goal's last target of completely eliminating malaria infection by 2020. As for tuberculosis, Malaysia has made some good progress, such as achieving the target of detecting 70% of estimated cases and successfully treating 85% of these cases. However, like many other countries, achieving this target for tuberculosis is a challenge. Malaysia is committed to the WHO's Strategic Plan to Stop TB in the Western Pacific, and we hope to achieve all the targets set by 2015.

As briefed to the Director-General during her visit in November last year, Malaysia aspires to become a high-income country within which the health-care system will be transformed to meet the needs of the population. This initiative, called "1 Care for 1 Malaysia" brings a partnership between the public and private health-care providers. It is designed as an integrated health-care system that is responsive and provides choice of quality health care, enhancing universal coverage for the population, based on the concept of solidarity and equity. In this endeavour, we must preserve the strength of our current health-care system which is acknowledged internationally. This initiative by Malaysia can also be an example for other developing countries facing similar challenges.

Lastly, we would like to congratulate Dr Margaret Chan on her leadership during the pandemic (H1N1) 2009 crisis and look forward to seeing her in Malaysia later this year for the meeting of the Regional Committee for the Western Pacific, which Malaysia will be hosting. Hopefully, she will be wearing the Malaysian batik that was presented to her during her last visit. I thank you for your attention.

Dr HAQUE (Bangladesh):

Madam Chairperson, Madam Director-General, excellencies, distinguished delegations, ladies and gentlemen, *Assalamu alaikum*. It gives me a great pleasure to congratulate you on your election to the Chair. We are confident that under your able stewardship, the Sixty-third World Health Assembly will achieve its mandated tasks.

We would like to convey our appreciation to Dr Margaret Chan, the Director-General of WHO, for her comprehensive and forward-looking statement. I would like to thank her for visiting Bangladesh in March 2010, and appreciating the commendable efforts of Bangladesh under the leadership of the Honourable Prime Minister, Skeikh Hasina, towards achieving Millennium Development Goals 4 and 5. I particularly thank Dr Margaret Chan for personally visiting the work in progress at the community level.

The overarching theme of this year's Health Assembly revolves around the progress made in the achieving the health-related Millennium Development Goals 4, 5 and 6. In Bangladesh, we are on track to achieve Goal 4 on reducing under-five child mortality. A recent UNICEF report, *Countdown to 2015 decade report*, places Bangladesh among the 16 countries in a position to do so. In 2007, the under-five mortality rate was 60, which is in fact a three-fifths reduction from the base year. A combined approach to immunization, diarrhoeal disease control and Vitamin A supplementation

programmes has significantly contributed to the decline in child and infant deaths. In 2009, we passed a National Neonatal Strategy which, if implemented properly, will have a significant impact on newborn survival.

Monitoring the exact progress in respect of Millennium Development Goal 5 on reducing maternal mortality remains a challenge. Based on the outcomes of the number of sub-national programmes, it can be concluded that, as in the case of most developing countries, we are not yet completely on track in achieving all target indicators for Goal 5. The presence of low-skilled professionals at the time of delivery still continues, along with low institutional delivery. Low rate of antenatal care received, high adolescent fertility and around 20% unmet need for family planning are some of the key concerns that deserve priority attention.

Our initial focus on the supply side of service utilization resulted in lowering maternal mortality by almost half, from 574 in 1990 to an estimated 240 per 100 000 live births in 2010. However, we noticed that the rate of return on supply-side investments remained sub-optimal due to demand-side barriers. In 2004, we introduced an innovative demand-side financing intervention, the Maternal Health Voucher Scheme.

Bangladesh has performed well in halting the communicable diseases like HIV/AIDS, malaria and tuberculosis under Millennium Development Goal 6. HIV/AIDS data reveal that the prevalence of HIV infections among adults is now 0.32 per 100 000 population, and it is estimated that it will be at 1.3 per 100 000 population by 2015. The disease is at an epidemic stage among the injecting drug-users in the large cities. The prevalence of malaria and tuberculosis show that Bangladesh will be able to halt the two diseases by 2015. In 2008, the prevalence of malaria was 59 per 100 000 population, and the prevalence of tuberculosis was 225 per 100 000 population in 2007. Effective public–private partnership in these areas has been one of the main driving forces behind the progress made and projected into the future.

In order to sustain the momentum of the achievements made, I would like to make the following observations in light of our experiences in Bangladesh. The renewal of primary health care can be instrumental in accelerating the achievement of the Millennium Development Goals, especially in the low-income countries. In Bangladesh, we are working to establish and operationalize 18 000 community clinics across the country, with one such clinic for every 6 000 population. The health-sector initiatives need to be matched with substantial investments in the social determinants of health. The current Millennium Development Goal review process may consider incorporating specific target indicators for noncommunicable diseases for 2015 and beyond in a realistic manner. Access to essential medicines, vaccines and diagnostic kits is crucial for health security in the developing world. WHO should continue to work for enhancing access to essential drugs and vaccines in this progress, and in Bangladesh we are in the process of producing vaccines soon. The health dimension of climate change impact needs to be mainstreamed into the ongoing climate change negotiations in order to develop a holistic response to the rapidly evolving challenges. The international community should close ranks to develop innovative finance mechanisms to fill in the resources gaps in meeting the Millennium Development Goals by 2015. Information and communication technologies have the potential to change the health-care delivery landscape in the developing world. WHO should use its expertise to develop the necessary standards for the application of e-health facilities and assist countries in developing progressive national policies in this regard. As regards mainstreaming of efforts, inclusion of common people in e-health projects in Bangladesh has been very effective.

In our experience it is not the lack of innovative ideas or cost-effective schemes that hinders national progress towards achieving the Millennium Development Goals. Rather, it is the difficulties faced when attempting to scale up successful initiatives into national programmes. With its global presence, WHO is ideally suited to provide the necessary guidance in this regard. It is the collective responsibility of the membership to equip WHO financially and procedurally to undertake the enhanced and additional responsibilities that we expect the Organization to discharge. Thank you all for listening to me patiently.

Mrs MUGO (Kenya):

Madam Vice-President, distinguished delegates, the Kenyan delegation congratulates you on your election to steer this Sixty-third World Health Assembly. We also commend the Director-General for convening the Health Assembly and for her statement.

We have been reviewing our performance towards attaining the health-related Millennium Development Goals as we draw closer to 2015. Although we are not on track on most of the indicators, a lot of progress has been made over the last five to six years. In reducing child mortality, significant progress has been noted, with the under-five mortality rate falling from 115 per 1000 live births in 2003 to 74 per 1000 by 2008. Over the same period, infant mortality rate fell from 77 per 1000 live births to 52 per 1000. Similarly, neonatal mortality rate fell from 33 per 1000 live births to 31 per 1000. However, we are still not on track and a lot more needs to be done to improve these indices. In improving maternal health, the country is not on track, and maternal mortality rate is still high at 410 per 100 000 live births.

HIV/AIDS, malaria and tuberculosis remain the greatest causes of morbidity and mortality in the country. However, the country has registered some successes in the fight against these diseases. In the prevention and control of HIV/AIDS, the AIDS Indicator Survey of 2008 revealed a prevalence of 7%. Currently over 370 000 people living with HIV receive antiretrovirals as compared with only 2000 people in 2003. About 30 0000 out of the 120 000 eligible children are also on antiretrovirals. Male circumcision has also picked up as an HIV-prevention strategy, and over 90 000 people have undergone the procedure in targeted regions in the country.

In malaria prevention and control, the country is on track towards attaining the Abuja targets for access to artemisinin-based combination therapies in all public health facilities. In 2008–2009, about 3.4 million insecticide-treated nets were distributed to children under five years and pregnant women. Over the same period, 51% of children under five years and 53% of pregnant women used such nets. Indoor residual spraying is carried out in all epidemic-prone districts and in some endemic areas. However, additional resources are required to sustain these gains and the strategies for the ultimate eradication of malaria.

Our tuberculosis treatment success rate is 85.4% while the case detection rate is 80%. However, we face challenges with multidrug-resistant and extensively drug-resistant tuberculosis. There are about 800 detected cases of multidrug-resistant tuberculosis in the country and only 390 of these are being treated. The rest are at risk of spreading infection. One case of extensively drug-resistant tuberculosis has been detected and is being treated with WHO help. We urgently require support to provide treatment for all detected cases of multidrug-resistant tuberculosis. We also request support to adopt rapid diagnostic methods for tuberculosis, improve mop-up of undiagnosed cases and conduct tuberculosis mortality surveys. We further request WHO to advocate for the reduction of the price of second-line tuberculosis medicines.

It is noted that strengthening of health systems is key to attaining the Millennium Development Goals by 2015. Over the last year, the country has adopted some innovative strategies to address this issue. Key among this has been the implementation of an Economic Stimulus Programme, which includes the employment of 4200 additional nurses, the construction of 210 Model Health Centres and the provision of essential medicines to primary health facilities. Through the Programme, we hope to improve access to health services at the primary level and thus address some of the key challenges faced in improving maternal and child health.

We recognize the important role played by human resources in health systems strengthening. We continue working towards having adequate health workers. Over the last five years, more than 6000 health workers have been recruited with resources from the Government and development partners. Currently we are implementing the National Human Resources for Health Strategy (2009–2012) which puts the emphasis on rational distribution of the health workforce in the country and human resource development. However, we still experience the challenge of inadequate health workers and insufficient funds in training.

Kenya reiterates its commitment to the implementation of the International Health Regulations (2005). We are in the process of developing our minimum core capacities for surveillance and response. However, our key challenge is the strengthening of ports of entry especially at border posts

shared with countries experiencing political instability. This calls for regional collaboration in implementing the International Health Regulations (2005). We therefore request WHO to step up support in strengthening such collaboration.

In conclusion, I would like to thank the Director-General for the 50 000 doses of Tamiflu® and 730 000 doses of the H1N1 vaccine that Kenya received recently from WHO. We are currently conducting an immunization drive that will cover 100 000 health workers, pregnant mothers and other at-risk groups.

Mr YAAR (Israel):

Madam Vice-President, distinguished ministers, distinguished delegates, the State of Israel, with its well-esteemed health system has long since achieved in all terms the Millennium Development Goals. Low infant and maternal mortality, low HIV incidence, an efficient national tuberculosis control service that is well appreciated throughout the European Region, no local malaria case for several years and high-quality drinking-water accessible to all in a region where water is a scarce commodity.

Nevertheless, we all realize that the challenge in front of us all is for the global achievement of the Millennium Development Goals. This coming September, the United Nations General Assembly will hold a special high-level meeting on this very important issue. The situation does not bode well and too many countries are not on course to achieve the Goals by 2015. It is our common responsibility to work together and enhance these efforts. Israel is committed and will pay its share to this global effort.

For the last 52 years Israel, though MASHAV, its agency for international development cooperation, has shared its experience, expertise and knowledge with other countries in various projects and capacity-building programmes in many thematic areas. This is done in many health fields such as public health; emergencies and disaster medicine; humanitarian assistance, for example setting up a field hospital in Haiti less than 36 hours after the earthquake; upgrading water and sanitation quality including the purification of sewage water for use in agriculture and to increase water resources; building public-health capacity and community medicine, and more. All these efforts are consistently undertaken with the primary goal of ensuring the Millennium Development Goals are realized in a coordinated manner and according to the agreed principles of aid effectiveness, country ownership, sustainable development and others.

I am also happy to report that the State of Israel has initiated discussions with the WHO on a Memorandum of Understanding with a view to increasing Israel's cooperation and contribution to the Organization and its activities. Israel is itself an example of a country that went through the entire development process from a new and developing country to a developed country that has recently joined OECD.

Like so many other countries, Israel is coping with the world pandemic (H1N1) 2009. In 2009, the State of Israel followed the leadership of the WHO and its Director-General Dr Chan. In light of the possibility of a huge public health disaster, Israel also diverted a large amount of resources for the purchase of Tamiflu® and flu immunization for its entire population, in order to minimize any potential outbreak in the country.

At the same time, Israel is of the opinion that, in the future, a joint front of all Member States, with the leadership of WHO, has the ability to change the medical market of purchasing medications, immunization and other equipment in the face of potential world disaster. This in turn, will cause the market of sellers to lower the prices of these commodities, resulting in much-needed capital for health systems to reach the Millennium Development Goals.

Israel follows closely the discussions on various agenda items discussed at this session. Such as the new strategy to reduce the harmful use of alcohol, food safety, the treatment and prevention of pneumonia, health and migration, and international recruitment of health personnel.

And last but not least, Madam Vice-President, Israel and the Palestinian authority have just launched proximity talks under the stewardship of the United States of America. Israel considers public health as a real bridge to peace. WHO headquarters and the European and the Mediterranean regions have the ability to contribute more to the strengthening of important cross-border health

cooperation. These contributions are also further necessary for the implementation of the International Health Regulations in the Middle Eastern countries.

Focusing on these efforts is more efficient and glorious than spending time in the Health Assembly on the yearly ritual of condemnation of Israel which, has never brought any benefit to either side. The steadfast example of cross-border cooperation, exchange of information and common preparation with our Palestinian neighbours and others that have relations with Israel, as evidenced at the time of the avian flu and the 2009 flu pandemic, can be extended to other neighbouring countries as well. It is an innovative and successful pattern for cooperation that should complement and support efforts to achieve peace in the Middle East.

M. LARSEN (Haiti):

Madame la Vice-Présidente, Monsieur le Président, Madame le Directeur général, chers collègues, membres des organisations internationales et des organisations non gouvernementales.

Le séisme du 12 janvier a été pour la République d'Haïti une catastrophe majeure. Les chiffres sont là pour le prouver : 300 000 morts, 250 000 blessés, 1 300 000 sans-abri, 600 000 déplacés vers des régions non atteintes. Toutes les structures de l'Etat ont été affectées avec l'effondrement de tous les bâtiments publics. Le système de santé déjà faible s'est vu contraint à faire face à ce grand défi, avec comme handicap l'effondrement de 30 des 49 hôpitaux de la région affectée, des difficultés de déplacement et de communication. Nous avons pu faire face à cette urgence extrême grâce à la solidarité des Haïtiens, de sa diaspora, mais surtout grâce à la mobilisation internationale sous la forme d'envoi de matériel, de médicaments et, surtout, de ressources humaines. Ainsi, tous les blessés ont pu être soignés dans les structures d'urgence. Les mesures préventives prises (vaccination, assainissement des camps, mesures soutenues par beaucoup d'entre vous) nous ont permis jusqu'à présent d'éviter des épidémies.

La période d'urgence passée, il nous reste à reconstruire notre système de santé et apporter des soins aux nouveaux groupes vulnérables (les handicapés physiques et psychiques) dans un contexte économique difficile : le pays a en effet perdu 150 % de son PIB et nous comptons 4000 amputés. Pour atteindre l'objectif du Millénaire pour le développement, nous avons plus que jamais besoin de votre aide à tous.

Mais en fait, nous avons pris la parole aujourd'hui non pour faire un exposé exhaustif de la situation, mais pour reconnaître devant cette Assemblée de la Santé ce que vous avez fait pour le peuple haïtien. Nous voulons remercier les différents pays ici présents pour leur solidarité agissante. Nous remercions particulièrement l'OMS et son Directeur général, Mme Margaret Chan, pour sa constance active et son efficace présence à nos côtés : elle a su adapter rapidement son mode d'opération de façon efficiente à notre urgence. Permettez-moi de remercier d'une façon toute spéciale deux personnes qui dans notre malheur nous ont aidés d'une façon extraordinaire : il s'agit du Directeur de l'OPS/OMS, le Dr Mirta Roses, et de la représentante en Haïti, le Dr Henriette Chamouillet. Que vive le monde dans la paix et la fraternité, merci à tous.

The PRESIDENT:

I thank the delegate of Haiti; our deepest sympathies and our prayers for a fast recovery of Haiti. I now give the floor to the delegate of Pakistan.

Mr SHAHABUDDIN (Pakistan):

Madam Vice-President, ministers, excellencies, ladies and gentlemen, at the outset let me congratulate the President of this Health Assembly, the Vice-Presidents and the Chairmen of the Committees on their election. We certainly have a challenging agenda in front of us, and several important issues are to be discussed. I am confident that under this able leadership, the Health Assembly will certainly be able to achieve its objectives.

In the past year, implementation of the International Health Regulations (2005) has remained a priority in Pakistan and we have adopted various measures for surveillance and response activities.

One achievement is the formulation of a draft Pakistan Public Health (Surveillance and Response) Act 2010, which addresses all issues related to infectious disease hazards, zoonotic events, food safety, chemicals and radiological events. I would like to acknowledge the invaluable assistance of the WHO's legal team in the preparation of our legislation.

Our flagship National Programme for Family Planning and Primary Health Care, with 100 000 lady health workers and 5000 supervisors, which was recently subjected to an external third party evaluation, has shown better results from the covered areas relating to the contraceptive prevalence rate, use of modern methods of contraception, at least one antenatal visit at a health facility, fully immunized children and births attended by skilled health workers. A real health revolution is in the offing through the outreach services of our lady health workers, who are embedded in their catchment communities.

Prior to 2007, approximately 1500 kidney transplants were performed in Pakistan every year for foreigners who obtained kidneys via remunerated local donors. This was a matter of serious concern for the Government of Pakistan. Legislation has been adopted to control these commercial transplants and subsequently there is sufficient evidence to suggest that unethical practices relating to transplant tourism have declined significantly.

Pakistan remains one of the four countries suffering from endemic poliomyelitis; and in 2010 so far, 19 cases have been confirmed. We are cognizant of the dangers this poses to the nations free of the virus, as has been highlighted by the outbreak in Tajikistan and the recent related case in Moscow. In the past year, the Prime Minister's action plan for poliomyelitis eradication that my Ministry formulated has broken new ground and expanded the partnerships for immunization. However, the review commissioned by the Director-General last year has highlighted some regional programmatic weaknesses in our eradication efforts, which we have attempted to address by identifying the districts with persistent virus transmission and devising immunization plans specific to those 15 districts. Areas undergoing law enforcement operations remain a barrier to high coverage, and with a majority of cases being reported from these areas we resolve to be aggressive and innovative in improving our access to the under-fives in these reservoirs of poliovirus.

A preliminary experience with incentivising high coverage of vaccination has been encouraging, and we hope to extend this regular engagement with the administration of Karachi. My Ministry in the past year has borne the fruits of inlands campaign quality, and we plan to place the spotlight now on the three high-risk districts of Baluchistan in an attempt to catalyse improved performance there. I wish to assure the Health Assembly that political commitment at the highest levels of all the tiers of the Government in Pakistan is robust and will continue to be so until the job is finished.

Madam President, in conclusion I would like to place on record Pakistan's appreciation of Dr Margaret Chan for her leadership role in global health promotion, and I wish the Sixty-third World Health Assembly a great success in its deliberations under the President's guidance. Thank you very much indeed.

M. TOURE (Mali):

Monsieur le Président de la Soixante-Troisième Assemblée mondiale de la Santé, Mesdames, Messieurs les Ministres et chefs de délégation, distingués participants, Mesdames et Messieurs, je voudrais, à l'entame de mon propos, adresser mes vives et chaleureuses félicitations au Président de la Soixante-Troisième Assemblée mondiale de la Santé, M. Mondher Zenaidi, Ministre de la Santé de la Tunisie, pour sa brillante élection, ainsi qu'à tous les membres du Bureau. Je remercie également Mme le Directeur général, Margaret Chan, pour tous les efforts déployés en faveur du renforcement des soins de santé primaires et des systèmes de santé et particulièrement aujourd'hui pour son excellent discours plein de dynamisme et de vision.

Permettez-moi également de vous transmettre les félicitations et remerciements du Gouvernement de mon pays, le Mali, pour la bonne collaboration avec l'OMS.

De l'indépendance de notre pays à nos jours, le Mali a fait siennes les grandes stratégies mondiales de développement sanitaire tels les soins de santé primaires d'Alma-Ata, le scénario de développement de Lusaka, l'Initiative de Bamako, la Déclaration de Ouagadougou sur les soins de santé primaires et les systèmes de santé en Afrique, la Déclaration d'Alger pour renforcer la recherche

en santé ainsi que l'Appel à l'action de Bamako sur la recherche pour la santé. Il a également souscrit à la Déclaration de Paris et aux objectifs du Millénaire pour le développement.

Comme réponse nationale, nous signalons l'élaboration et l'adoption de la déclaration de la politique sectorielle de santé en 1990, devenue en 2002 Loi d'orientation sur la santé. La mise en œuvre de la politique sectorielle de santé et de population se fait à travers le plan décennal de développement sanitaire et social 1998-2007 en deux phases quinquennales nommées Programme de développement sanitaire et social, plus connu sous le nom de PRODESS. Ce Programme contribue aux résultats du Cadre stratégique pour la croissance et la réduction de la pauvreté et à la réalisation des objectifs du Millénaire pour le développement à l'horizon 2015. Mon pays a aussi adopté une série de gratuités concernant la césarienne, la prise en charge du paludisme chez la femme enceinte et les enfants de moins de cinq ans, et les antirétroviraux pour les personnes vivant avec le VIH et le sida. De même, le dispositif de réduction de la mortalité maternelle et infantile est soutenu par l'adoption d'une loi sur la santé de la reproduction.

Les nombreux efforts, déployés de concert avec les partenaires techniques et financiers, ont permis de réaliser des progrès importants comme en témoignent les résultats de l'enquête démographique et de santé du Mali de 2006. Ainsi, l'accessibilité géographique aux services de santé est de 85 % dans un rayon de 15 km et de 54 % dans un rayon de 5 km. Près de 64 % des accouchements sont assistés par du personnel qualifié, et la couverture en consultation prénatale est de 90 %. Quant à la prévalence contraceptive, elle est de 7 % et les besoins non satisfaits en planification familiale sont estimés à 31 %. Le taux de mortalité maternelle est de 464 pour 100 000 naissances vivantes, la mortalité infanto-juvénile de 191 pour 1000 naissances vivantes, la mortalité infantile de 96 pour 1000 et la mortalité néonatale de 46 pour 1000. La prévalence du VIH/sida, quant à elle, est de 1,3 %. En matière de prévention et de lutte contre le paludisme, 81,7 % des ménages disposent au moins d'une moustiquaire imprégnée d'insecticide, 78,5 % des enfants de moins de cinq ans et 73,9 % des femmes enceintes dorment sous une moustiquaire imprégnée d'insecticide. En outre, les ratios personnels soignants sont respectivement de 1 médecin pour 12 920 habitants, 1 sage-femme pour 21 003 habitants et 1 infirmier pour 3319 habitants.

La mortalité maternelle et infantile ainsi que l'utilisation des services par les populations restent un défi majeur malgré les progrès enregistrés. Ainsi, les maladies transmissibles et non transmissibles, les épidémies, par exemple de méningite, de choléra, de fièvre jaune et de rougeole, les catastrophes naturelles liées aux inondations et au changement climatique ont une incidence non négligeable sur la morbidité et la mortalité des populations. Il s'agit donc d'inverser la tendance pour accélérer la réalisation des objectifs du Millénaire pour le développement. À ce propos, je citerai certaines réformes et initiatives entreprises, comme le renforcement des soins de santé primaires en vue de l'accès universel, la politique de développement des ressources humaines, le développement de la télémédecine à travers l'Agence nationale de télésanté et d'informatique médicale. Je citerai également la création du Centre de recherche et de lutte contre la drépanocytose, l'adoption des documents de politique nationale de lutte contre le cancer et de sécurité transfusionnelle, et l'élaboration du guide de transfert de compétence aux collectivités locales décentralisées.

Des approches novatrices au titre des initiatives internationales sont en cours dans mon pays. Il y a l'initiative pour le leadership ministériel, qui porte sur les domaines de la mutualité, du développement des ressources humaines et de la santé de la reproduction. Il y a aussi le Partenariat international pour la santé et l'Harmonisation pour la santé en Afrique qui se sont concrétisés au Mali par la signature du Compact le 20 avril 2009. Le Compact est un contrat entre le Gouvernement et 14 de ses partenaires techniques et financiers, qui définit un cadre commun d'interventions, d'augmentation et d'amélioration de l'efficacité de l'aide dans le secteur de la santé. Il engage le Gouvernement et les partenaires signataires à appuyer un seul et unique plan national de développement du secteur de la santé orienté vers les résultats. Il contient tous les aspects de la politique nationale de développement du secteur et met l'accent sur la prévisibilité accrue de l'aide. L'effet escompté de l'ensemble des réformes et initiatives est de créer les conditions nécessaires à une meilleure utilisation des services de santé par les populations pauvres. À cet effet, nous comptons encore une fois sur l'appui de l'Organisation mondiale de la Santé et de l'ensemble des partenaires techniques et financiers qui nous appuient quotidiennement et que je remercie infiniment à cette

tribune. Vive la solidarité internationale ! Que Dieu vous bénisse ! Je vous remercie de votre aimable attention.

Dr R. Sezibera (Rwanda), Vice-President, took the presidential chair.
Le Dr R. Sezibera (Rwanda), Vice-Président, assume la présidence.

Ms LARSSON (Sweden):

Mr Vice-President, ministers and honourable delegates, I am glad that the Millennium Development Goals are on top of this agenda today. Let me start by thanking WHO and Dr Chan for her strong leadership during the fight against pandemic (H1N1) 2009, an issue that dominated the health agenda in 2009. As this is the first real test of the International Health Regulations (2005), I look forward to the results from the ongoing review process. I fully agree with what Dr Chan said in her opening speech today: we need to seek lessons about how the International Health Regulations (2005) have functioned, about how WHO and the international community responded to the pandemic. We need to learn lessons about what worked well and what can be done better. Independent, open and transparent processes are fundamental.

On another note, we have for quite some time been facing another major challenge: the rapid increase of antimicrobial resistance. In the autumn of 2009, Sweden held the Presidency of the European Union, and it became clear that all Member States, through Counsel conclusions, were committed to work on the issue nationally. But the Member States also want to bring forward an action plan on how to counteract the problem. This should not, however, be an internal issue to the European Union, but a global one. We can note that there is an increasing awareness about this major health threat but far from enough action. WHO leadership is urgently needed in this area. There is a strong need to limit excess use of antibiotics, both by more restrictive use of our health and medical services and by more effective regulations on marketing and sales.

At the same time there are a number of regions in the world that have no access at all to effective antibiotics. We also need to speed up the development of new medicines with the capacity to replace the antibiotics that no longer work. In November 2009, the European Union and the United States of America decided to join forces and establish a task force on antimicrobial resistance. The matter at hand is so urgent that I encourage all Member States to do their utmost to reduce such resistance. And at the same time, I urge WHO to commit itself to this matter in accordance with the resolution from 2005, and report back on its work to the Health Assembly, preferably next year.

Let me then move to the matter of the future financing of WHO. Many of us are deeply concerned with the current financial situation. It is problematic that the governing bodies only have a direct influence over about 20% of the total budget. Over the past decade we have discussed how to come to grips with this situation. At the same time the proportion of earmarked funding has continued to expand. The situation is not sustainable. We are now living with the situation where decisions by the Health Assembly can be implemented only partially, and sometimes not at all within a reasonable time frame. Therefore, my Government warmly welcomes the initiative by the Director-General on innovative financial mechanisms. We are prepared to actively engage in your efforts.

I want to conclude with some words about the global strategy to reduce harmful use of alcohol. We have been through a lengthy and sometimes difficult process. I am very pleased that we have hopefully now finally reached the adoption phase. The outcome of the broad consultations has led to a draft strategy that is both well-balanced and based on best available evidence and practice. It is well adapted to the various resources, context and circumstances at hand in different Member States. An excellent WHO report was recently published called *Global health risks*. It confirms the great impact of the harmful use of alcohol, the impact especially on our children and on families. The report contains an update of the global burden of disease where alcohol ranks number three as a risk factor – closely behind underweight and unsafe sex. So arguments strongly support the urgent need for us all to agree on and support the implementation of this strategy. I want to thank all Member States that have jointly and actively embarked on this effort. I am convinced that the global strategy to reduce harmful use of alcohol has the potential to become a landmark in combating alcohol-related health and social harm, and I would like to urge all of us to support WHO's future work.

La Dra. MARTÍNEZ (Paraguay):

Señor Vicepresidente, señoras ministras, señores ministros, señoras jefas y señores jefes de delegación: En primer lugar permítame felicitarlo por su elección como Presidente de esta 63.ª Asamblea Mundial de la Salud, así como a los demás miembros de la Mesa. Es con mucho placer que me uno a los reconocimientos, ya expresados por otros oradores, a los esfuerzos colectivos que se han realizado en el mundo para avanzar con las políticas de salud que permitan a nuestros pueblos alcanzar un mejor estado de salud y de calidad de vida.

Destacamos y felicitamos la agenda de trabajo de la 63.ª Asamblea Mundial de la Salud, sobre todo por el abordaje de temas estratégicos como el monitoreo de los Objetivos de Desarrollo del Milenio, la evaluación de la pandemia de virus humano A H1N1; la aplicación del Reglamento Sanitario Internacional; la salud pública y la innovación de la propiedad intelectual; el código de prácticas mundial para la contratación internacional del personal de salud, así como los determinantes relacionados con la salud.

El Gobierno del Paraguay apuesta firmemente al cumplimiento de las metas del Milenio, es por eso que impulsa políticas públicas adecuadas con miras a financiar los programas sociales. El Ministerio de Salud Pública y Bienestar Social, en consonancia con estos objetivos se ha trazado metas a corto, mediano y largo plazo. El escenario global de los ODM en el Paraguay indica que tanto las metas de progreso compatibles con el cumplimiento, como las de progreso insuficiente, requerirán de un esfuerzo sostenido e importante. El logro de las metas pendientes dependerá de un crecimiento económico de calidad, el incremento en cantidad y eficiencia del gasto social, políticas de Estado y la participación de la sociedad, en toda su diversidad.

La delegación del Paraguay reitera su apoyo a la resolución 06/2010 del Consejo de Salud Suramericano del UNASUR, con relación a la vacunación contra el virus de la influenza A (H1N1) y reitera su solicitud al Fondo Rotatorio y proveedores de vacunas a extremar todas las medidas para cumplir de manera estricta el cronograma de entrega del biológico a fin de garantizar la implementación del Plan de Inmunización de manera oportuna en cada uno de los Estados Miembros.

Hace un año compartíamos con ustedes los avances del proceso de cambio político, económico y social que se venía desarrollando en el Paraguay a partir del nuevo Gobierno, que asumió su mandato el 20 de agosto de 2008. Un proceso de cambios que ha significado la ruptura con un modelo político donde el gobierno estuvo en manos de un solo partido político por más de 60 años; así como un fuerte compromiso del Gobierno y la ciudadanía con los sectores sociales, y en particular con los más excluidos, para garantizar la vigencia plena de los derechos humanos, el avance hacia la cobertura universal de la salud, el combate a la pobreza y la inequidad económica y social.

Al inicio del Gobierno, se ha consolidado un gabinete social integrado por todos los ministerios y secretarías de estado del ámbito social. Con ellos, en febrero de este año, se ha concluido el documento de la Política Pública para el Desarrollo Social 2010-2020, «Paraguay para todos y todas». El mismo surge de un gran debate dentro del Gobierno nacional y departamental y con todos los sectores políticos, sociales, gremiales, sindicales y ciudadanos. El documento contiene una visión de corto, mediano y largo plazo, con metas para el año 2011, año en que se conmemora el Bicentenario del nacimiento de la República del Paraguay; metas para el año 2013, que serán el legado de este Gobierno para el próximo electo ese año; y metas para el año 2020, apuntando a consolidar la construcción de políticas de Estado, en el ámbito de lo social.

El Presidente de la República, dos semanas antes de ser electo, asumió un compromiso nacional el día 7 de abril de 2008, Día Mundial de la Salud, de llevar adelante la «Política Pública de Calidad de Vida y Salud con Equidad en el Paraguay». Esta política, orienta la construcción del Sistema Nacional de Salud (SNS) que tiene por objetivo disminuir hasta eliminar las inequidades en salud y promover un Estado social de derecho. Así también, el cambio de los modelos de atención o de abordaje a la salud pública, adoptada a lo largo de la historia en el Paraguay, un modelo insuficiente e incapaz de dar respuesta a los problemas más elementales, cuyo fracaso se expresa hoy como una dramática deuda social acumulada en salud.

Las nuevas políticas representan un cambio de dirección y de rumbo en el quehacer del Ministerio de Salud Pública y Bienestar Social, en su rol rector del Sistema Nacional de Salud (SNS),

que se centra en el desarrollo del individuo, su familia y su comunidad, que no tiene vuelta atrás y que se encuentra en una fase plena de implementación.

El nuevo modelo sanitario tiene como eje transversal la estrategia de atención primaria de salud y la organización de las Unidades de Salud de la Familia (USF), como la puerta de entrada a la red de servicios de salud y distribuida según territorio y población asignada, y pretende llegar a una cobertura universal para el año 2013. El modelo sanitario apunta también a la consolidación de redes de atención según complejidad y la articulación en la prestación de servicios de la red pública, la seguridad social y el sector privado. Se están desarrollando grandes esfuerzos en la modernización institucional, el fortalecimiento institucional, el desarrollo del sistema nacional de información y la lucha contra la corrupción, así como el apoyo a la transparencia y la rendición de cuentas de manera participativa.

Dos aspectos a destacar. El primero, el proceso de gratuidad en la prestación de servicios de la red pública, eliminando los aranceles y el pago directo de bolsillo de la gente, lo que ha permitido el incremento del uso de los servicios por encima del 25%. El segundo, la política de medicamentos, que ha permitido la compra centralizada, con economía de escala, así como la ruptura con prácticas oligopólicas y especulativas del mercado de medicamentos e insumos. Esto ha permitido millonarios ahorros para el Ministerio de Salud. Solo en la compra de oxígeno se ha conseguido un ahorro en dos años de más de US$ 11 millones. Y estimamos que la compra internacional de los retrovirales para el VIH/sida pueda significar un ahorro de más de US$ 4 millones durante el 2010. Como han podido apreciar, todo el compromiso del Gobierno es firme y no tiene retroceso. Estos avances son estratégicos para enfrentar la amplia brecha que aún tiene el país con relación a los Objetivos de Desarrollo del Milenio.

Para finalizar nuestra intervención quisiéramos en nombre del Gobierno y del pueblo paraguayo reiterar nuestra solidaridad con los pueblos hermanos de Haití y Chile que han vivido momentos de gran tragedia y conmoción social el pasado 22 de enero y el 27 de febrero de este año, respectivamente. Debemos seguir avanzando entre nuestros países hacia una visión internacional del derecho a la salud. Manifestamos nuestro compromiso con los pueblos hermanos de esas naciones, reafirmando una vez más la vocación de servicio del Paraguay, aún en el marco de nuestras limitaciones impuestas por la pobreza. Muchas gracias.

Le Dr FADA (Sénégal):

Monsieur le Président de séance, Mesdames et Messieurs les Vice-Présidents, Mesdames et Messieurs les Ministres et chefs de délégation, Excellences, Mesdames et Messieurs, honorables délégués, dans la Région africaine, les décideurs ont pris des engagements forts dans le but d'accélérer la réalisation des objectifs du Millénaire pour le développement liés à la santé. Malgré tout, les derniers rapports ont présenté des résultats mitigés. Au Sénégal, nous avons très tôt augmenté les ressources destinées à la santé. Le budget est passé de 29 milliards de FCFA en 2000 à 108 milliards en 2010. Ainsi, d'importantes initiatives de gratuité de soins ont pu être prises par le Président de la République, M. Abdoulaye Wade, en faveur des groupes les plus vulnérables. Il s'agit notamment du plan sésame qui permet de dispenser des soins gratuits aux personnes de 60 ans ou plus ; de l'accès gratuit aux antirétroviraux pour tous les malades du sida, et aux antibiotiques spécifiques pour tous les malades de la tuberculose ; de la gratuité de l'accouchement et de la césarienne ; et, depuis le 1er mai 2010, de la gratuité des associations thérapeutiques à base d'artémisinine pour le traitement du paludisme.

Dans un tel contexte de décisions et d'initiatives volontaristes, nos résultats dans la réalisation des objectifs du Millénaire pour le développement liés à la santé sont les suivants. Pour la mortalité infantile : le nombre de décès d'enfants de moins de cinq ans a connu une baisse importante, mais nous sommes loin de l'objectif pour 2015. Les causes de décès dans ce groupe d'âge sont les maladies diarrhéiques, la malnutrition et les infections respiratoires aiguës. Pour la santé maternelle : nous avons fait des progrès importants. En effet, nos efforts se sont traduits par la hausse de la proportion d'accouchements assistés par un personnel qualifié, du taux de prévalence contraceptive et des consultations prénatales. Pour accélérer ces deux indicateurs, le Sénégal a lancé l'initiative « Badienou Gokh » qui signifie littéralement « la marraine du quartier ». Il s'agit d'un programme de parrainage

qui permet l'encadrement rapproché des femmes en âge de procréer aux différentes étapes de la maternité. La marraine sert de conseiller contre, notamment, les maladies sexuellement transmissibles et le sida, les grossesses non désirées, les avortements. Concernant l'objectif 6 du Millénaire pour le développement, le Sénégal a un taux de prévalence du sida relativement faible de 0,7 %, que nous nous efforçons de maintenir voire de réduire. Pour ce qui est de la lutte contre le paludisme, les résultats que nous avons enregistrés sont très bons. De 8000 cas de décès en 2000, nous en sommes à 577 en 2009. Aujourd'hui, on est en phase de préélimination du paludisme au Sénégal. En ce qui concerne la tuberculose, le taux de dépistage est aujourd'hui de 60 % et celui de guérison de 78 %. Le taux d'abandons est passé de 25 % en 2002 à 7 % en 2008. Mais, pour faciliter la réalisation des objectifs du Millénaire pour le développement, il faut aller vers une approche intégrée. Quant à la lutte contre les maladies non transmissibles, elle constitue aujourd'hui un grand défi pour le Gouvernement. Elles sont l'objet d'une très grande attention du Gouvernement qui développe des initiatives pour alléger le coût de certains traitements. Nous avons réduit au mois d'avril dernier le prix de l'hémodialyse de 80 % et envisageons de l'inscrire parmi les initiatives de gratuité dès le 1er janvier 2011. Un autre sujet de préoccupation est lié aux maladies réémergentes. À ce propos, nous remercions l'Organisation mondiale de la Santé et ses partenaires pour le lancement en Afrique de l'Ouest d'une campagne de vaccination synchronisée contre la poliomyélite. Dans ce cadre, nous avons pu, après trois passages, vacciner 99 % des enfants de moins de cinq ans. De tels programmes sont à encourager.

Au Sénégal, nous sommes conscients de la nécessité d'une approche globale qui agit sur les déterminants sociaux – éducation, assainissement, eau et environnement. Nous travaillons également à réduire la fracture numérique entre les différents milieux de notre communauté. Un grand chantier, que nous avons ouvert avec optimisme, est celui de l'utilisation de la télémédecine/télésanté pour rapprocher davantage nos spécialistes des populations rurales. Nous avons inscrit dans notre plan national de développement sanitaire 2009-2018 deux axes prioritaires : la révision de notre politique hospitalière et la création d'un fonds national de solidarité santé, financé par les taxes provenant du tabac, de l'alcool et des entreprises polluantes. Nous restons également attentifs à la nécessité de promouvoir l'industrie pharmaceutique locale, nationale ou régionale pour soulager nos faibles économies et favoriser l'accès de nos populations à des médicaments de qualité en attendant la réalisation de notre souveraineté thérapeutique à laquelle notre riche médecine traditionnelle devrait pouvoir contribuer.

Tous nos efforts internes resteront toujours vains si un investissement financier important, que nous ne pouvons mobiliser seuls, n'est pas alloué au secteur de la santé. Il nous faut incontestablement la collaboration et l'assistance de la communauté internationale. C'est toute l'importance qu'il y a à réaliser l'objectif 8 du Millénaire pour le développement « Mettre en place un partenariat mondial pour le développement ». Mesdames et Messieurs, enfin, je vous invite à méditer ces phrases tirées du dernier rapport du Secrétaire général de l'ONU sur les objectifs du Millénaire pour le développement : « La Déclaration du Millénaire est la plus importante promesse collective jamais faite aux populations les plus vulnérables de la planète. Cette promesse, qui ne doit rien à la pitié ou à la charité, repose sur la solidarité, la justice et le sentiment que nous sommes de plus en plus dépendants les uns des autres pour notre prospérité et notre solidarité collectives. ». Je vous remercie de votre aimable attention.

Dr SEDYANINGSIH (Indonesia):

Mr Vice-President, excellencies, ladies and gentlemen, it is a great honour for me to be here in Geneva to deliver my statement at this Sixty-third World Health Assembly. I congratulate His Excellency, Mr Mondher Zenaidi of Tunisia, on his assumption of the Presidency of the Health Assembly. This Health Assembly is indeed of utmost importance as an annual event discussing the global health agenda and recommending policy direction, aimed at achieving healthy global communities.

It has been 10 years since the United Nations Millennium Summit agreed to a 2015 deadline for attaining the Millennium Development Goals. Therefore, it is timely for us to undertake a review on our achievements and consider ways forward to accelerate attainment of the agreed Goals for those that are lagging behind. Indeed, public health inputs constitute the major components of the

Millennium Development Goals, namely: nutrition, maternal health, child health, water and sanitation and HIV/AIDS and other prevalent communicable diseases. Furthermore, poverty alleviation and gender mainstreaming are closely linked to public health intervention.

I am pleased to note that some Member States have achieved significant progress in attaining the Millennium Development Goal targets. However, we must also recognize that major and often unforeseen challenges such as political instability and conflict, lack of resources and economic and humanitarian crises have impeded the efforts of some countries in meeting the Goals. Given that we now only have five years to meet the 2015 deadline, Member States need to reaffirm their commitment and continue in their efforts to reinvigorate and strengthen mutual cooperation and partnerships. In this regard, Indonesia is fully committed to achieving the Millennium Development Goals as scheduled. President Susilo Bambang Yudhoyono emphasized that the effort to achieve the Goals is a moral obligation, not only for the fulfilment of international commitment, but also for our national need to increase the welfare of the people.

Indonesia, with its disparities in geographic locations of about 17 000 islands and level of socioeconomic development, combined with its cultural and social diversities, is experiencing different levels in the achievement of the Millennium Development Goals targets as far as comparative analyses between areas are concerned. Decentralized areas, with their diverse resources, have contributed to diverse responses to public health interventions, posing serious challenges to attaining the agreed Goals.

Although significant investment has been undertaken by the Government of Indonesia, including the use of international aid, aimed at achieving the Goals, there is an urgent need for us to consider constructive ways to accelerate their achievement. In this regard, I should recall the statement of the Indonesian Vice-President Boediono, at the United Nations headquarters last April 2010 that "Increased and secure funding is essential to increasing the momentum towards achieving the Millennium Development Goals". On the other hand, based on the analysis in Indonesia, the Government could only fulfil health financing for less than 80%. It is therefore pertinent that the levels of Official Development Assistance from donor countries remain consistent and in place, as stated by the United Nations Secretary-General, Mr Ban Ki-moon. Nevertheless, we should not preclude governance in facing this reality. I urge that international aid be made effective by synchronising and synergizing the national policies and strategies.

All measures and strategies implemented by the Government of Indonesia adopt a "pro-poor" approach focusing, among others, on maximizing the natural and cultural assets of poor communities and creating an environment in which opportunities to make income can be generated. All stakeholders, including the Government, private sector and civil society, should make meaningful contributions to this process and their participation and cooperation at all levels are required.

Allow me to reiterate the principle that "Health is an investment, not a cost!" Clearly it is essential that any health-care system be financially viable, but this financial viability should not be calculated in isolation from the business perspective or from long-term saving strategies. Access to health care allows millions of people to live longer, healthier and more productive lives, and is a fundamental human right for the people on whose behalf we speak today. All countries, particularly those that are more economically developed, have a collective responsibility to support and develop the principles of human dignity and equality, both in their own countries and internationally.

In this regard, I welcome the result of the Open-Ended Working Group of Member States that has successfully projected the vision of addressing the Pandemic Influenza Preparedness Framework. The final objective of its work is to achieve a fair, equitable and transparent mechanism that covers both the sharing of biological material as well as the sharing of benefits derived therefrom. I hope the final agreement will be reached in the near future in order to be able to see the effective work of the Framework.

Finally, I emphasize that through the revitalization of our primary health-care services and through health system reforms, we sincerely hope that our objective of providing equal access to health-care facilities and improving the quality of health of all Indonesians can be met. In turn, the global population will be better off in terms of health status.

Professor CHUKWU (Nigeria):

Mr Vice-President, honourable ministers, delegates, on behalf of the President of the Federal Republic of Nigeria, His Excellency Dr Goodluck Ebele Jonathan, I bring you greetings from my country Nigeria and her people. I also wish to use this forum to congratulate the President of the Sixty-third World Health Assembly, Mr Mondher Zenaidi, Minister of Health of Tunisia, on his election and wish him success in steering the course of this Health Assembly. Mr President, I am sad to inform this Health Assembly of the recent passing-on of our President, Umaru MusaYar'Adua, who died on Wednesday, 5 May 2010 and has since been buried. May his gentle soul rest in perfect peace.

Mr Vice-President, kindly allow me to thank and appreciate the contributions of Dr Margaret Chan the Director-General of WHO, for her continued promotion of the mandate of this global body, especially the prompt and efficient way in which WHO, under her leadership, has risen to the many new emerging global health challenges such as the threat posed by pandemic (H1N1) 2009 and climate change challenges to health. The Government of Nigeria also uses this opportunity to commend the other nations of the world for their immediate and prompt response to these important health challenges and also commiserate with countries that have directly suffered untold damages, fatality and other attendant consequences.

During the Sixty-first and Sixty-second World Health Assemblies, several issues were at the heart of the agenda which Nigeria had committed to address, especially eradication of poliomyelitis, maternal and child health, malaria control, pandemic influenza prevention and control, noncommunicable disease prevention and control, climate change and national legislation on health including the National Strategic Health Development Plan, among others. These issues remain very important to Nigeria, and our commitments to continuously respond to them remain unwavering.

As you may be aware Nigeria has made tremendous progress in poliomyelitis eradication since the last Health Assembly, when we were one of only four countries that were yet to interrupt wild poliovirus transmission in the world. As of today, Nigeria has introduced new innovations aimed at improving effectiveness of poliomyelitis eradication activities, utilized the more effective monovalent and bivalent oral poliovirus vaccine using an integrated approach, and adopted the Immunization Plus Days. During the Days, a broad range of child survival interventions are employed, resulting in marked improvement in vaccination coverage and quality and a significant decline in the transmission of wild poliovirus, leading to an unqualified endorsement by the Lancet of the progress made by Nigeria.

Closely following the poliomyelitis issue is the problem of the outbreak of other infectious epidemics in Nigeria in the recent past. We have effectively contained these outbreaks and put measures in place to ensure prevention of future outbreaks. These include enhancing surveillance activities, providing relevant drugs for case management and thus reducing mortality, strengthening laboratory and diagnostic capacities, and conducting relevant training of the health workforce.

We wish to reassure you and reiterate that Nigeria is fully prepared for the outbreak of pandemic (H1N1) 2009 that has affected a large number of countries worldwide. We have taken steps such as strengthening national epidemic preparedness and response, increased collaboration with States and other stakeholders by expanding the National Epidemic Preparedness and Response Committee to involve States, relevant ministries and stakeholders. Similar bodies have also been established in all the States and local government areas. Disease surveillance has been strengthened, not only in the health facilities and communities but also at all ports of entry into the country. We are also implementing the International Health Regulations (2005), of which Nigeria is a signatory.

As part of efforts to fulfil our compact with the people and also our commitment to the international community, Nigeria is working hard to be on track for the achievement of the Millennium Development Goals. While we are on track for health-related Goal 6, we are challenged on Goals 4 and 5. In response to this, we are addressing the issues relating to the inadequate health system, resource allocation and human resource gaps as part of efforts to achieve these two Goals. Nigeria is currently implementing the Integrated Maternal, Newborn and Child Health Strategy as an integral component of the National Strategic Health Development Plan. The Government of the Federal Republic of Nigeria has also embarked on a specific unique health intervention called the "Midwives Service Scheme" as one of the interventions to address Millennium Development Goal 5.

As of today, 2488 midwives have been deployed in over 650 primary health-care centres in the remotest communities, thus ensuring skilled attendance at birth.

Diseases related to poor lifestyles are also on the increase, thereby creating a dual epidemic of communicable and noncommunicable diseases for the country. We have therefore responded by reinvigorating the Non-Communicable Disease Programme to meet national and global targets. Following the health systems strengthening initiatives, Nigeria is now expanding services in line with the African Union Summit Declaration of 2006. Nigeria is on course to eradicate guinea-worm disease, having reported the last case in November 2008. We will continue working to ensure that we remain guinea-worm free and thus earn WHO certification within the next two years.

The Federal Government of Nigeria, recognizing the poor health status of the population and the urgent need to strengthen health systems, has developed a National Strategic Health Development Plan through an extensive consultative process involving the States and local governments and other key stakeholders. This Plan provides one plan, one budget, one results matrix and one monitoring and evaluation framework.

Finally, I wish to use this opportunity to once again express appreciation to WHO and all of our development partners in their commitment towards the success of our efforts. Please do not relent, as we will continue to solicit your support in our efforts at meeting the global health goals. As we say in Nigeria, it is not over until it is over. God bless you all.

Mrs WIDMANN-MAUZ (Germany):

Madam Director-General, Mr Vice-President, ladies and gentlemen, it is an honour for me to be with you all at the Sixty-third World Health Assembly. If we did not have the Millennium Development Goals, we would have to invent them. All of the Goals contribute to health, and the German Government is fully committed to supporting our partners in achieving them.

The Millennium Development Goals, especially those directly related to health outcomes, have become the international frame of reference for global health. They are concise, measurable and have immense mobilizing power. Merely five years remain until 2015. At this point, we can see that progress on the health-related Goals is mixed: considerable progress has been made, but there are still substantial challenges. Coherent national Millennium Development Goal strategies and efforts are the key to success. This includes enhanced investment and capacity building in health systems.

Germany believes that robust health systems are crucial for achieving all health-related Millennium Development Goals. They will accelerate progress in other Goals such as education and especially poverty reduction. Goal 1 expresses the aim to overcome extreme poverty and hunger. Therefore, it is unacceptable that more than 100 million people are driven into poverty each year because of health-care costs and insufficient health protection. Hence, Germany explicitly welcomes the Director-General's decision to focus the forthcoming *World health report* on the issue of "financing for universal coverage".

Germany has decided to promote the topic of health systems financing through a high-level ministerial conference in Berlin on 22 and 23 November of this year. Our conference with the title "Health System Financing – Key to Universal Coverage" will provide a political framework for the high-profile launch of *The world health report*. It is our goal to move the issue of health systems financing to the top of the global health agenda. We believe that this focus on health systems strengthening and health systems financing will provide a meaningful contribution for the achievement of the Millennium Development Goals by 2015. We invite all Member States to participate in this process.

Although progress had been made, health systems continue to fail to meet the health-care needs of women at key moments of their lives. With its global report, *Women and health: today's evidence tomorrow's agenda*, WHO has taken stock of the worldwide health situation of women across their life-course. The evidence it contains is compelling, and the agenda for action it proposes is one that should engage us all. The fact that widespread inequities in the health of women and girls persist is unacceptable when we know what needs to be done.

Strategies to improve women's health must be based on improving gender equality and women's empowerment – Millennium Development Goal 3 promotes gender equality and empowers

women – is vital for the achievement of all Goals. We call upon all stakeholders to reaffirm the global commitment to achieving the Millennium Development Goals by 2015 and to develop coherent strategies to accelerate progress.

Ladies and gentlemen, this Health Assembly truly has a very full agenda this year. We will be working on issues vital to global health. Some of these will need considerable discussion and profound deliberation. These include the exchange of viruses with pandemic potential, the International Health Regulations (2005) review, counterfeit medicines and the draft Code of Practice on the International Recruitment of Health Personnel.

Mr Vice-President, ladies and gentlemen, be assured of the support of Germany in all these efforts.

M. MALLY (Togo):

Monsieur le Président de séance, Mesdames et Messieurs les Vice-Présidents et membres du Bureau, chers collègues Ministres de la Santé, distingués invités, Mesdames et Messieurs, permettez-moi d'utiliser cette opportunité pour vous féliciter de votre élection à la tête de la Soixante-Troisième Assemblée mondiale de la Santé.

Dans le cadre de la Déclaration du Millénaire, les autorités togolaises se sont engagées à contribuer à réaliser un certain nombre d'actions prioritaires dont l'accroissement des efforts en faveur de l'élimination de la pauvreté et de l'avancement des principes de la dignité humaine. C'est dans ce cadre que le Togo a préparé en 2003, puis en 2008, les rapports de suivi des objectifs du Millénaire pour le développement pour informer le grand public sur les progrès à réaliser dans le but de les atteindre en 2015. Notons que le dernier rapport sur le suivi des objectifs du Millénaire pour le développement en 2010 est en cours de validation par mon pays. Concernant l'objectif 4 du Millénaire pour le développement, la réduction de la mortalité, notamment de la mortalité infantile et infanto-juvénile, est un gage pour la reproduction efficace de la population et des ressources humaines indispensables au développement de l'économie nationale. La prévention des maladies par la vaccination joue un rôle important dans l'élimination de certains facteurs de décès des enfants de moins de cinq ans. Ainsi, en dehors de la vaccination de routine, les campagnes de vaccination contre la rougeole initiées depuis 2001 ont fait baisser les décès dus à cette maladie. Une nouvelle approche utilisée au Togo est la campagne intégrée. En effet, prenant en compte la rareté des ressources, l'intégration des interventions s'avère une des stratégies efficaces pour la réalisation des objectifs du Millénaire pour le développement. Le Togo a expérimenté en 2004 la stratégie d'intégration de la campagne de vaccination contre la rougeole et la poliomyélite et, en 2008, la distribution gratuite des moustiquaires imprégnées d'insecticide de longue durée, la supplémentation en vitamine A et le traitement des parasitoses à travers l'administration de l'albendazole. Cette campagne nationale a été réalisée avec l'appui de plusieurs partenaires et a concerné les enfants de moins de cinq ans qui sont les cibles vulnérables aux maladies évitables. Celle de 2008 figure parmi les premières expériences africaines de couplage de la vaccination à la distribution de moustiquaires imprégnées. Ce résultat constitue un progrès considérable en comparaison des conclusions de l'étude réalisée en 2006 par les Centers for Disease Control and Prevention d'Atlanta qui montrait que seulement 58 % des enfants de moins de cinq ans et 55 % des femmes enceintes dormaient sous des moustiquaires imprégnées d'insecticide de longue durée.

Concernant l'objectif 5 du Millénaire pour le développement (Améliorer la santé maternelle), au Togo, le taux de mortalité maternelle demeure encore loin du seuil de 160 décès pour 100 000 naissances vivantes attendus en 2015 en comparaison du niveau de 1990 qui était de 640 décès pour 100 000 naissances vivantes. Le pourcentage des accouchements assistés par le personnel de santé qualifié a évolué légèrement, passant de 61 % en 2003 à 62 % en 2006. La proportion des mères ayant bénéficié de consultations prénatales a légèrement baissé, passant de 86 % en 2003 à 83,8 % en 2006. La mortalité maternelle reste une question préoccupante au Togo en raison notamment de l'insuffisance des visites prénatales liée au faible revenu et de l'ignorance des ménages. Ainsi, pour résoudre ce problème, le Gouvernement togolais vient de recruter près de 2000 agents de santé, toutes catégories confondues. La problématique de la prise en charge de la césarienne est en cours d'étude et de réalisation au niveau du pays. S'agissant de l'objectif 6 du Millénaire pour le développement pour ce qui concerne le VIH au Togo, la prévalence du VIH dans la population générale est estimée à 3 %

en 2008 contre 3,6 % en 2001 et 3,3 % en 2005. La prise en charge des personnes malades s'améliore du fait de la gratuité des antirétroviraux rendue effective depuis le 17 novembre 2008. Le nombre de malades bénéficiant d'un traitement antirétroviral est ainsi passé de 700 en 2002 à 11 211 en 2008 et à près de 17 000 en 2009 avec 115 centres accrédités. Sur le plan institutionnel, le Togo a mis en place en 2001 le Conseil national de lutte contre le sida dans une perspective de réponse multisectorielle ; ce Conseil est présidé par le Président de la République. La réponse à l'épidémie du VIH au Togo s'organise sur la base des plans stratégiques nationaux. Le Togo vient de bénéficier du Round 8 en cours de mise en œuvre, ce qui lui permet de renforcer les interventions de lutte contre le VIH/sida dans le pays. En matière de lutte contre le paludisme, malgré les progrès importants réalisés dans ce domaine, le paludisme demeure un réel problème de santé publique compte tenu des préoccupations socio-économiques chez les populations vulnérables. Il représente au Togo la première cause de morbidité et de mortalité dans les formations sanitaires. Il est endémique et stable avec une transmission qui dure presque toute l'année sur l'ensemble du pays. Les taux de mortalité hospitalière proportionnelle du paludisme étaient de 46 % en 2007 et occupaient ainsi le premier rang des pathologies avec une létalité moyenne de 4 %. Les informations sur la protection et le traitement du paludisme aux niveaux national et régional permettent de conclure que des progrès ont été réalisés dans la lutte contre cette endémie. L'opportunité du pays d'avoir accès au Round 9 après les prochaines négociations permettra le renforcement des actions de lutte contre le paludisme en vue de pouvoir parvenir à l'accès universel.

Au Togo, le Gouvernement a élaboré et adopté la Stratégie nationale de développement à long terme axée sur les objectifs du Millénaire pour le développement en 2006 et le Document de stratégies de réduction de la pauvreté complet en 2009. Au niveau sectoriel, un plan national de développement sanitaire 2009-2013 vient d'être adopté prenant en compte les indicateurs des objectifs du Millénaire pour le développement. Par ailleurs, le cadre juridique et institutionnel a été renforcé par l'adoption du code de la santé en 2009 et le plan national de développement et de gestion des ressources humaines en santé en 2010. Malgré les efforts accomplis, beaucoup de défis restent à relever dans les domaines suivants : mobilisation des ressources financières du secteur dans le cadre de la réalisation des objectifs du Millénaire pour le développement ; renforcement des effectifs de personnels de santé ainsi que de leurs compétences ; amélioration de l'environnement de travail à travers des constructions et la réhabilitation des infrastructures sanitaires ainsi que de leurs équipements ; amélioration de la qualité des soins et de leur accès à travers des interventions intégrées efficaces et à moindre coût ; renforcement du système national d'information sanitaire.

C'est pourquoi, tout en remerciant l'OMS pour son appui constant, le Togo sollicite la poursuite et le renforcement du soutien de l'Organisation en vue de la réalisation des objectifs du Millénaire pour le développement liés à la santé. Je ne saurais terminer mon propos sans rendre un hommage mérité à Mme le Directeur général de l'OMS pour le leadership et l'efficacité avec lesquels elle gère les différents problèmes de santé auxquels le monde est confronté. Le Togo souhaite la poursuite des efforts entrepris pour préserver les pays à faible revenu de nouvelles maladies qui risquent de compromettre dangereusement leurs efforts de développement pour la réalisation des objectifs du Millénaire pour le développement. Je vous remercie.

El Dr. PORTAL MIRANDA (Cuba):

Excelencias: Según el informe distribuido por la OMS, a tan solo cinco años del 2015, aunque hay indicios de progresos, las tendencias actuales indican que desafortunadamente muchos países no alcanzarán el cumplimiento de los Objetivos de Desarrollo del Milenio. Se señala que la desnutrición es la causa de más de un tercio de las defunciones infantiles y que aun cuando hay progresos en la tasa de mortalidad en menores de 5 años, se está lejos de la meta.

La mortalidad materna tiene una situación que casi no ha cambiado desde 1990, lo que es particularmente dramático en África, con una tasa de 900 muertes maternas por 100 000 nacidos vivos en comparación con 27 en la Región de Europa. Persisten necesidades insatisfechas de anticonceptivos, lo que provoca que se mantenga alto el número de embarazos en adolescentes. Se consignan mejorías en enfrentamiento a la malaria, tuberculosis y sida y llama la atención que de

9,5 millones de personas de países de ingresos bajos y medios que necesitaban tratamiento antirretrovírico, más de cinco millones no tuvieron acceso a él.

Se plantea como riesgo, que luego de sobrepasada la actual crisis económica la atención del mundo se desvíe del objetivo de reducir la pobreza y alcanzar los Objetivos de Desarrollo del Milenio y que los países desarrollados no puedan mantener su incumplido compromiso de ayuda oficial al desarrollo y aportar el 0,7% de su producto interno bruto para los países pobres.

El Primer Vicepresidente de los Consejos de Estado y Ministros de Cuba, José Ramón Machado Ventura, en la Asamblea General de las Naciones Unidas en septiembre de 2008, planteó que «… La realización de las metas de Desarrollo del Milenio, exige el establecimiento de un orden internacional basado en la solidaridad, justicia social, equidad y respeto a los derechos de los pueblos y de cada ser humano. [...] La cuestión es saber si los responsables del mundo caótico y desigual en que vivimos están dispuestos a renunciar siquiera a una parte de sus privilegios y derroches».

Hondamente preocupado por esta situación mundial, me permito señalar que en lo que se refiere a mi país, el cumplimiento de los Objetivos de Desarrollo del Milenio es como sigue:

Con relación al Objetivo 1, Cuba se sitúa entre los pocos países de América Latina que han logrado descender la insuficiencia de peso en niños menores de cinco años a menos del 5%, al alcanzar en el 2008 el 4% en este grupo etario.

El índice de bajo peso al nacer ha descendido progresivamente, alcanzándose una cifra de 5,1%, con lo que según el informe del UNICEF, Cuba se sitúa entre los países con más bajo índice a nivel mundial.

En cuanto al Objetivo 4, Cuba, con una tasa de mortalidad infantil de 4,7 por 1000 nacidos vivos obtenida en el año 2008, muestra indicadores de salud infantil al nivel de los países desarrollados, con una tasa similar a la del Canadá y por debajo del resto de los países de la región, incluido los Estados Unidos, con lo que se considera cumplido este objetivo. La tasa de mortalidad en menores de cinco años fue de 6,2 por 1000, la mas baja de Latinoamérica.

En el Objetivo 5, señalamos que en nuestro país el 99,9% de los partos son institucionales y atendidos por médicos, habiéndose alcanzado una razón de mortalidad materna de 46,5 por 100 000 nacidos vivos, lo que también nos sitúa entre los mejores resultados de America Latina.

En el Objetivo 6, en referencia a la epidemia de sida, podemos decir que aunque no se aprecia una tendencia a la disminución, es considerada una epidemia de baja intensidad, al tener una prevalencia de 0,1% en la población de 15 a 49 años de edad, garantizándose el tratamiento antirretroviral a todos los que lo necesitan, siendo seis de estos medicamentos de producción nacional. La malaria fue erradicada desde 1967. En cuanto a la tuberculosis, la incidencia es de 6,6 por 100 000 habitantes.

En el Objetivo 7 se aplica la Política y Estrategia Ambiental Nacional, que incluye planes de reforestación, de áreas protegidas y de eficiencia energética, a lo que se añade que desde el 2004, el 95,6% de la población disfruta de acceso sostenible al agua potable, y el 95% recibe los beneficios de un saneamiento adecuado de los residuales sólidos.

En el Objetivo 8, en cuanto a la cooperación y ayuda al desarrollo, Cuba mantiene hoy más de 38 000 trabajadores de la salud en 78 países y trabaja para formar 100 000 médicos en 10 años para países hermanos, lo que equivale a un aporte de cientos de millones de dólares.

Con relación al acceso a medicamentos, el país produce el 86% de los medicamentos que consume. Entre el 95% y el 98% de la población tiene un acceso estable a medicamentos esenciales a precios razonables,

Todo esto ha sido posible aun cuando durante cinco décadas nuestro país ha sido sometido a un cruel bloqueo por el Gobierno de los Estados Unidos de América, no cuantificable en el dolor y sufrimientos de las familias. A pesar del rechazo casi absoluto de la comunidad internacional en la Asamblea General de las Naciones Unidas, esta política genocida se mantiene y su impacto económico a los servicios de salud son superiores a los US$ 2000 millones y más de US$ 90 000 millones a la economía nacional.

Excelencias: Hago propicia la ocasión para desearles éxitos en los trabajos de esta 63.ª Asamblea Mundial de la Salud y la Tercera Reunión de Ministros del Movimiento de los Países No Alineados, las que sin duda alguna contribuirán a la obtención del mayor grado de salud para todos.

Y concluyo recordando que en ocasión del 50.º Aniversario de la Organización Mundial de la Salud y en referencia a los importantes desafíos que esta Organización enfrenta, el compañero Fidel Castro expresó «Contra estas realidades lucha heroicamente la Organización Mundial de la Salud, y tiene, además, el deber de ser optimista».

Con este optimismo redoblemos el compromiso con la salud de nuestros pueblos. No perdamos un solo minuto. Muchas gracias.

Mr OSMAN (Brunei Darussalam):

Bismillah ar-rahman arrahim.

Mr Vice-President, honourable ministers, excellencies, ladies and gentlemen, first of all, on behalf of the Government of Brunei Darussalam, I would like to take this opportunity to congratulate you, Mr President, on your election as the President of the Sixty-third World Health Assembly and also to the Vice-Presidents and other office-bearers for their appointments. I am confident that under your stewardship, you will guide the work of this august Health Assembly to a successful conclusion.

I would also like to extend my delegation's appreciation to the Director-General, Dr Chan, for her opening remarks. You have raised issues which are central to our work here. Ten years have elapsed since the United Nations General Assembly unanimously endorsed the Millennium Declaration. Since then, as reported by the WHO Secretariat, globally, fewer children are dying; fewer children are underweight; more women get skilled help during childbirth; fewer people are contracting HIV/AIDS; tuberculosis treatment is more successful; and more people have access to safe drinking-water. There has been significant progress in this respect in some countries, while in others, progress has been limited because of conflict, poor governance, economic or humanitarian crises and lack of resources.

Despite the decreasing trends in the total annual number of deaths among children under five and the availability of financial and technical aid, millions of children still die from lack of health care every year. Hundreds of thousands of women continue to die in pregnancy and childbirth each year, despite having access to family planning services and increases in the rate of attended deliveries. The maternal mortality health indicator shows the widest gaps between the rich and poor, both between and within countries. With regard to efforts to combat HIV/AIDS, malaria and other diseases, despite relative success in selected countries, there is still slow progress in halting the global pandemic of HIV/AIDS. Efforts made to close the gaps through the sharing of information, discussions on progress, major challenges that remain, lessons learnt from successes and failures and the strategies for the way forward to achieve the Millennium Development Goals are very much welcome. Crucial, unending and sustained collaborative efforts need to be extended, and technical help by WHO, other United Nations agencies and other interested parties is invaluable in assisting countries.

Brunei Darussalam is strongly committed to achieving the target set in the Millennium Development Goals. Brunei Darussalam has been classified as an early achiever in meeting the United Nations Millennium Development Goals. Improvement in these indicators is a result of rising standards of accessible health services, a higher standard of living with improved hygiene and sanitation, improved levels of education and increasing empowerment of women.

For a country that has attained most of the health-related Millennium Development Goals, the challenge before Brunei Darussalam is to maintain and improve our achievements, in particular by reducing neonatal deaths; and to maintain low levels of maternal mortality ratios by ensuring continued access to quality antenatal and postnatal care.

Maternal and child health services in Brunei Darussalam have also contributed significantly to the reduction in child mortality. A well-established, free comprehensive National Childhood Immunization Programme has been successful in protecting children against vaccine-preventable diseases. Immunization coverage in Brunei Darussalam has consistently remained above 95% for all vaccines in the Programme, thus meeting the target set by WHO.

The incidence of HIV/AIDS in Brunei Darussalam remains at a low level. By the end of 2009, there were altogether 34 people living with HIV in Brunei Darussalam, all of whom had access to equitable care and free antiretroviral treatment. Since 2005, no cases of mother-to-child transmission have been recorded, and at present there are no children living with HIV in Brunei Darussalam.

Serosurveillance for HIV is currently incorporated in all antenatal screening, blood donors, frequent blood recipients, all tuberculosis and sexually transmitted-illness patients, prisoners and selected pre-employment screening.

Brunei Darussalam's full commitment to combating tuberculosis is clearly reflected through the continuous availability of resources for the management of the disease. These include ensuring a free and uninterrupted supply of drugs and vaccines as well as strengthening existing capacity and capability in tuberculosis management, including diagnostic services as well as training of health and medical personnel.

The National TB Prevention Control Programme established in March 2000 undertakes contact tracing as well as the directly observed treatment, short course (DOTS) and has achieved 100% DOTS coverage in the past five years. Notification of all forms of tuberculosis has shown a steady declining trend consistent with the report of other parameters in the Programme, including high cure rates, high success rates, no treatment failures, negligible defaulters, and no multidrug-resistant tuberculosis.

We realize that the Millennium Development Goals are subject to many new and evolving challenges such as globalization, escalating health-care costs, natural disasters, complex emergencies, ageing population, urbanization and changing socioeconomic and cultural values, to name a few. We are also increasingly faced with the challenge of combating noncommunicable disease groups, such as cancer, cardiovascular diseases and diabetes mellitus.

In addressing these challenges, we are indeed indebted to the technical support of WHO, offered through collaboration of various forums in the region. This has significantly assisted our efforts to strengthen our capacity and capability to address the many challenges. The pivotal role played by regional and international cooperation, which has led to many achievements thus far, therefore needs to be further enhanced.

The issues of the borderless world of health economics and the sociopolitical sphere have posed greater challenges to us all. The situation is even worse now with the global food, energy, financial and economic crisis as well as increasing environmental hazards. The cross-cutting nature of the issues required us to work in tandem with all our stakeholders beyond the health sector. Multi-sector involvement, including public–private partnerships needs to be established, together with strengthened community participation, empowerment and ownership in many health activities.

With the present financial crisis, however, the resource gap is growing. In addition, the burden posed by natural disasters has in some way delayed, and in some countries halted, progress towards meeting the Millennium Development Goals. Secondary to this, it has in turn directly and indirectly affected human health and put vulnerable populations at greater risk.

Availability of the trained human resources required to adequately run services to enable accessibility in particular to services related to the Millennium Development Goals is also a real challenge. In this regard, innovative ways where non-traditional human resources may be utilized to fill the gap without compromising standards need to be thought of according to each country's individual set-up.

Lastly but not least, as we all know, the United Nations Summit on the Millennium Development Goals is going to be held in September 2010, let us here work together to address the problems in achieving the targets of the Goals. Stronger and sustained international action is needed to accelerate implementation within the next five years. Unless existing barriers are addressed, achieving the Millennium Development Goals by 2015 will be very challenging and may be unattainable for some countries.

Dr RISIKKO (Finland):

Honourable Director-General, Mr Vice-President, distinguished colleagues, ladies and gentlemen, it is a great pleasure for me to address this Health Assembly on behalf of the Government of Finland. We fully associate ourselves with the European Union statement.

Finland is looking forward to WHO's continued and strengthened global leadership and guidance on strengthening health systems. Accessible, good-quality and an equitable health services with an adequately trained sustainable workforce are key factors in improving health. To ensure universal access and care, we may have to tailor services to meet the needs of specific population

groups. The need for well-functioning and accessible health services has been apparent in, for example, examining the progress on health-related Millennium Development Goals, such as maternal health.

The importance of preventing noncommunicable diseases cannot be overstated. Last week's decision by the United Nations General Assembly to have a high-level meeting on noncommunicable diseases in September 2011 highlights this. We are delighted about this decision. The decision also calls for further leadership by WHO.

Finland warmly welcomes the alcohol strategy as well as the noncommunicable disease strategy progress report, including its annex. We look forward to their implementation, as well as monitoring and evaluation of their effectiveness.

At national level, Finland recently implemented several measures to prevent noncommunicable diseases. The Government has established an intersectoral policy programme on health promotion, and the Ministry of Health issued an intersectoral plan of action to reduce health inequalities. We have a comprehensive tobacco policy, with recent additional measures. As regards alcohol, our current Government has increased taxes on alcohol on public health grounds. We are also considering taxes on sugar-containing beverages and sweets. Other measures, such as possible incentives for industry to produce healthy food, are being discussed. Health education, through schools, media and in health services is crucial.

We would like to congratulate WHO and Kenya for the excellent Global Conference on Health Promotion held last autumn. We would also like to inform you that Finland has preliminarily agreed to hold the next Global Conference in Helsinki in 2013. Last but not least, I want to express my sincere thanks to you, Director-General, for the guidance and leadership provided by WHO during the pandemic influenza. We count on your continuing support in this area.

Mr Vice-President, I am looking forward to the deliberations in this Health Assembly. Thank you for your attention.

The PRESIDENT:

We have had a very long and productive day and it is time for us to adjourn the meeting.

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

FOURTH PLENARY MEETING

Tuesday, 18 May 2010, at 09:05

President: Mr Mondher ZENAIDI (Tunisia)
later: Professor R. AKDAĞ (Turkey)

QUATRIÈME SÉANCE PLÉNIÈRE

Mardi 18 mai 2010, 9h05

Président: M. Mondher ZENAIDI (Tunisie)
puis: Professeur R. AKDAĞ (Turquie)

ADDRESS BY THE DIRECTOR-GENERAL (continued):
ALLOCUTION DU DIRECTEUR GÉNÉRAL (suite):

Le PRÉSIDENT:

Je déclare l'Assemblée ouverte. Mesdames et Messieurs, ce matin, l'Assemblée va reprendre l'examen du point 3 de l'ordre du jour. Avant de poursuivre, je souhaite demander aux délégués de bien vouloir remettre au responsable de la liste des intervenants le texte de l'allocution qu'ils ont l'intention de prononcer afin de faciliter l'interprétation et la transcription des débats. Cela vaut aussi pour les délégués qui doivent quitter Genève et qui ne pourront pas s'exprimer sur ce point de l'ordre du jour avant leur départ ; ils peuvent demander que le texte de leur intervention soit publié dans le compte rendu de l'Assemblée de la Santé. Les deux premiers orateurs sont le délégué de la Fédération de Russie et le délégué de la Tanzanie. Je les invite à venir à la tribune.
Je donne la parole au délégué de la Fédération de Russie.

Professor SKVORTSOVA (Russian Federation):
Профессор СКВОРЦОВА (Российская Федерация):

Уважаемый г-н Председатель, уважаемые коллеги,

В прошедшем году важными для всех нас стали события глобального масштаба, связанные с пандемией гриппа и финансово-экономическим кризисом. Опыт Российской Федерации показал, что с этими испытаниями не только можно справиться, но пройдя через них, можно стать значительно сильнее. Ситуация с пандемическим гриппом позволила отработать систему быстрого реагирования на инфекционную угрозу благодаря информации, представленной Всемирной организацией здравоохранения, о глобальном распространении гриппа H1N1 и разработке Международных медико-санитарных правил. В Российской Федерации были своевременно предприняты все необходимые противоэпидемические меры. В сжатые сроки российскими специалистами были разработаны, прошли полный цикл доклинических и клинических испытаний и разрешены к применению четыре вида вакцины против пандемического гриппа, проведена массовая иммунизация населения, относящегося к

группам высокого риска. В рамках сотрудничества со Всемирной организацией здравоохранения технология производства российских противогриппозных вакцин передается Таиланду, Индии и другим странам. Создание российских эффективных противовирусных препаратов, к которым высокочувствителен штамм вируса H1N1, позволило нам не только обеспечить население России своевременным и адекватным лечением, но и оказать гуманитарную помощь Украине.

На фоне развивающегося финансово-экономического кризиса нам удалось осуществить целый ряд комплексных мер по активному развитию здравоохранения. Финансовые средства были сконцентрированы на программах профилактики и лечения социально значимых заболеваний в рамках национального приоритетного проекта. Наряду с осуществляемыми мероприятиями по борьбе с сосудистыми заболеваниями, комбинированными травмами при дорожно-транспортных происшествиях, ВИЧ-инфекции, гепатитом, были успешно внедрены широкомасштабные программы по формированию здорового образа жизни, борьбе с онкологическими заболеваниями и туберкулезом, подготовлены к внедрению программы, направленные на развитие сельского здравоохранения, ядерной медицины, биомедицинских технологий. В настоящее время активно осуществляется системное реформирование здравоохранения, созданы и внедряются единые для всей страны стандарты оказания медицинской помощи, экономически обоснована программа государственных гарантий бесплатной медицинской помощи, существенно реформируется система обязательного медицинского страхования, обновляется и переоснащается вся сеть лечебно-профилактических учреждений в 83 регионах страны, развивается телемедицина и информационные технологии, совершенствуется непрерывное медицинское образование и кадровая политика.

Высокая эффективность предпринимаемых мер очевидна. За четыре года снижена общая смертность населения России более чем на 9%, в том числе младенческая на 24%, материнская на 17%, от сосудистых заболеваний на 8%, от дорожно-транспортных происшествий более чем на 26%, от туберкулеза на 21%. Продолжительность жизни россиян увеличилась на три года. Таким образом, в России достигнут значительный прогресс в решении демографических задач, улучшении здоровья населения страны и повышении качества жизни, независимо и на фоне развивающегося финансово-экономического кризиса.

Столь позитивные результаты доказывают правильность выбранных путей и внушают большой оптимизм. Именно поэтому правительство Российской Федерации приняло решение о дальнейшем наращивании поддержки реформ здравоохранения. В ближайшие годы государственное финансовое обеспечение российского здравоохранения будет удвоено, что позволит обеспечить равнодоступность качественной медицинской помощи населению.

Особое внимание мы уделяем проблемам глобального здравоохранения. Можно с удовлетворением отметить тенденции к укреплению нашего сотрудничества со Всемирной организацией здравоохранения, расширению участия России в развитии здравоохранения стран СНГ, ряда стран Африки, Азии, Южной Америки. Во многом этому способствовало подписание Меморандума о взаимопонимании между Министерством здравоохранения и социального развития Российской Федерации и Всемирной организацией здравоохранения, а также встреча Генерального директора ВОЗ Маргарет Чен с Председателем правительства Российской Федерации Владимиром Путиным.

Одним из примеров нашего продуктивного сотрудничества явилась чрезвычайно успешная, по мнению международных участников, первая Всемирная министерская конференция по безопасности дорожного движения, проведенная в России в 2009 году.

Мы хотим пригласить всех представителей государств - членов ВОЗ на шестидесятую сессию Европейского регионального комитета ВОЗ, которая состоится в Москве в сентябре 2010 года.

Нам также приятно сообщить, что на прошлой неделе Генеральная Ассамблея Организации Объединенных Наций поддержала предложение ВОЗ о проведении в Москве в июне 2011 г. Всемирной конференции по формированию здорового образа жизни и борьбе с неинфекционными заболеваниями.

Российская Федерация готова наращивать инвестиции в глобальное здравоохранение. Мы надеемся, что это послужит достижению Целей тысячелетия, улучшению здоровья населения, повышению политической и социальной стабильности во многих странах мира. Спасибо за внимание.

Le PRÉSIDENT:

Je vous remercie, Madame. Je donne maintenant la parole au délégué de la République-Unie de Tanzanie qui s'exprimera au nom des pays de la Communauté de développement de l'Afrique australe.

Professor MWAKYUSA (United Republic of Tanzania):

On behalf of the Member States of the Southern African Development Community, or SADC, I am honoured to be able to provide a statement to the Sixty-third World Health Assembly. The SADC region has an estimated combined population of 200 million people distributed among the 15 Member States, with health indicators below the expected standards in terms of infant mortality rates, child mortality rates and maternal mortality rates. Communicable diseases such as HIV/AIDS, malaria, tuberculosis and other emerging epidemics, including multidrug-resistant tuberculosis, are still responsible for high morbidity and mortality in the region, which is also experiencing an increase in lifestyle diseases in the form of such noncommunicable diseases as heart ailments, hypertension, cancer, injury and trauma.

The SADC Member States face high levels of maternal, perinatal and child mortality. We are aware that not all countries in the SADC region will be able to meet Millennium Development Goals 4, 5 and 6. The region will, however, be able to meet the malaria targets if the current level of support is scaled up, maintained and sustained. We also recognize that to meet the Millennium Development Goals, particularly Goal 5, more resources and increased efforts will be required from other sectors and stakeholders. In addition, countries will be required to report progress on these Goals in 2011. We therefore call on WHO to work with the region and countries to scale up implementation and reporting mechanisms.

Due to the challenges to which I have referred, the region has identified health as one of the most important priority areas in its regional cooperation and deeper integration and development agenda. It has been widely acknowledged that access to quality health care is not only central to the ultimate goal of poverty eradication – improvement of the standard and quality of life of the people of the region – but also a critical factor in accelerated and sustainable economic development. It is indeed sad to note that on an annual basis more than 13 million cases of malaria are reported in the SADC region alone. In some Member States, up to 40% of the population suffer from malaria at a given point during the year. For this reason, the SADC region has welcomed the recent decisions to allow the use of DDT for malaria control and possible eradication. We also welcome the support received from the Roll Back Malaria Partnership in assisting SADC Member States to implement the Road Map in order to meet the 2010 targets.

As a region, our fundamental goal is to build strong health systems that are based on the foundations of equity, good governance and justice. In pursuit of our goals, we are fully aware that there will be no easy victory and that there will be many obstacles along our path. In view of this fact, the SADC region remains committed to its vision and practical implementation because, for us, access to health care is above all a human right.

Regarding elimination of paediatric HIV, as a region, we strongly believe we should invest together with our partners in interventions that are working, that are cost-effective, and that are being used to strengthen maternal, newborn and child health systems. I refer to prevention of mother-to-child transmission of HIV, where we have made tremendous strides as a region; we want to add our call to an emphatic and resolute decision to work to eliminate paediatric HIV.

One of the major concerns in the region is the high prevalence of tuberculosis which continued to contribute to avoidable morbidity and mortality. We have noted with concern that, as a region most affected by tuberculosis, we have not benefited fairly from the global initiatives that are intended to

support the most tuberculosis-affected communities. For instance, while seven out of 10 countries in the world with the highest per capita tuberculosis cases are in southern Africa, the majority of them have not benefited from global initiatives that are enjoyed by other high-burden countries. We would like to call on the Health Assembly to revise its criteria for high tuberculosis-burden countries, so that countries such as Botswana, Lesotho, Namibia and Swaziland, with high per capita tuberculosis, could be prioritized on initiatives such as tuberculosis prevalence surveys.

The other challenge that the SADC region is facing is the emergence of resistance to first-line antiretroviral medicines. It is worth mentioning that patents on newly developed essential medicines have exacerbated already constrained resources and limited access to essential medicines. Close to 50% of the population in the SADC region lack regular access to newly developed affordable, quality, safe and efficacious essential medicines. To address this, Member States in the SADC region profoundly express their political will and commitment to improve pharmaceutical programmes in their countries. In addition, the SADC region has embarked on and is prioritizing regional production of essential medicines for HIV/AIDS, tuberculosis and malaria, based on the African Union Pharmaceutical Manufacturing Plan for Africa. We, therefore, as a region, call on WHO to first, support SADC Member States and the region in strengthening their regulatory mechanisms; and second, to provide the necessary assistance and information to the SADC countries with a view to facilitating speedy prequalification of products by WHO.

The SADC region is also addressing the issue of migration of health workers to industrialized countries, particularly highly trained and skilled health personnel moving from the SADC region to developed countries. To address the situation, SADC health ministers have resolved to improve the conditions of service of their staff and use of bilateral agreements between and among the SADC Member States to address the human resources challenge. We therefore welcome the draft global code of practice on the international recruitment of health personnel, which we believe will go a long way towards addressing the uncontrolled migration of health workers.

The SADC region has now adopted a new approach in addressing public health issues for combating noncommunicable diseases, in line with the principles of the Declaration of Alma-Ata. It is also gratifying to note that SADC was the first region to launch and subsequently commemorate the Healthy Lifestyles Day on the last Friday of February each year. We are advocating a shift from ill health to health, and as we continue to implement this decision, we will encourage the people of our region – young and old alike – to be more physically active and eat healthy foods, thus reducing lifestyle diseases.

The SADC region recognizes the threat posed by emerging epidemics such as pandemic (H1N1) 2009. The spectators will certainly bring the virus to South Africa, as the African continent, through the SADC region, will be hosting the 2010 FIFA World Cup in the next few days in South Africa. This event will bring large numbers of soccer teams and soccer fans to our region. We however, remain firm and vigilant and prepared for any outbreaks like H1N1 that may erupt. This is in addition to our resolve to continue the fight against such epidemics and pandemics.

The future of the SADC region, that is the unborn babies, children and our mothers, is under threat due to rampant trafficking and internal and external immigration. This vulnerable group of our region is in danger due to forced and unforced migration on economic, geographical and ethical grounds. Interventions are required that address root causes of vulnerability of children and the youth within a context defined by HIV/AIDS, poverty, ignorance and hunger. SADC commits itself to safeguarding their rights to access social commodities and facilities to sustain their lives.

Let me conclude, Mr President, by thanking the WHO Director-General, Dr Margaret Chan, for her stewardship and vision for WHO. In addition, my colleagues in the SADC region and I would like to reiterate our commitment to work alongside Dr Sambo, WHO Regional Director for Africa, to improve the lives of the people of our region. I thank you.

Ms TEODORO JORGE (Portugal):

Mr President, ladies and gentlemen, I would begin by highlighting that Portugal is a long-standing advocate of the health determinants approach, both at the international and national levels. As an active participant in Alma-Ata, Portugal made primary health care the cornerstone of the

Portuguese Health System created in 1978. The very existence of the National Health System guided by the principles of universal coverage, equity and solidarity, is itself a landmark of Portuguese democracy. Thirty years later, the citizen's rights-centred approach has allowed for steady progress in pursuit of "More Health for all". Health is indeed a right for all: for men and women, for rich and poor, for all human beings regardless of their status. On the ongoing reform of primary health care, Portugal has met and even exceeded set targets. Yesterday, however, we all heard Dr Chan and I quote: "National average is not enough". National average results do not reflect the needs of the poor and social minorities, and I quote again Dr Chan: "If we miss the poor we miss the point". We should be aware that a correct reading of health is very much cross-cutting. It also includes education, good housing, water and sanitation, gender equality, access to health care and affordable medicines.

At the crossroads of an economic and financial crisis, the challenge is to achieve our goals with better use of existing resources. This need is accentuated by the expenditure on health being driven by an ageing population, chronic disease and complex technologies. Two months ago, European Union health ministers met to debate the critical issue of equity in health. It has been decided to take the necessary steps to develop comparable indicators and improve methodologies to monitor and control health inequalities. However, the health sector cannot go it alone. There is a need to develop cross-sector policies. This calls for a shift from the traditional approach to health problems to one that addresses the social determinants as root causes of poor health. This was already been perceived by the visionary leaders in Alma-Ata, thirty years ago.

At the national level, Portugal's health strategies represent a commitment to a highly participatory process, with an increasingly bottom-up approach to strategic management by the various layers of the health system, and an interministerial committee to foster intersectoral action. Benefiting from close cooperation with the WHO Regional Office for Europe, the strategy was evaluated by leading external experts. The new Health Strategy 2011–2016 chose four cross-cutting themes: citizenship in a perspective of participation and empowerment; healthy public policies following an approach to Health-in-All-Policies; equity and access to health care focusing on primary health care; and quality in terms of both structures and processes.

Finally, I would underline that Portugal co-hosted with Spain a side event to the Health Assembly, following on the Global Consultation on Migrant Health. It is Portugal's firm belief that migrant health is crucial to the promotion of health equity and inclusive societies. Portugal considers that the international community should follow up the recommendations of the Sixty-first World Health Assembly on migrant health, towards a greater contribution to the promotion of Health for All. In a time of economic and social crisis, migrants are among the more vulnerable groups.

Despite growing awareness, policies do not sufficiently address existing health inequities. And health can and should play an important role in avoiding social exclusion. There is much work ahead. The challenges before us demand continuous and concerted action – action to be driven by all, together. Thank you, Mr President.

La Dra. ITURRIA CAAMEÑO (República Bolivariana de Venezuela):

Muy buenos días, muy buenos días a todos, a la Presidencia, a las compañeras trabajadoras y compañeros trabajadores por la salud y la vida que nos acompañan hoy.

Hace diez años, fue aprobada la Declaración del Milenio, como una promesa colectiva, para atender problemas estructurales que afectan a los pueblos, en especial a los más vulnerables y excluidos del mundo. Ahora podemos decir que los avances en algunos de los objetivos han sido lentos y desiguales, el compromiso y apoyo internacional no se han visto reflejados con la contundencia y celeridad necesarias. Hemos escuchado las cifras de los diferentes países, pero nos falta evaluar los indicadores de equidad. Los promedios ocultan las inequidades, y tiene que ser nuestro compromiso ahora analizar las brechas en los países, entre los países y entre las regiones, y sobre todo: generar estrategias que permitan reducir las diferencias evitables en los indicadores de salud entre los pueblos.

Las causas de estas diferencias radican en la naturaleza propia del modelo capitalista, que privilegia intereses económicos, comerciales e individuales, por encima de derechos sociales fundamentales, por encima de una verdadera justicia social, por encima del derecho a la salud de nuestros pueblos. Los beneficios económicos del modelo capitalista se reparten entre muy pocos, pero

las consecuencias negativas se distribuyen entre todos. La crisis financiera y el cambio climático son expresiones contundentes del fracaso de este modelo y es evidente que los países del sur recibimos de manera directa sus nefastas consecuencias.

En la Republica Bolivariana de Venezuela hemos trabajado partiendo de la reducción de brechas e inequidades desde 1998, entendiendo la salud como derecho constitucional y humano y no como mercancía, con resultados exitosos en varios ámbitos.

Entre 1990 y 2009 hemos logrado reducir en más de 70% el número de personas que vivían en situación de pobreza extrema, de 25% a 7,4% de la población total. El índice de prevalencia de subnutrición era de 11 puntos, y lo llevamos a seis puntos, con reducción cercana al 50% respecto a 1990.

Se han fortalecido las políticas de acceso a la educación en sus diferentes niveles, a través de las misiones educativas que ofrecen oportunidades de estudio a adultos y personas excluidas por diversas razones del sistema tradicional, alcanzando en 2005 la declaratoria de la UNESCO de país libre de analfabetismo, y subimos la tasa de escolaridad neta de 86% en 1998 a 92,3% en 2009. El índice de desarrollo humano pasó del rango medio, 0,77, en 1990 a 0,85 (rango alto) en 2008.

La tasa de mortalidad de los niños menores de cinco años pasó de 32 por 1000 nacidos vivos registrados, a 16,35 en 2008, lo que significa un 76% del cumplimiento de la meta del Milenio para el 2015.

El Estado brinda atención integral gratuita (incluyendo antirretrovirales desde 1998) al 100% de las personas afectadas por VIH/sida registradas. En Venezuela se redujo la tasa de mortalidad por tuberculosis a 2,15 por cada 100 000 habitantes, lo que representa una disminución del 39%. La prevalencia notificada de tuberculosis se redujo en 22% desde 1990, llevándola a 23 por cada 100 000 habitantes en 2007.

Superando la meta, el Gobierno bolivariano ha logrado que la población sin acceso al agua potable disminuyera en 81%, y la falta de acceso a redes de recolección de aguas servidas bajó 67% con respecto a 1990. En cuanto a la equidad en la distribución del ingreso en los hogares, el coeficiente de GINI mejoró de 0,49 en 1998 a 0,39 en 2009.

Con la Misión Barrio Adentro, creada en el año 2003, hemos garantizado acceso universal y gratuito a la atención integral de salud, incluyendo el suministro gratuito de medicamentos. En esos siete años pasamos de 4804 a 11 915 establecimientos de salud del primer y segundo nivel, lo cual representa un incremento de 248%. Se construyó el Hospital Cardiológico Infantil Latinoamericano, que desde 2006 brinda atención gratuita en cirugía cardiovascular, hemodinamia y electrofisiología a más de 4000 niñas, niños y adolescentes (45 de ellos de otros países), con un incremento en 1418% con respecto al 1998. En promedio, en Venezuela se hacían 5000 cirugías oftalmológicas al año; con Misión Milagro se han realizado 1 104 150 en seis años, incluyendo 333 710 pacientes internacionales gratuitamente operados en cirugía oftalmológica, expresión de la solidaridad de Venezuela como parte de la cooperación Sur-Sur entendida como compromiso y no como transacción.

Estos logros, obtenidos durante el Gobierno Revolucionario del Presidente, Hugo Chávez Frías, demuestran que los Objetivos del Milenio se pueden alcanzar si existen cambios radicales en el modelo de desarrollo, sustentados en principios como la justicia, la equidad y la solidaridad. El reto que ahora tiene nuestra Revolución es profundizarlos para consolidar en nuestro país el socialismo bolivariano y humanista que elegimos las venezolanas y los venezolanos. Muchas gracias.

Professor AKDAĞ (Turkey):

Mr President, excellencies, ladies and gentlemen, it is a great pleasure to see that today, we have achieved a certain success in many areas of health. I consider all this progress also very promising. Furthermore, we have come a long way towards achieving the Millennium Development Goals. Indeed, a number of countries have already reached most of their targets. Yet inequalities between countries still exist. And there are some who say that many developing countries will not be able to accomplish the Millennium Development Goals. There is a clear need for sufficient financial resources and infrastructures to achieve the said Goals and ensure their sustainability. Moreover, equity should be embraced as a fundamental human right.

As we work to the best of our capacities, I wish to emphasize the importance of solidarity and cooperation. One country's sole success shall not be enough unless the Millennium Development Goals are achieved globally. In this context, the countries that reach the targets are not free from responsibility. That is why, under WHO's leadership, we should reinforce and further improve our collaboration. We should share our experiences and best practices. Turkey has always been ready for such cooperation and exchange of experience. We believe that working together is the only way to come to the end of this long and difficult road.

I would like to share briefly two examples of our most significant achievements in Turkey related to the Millennium Development Goals. Let me say that, as a paediatrician, this success is particularly important for me. We have witnessed in Turkey a remarkable decrease in both maternal and child mortality by our health transformation programme. We have made special efforts to improve the situation. Over the last 10 years the maternal mortality rate has decreased from 70 to 20 per 100 000, while the infant mortality rate has fallen from 43 to 13 per 1000. We expect to reduce the maternal mortality rate to below 15, and the infant mortality rate to below 10 in 2010.

The last two years so far have seen intense efforts in the field of health. Along with the financial crisis, pandemic (H1N1) 2009 has been a major challenge for many countries. As you know, cooperation, transparency and rapid communication are crucial to effectively combat any pandemic. Having said that, I would like to thank Madam Director-General, her team and WHO for their determined and strong management during the pandemic. This pandemic has also shown us the importance of preparedness and rapid action, and given us an opportunity to see what we should do further.

Let me underline that the key point here is acting together. During the recent pandemic, we unfortunately observed that some countries could not access the vaccine while the others spent large amounts. The availability of any pandemic vaccine is so crucial that it should not be left up to market dynamics. Taking account of recent experiences, WHO should play a more proactive role. For example, a global fund could be established, whereby WHO could manage the production process and ensure fair distribution.

I would like to express my condolences to the tragedy-stricken countries and people who suffered from earthquakes in the last couple of months. Turkey, unfortunately, has witnessed a number of dramatic disasters, especially earthquakes in her history. Natural disasters are priority items on the agenda of every country. In this regard, vigilance, preparedness, early and timely response are essential factors for each country. Not only at country level, but also internationally, we should have efficient, effective and sufficiently rapid operational mechanisms to further develop response capacities. For instance, our well-trained medical rescue teams aided rescue efforts in many countries such as Haiti, Indonesia, Iran and Pakistan. During these experiences, we recognized that challenges such as communication failures, formalities and organizational weaknesses are usually a hindrance. Therefore, WHO should establish an operational global emergency response mechanism.

I would also like to draw the Health Assembly's attention to the people living in the occupied territories, including the Gaza Strip, where difficulties persist, even for addressing the most essential health services. I believe that taking a more active role in this matter is necessary for WHO in order to meet the needs of such people, taking into account the principle of "Health for All".

We all aim to ensure a better world for our children, and know that solidarity and cooperation are always important for us. Thank you.

M. BIANCHERI (Monaco):

Monsieur le Président, Madame le Directeur général, Excellences, Mesdames et Messieurs, la crise économique et financière qui nous a tous durement frappés, touchant des domaines prioritaires tels que la santé, l'éducation et l'aide publique au développement, a aujourd'hui pour conséquence de fragiliser encore davantage les conditions de vie des populations les plus vulnérables. Cela est très préoccupant car il ne faudrait à aucun prix que les objectifs du Millénaire pour le développement soient perdus de vue ou relégués à un faible rang de priorité.

Dans ce contexte, l'Assemblée de la Santé qui nous réunit aujourd'hui revêt une importance particulière. Il appartient en effet à l'Organisation mondiale de la Santé de jouer un rôle de chef de file

pour tout ce qui concerne les objectifs du Millénaire pour le développement liés à la santé et, de la sorte, de contribuer dans son domaine à la meilleure préparation possible de la réunion de haut niveau de l'Assemblée générale des Nations Unies du mois de septembre. Ce rendez-vous sera décisif, tant il est vrai que les objectifs sont fortement liés les uns aux autres. Un accès efficace aux soins de santé passe par l'éducation ; le respect de l'environnement a un impact direct sur la santé ; il n'est pas de développement possible sans élimination du problème de la faim et de la malnutrition. Il est facile de multiplier les exemples. Parmi les priorités de notre engagement en faveur du développement doit aussi figurer la lutte contre la contrefaçon ou la falsification des médicaments et dispositifs médicaux. Efforçons-nous de faire avancer ce dossier sans que les questions juridiques n'aboutissent à paralyser notre détermination. Peut-être une approche allant du plus simple au plus complexe, et qui consisterait à évoquer simplement, dans un premier temps, les « faux médicaments », pourra-t-elle recentrer notre débat sur l'essentiel.

Depuis l'an 2000, la Principauté de Monaco place la réalisation des objectifs du Millénaire pour le développement en tête des objectifs de sa politique de coopération et met tout en œuvre pour y parvenir. S. A. S., le prince souverain, l'a réaffirmé en septembre dernier lors de l'ouverture de la 63e Assemblée générale : notre effort de consacrer 0,7 % de notre PIB d'ici 2015 à l'aide publique au développement doit être poursuivi. « Celle-ci ne doit pas être sacrifiée en raison de la situation économique et financière actuelle. Elle doit être au contraire renforcée au moment où les plus vulnérables en ont davantage besoin. ». Ainsi, en 2010 environ € 303 par habitant seront affectés à l'aide publique au développement et, sur ce montant, plus de la moitié est destinée à des programmes couvrant les secteurs sanitaire et social, dans une approche diversifiée allant du partenariat hospitalier à l'accès à l'eau potable, en passant par la formation des personnels de santé, la lutte contre les pandémies mais aussi contre les maladies orphelines et tropicales négligées, la lutte contre la malnutrition, la prise en charge du handicap ou la construction de structures sanitaires. La lutte contre la poliomyélite est également pour nous une priorité et nous espérons voir prochainement l'éradication complète de cette maladie. Par ailleurs, la Principauté de Monaco développe prioritairement des programmes de coopération internationale qui visent à promouvoir l'autonomisation des femmes et la parité des sexes, dans les domaines de l'éducation, de la lutte contre la pauvreté ainsi que de la santé maternelle et infantile. Tout cela ne se conçoit, bien sûr, qu'à travers une coopération avec l'Organisation mondiale de la Santé, notre partenaire principal, dont je veux saluer ici l'engagement sur le terrain partout dans le monde et au bénéfice de tous. Nous poursuivrons cette coopération sous forme de participation à des programmes, tout en mobilisant également des contributions non affectées. Ainsi au cours de la période biennale écoulée, nos contributions volontaires à l'OMS se sont élevées à plus de un million de dollars, soit plus de 50 fois le montant de nos contributions obligatoires.

Enfin, je souhaiterais revenir rapidement sur la gestion de la grippe A (H1N1). Le Directeur général et son équipe, confrontés à une situation porteuse de risques considérables mais qui n'était ni totalement connue ni totalement prévisible, ont réagi en fonction des données en leur possession au moment où ils l'ont fait. Il n'en est pas moins nécessaire d'en tirer un bilan et des recommandations pour le futur, en particulier dans le domaine de la communication, des critères de déclenchement des différents seuils d'alerte et de l'accès équitable aux médicaments. Une réflexion plus large sur la signification et la portée exactes qu'il convient de conférer au principe de précaution pourrait également s'avérer souhaitable. Je vous remercie de votre attention.

Mr NGUYEN QUOC TRIEU (Viet Nam) (*Interpretation from the Vietnamese)*:[1]

Mr President, ladies and gentlemen, on behalf of the Vietnamese delegation, I would like to express gratitude to WHO for having invited Viet Nam to this Health Assembly and for having given our country precious support in the area of public health. Within the context of the Millennium Development Goals, Viet Nam has reaffirmed its respect for the values and principles of the United Nations Millennium Declaration, which was made by 189 Heads of State and Government at the

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

Millennium Summit convened at United Nations Headquarters in September 2000. We are accelerating our implementation and have achieved encouraging results as regards the eight Goals, three of which are in the area of health. Viet Nam has achieved almost all of them in the period 2006–2010.

With regard to Millennium Development Goal 4, infant mortality, in 2009 the level for children under five was 25/1000. The figure for children under one was 15/1000. The level of malnutrition among children under one was 18.9%. We have also received great support from the GAVI Alliance. With regard to Millennium Development Goal 5, in 2009 the maternal mortality rate fell to 75/100 000. The level of women benefiting from three consultations during their pregnancy was 84.6%; the level of births attended by obstetricians was 94.8%. With regard to Goal 6, namely malaria, HIV/AIDS and other epidemics, we have achieved great success, as the level of infection is below 0.3% in the population.

Furthermore, we have managed to do a great deal. We have been implementing the Millennium Development Goals. Viet Nam is a country that is developing. It has a long path ahead of it, with many obstacles in the area of health. It has a significant divide with regard to access to medical services between regions and social groups. There are shortcomings and different levels in the provision of medical equipment, which means that there are still many challenges ahead. The Vietnamese Government has agreed to ensure that all social classes should be supported in their access to health care. In addition, we call for further support from donors and United Nations bodies in order to accelerate the Millennium Development Goals.

Professor MYA OO (Myanmar):[1]

Mr President, Director-General, excellencies, ladies and gentlemen Myanmar is one of the developing countries of the WHO South-East Asia Region and is also a member of ASEAN. It has a population of over 58 million, 70% of which reside in rural areas.

Myanmar, like all other developing countries of the Region, is experiencing a double burden of disease with communicable diseases such as malaria, tuberculosis, HIV/AIDS and new emerging diseases like H5N1 and the current human influenza pandemic due to the new pandemic influenza A (H1N1) 2009 virus on the one hand, and noncommunicable diseases such as heart disease, hypertension, stroke, diabetes, cancer, substance abuse, and traffic accidents on the other hand. In addition, maternal newborn and childhood health including malnutrition are also national health priorities.

Myanmar, as a member of the United Nations family, is committed to attaining the United Nations Millennium Development Goals by 2015 by strengthening its health system to provide essential health care to all people in general and meet the health needs of the poor, women, children and other vulnerable groups in particular.

Poverty is the world's most ruthless killer and the greatest cause of human suffering. It is one of the major challenges of the country particularly in remote and border areas. The Government launched a multisectoral border area development plan in 1989 to meet the basic needs of nationalities residing in remote and border areas. The Ministry for the Progress of Border Areas and National Races and Development has taken on responsibility of implementing the plan in collaboration with the other ministries concerned. Priority has been given to the development of transport and communication, health, education, agriculture and livestock breeding in 68 townships of 7 states and 2 divisions, with 5 million people of national races residing in the area.

The Government also launched an integrated Rural Development Plan which includes a five-point agenda to meet Millennium Development Goals, namely: the construction of roads, linking village to village and village to urban township, and district to district; the provision of safe drinking-water and sanitation as well as water for cultivation; education; the provision of essential health services and a referral system to station and township hospitals; and promotion of agriculture and livestock breeding for income generation.

[1] The following is the full text of the speech delivered by Professor Mya Oo in shortened form.

The 2001 household income and expenditure survey found that the estimated poverty rate was 20% in urban areas, 28% in rural areas and 26% for the country as a whole. The poverty gap ratio was 6.8%. We fully recognize that investment in health will lead to poverty reduction and economic development. Malnutrition is recognized as an outcome as well as a cause of poverty. Nutrition plays a major role in the survival, growth and development of young children, and malnutrition also contributes to 50%–60% of child deaths in developing countries. Protein energy malnutrition, iodine deficiency disorders, iron and folic acid deficiency anaemia are major nutritional problems similar to those of many developing countries. Mothers and children are the most vulnerable to undernutrition and micronutrient deficiencies especially in rural and peri-urban areas. There has been significant progress with regard to iodine deficiency due to universal iodization of salt, with household consumption of iodized salt increasing from 10.8% in 1994 to 86% in 2005. During the same period, goitre prevalence dropped from 33% to 2% in 2006. Strong political commitment, effective cooperation of relevant Government ministries, private salt producers, support from UNICEF, and many others contribute to the progress of Myanmar's programme for universal salt iodization.

A recent survey indicated that 50% of pregnant women and 25% of adolescent girls are anaemic; we are implementing behavioural change communication as regard to food habits and health-seeking behaviour, and also iron folic acid and vitamin B1 supplementation. Vitamin A supplementation was initiated during the years 2000 through to 2002 together with vaccination against poliomyelitis on the national immunization days and through Nutrition Promotion Week campaigns started in 2003 up till now. Today blindness due to vitamin A deficiency is almost unknown in Myanmar.

There was a gradual decline in the prevalence of protein-energy-malnutrition among children under five from 38.6% in 1997 to 36.3% in 2000 and 31.8% in 2003. But these current prevalence rates are still high, and at the same time 32.2% of children are stunted and 8.6% are wasted. Undernutrition is more common among rural children than their urban counterparts. Nutrition rehabilitation and supplementary feeding for malnourished children are being implemented in both rural and urban areas with joint collaboration between local and international nongovernmental organizations and community participation for sustainability. The 2003 National Body Mass Index survey indicated that 20% of women were underweight with a BMI of less than 18.5. The false beliefs of women in some traditional communities stop them from eating a variety of nutritious foods during the critical period of pregnancy and lactation. Household food security is the most critical factor in malnutrition.

As women and children make up 60% of the population, the Government of Myanmar is strengthening its health system to enhance the health status of all people in general and the health needs of the women, newborns, children, the poor and the other vulnerable groups in particular. I would like to point out that 13 developing countries account for 70% of global maternal deaths and five countries in Asia and the Pacific region are responsible for 50% of global maternal deaths. According to a United Nations estimate in 2003, the maternal mortality ratio was 380 per 100 000 live births in Myanmar, which is still high in the Region. About 60% to 80% of maternal deaths are due to postpartum haemorrhage, sepsis, obstructed labour, hypertensive disorder of pregnancy and septic abortion.

The South East-Asia Region carries a proportional burden of morbidity and mortality amongst children under five. The under-five mortality rate is 66 per 1000 live births in Myanmar. Although this rate has declined significantly in past decades, the infant mortality rate of 49.7 per 1000 live births has not changed significantly: over 80% of under-five mortality occurs in rural areas, and 73% of deaths occur before the first birthday. Moreover, two thirds of neonatal deaths occurred within the first week of life, and two thirds of these deaths take place in the first 24 hours of life. Therefore, attention to neonatal survival is imperative for achieving the targeted reduction of the infant mortality rate and the under-five mortality rate, especially in rural areas. The availability of skilled attendants at every pregnancy and childbirth is crucial for improving access to maternal and newborn care services. The proportion of births attended by skilled persons increased from 57% in 2001 to 67.5% in 2003. Improving the health of mothers and newborns requires a continuum of good-quality reproductive health care, starting from the period before pregnancy to some months after delivery. Also recognized is the need for a better functioning referral system for emergency obstetric care and care for newborns

with problems. We are striving to achieve universal access to reproductive health by the year 2015 so as to reach the Millennium Development Goal targets for maternal and neonatal mortality. Regarding the under-five mortality rate, the major killers are pneumonia, diarrhoea, malaria, measles and HIV/AIDS, with malnutrition contributing to more than 50% of all deaths. For these, there are already cost-effective health interventions. The major challenges are due to lack of resources in developing countries; it is noted that the Millennium Development Goals monitoring framework includes a new target "Achieve, by 2015, universal access to reproductive health" under Millennium Development Goal 5, which recognizes the centrality of reproductive health services and reproductive health rights in improving maternal newborn and child-health and reducing poverty.

To ensure successful implementation of the reproductive health strategy it is also necessary, to address poverty-related health issues including malnutrition, lack of safe drinking-water and sanitation, and a low level of exclusive breastfeeding and skilled birth attendance. International stakeholders should provide adequate technical and financial support to resource-limited developing countries and the developing countries should also scale up their investment in health, as recommended by the Commission on Macroeconomics and Health. Health professionals also need to redouble their efforts; and only then will we be able to achieve the targets of health-related Millennium Development Goals by 2015.

Based on evidence and lessons learnt from previous strategies and interventions, we have formulated a Five-year Strategic Plan for Child Health (2010–2014), with technical inputs from main stakeholders. It has been implemented in close cooperation and collaboration with the Five-year Strategic Plan for Reproductive Health (2009–2013) and the Five-year Strategic Plan for Adolescents (2008–2011). These three strategic plans have commonality of strategic directions and approaches.

To achieve Millennium Development Goals 4 and 5 by 2015, we need to ensure the continuum of maternal, newborn, child health and nutrition in a sustainable manner. Therefore, it is of utmost importance to effectively coordinate and collaborate among stakeholders such as the Government, WHO, UNICEF, UNFPA and other United Nations organizations, international nongovernmental organizations as well as private-sector national nongovernmental organizations and the communities themselves, for human, technical and financial resources.

Malaria, tuberculosis and HIV/AIDS are national priority diseases hindering the socioeconomic development of the country. We are combating these three diseases in accordance with national programmes, with a high level of political commitment. Over 70% of the population reside in malarious areas. During the last two decades, malaria morbidity and mortality have been declining. In the 1990s the morbidity rate was 24.5 per 1000 population, and the mortality rate was 10.4 per 100 000 live births. At present, morbidity and mortality have been reduced to 10.7 per 1000 population and 1.8 per 100 000 live births, respectively. Human behaviour in using insecticide-treated bednets, an adequate supply of rapid diagnosis tests and artemisinin-based combination therapy are key factors in reducing the malaria morbidity and mortality. Human resource training and supportive supervision are also crucial for malaria programmes.

Tuberculosis is also a major public health problem and Myanmar is one of 22 high tuberculosis burden and 27 high multidrug-resistant tuberculosis countries in the world. Recent estimates suggest that 1.5% of the population becomes infected with tuberculosis ever year, and that some 130 000 people go on to develop tuberculosis. Half of these cases are infectious with positive sputum smears. The national tuberculosis programme began implementing a directly observed treatment, short course strategy in 1997, and all townships in the country were covered by the year 2003. We have formulated a revised national strategic plan for 2010–2015, which includes six principal components of the new WHO's Stop TB strategy. We achieved a case detection rate of 94% and a treatment success rate of 85% in 2008. The uninterrupted supply of good-quality first-line anti-tuberculosis drugs supported by the Global Drug Facility was completed in 2009, but fortunately will be backed in 2010 with support from the Three Diseases Fund and Japanese Grant Aid.

South-East Asia has the second highest HIV/AIDS disease burden and the epidemic is still concentrated in the population with high-risk behaviour, such as commercial sex workers and injecting drug users. Considerable progress has been made in fighting this epidemic by implementing a national plan with full involvement of various Government agencies, the private sector and nongovernmental organizations. HIV prevalence in Myanmar started to decline from 0.94% in the year 2000, falling to

0.67% in 2007 and to 0.61% in 2009. But prevalence in high-risk groups such as commercial female sex workers and injecting drug users remains high, ranging from 20% to 38% in 2008. Success in reducing prevalence is the result of firm political commitment and the scaling-up of coordinated efforts of all stakeholders. However, the 2003 target of antiretroviral treatment reaching at least half of those in need of therapy has not been met and only one in five receives treatment. We are confident that with the Three Diseases Fund and additional support from the Global Fund, the goals and targets of Millennium Development Goal 6 will be achieved in 2015.

Essential medicines are vital tools for the health care system. The primary objective is to ensure safe and good-quality essential medicines at an affordable price. The proportion of the population with access to affordable medicines is about 60%. Due to the TRIPS agreement, the developing countries cannot afford the prices of patent-protected drugs. The Commission on Macroeconomics and Health recommended broader licensing to produce high-quality generic drugs for use on the domestic markets of low-income countries. This means that the rich countries would bear the cost of research and development while the poor countries would pay a price close to the production cost. I would like to urge the multinational pharmaceutical industry, WHO, WTO and the low-income countries to work together to ensure that the poor countries can access medicines at the lowest viable commercial price.

I have presented progress and achievements with regard to the health-related Millennium Development Goals in Myanmar. However, we fully recognize the need to sustain political momentum and scale up investment in health. It is also crucial for the international community and financial organizations to sustain their commitment to assist low-income countries, without which the latter will not be able to achieve the Millennium Development Goals and targets by 2015. Myanmar is also building a stronger health system so as to ensure comprehensive, good-quality health-care services for all people and protection against financial disaster, especially for poor people during illness, covering reproductive health services as well.

At this juncture, I would like to commend the efforts of WHO to work with the GAVI Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank in developing a common platform for health systems funding in line with the recommendation of the High-level Task Force on Innovative International Financing for Health Systems. We are also strengthening health information systems in collaboration with WHO to enhance the availability of quality health data, especially on the health-related Millennium Development Goals and other indicators.

I would like to express my profound gratitude and appreciation to WHO, other United Nations agencies, international communities and international financial organizations, and all respective stakeholders for their assistance to the Union of Myanmar. We also support the Secretariat's report on monitoring of the achievements of the health-related Millennium Development Goals, and the Executive Board resolution EB126.R4. Finally, I would like to reiterate our commitment to achieving the health-related Millennium Development Goals by the year 2015. Thank you for your kind attention.

Mr JEON Jae-hee (Republic of Korea):

Mr President, distinguished delegates, ladies and gentlemen, it is a great honour to speak today on behalf of the Republic of Korea.

I remember standing here at the Sixty-second World Health Assembly last year, talking about solidarity in the fight against pandemic (H1N1) 2009. I am pleased to tell you that Korea has successfully kept the pandemic under control, like many other countries. This year, we are gathered to discuss yet another challenge for health ministers and professionals that requires our urgent attention: the health-related Millennium Development Goals. I wish to express my appreciation to Dr Chan and WHO for the timely decision to bring this pressing issue to our attention. It should sound an alarm for us all that, among all the Millennium Development Goals, the least progress has been made in achieving maternal and infant mortality reduction. Health-related goals cannot be met with the efforts of the foreign affairs ministries or organizations in charge of official development assistance alone. It will not be possible without a strong commitment of health leaders and expertise of health professionals. Recognizing their indispensable role in the drive to achieve the health-related Millennium Development Goals, United Nations Secretary-General Ban Ki-moon has organized a

meeting to gain insight from health officials in the run-up to the September 2010 Summit on the Millennium Development Goals. I believe it is our noble duty as health ministers and professionals to turn our eyes and reach out to those who suffer from dreadful health conditions within or outside our borders.

The Korean Government has pledged on many occasions to expand its official development assistance volume to pay back the help we have received from the international community. President Lee Myung-bak promised at the United Nations General Assembly last September to triple the 2008 official development assistance to US$ 3 billion by 2015. As the first recipient-turned-donor country, we still remember the hardship that may be suffered by developing countries today. The Korean Government is more than ready to share our development experience. What made us improve our dismal health care in a country devastated by war 50 years ago? First, technical assistance as well as material aid from the international community were important. With the support of WHO, we were able to effectively eradicate the malaria parasite and waterborne diseases. Second, training health-care workers was also a key success factor. Our Government focused on fostering public health doctors and community health practitioners who could work in the field. They were deployed at the basic administrative level and helped establish the primary health-care system in rural areas. They cared about mothers' health before and after childbirth, and led people to make changes in lifestyle and attitudes, enabling grassroots social reform.

The ideas are in line with the established principles and guidelines on international cooperation. The Korean Government truly understands the value of the principles, as we learned them through our experience, and wishes to make them more valuable by sharing them with others. We have already started projects to assist developing countries. Hopefully, the success stories will be shared with you here someday.

The right to health is one of the most fundamental human rights. We representatives here today, stand at the forefront to uphold that right. The international community calls on us to work together to make progress towards the health-related Millennium Development Goals. It is time for us to join forces and stand united again, as we did in the fight against pandemic influenza, to achieve the ambitious goals by 2015, under the strong leadership of WHO. Thank you.

Mr MCKERNAN (New Zealand):

Mr President, honourable ministers, delegates, *tēnā koutou, tēnā koutou, tēnā koutou katoa*, warm greetings from the people of New Zealand.

New Zealand welcomes this debate in the Health Assembly. We welcome WHO's work to assist Member States in achieving the Millennium Development Goals, and we also welcome the reports by other Member States here today on their progress.

I want firstly to acknowledge the progress that has been made towards achieving the health-related Millennium Development Goals, in particular the reductions in child mortality. However, like many we do agree that there is also much that can and should be done to step up action where progress has been poor. There is strong agreement about the need to strengthen health systems to further progress the Millennium Development Goals. In New Zealand, we have placed particular emphasis on health systems strengthening, including the key role of primary health care. Our surveys in New Zealand show that investment in primary care has benefited the whole population but in particular vulnerable groups, especially those on low incomes or living in areas of economic deprivation. The New Zealand Government is working with health professionals to drive change within primary care to achieve "better, sooner, more convenient" primary care services. This includes: services which are delivered closer to home by a wider range of health professionals; the more effective prevention, identification and management of chronic diseases; new models of delivery to improve maternal and child health; improved access to diagnostic and traditionally hospital-based treatment services that are now delivered in the primary care setting. Furthermore, the New Zealand Government recently announced a new approach to addressing the social and economic needs of families, with a focus on those families most at risk. The approach, named *Whānau Ora*, which loosely means "family well-being", is designed to allow families to take greater control of their future by reorientating the delivery of health and social services around their identified needs. This initiative draws on indigenous

Maori approaches, shifting the emphasis from individualized service delivery to one that better supports the needs and aspirations of the family or *Whānau.*

Internationally, New Zealand has taken a lead role at the United Nations Human Rights Council in raising the issue of maternal mortality and the potential failure to meet Millennium Development Goal 5 as a significant human rights question. Universal access to sexual and reproductive health information and services is integral to good maternal health. The progress report that will be considered later in the Health Assembly on reproductive health highlights the uneven progress in achieving international targets related to maternal, sexual and reproductive health. This is of great concern to us, and it must continue to be a focus for our efforts at country, regional and global levels. In 2009, the New Zealand Parliamentarians Group on Population and Development convened an open hearing on maternal health in the Pacific, to highlight the continued need to address the complex issues limiting improvements to maternal health in our region. The resulting findings and recommendations will guide New Zealand's efforts in working in the Pacific region and with other development partners. The report also highlights once again the need to improve data collection and information systems to better support monitoring progress on the Millennium Development Goals.

The world faces many pressing health issues, and while we would like to act on them all simultaneously, the reality is we cannot and priorities must be set. The New Zealand Government has established a health target regime that identifies six key targets. These include targets for immunization, the management of cardiovascular disease and diabetes, and smoking. Our experience is that a focus on a few important health priorities leads to rapid improvement, for example our historically poor immunization rate has increased 17% over a two-year period to 85% and continues to climb. Youth smoking rates have halved in the last five years, while wider availability of highly cost-effective nicotine replacement therapy has seen a 200% increase in its use over the past 18 months.

New Zealand is pleased that noncommunicable diseases are now being seriously discussed in the context of the Millennium Development Goals. We cosponsored the resolution agreed in New York last week, calling for a United Nations high-level meeting on noncommunicable diseases in September 2011. Preventing and managing such diseases is not only an important new challenge in its own right, but will be essential for continued progress with the existing health-related Millennium Development Goals.

Finally, New Zealand continues to place a high value on opportunities such as this Health Assembly to learn from and share our experience with other countries, both developing and developed. There is much that we can all learn from the rapid improvements in Millennium Development Goal indicators in a number of developing countries, often with limited resources. The Goals are our collective responsibility and we will all benefit when all countries achieve them – the sooner the better.

For me, this is perhaps best summed up by a Māori proverb from New Zealand, which goes *Nā tō rourou, nā taku rourou ka ora ai te iwi* translated, this means "With your basket with my basket, the people will thrive".

Thank you, Mr Chairman *Nō reira, tēnā koutou, tēnā koutou, tēnā koutou katoa*.

Dr ZHARKO (Belarus):
Д-р ЖАРКО (Беларусь):

Уважаемый г-н Председатель, уважаемые делегаты, дамы и господа,

Процесс достижения Целей тысячелетия в области развития в условиях глобализации, возрастающей роли социально-экономических детерминант здоровья и таких современных вызовов, как последствия мирового финансового кризиса, чрезвычайные ситуации и вспышки болезней, требует особой консолидации усилий как на глобальном, так и на национальных уровнях. В своем поступательном движении к достижению Целей тысячелетия в области развития здравоохранение Республики Беларусь основывается на широкомасштабных государственных программах по охране здоровья, направленных, в том числе, на охрану здоровья матери и ребенка, борьбу с ВИЧ/СПИДом, другими болезнями, а также на решении иных задач, связанных со здоровьем. Своевременно принятые меры по экономии финансовых ресурсов и слаженная работа правительства и руководства отрасли здравоохранения

обеспечивают устойчивое финансирование мероприятий, предусмотренных национальными программами, и позволяют достичь положительной динамики.

Так, младенческая смертность снизилась, с учетом младенцев с чрезвычайно низкой массой тела при рождении, до 4,7 промилле при 11,9 промилле в 1990 году. Коэффициент смертности среди детей до пяти лет как один из основных показателей благосостояния общества составил 6,1 промилле, в 1990 г. - 15,2 промилле, что сопоставимо с уровнем высокоразвитых стран мира и позволяет надеяться на достижение поставленных целей к 2015 году. Материнская смертность составляет 0,9 на 100 000 живорожденных, в 1990 г. - 22. Положительные результаты в Республике достигнуты благодаря устойчивому приоритетному государственному финансированию отрасли, мероприятиям по обеспечению детей качественными продуктами питания, своевременному совершенствованию системы перинатальной помощи путем создания разноуровневой системы ее оказания, улучшению перинатальной диагностики врожденных пороков и наследственных болезней, совершенствованию неонатальной реанимации и выхаживания недоношенных новорожденных, неуклонному повышению квалификации врачей и специалистов детского здравоохранения. Активно развивается высокотехнологичная медицинская помощь детям. Каждой беременной женщине гарантируется бесплатное медицинское наблюдение в государственных учреждениях здравоохранения, стационарная медицинская помощь во время и после родов, а также медицинская помощь и медицинское наблюдение за новорожденными.

Важнейшим для сохранения здоровья является проведение мероприятий, направленных на профилактику заболеваемости детей. В Республике осуществляется обязательная иммунизация детей против туберкулеза, дифтерии, коклюша, кори и полиомиелита, краснухи и вирусного гепатита В. Охват детей профилактическими прививками в отношении всех инфекций, входящих в Программу иммунизации, в 2005 г. составил 98,7%, что превышает рекомендуемые критерии ВОЗ в 95%. Республика Беларусь также добилась прогресса в достижении целей, отраженных в Декларации о приверженности делу борьбы со СПИДом, и национальных целей всеобщего доступа к профилактике и лечению, уходу и поддержке в связи с ВИЧ-инфекцией. Главными принципами политики в области ВИЧ и СПИДа в Беларуси являются: обеспечение полного и равного доступа к информации, средствам профилактики, лечению, уходу и поддержке в связи с ВИЧ-инфекцией; уважение прав человека; борьба с дискриминацией и стигматизацией в связи с ВИЧ-статусом; сотрудничество государственных учреждений, международных общественных организаций, а также людей, живущих с ВИЧ; признание профилактики приоритетной стратегией противодействия эпидемии.

В настоящее время заболеваемость малярией в Республике оценивается как стабильная, с низким уровнем. Население Республики, особенно социально уязвимые группы, имеет полный доступ к услугам по профилактике туберкулеза и информации, а лица, живущие с туберкулезом, имеют доступ к лечению, уходу и поддержке. При этом суммарное снижение заболеваемости туберкулезом за пять лет, с 2005 по 2009 год, составило 13,8%, с 54,3 до 46,8 на 100 000 населения. Снижение смертности от туберкулеза - 33,1%, с 12,1 до 8,1 на 100 000 населения. Опираясь на международный опыт и лучшие мировые достижения в области борьбы с туберкулезом, еще предстоит решать актуальные проблемы современного этапа, такие как борьба с туберкулезом с множественной лекарственной устойчивостью, заболеваемость которым возросла с 9,9% в 2005 г. до 20,3 в 2009 г. и ВИЧ-ассоциированным туберкулезом.

По задачам обеспечения доступа к основным лекарственным средствам следует отметить, что в Республике Беларусь соотношение доли генериковых и оригинальных лекарственных средств составляет 82% и 18%, соответственно. В Республике Беларусь для сдерживания роста цен практикуется подписание Меморандума по сдерживанию цен с производителями лекарственных средств. Здравоохранение Республики Беларусь ставит перед собой стратегическую цель развития по созданию современной и эффективной системы здравоохранения, по укреплению ее потенциала для обеспечения граждан доступными лекарственными средствами и медицинской помощью.

Благодарю за внимание.

Le Dr AOUELE (Côte d'Ivoire):

Monsieur le Président, Mesdames et Messieurs, honorables délégués, avant tout propos, je voudrais vous féliciter, Monsieur le Président, pour votre élection à la présidence de nos travaux et aussi féliciter tous les membres du Bureau mis en place. La Côte d'Ivoire par ma voix remercie et félicite l'OMS et son Directeur général pour l'intérêt accordé au suivi de la réalisation des objectifs du Millénaire pour le développement.

À cinq ans du délai fixé en 2015 par la Déclaration du Millénaire, le bilan concernant la réalisation des objectifs du Millénaire pour le développement est mitigé, notamment pour les pays en développement dont fait partie la Côte d'Ivoire. En effet, la crise sociopolitique qu'a connue la Côte d'Ivoire a occasionné bien des difficultés dans la mise en œuvre de la politique sanitaire ivoirienne avec la partition du pays et la restriction de l'autorité sanitaire à la moitié sud du pays. Mais avec le processus de sortie de crise suite aux accords politiques de Ouagadougou en 2007, les activités sanitaires développées par le Gouvernement se sont à nouveau étendues à l'ensemble du pays et des signes d'amélioration de l'état des indicateurs sont perceptibles. Ainsi, les indicateurs concernant la santé des enfants se sont sensiblement améliorés. En effet, le taux de mortalité infanto-juvénile est passé de 150 pour mille en 1990 à 125 pour mille en 2005, soit une réduction de 17 %. L'adoption de la stratégie d'accélération de la survie de l'enfant et de la prise en charge intégrée des maladies du nouveau-né et de l'enfant ainsi que l'adoption de nouvelles stratégies pour l'amélioration de l'état nutritionnel de ces derniers et l'amélioration de la couverture vaccinale avec l'appui de partenaires tels que l'Alliance GAVI, nous donnent bon espoir d'approcher de cet objectif.

Au sujet de la santé maternelle, des efforts sont à noter. En effet, le taux de mortalité maternelle a légèrement baissé, passant de 597 décès pour 100 000 naissances vivantes en 1999 à 543 décès pour 100 000 naissances vivantes en 2005, soit une réduction de 10 %. Le taux d'accouchement assisté par un personnel qualifié a connu une amélioration passant de 45 % avant l'an 2000 à plus de 56,9 % en 2006, puis à 64,49 % en 2009, avec une augmentation de la capacité de formation des sages-femmes. Nous notons également que la couverture des besoins sanitaires en matière de prise en charge des complications obstétricales est passée de 42 % en 1999 à 60,1 % en 2004, entraînant ainsi une baisse du taux de létalité due aux complications obstétricales au sein des structures assurant les soins obstétricaux d'urgence de 2,7 % en 2000 à 1,7 % en 2004.

Concernant l'objectif 6 du Millénaire pour le développement, des efforts ont également été faits au niveau de la Côte d'Ivoire, avec l'appui de plusieurs partenaires au développement. Ainsi, au niveau du VIH/sida, la prévalence est passée de 7 % en fin 2003 à 4,7 % en fin 2005 et les estimations actuelles font état d'une légère baisse de cette prévalence. Le nombre de personnes vivant avec le VIH ayant accès au traitement antirétroviral a connu une augmentation de plus de 183 % entre 2005 et 2007. L'intégration des activités de prévention de la transmission mère-enfant au paquet minimum d'activités et l'intégration de la prise en charge nutritionnelle dans la prise en charge globale des personnes infectées et affectées par le VIH ainsi que le développement d'activités pour le changement de comportement, en liaison avec les groupes communautaires et les organisations intergouvernementales devraient permettre une accélération de la lutte contre le VIH, qui demeure une préoccupation majeure pour le Gouvernement ivoirien.

Pour ce qui est de la lutte contre le paludisme, qui reste la première cause de décès en Afrique, l'intégration des associations thérapeutiques à base d'artémisinine dans la prise en charge des cas est une réalité, mais l'accessibilité financière à cette intervention reste une problématique dans nos pays. Fort heureusement, la Côte d'Ivoire bénéficie du soutien du Fonds mondial pour son projet de « Passage à échelle des interventions de lutte contre le paludisme dans le contexte de reconstruction nationale ». Ce projet permettra la distribution d'environ 9 millions de moustiquaires à imprégnation durable au cours de cette année, permettra l'achat d'antipaludiques pour toute la population, la vulgarisation des tests de diagnostic rapide dans les centres de santé périphériques et la prise en charge à domicile avec le médicament de première intention. Toutefois, nous pensons qu'un appui à l'assainissement de l'environnement et à l'amélioration de l'hygiène environnementale des populations demeure une voie à encourager dans la lutte contre la maladie qui est aussi une lutte antivectorielle. C'est pourquoi nous sollicitons encore l'appui des partenaires multilatéraux.

Concernant la lutte contre la tuberculose, nous avons adopté la Stratégie Halte à la tuberculose recommandée au niveau mondial par l'OMS pour stopper la tuberculose et atteindre les objectifs du Millénaire pour le développement d'ici 2015. En 2006, 21 204 cas ont été déclarés pour toutes les formes de tuberculose et 12 964 cas pour les formes à frottis positifs. Le taux de succès thérapeutique est encourageant car il est passé de 64 % en 2000 à 75 % en 2007.

Je voudrais terminer mon propos, en insistant sur la nécessité du suivi de la réalisation des objectifs du Millénaire pour le développement. Pour cela, il nous faudra des données de qualité qui permettent d'évaluer la situation de départ à sa juste valeur et de mesurer les efforts accomplis sur une période déterminée. La Côte d'Ivoire se trouve aujourd'hui en situation de sortie de crise et est classée comme pays fragile. Elle lance donc un appel à la solidarité internationale pour une amélioration et un renforcement de son système de santé. Je vous remercie.

La Dra. JADUE (Chile):

Buenos días. Es un honor para mí representar al Gobierno de Chile en esta Asamblea, a dos meses de asumir el nuevo Gobierno, en condiciones muy particulares.

A partir del 27 de febrero de este año, nuestro país enfrenta serios desafíos después del terremoto y el tsunami que asoló el centro sur, afectando a más de dos millones de personas. Se perdieron casas, escuelas, hospitales, caminos y puentes. Comienza el invierno y deberemos enfrentar la pandemia con una red hospitalaria que perdió el 10% de su capacidad instalada con 4000 camas. De un total de 26 000 camas hospitalarias en el país, 17 hospitales desaparecieron, otros 30 tienen daños graves. La red de consultorios de atención primaria quedó en mejores condiciones y esta fue capaz de asumir rápidamente el control de la situación, para restaurar los servicios a la población. Sin embargo, estamos en una situación tremendamente disminuida.

Esto ha significado desarrollar rápidamente otras estrategias de protección de la salud de la población, como la vacunación masiva contra la influenza A H1N1 y la creación de maneras nuevas de reponer las capacidades en los servicios de salud, instalando redes funcionales, trasladando los pacientes de un lugar a otro dentro del país en el lugar donde están los servicios requeridos.

Superada la fase de la emergencia inicial, estamos hoy poniendo nuestro esfuerzo en las labores de reconstrucción, lo que supone llevar ayuda, alivio, consuelo y protección a los cientos de miles de chilenas y chilenos damnificados por este cataclismo.

Nuestro Presidente, Sebastián Piñera, está preparando un proyecto de ley que financia la reconstrucción del país, que contempla obtener recursos por más de US$ 20 000 millones para reponer, también entre otras cosas, la infraestructura hospitalaria.

Lo más doloroso y lo más sensible, porque es irrecuperable, son las numerosas victimas fatales que dejó este cataclismo, con 452 fallecidos y aún 56 personas que no han podido ser encontradas.

Sin perjuicio de lo anterior, la vida sigue y debemos seguir avanzando y preocuparnos de la salud de todos los chilenos y chilenas. Los ODM, que representan una manera mucho más integral de mirar los avances en el nivel de salud de los pueblos, son una prioridad para nuestro país y superar la pobreza que afecta a un porcentaje de nuestra población, avanzando con equidad en el logro de una mejor salud son prioridades para nuestro Gobierno. Hoy en la tarde de hecho presentaremos algunos de los avances en estos años, con resultados que son alentadores en varios casos.

En este sentido, la OMS es un espacio de cooperación multilateral y Chile estará siempre dispuesto a compartir las experiencias y aprender de buenas prácticas para buscar mejor vida para todos.

La cooperación internacional fue muy importante para poder superar la emergencia: muchos países acudieron en nuestra ayuda, con hospitales de campaña, con equipos de profesionales para colaborar con insumos. Deseo aprovechar la oportunidad en esta Asamblea para reiterar nuestra gratitud por la solidaridad recibida, valor ético en el mundo global que estamos construyendo día a día y que tienen mucha importancia.

Hoy tenemos que mostrar y compartir las lecciones aprendidas para tratar de cometer cada vez menos errores y para que todos podamos enfrentar las situaciones de emergencia, cada vez más frecuentes en el mundo, de mejor manera.

Reconstruir piedra por piedra y ladrillo por ladrillo, no solamente lo que el terremoto y el maremoto destruyeron, sino que algo más grande y ambicioso aún, reconstruir un país mejor, con tecnologías más modernas, con estándares de seguridad más exigentes, pero también con valores más sólidos son nuestros objetivos. Muchas gracias.

M. DI BARTOLOMEO (Luxembourg):

Monsieur le Président, Madame le Directeur général, chers tous, je voudrais tout d'abord me rallier à la déclaration faite hier par ma collègue espagnole au nom de l'Union européenne. Nous sommes tous conscients que la crise financière et économique qui nous a frappés ne facilitera pas la réalisation des priorités de développement en général et des objectifs du Millénaire pour le développement liés à la santé en particulier. Mais nous sommes attendus au tournant.

Notre débat sur les objectifs du Millénaire pour le développement (OMD) tombe à point nommé, alors que nos travaux pourront être une contribution importante à la réunion de haut niveau consacrée à cette question qui aura lieu dans quelques semaines à New York. J'espère qu'elle adoptera par consensus la résolution que le Comité exécutif lui soumettra en vue d'accélérer les progrès en matière d'OMD liés à la santé, ce qui devrait être un signal fort pour souligner notre engagement consensuel et fournir un cadre ambitieux de mesures à prendre dans le domaine de la santé. Le nombre élevé d'acteurs gouvernementaux et non gouvernementaux, la dimension globale des questions de santé et l'interdépendance des objectifs du Millénaire pour le développement demande un leadership fort de l'OMS. J'aimerais rendre hommage à Mme le Directeur général, le Dr Chan, à son engagement inlassable et son bilan en termes de réalisation des OMD liés à la santé, surtout depuis 2008 lorsque ma délégation avait suggéré de lancer un processus annuel de suivi par les ministres de la santé. En juillet 2009 s'est tenue, sous la présidence luxembourgeoise, ici à Genève, l'Examen ministériel annuel du Conseil économique et social (ONU). Il a été consacré à la « Mise en œuvre des objectifs et engagements adoptés au niveau international en matière de santé publique mondiale ». L'adoption par consensus de la déclaration ministérielle constitue un pas important dans les travaux préparatoires pour septembre. La santé est au cœur des objectifs du Millénaire pour le développement. Une gouvernance soucieuse des droits de l'homme, de la démocratie et de la stabilité sont autant de facteurs essentiels à une société en bonne santé. La santé est un élément primordial dans la lutte contre la pauvreté et la promotion d'une croissance durable. Des progrès réels et mesurables ont été obtenus en santé publique, notamment dans la lutte contre le sida et la tuberculose, et dans la réduction de la mortalité infantile. De graves lacunes subsistent pourtant. Ainsi, les avancées en matière de santé maternelle sont négligeables, ce qui compromet bien évidemment aussi la santé du nouveau-né. Répondre aux besoins des femmes en termes de services de santé sexuelle et génésique pourrait améliorer leurs chances de terminer leurs études et d'échapper à la pauvreté. Nous croyons également qu'avec une participation accrue des femmes aux processus décisionnels, une plus grande attention sera accordée aux besoins sanitaires des femmes et des filles.

L'incapacité des pays – souvent fragiles, se relevant de conflits ou ne disposant pas d'institutions suffisamment solides ou de ressources appropriées – à mener des politiques de santé publique efficaces, notamment en garantissant l'accès à des services de santé adaptés, en particulier des soins de santé primaires, constitue un défi majeur. Nos débats devraient aussi faire état de la nécessité de mettre en place des systèmes de santé durables pour atteindre, à long terme, les objectifs liés à la santé. Cela implique en particulier des ressources financières suffisantes et donc accrues face au dénuement de nombre de ministères de la santé, surtout dans les pays les moins avancés. Nous devons renforcer tous les efforts susceptibles d'être déployés pour souligner la priorité qu'il convient de réserver à la santé, pour accorder une part accrue des moyens nationaux disponibles et de l'aide publique au développement à la santé, pour développer en même temps des mécanismes de financement innovants tant sur le plan national que sur le plan international. Une feuille de route précise de l'OMS pour guider ses États Membres dans leurs efforts de renforcement des systèmes de santé serait à cet égard un outil essentiel que mon pays encouragerait. La réalisation des OMD ne peut être fondée seulement sur l'assistance. Pour rendre cette stratégie durable, nous devons mettre l'accent sur le développement des capacités de production. Le développement de l'appareil productif et de l'emploi engendre des revenus pour les personnes et pour l'État. Sans un tel développement, les

avancées sociales qui pourraient être faites dans l'éducation, la santé et les indices de pauvreté ne seraient pas durables ; on traiterait les symptômes plutôt que les causes profondes de la pauvreté. L'année 2010 est une occasion unique pour nous de redynamiser et de coordonner nos efforts en vue d'atteindre les OMD. C'est également le moment de rendre des comptes, un certain nombre d'objectifs et d'échéances intermédiaires ayant été fixés pour les OMD, notamment ceux énoncés pour l'aide publique au développement et pour l'efficacité de l'aide. Il est crucial pour la réalisation des OMD d'atteindre les niveaux d'aide publique au développement déjà engagés et le Luxembourg ne manquera pas à ses engagements ; 1,04 % de notre revenu national brut est actuellement dédié à l'aide publique au développement. Lors de la réunion plénière de haut niveau des Nations Unies, nous devons montrer comment nous comptons tenir nos promesses. Les OMD liés à la santé sont réalisables ; nous devons les atteindre. Pour cela, il faut anticiper et faire preuve de volonté politique. Tel doit être l'objectif ambitieux qui déterminera, pour l'avenir, la perspective de notre action commune. Le Luxembourg, au sein de l'OMS, y prendra toute sa part.

Je ne voudrais pas terminer sans évoquer les problèmes que nous avons rencontrés lors de la gestion de la crise autour de la grippe A (H1N1). Avec beaucoup de nos collègues, je me suis demandé ce qu'on aurait pu faire d'autre ? Avec ce que l'on savait au début de l'épidémie, on n'aurait pas pu faire autrement. J'assume. Nous devons assumer. Mais avec ce qu'on a appris de la crise on pourra faire mieux à l'avenir. Nous savons entre-temps combien de confusion peut créer la collision entre le principe de précaution voulant garantir à nos populations au plus vite un vaccin efficace et l'autre principe de précaution lié à un risque hypothétique associé à ce même vaccin. Nous savons, aujourd'hui plus que jamais, que nous devons mettre en réseau nos experts indépendants et crédibles pour éviter une cacophonie préjudiciable à notre politique de vaccination en général qui est sans alternative. Finalement, je voudrais m'insurger contre le fait que la crise mondiale de la grippe a fait l'affaire de l'industrie du vaccin qui affiche des bénéfices records, ce qui est particulièrement indécent à un moment où tous les États font face à des problèmes financiers énormes. J'aimerais répéter mon invitation à mes collègues de mener des négociations communes et non pas sur une base individuelle avec l'industrie pharmaceutique afin de nous garantir des prix honnêtes et des contrats équilibrés. Si crise mondiale il y a, il doit y avoir solidarité globale et réponse commune. Je vous remercie de votre attention.

Mr DUKPA (Bhutan):

Mr President, Madam Director-General, excellencies, ladies and gentlemen, I bring to this august gathering, the warmest greetings from His Majesty the King, the Government and the people of Bhutan. Mr President, I join our friends in congratulating you on your election as President of the Sixty-third World Health Assembly. We are confident that your leadership and wisdom will steer the deliberations to fruitful results. As always, Madam Director-General, your statement yesterday was very inspiring and illuminating.

With only five years remaining to 2015, it makes sense that we deliberate and review the status and progress of the health-related Millennium Development Goals. I would like to thank WHO and the Executive Board for selecting these Goals as the theme for this Health Assembly. The first democratically elected Government in Bhutan not only fully subscribes to the commitment made towards the achievement of the Millennium Development Goals, but we have brought forward the date from 2015 to 2013 for the health-related Goals. Last year, the Ministry of Health signed the compact with the Prime Minister for the acceleration of achievement of various aspirations, one of which is the health-related Millennium Development Goals. Further, poverty reduction, if not elimination, is the main theme of the current 10th Five-Year Development Plan (2008–2013). Obviously, the Millennium Development Goals, as the Director-General said yesterday, are part of the overarching goal of poverty reduction. Our development goals and programmes are based on the development philosophy of gross national happiness, not gross national product, which focuses on sustainable and equitable economic development, preservation of the environment, cultural and spiritual pursuits, and more importantly, good governance. Health is one of the nine domains of gross national happiness.

If we are to achieve the Millennium Development Goals, which were conceived and designed to bring about equity and social justice, it is time that we review and revisit the fundamentals of the

economic development paradigms. There is a need to harmonize the two dominant economic models of capitalism and communism. This is what we in Bhutan strive to do through the application and adoption of the economic model infused by development philosophy of gross national happiness. You know, and I know, that gross domestic product does not take into account the parameters like environment, climate change, and so on.

As regards the acceleration of the achievement of the health-related Millennium Development Goals, we have also done some exercises on the requirements of financial input. For a small and developing country like ours, we need over US$ 600 million, a substantial amount given the size of our economy.

Bhutan now stands at a critical juncture – politically, economically and socially. For the first time, we have successfully hosted the Summit of the South Asian Association for Regional Cooperation, the 16th such event, when a large and unprecedented number of high-level delegates from 17 countries and journalists from many countries gathered recently in the small Himalayan Kingdom of Bhutan. The hosting of such major events is necessary to help institutionalize the clean and vibrant democracy and also showcase the capability and goodness of the Government. Only if the people have faith and trust in the elected Government will democracy flourish in a country. Mindful of this, we have embarked on several reforms, including the Economic Development Policy, based on which the National Health Policy is being drafted. This will provide a clear and concrete direction for the delivery of health-care services on the basis of equity and social justice.

We look forward to continued support and cooperation from our development partners as we tread past these milestones of health system development, which is founded on principles of primary health care. Lastly, and in conclusion, I would like to thank WHO for its stewardship in global health. May this exemplary stewardship translate into a timely attainment of all health-related Millennium Development Goals in countries across the globe.

I would like to thank you all for listening and *Tashi Delek!* Thank you.

Mr NAGAHAMA (Japan) (*interpretation from the Japanese*):[1]

Mr President, Director-General, honourable ministers, distinguished delegates, ladies and gentlemen, on behalf of the Government of Japan, I would like to commend Dr Chan and WHO on their outstanding leadership in global health.

I would also like to express my heartfelt sympathy for those who lost their lives in the Haiti earthquake and other recent natural disasters. Japan greatly appreciates the role WHO plays in humanitarian response such as in Haiti, and the Japanese Government is always supportive of such efforts.

Pandemic (H1N1) 2009 poses a serious threat to global health security. Since last year. WHO and the Member States have taken collective action to address the pandemic, by making best use of preparedness gained so far. In Japan, we have taken active measures, such as enhancing surveillance, enforcing preventive measures in schools and public facilities, and providing appropriate medical services at community level. Japan has successfully contained the mortality rate at 0.15 per 100 000 people, which is relatively low compared to other countries. At the global level, Japan has actively contributed to efforts in developing countries, including through WHO vaccine distribution. It is essential for the Secretariat and the Member States to strengthen preparedness based on the lessons learnt from the most recent experiences. We should further enhance the function of the International Health Regulations (2005) as well as promote international cooperation.

We have only five years left to achieve the Millennium Development Goals. “To protect people’s lives” is one of the policy pillars to which the Administration of Prime Minister Hatoyama attaches particular importance. With its rich knowledge and experience, Japan is committed to keep focusing on its support to maternal, newborn and child health and the fight against infectious diseases in developing countries for reducing infant and maternal mortality rates. For this purpose, Japan believes that health systems strengthening such as health workforce development is critical, while

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

stronger collaboration across other sectors, such as safe water, sanitation and education, is also essential.

As for infectious diseases, Japan is committed to maintaining our global fight against three major infectious diseases and our efforts towards global immunization. In addition, we should closely watch recent developments such as the spread of poliomyelitis and multidrug-resistant tuberculosis. For global poliomyelitis eradication, the affected countries and all partners should work as one, with strong political will. Controlling noncommunicable diseases is also an important issue. Our new Administration has decided to increase the price of tobacco. On 31 May, the World No Tobacco Day event will be held in Japan for the first time. In addition, we are actively engaged in the World Health Day campaign in Japan regarding healthier cities promoted by the WHO Centre for Health Development, Kobe. I look forward to the Global Forum on Urbanization and Health, which will take place in Kobe in November of this year.

Today, the international community faces more complex health challenges. WHO is expected to serve as a leading organization in coping with them. It is important for WHO to operate more effectively and efficiently, while mobilizing its resources for activities where it enjoys a comparative advantage. To conclude my statement, I would like to express Japan's willingness to further enhance its cooperation with WHO for a more significant impact. Thank you very much for your attention.

M. VAN MEEUWEN (Belgique):

Monsieur le Président, Excellences, Mesdames et Messieurs, la réunion de haut niveau de l'Assemblée générale des Nations Unies sur les objectifs du Millénaire pour le développement (OMD) fait de l'année 2010 une année clé pour le développement dans le monde. Et dans ce contexte, l'importance du secteur de la santé et de l'OMS dans la réalisation des OMD ne peut être trop soulignée.

En effet, pas moins de trois des huit objectifs du Millénaire portant respectivement sur la mortalité infantile, la santé maternelle et le sida, le paludisme et d'autres maladies concernent directement le secteur de la santé. Il va sans dire que d'autres objectifs tels que l'élimination de la pauvreté, la généralisation de l'enseignement primaire et l'égalité des sexes ont une relation directe avec ce qui se réalise dans le secteur de la santé. Cette relation, cela est suffisamment clair, est une relation de causalité à double sens. La Belgique veut approcher les OMD de façon holistique. Pour nous, les OMD sont un tout indissociable d'objectifs qui doivent se réaliser en menant des efforts qui se renforcent mutuellement et qui s'appliquent sur un front vaste couvrant l'ensemble du domaine du développement humain. Notre vision des OMD suppose une approche globale des 8 objectifs, des 21 cibles et de la soixantaine d'indicateurs. Dans ce cadre, le renforcement de systèmes de santé durables est la pierre angulaire d'une telle politique. Le débat sur « le renforcement des capacités des gouvernements pour amener de façon constructive le secteur privé à fournir des soins de santé essentiels » est crucial tant il s'agit de l'organisation et de la gestion des soins de santé en continuelle adaptation que du rôle de contrôle qui doit être joué par l'État grâce à un cadre législatif solide et évolutif.

Nous avons suivi avec grand intérêt les débats sur les maladies non transmissibles qui restent un défi majeur dans nos pays mais aussi dans les pays du Sud. La Belgique se félicite de la mise en place du Réseau mondial de lutte contre les maladies non transmissibles (NCDnet) à l'inauguration duquel la Princesse Mathilde et la Ministre de la Santé, Mme Onkelinx ont assisté, ce qui montre l'importance que nous y accordons. Même si les maladies non transmissibles ne font pas expressément partie des OMD en tant que telles, une attention particulière à leur égard n'est pas contradictoire avec l'approche générale des OMD. Pour lutter efficacement contre les maladies transmissibles et non transmissibles, il est impératif de consolider les systèmes de soins de santé primaires. Pour être en état de répondre aux défis globaux nécessitant des systèmes de santé solides, l'efficacité d'un acteur tel que l'OMS est essentielle. Soutenir cette efficacité est une responsabilité partagée entre les organisations multilatérales elles-mêmes, leurs constituants et leurs partenaires. La Belgique souhaite contribuer à cette tâche, comme faisant partie de son engagement vis-à-vis du « good multilateral donorship ». Comme vous le savez, la Belgique a fait un choix clair pour les contributions souples et pour la réorientation des contributions multilatérales belges vers le financement de base.

Je ne saurais conclure mon intervention sans mentionner la première urgence de santé publique à répercussion internationale qu'a représenté la pandémie de grippe A (H1N1). Cette pandémie a démontré l'utilité et l'importance du Règlement sanitaire international (2005). Elle a également mis en évidence la nécessité de maintenir et de renforcer les efforts pour la complète mise en œuvre des dispositions requises par ce Règlement. La Belgique continuera à appuyer les efforts pour la mise en œuvre complète des capacités au niveau national et soutient le processus d'examen mis en œuvre actuellement afin de tirer les leçons de l'expérience vécue. Je vous remercie.

Professor R. Akdağ (Turkey), Vice-President, took the presidential chair.
Le Professeur R. Akdağ (Turquie), Vice-Président, assume la présidence.

Mr MARUŠIC (Slovenia):

Mr Vice-President, Madam Director-General, colleagues and excellencies, allow me first of all to congratulate the President on his election to the post of the President of the Sixty-third World Health Assembly. On behalf of my delegation, I would like to assure him and the Bureau of our full support.

Allow me to add a few national points to what was already expressed by the distinguished colleague, Dr Jiménez García-Herrera, Minister of Health of Spain yesterday, on behalf of the European Union. The health-related Millennium Development Goals have been rightly chosen as a leading theme of this year's Health Assembly opening debate. We are fast approaching 2015, the year which our leaders set as a deadline for achieving the Millennium Development Goals. Over the last nine years, much has been done but we have to admit that we have left many promises unfulfilled. I fully agree with the Director-General that the Goals should not be seen independently but in a holistic manner, in the context of strengthening health systems and applying robust and effective national and regional preventive measures.

Among the items on our indeed large agenda, there are three items that Slovenia deems important. Firstly, Slovenia attaches particular attention to the adoption of the global strategy to reduce harmful use of alcohol. Harmful use of alcohol has serious effects on public health globally. Today, too many young people die all over the world because of it. That is why we need a global tool. Many countries, including my own, have adopted national and regional strategies. For many years, it has been clear that these individual efforts are simply not enough – we need a global approach, taking in account difference of our countries and proposing evidence-based action. I hope that this Health Assembly will adopt the proposed strategy by consensus, thus enabling us to act in a more coordinated manner.

Second, let me mention the issue of the Strategic Approach to Integrated Chemicals Management. Slovenia is currently chairing the Bureau of the third Session of the International Conference on Chemicals Management that took place a year ago here in Geneva. This Health Assembly is discussing the Strategic Approach for the second time. In 2006, our discussion was on a general level. This year we have to go deeper. The health effects of obsolete pesticides are not only a problem today, not of a single country and not of a single region. Indiscriminate overconsumption of pesticides, together with unsafe dumping, have been and still are a reality of the present world. The recent disaster that took place in Armenia is clear proof of this. This is why the European Union is proposing a resolution on better management of obsolete pesticides and other obsolete chemicals. We hope that the technical briefing Slovenia is organizing today will shed some new light on what could be done in this respect. Let me also add that the draft resolution on toxic waste proposed by Indonesia complements the discussion on obsolete pesticides and other obsolete chemicals.

Third, I would like to draw your attention to the issue of noncommunicable diseases. Like other developed countries, Slovenia has many problems stemming from these diseases. We cooperate with our fellow European Union partners and the WHO Regional Office for Europe. But we have to do more, particularly by preventing unhealthy behaviour in children and young people. We have to ensure conditions in which young people will be able to make healthy choices. That is why we support a draft resolution proposed by Norway on the marketing of food and non-alcoholic beverages to children.

In conclusion, let me reiterate our view that our joint problems could be solved only through genuine cooperation with each other. Together with WHO, we can address global health problems better and make this world a healthier place. I thank you, Mr Vice-President.

Mr IKRAMOV (Uzbekistan):
Г-н ИКРАМОВ (Узбекистан):

Уважаемый г-н Председатель, уважаемые господа министры, уважаемые делегаты, дамы и господа,

Разрешите от имени делегации Узбекистана поздравить Председателя и его заместителей с избранием на высокие посты в рамках Шестьдесят третьей сессии Всемирной ассамблеи здравоохранения и высказать свое отношение к глубоко продуманному докладу уважаемой г-жи Маргарет Чен, Генерального директора Всемирной организации здравоохранения. Мы все понимаем, что осталось только пять лет до достижения Целей тысячелетия в области развития, и, независимо от размеров стран, от количества населения, от потенциала стран, мы все за эти годы достигли достаточно многого.

Хотелось бы сказать, что в Узбекистане только детская и младенческая смертность за последние 10 лет была снижена более чем в два с половиной раза, достигнута стабилизация по СПИДу, ВИЧ и более чем в два раза уменьшена смертность от туберкулеза. Как это возможно и к чему мы должны идти? В первую очередь, - это усиление эффективности систем здравоохранения независимо от того, какими они являются в разных странах. Социальная защищенность населения и работа систем здравоохранения, от первичной медико-санитарной помощи до систем управления, должны быть в максимальной степени эффективными в последующие пять лет. Второе, - это работа с партнерами, которые представлены международными организациями. В этом направлении мы можем сказать, что работа Всемирной организации здравоохранения, других международных организаций, Глобального фонда дала свои плоды именно в партнерстве системы здравоохранения национального уровня с нашими партнерами, и это, я думаю, может в перспективе дать возможность достигнуть тех трех Целей развития тысячелетия, которые мы перед собой ставим. Вместе с тем, с этой высокой трибуны я хотел бы обратить ваше внимание и на седьмую Цель тысячелетия в области развития, - это Обеспечение экологической устойчивости, и сказать, что правительством нашей страны, президентом страны в 1993 г. с высокой трибуны Организации Объединенных Наций было акцентировано внимание на международную экологическую катастрофу в районе Аральского моря, и мне очень приятно, что высокая делегация во главе с Генеральным секретарем г-ном Пан Ги Муном и руководством Организации Объединенных Наций посетила в апреле этого года Аральский регион и привлекла внимание мировой общественности к проблемам экологии, которые в большой степени отражают негативное состояние здоровья населения как Аральского региона Узбекистана, так и здоровье наших соседей.

Говоря о проблемах пандемии гриппа, мы думаем, что она дала возможность приобрести опыт в двух направлениях. Первое, - это то, что любые заболевания, так или иначе, в наше время очень стремительно развиваются, и в короткие сроки, от трех до четырех месяцев, они охватывают практически весь мир. И говорить о том, что пандемия была, не приходится сомневаться. Второе, - это то, что мы уверены сегодня, что консолидация мирового сообщества и систем здравоохранения дает возможность в очень короткие сроки успешно бороться с теми или иными заболеваниями, если имеется единая стратегия. И главное то, что можно думать о том, оправданы ли те большие средства, которые были направлены на реализацию проблемы пандемии гриппа, вместе с тем это уже вопрос истории. И говоря сегодня о том, что в Центральноазиатском регионе мы имеем вспышку полиомиелита, мы можем сказать, что системы здравоохранения вместе с нашими партнерами прилагают максимальные усилия для нераспространения этой вспышки на территории других Центральноазиатских стран, и со вчерашнего дня, 17 мая, мы начали вместе с Всемирной организацией здравоохранения и ЮНИСЕФ Программу по вакцинации 3 миллионов детей от нуля до пяти лет в Узбекистане.

В заключение хотелось бы поблагодарить международные организации, Всемирную организацию здравоохранения, другие международные организации и фонды за поддержку систем здравоохранения и выразить уверенность, что в 2015 г. мы достигнем тех национальных и глобальных Целей тысячелетия тысячелетия, которые поставлены перед системами здравоохранения.

Спасибо за внимание.

El Sr. OBAMA ASUE (Guinea Ecuatorial):

Señor Presidente de la 63.ª Asamblea Mundial de la Salud, señores miembros de la Mesa, distinguidos delegados: En sintonía con la intervención, ayer, del representante del Grupo africano, a la vez Vicepresidente de esta Asamblea, séame permitido en primer lugar transmitirles los saludos muy calurosos del pueblo y Gobierno de Guinea Ecuatorial, que tengo el honor de representar en este encuentro. Aprovecho también la oportunidad para felicitar al Presidente y a los miembros de la Mesa por su acertada elección. Estoy convencido de que su acumulada experiencia contribuirá a que las deliberaciones y conclusiones sean lo más provechosas posible para nuestros respectivos países. Asimismo, saludamos respetuosamente a la Directora General, Dra. Chan, por su saber hacer así como a todos los Representantes de la OMS que prestan sus servicios por todo el mundo.

En este sentido, la Cumbre del Milenio celebrada en el año 2000 adoptó la Declaración del Milenio y los Objetivos de Desarrollo del Milenio (ODM) con metas fijadas al horizonte 2015 para mejorar las condiciones de vida y reducir la pobreza en los diferentes países. Para ello, los Estados y gobiernos se comprometieron a alinear sus políticas y planes de desarrollo de acuerdo a las necesidades nacionales y establecer mecanismos de abogacía, de coordinación, seguimiento y evaluación para medir periódicamente los proyectos y progresos alcanzados hacia el logro de dichos Objetivos.

En este sentido, Guinea Ecuatorial está firmemente comprometida para el logro de los Objetivos de Desarrollo del Milenio con la adopción y aplicación de una Estrategia Económica Nacional a mediano plazo para el periodo 1997-2001 en su primera Conferencia Económica y Social, y la adopción en 2007 del Plan Nacional de Desarrollo Económico y Social al horizonte 2020 en su segunda Conferencia Económica Nacional, que contempla el desarrollo de un sector social capaz de mejorar el nivel actual de los indicadores en el sector social, la formación de recursos humanos y la diversificación de la economía.

El presente foro que nos reúne hoy en día me ofrece la oportunidad para intercambiar con esta audiencia sobre los progresos más relevantes realizados para el logro de la implementación de los Objetivos de Desarrollo del Milenio en el sector salud en mi país, las lecciones aprendidas y las perspectivas de futuro. Con el escaso tiempo que tenemos, ponemos en evidencia algunas realizaciones actuales.

La promoción de la población con acceso al agua potable, que se estimaba en 45% en 2006, se está mejorando con la implementación del nuevo programa del Gobierno «Agua para todos» en el marco de la implementación del «Plan Guinea Ecuatorial 2020».

La tasa de cobertura vacunal de las campañas realizadas contra las enfermedades evitables por la vacunación alcanzó el 81% en 2008 y se ha adoptado y financiado un Plan Quinquenal de Reforzamiento del Programa Ampliado de Vacunación hasta 2013 para reforzar y mantener esta cobertura a un mínimo de 90%.

La mortalidad de los niños menores de cinco años ha pasado de 93 por 1000 en 2001 a 53 por 1000 en 2009, cuyas principales causas siguen siendo el paludismo, las enfermedades diarreicas, las infecciones respiratorias agudas, la malnutrición, las enfermedades parasitarias y la fiebre tifoidea.

La adopción y financiación de una hoja de ruta de reducción de la mortalidad materna y neonatal con fondos propios a través del presupuesto nacional de inversiones y la creación de un Fondo para el Desarrollo Social para facilitar la financiación de los proyectos del sector social con especial atención a la salud de la madre y el niño.

Se nota una fuerte implicación de la Primera Dama de la Nación para la reducción de la mortalidad materna y neonatal a través de las Campañas de reparación de fístulas obstétricas y de movilización de fondos para la mejora de salud de la madre y del niño en Guinea Ecuatorial. A

propósito de las fístulas obstétricas, tenemos la gentileza de agradecer a nuestros hermanos de Malí que han acogido a nueve estudiantes para esa especialidad.

La cobertura en telas mosquiteras impregnadas de insecticidas alcanza el 50% en la región continental y el 76% en la región insular; se observa una reducción significativa de vectores infectados gracias a la cobertura de pulverización intradomiciliaria de 79% en la isla de Bioko. La población se beneficia de un total acceso gratuito a las pruebas de diagnóstico rápido y tratamiento y el 100% de mujeres embarazadas tienen acceso gratuito a la quimioprofilaxis.

Las medidas tomadas en materia de prevención están aumentando el nivel de información de la población sobre la pandemia del VIH/sida. En el campo del tratamiento de esta pandemia se nota un reforzamiento progresivo de la calidad del diagnóstico y tratamiento a través de la formación del personal, la adquisición de equipos técnicos así como de medicamentos y antirretrovirales, con perspectiva de apertura de centros ambulatorios de tratamiento.

En materia de lucha contra la tuberculosis, el Gobierno está llevando a cabo un amplio programa nacional que prevé una asistencia médica gratuita y una alimentación adecuada de los pacientes ingresados. Con mucho esfuerzo se han recorrido muchas etapas, no obstante queda pendiente mucho que recorrer en esta línea de acciones. Las acciones decisivas deberán encaminarse en el futuro en los dominios siguientes: 1) reforzamiento del sistema de salud, con la puesta en marcha total de la Declaración de Uagadugú; 2) reforzamiento de los recursos humanos; 3) la disponibilidad de datos de base actuales que permiten medir los indicadores de progresos; 4) la disponibilidad de financiamiento global de planes y programas.

Señor Presidente, señores miembros de la Mesa, distinguidos delegados, señoras y señores: Esta evaluación rápida del progreso hacia la realización de los Objetivos de Desarrollo del Milenio en mi país muestra que de acuerdo con el tiempo que nos separa de 2015 queda mucho por hacer, pero con la visión que se ha fijado el país bajo el liderazgo de su Presidente, Su Excelencia Obiang Nguema Mbansogo, el Gobierno de Guinea Ecuatorial está altamente comprometido para alcanzar estos objetivos.

En este sentido, para la mejora de la nutrición y la alimentación están en curso actividades prioritarias para garantizar la productividad de alimentos, la intensificación de la promoción de la lactancia materna y la implementación de un sistema eficaz de información y educación sobre la nutrición y la alimentación, para aprovechar los productos disponibles a nivel nacional. Por otro lado, las grandes oportunidades a nivel del sector salud con la creación de un fondo para el desarrollo social que asigna más del 20% de sus recursos a la atención primaria de salud, a la eliminación de las fístulas obstétricas, la lucha contra el paludismo, la tuberculosis y el VIH/sida, la adopción y financiación de una hoja de ruta para celebrar la reducción de la mortalidad materna neonatal y sobre todo la encuesta de demografía y salud que está en curso de realización en mi país son, entre otras, acciones significativas del Gobierno que nos garantizan la posibilidad de alcanzar los Objetivos de Desarrollo del Milenio en materia de salud.

Distinguida audiencia, no puedo terminar mi intervención sin hacer un llamamiento a todos los socios al desarrollo, para pedir su constante apoyo para la materialización del deseo del Gobierno en el sector salud al horizonte 2020 para que «todos, las mujeres y hombres, niños, adolescentes y jóvenes gocen de una buena salud con acceso equitativo a una atención de calidad».

Convencido de que la contribución de los señores participantes durante los debates contribuirá en la mejora de la aplicación de las acciones definidas en nuestro Plan de Desarrollo Económico y Social para alcanzar los Objetivos de Desarrollo del Milenio en 2015, les agradezco a todos el tiempo que me han dispensado. Muchas gracias.

Professor KULZHANOV (Kazakhstan):
Профессор КУЛЬЖАНОВ (Казахстан):

Уважаемый г-н Председатель,

Позвольте поблагодарить Вас за предоставление мне слова и присоединиться ко всем прозвучавшим здесь поздравлениям по случаю избрания Вас Председателем Всемирной ассамблеи здравоохранения.

Хотелось бы также выразить Генеральному директору ВОЗ г-же Чен искреннее уважение и благодарность за поддержку и помощь в реализации совместных мероприятий, направленных на укрепление партнерства в области здравоохранения. Присутствие в этом зале коллег из более чем 190 государств - членов ВОЗ подчеркивает нашу общую политическую волю и готовность сообща развивать тесное партнерство на благо здоровья граждан наших стран.

Развитие современного мира предъявляет особые требования к устойчивому развитию и безопасности любой страны, в основе которых лежит здоровое население. В этой связи вопросы здоровья населения и развития системы здравоохранения являются наиболее важными в деятельности правительства Казахстана. Казахстан поступательно выполняет решения, принятые на сессиях Ассамблеи и Исполкома ВОЗ, международных конференциях, и остается приверженцем своевременного достижения Целей тысячелетия в области развития к 2015 году. Анализируя основные показатели здоровья населения Казахстана, мы приходим к выводу, что наблюдается поступательное улучшение медико-демографической ситуации, возрастает рождаемость, снижаются показатели общей смертности, увеличивается динамично средняя продолжительность жизни. Необходимо отметить, что снизилось и бремя основных неинфекционных заболеваний, в том числе основной причины смертности населения Казахстана, - сердечно-сосудистых болезней. Что же касается основных задач, связанных с достижением Целей тысячелетия, по итогам в отношении сокращения младенческой смертности наблюдается динамичное снижение этого показателя, несмотря на то, что мы уже с 2007 г. перешли на показатели живорождений по критериям ВОЗ. Отмечается также значительное снижение показателя материнской смертности. На сегодняшний день он составляет около 30 на 100 000 живорожденных, что за последние 10 лет это фактически двойное снижение этого показателя. По шестому показателю ЦТР, по ВИЧ/СПИДу, этот вид заболевания оказывает серьезное влияние на сферу не только медицины, но и остальные аспекты жизнедеятельности населения, и надо признать, что задача достижения этого показателя пока остается не полностью выполненной, хотя в Республике действует Страновой координационный комитет, в который входят не только представители медицины, но и представители неправительственных организаций, ассоциации людей, живущих с ВИЧ, ряда международных организаций, в том числе и ВОЗ, Глобальный фонд для борьбы со СПИДом. Казахстан сегодня находится в стадии концентрированной эпидемии. По распространенности и уровню ВВП он относится к странам выше среднего уровня развития, а уровень бедности ниже, чем показатель Всемирного банка, и по новым критериям Глобального фонда Казахстан не попадает под классификацию Глобального фонда для выделения грантов. Но реальная ситуация несколько иная. Остается проблема уязвимых слоев населения. Среди потребителей инъекционных наркотиков, работников некоммерческого секса распространенность ВИЧ остается высокой, также имеется тенденция роста передачи ВИЧ половым путем. Серьезной проблемой для здравоохранения Казахстана остается проблема распространения туберкулеза с множественной лекарственной устойчивостью. Лечение этого вида туберкулеза требует огромных финансовых и человеческих затрат, недостаточных для страны сегодня, и продолжение сотрудничества с Глобальным фондом в этих условиях было бы весьма актуальным и важным. Казахстан оперативно отреагировал на последствия финансового кризиса и приступил к реализации решительных мер, связанных с улучшением качества медицинской помощи населению. С 2010 г. внедряется новый принцип организации национальной системы здравоохранения, ориентированный на результат и оплату фактических расходов на оказание медицинской помощи. Значительно увеличились ассигнования правительства, фактически за пять лет они утроились. Внедряется принцип свободного выбора врача, медицинской организации, внедряются стимулы для охраны человеком собственного здоровья. Организуется принцип солидарной ответственности гражданина за охрану здоровья. В целях реализации стратегии развития Казахстана до 2020 г. и Целей развития тысячелетия в настоящее время разработан проект государственной программы развития здравоохранения Казахстана на 2011-2015 годы. Целью новой госпрограммы является дальнейшее укрепление здоровья граждан Республики Казахстан и формирование эффективной системы здравоохранения для обеспечения социально-демографического развития страны, основанной на сильной системе ПМСП. В проекте госпрограммы предусмотрены меры по

законодательному, инвестиционному, структурному, экономическому и кадровому усовершенствованию системы охраны здоровья с учетом необходимости межсекторального взаимодействия. В целях эффективного мониторинга достижения конечных результатов разработаны более 70 целевых показателей и показателей оценки деятельности организации здравоохранения Республики.

Г-н Председатель,

В заключение позвольте подчеркнуть, что центральное место в любой системе здравоохранения занимают кадровые ресурсы, которые играют ключевую роль в укреплении здоровья населения. Число и квалификация медицинских работников позитивно сказываются на эффективности проводимых медико-санитарных мер. Вместе с тем, и сами работники здравоохранения подвергаются серьезным рискам и опасностям. Низкий уровень заработной платы, недостаточное признание в обществе, слабые возможности для карьерного роста и другие факторы способствуют миграции внутри страны и за ее пределами. Эти примеры иллюстрируют, что решение проблем лежит и в других секторах экономики и социальной сферы. Нужны системные усилия по динамичному решению проблем медицинского образования кадров. Правительство Казахстана надеется на укрепление равноправного сотрудничества с ВОЗ и другими партнерами как на региональном, так и на глобальном уровнях, а также намерено усилить инвестиции в здоровье и построение более безопасного будущего.

В заключение позвольте подчеркнуть, что в XXI веке роль сектора здравоохранения в мировом развитии будет только возрастать, и мы уверены, что сможем внести свой вклад в устойчивое и динамичное развитие национальной системы здравоохранения и достижение основной цели развития тысячелетия.

Благодарю за внимание.

El Sr. OLESKER (Uruguay):

Buenos días. El Gobierno actual del Uruguay ha asumido hace aproximadamente tres meses con una continuación del primer gobierno de izquierda del Uruguay que, a partir del año 2005, emprendió un programa global cuyos dos objetivos eran el crecimiento económico y la redistribución de la riqueza.

Sobre la base de que es posible, al mismo tiempo, que la economía crezca y redistribuya su riqueza y romper el crecimiento concentrador y excluyente que el país había tenido en los años noventa, fruto de las políticas neoliberales, se planteó un objetivo central, que fue desarrollar un cambio en la distribución de la riqueza. Para ello, las políticas sociales son muy importantes, y desarrolló una política social que hemos denominado un «nuevo Estado de bienestar»: la construcción de un «nuevo Estado de bienestar» basado fundamentalmente en la participación del Estado. Recordemos que, en los años noventa, la política social había sido trasladada al mercado y solamente se generaban acciones focalizadas tendientes a resolver los problemas de mayor y de extrema pobreza. La visión de un Estado presente en el conjunto de la política social, un incremento presupuestal, que llegó a duplicar el presupuesto en términos reales para las políticas sociales, y la participación ciudadana en la gestión y dirección de las políticas sociales fueron los criterios de este «nuevo Estado de bienestar» o «Estado de bienestar de nuevo tipo», como llamamos al modelo que estamos construyendo en el Uruguay.

Para ello se hicieron al mismo tiempo cinco reformas sociales que modificaron los criterios políticos de determinación de ellas: la reforma de salud, a la que inmediatamente me voy a referir; la reforma de la educación; la reforma del sistema de protección social, basado en un nuevo régimen de asignaciones familiares y de jubilaciones; la reforma tributaria, cambiando el criterio de un país que no tenía impuesto a la renta, donde no se pagaba por la renta personal, a un sistema que incorporó el sistema a la renta personal sobre la base del criterio de que pague más quien tiene más; y, finalmente, en quinto lugar, luego de la desregulación laboral de los años noventa, la reconstrucción de las leyes de protección al trabajo y, en particular, una ley de negociación colectiva que obliga a la determinación de los salarios en todos los ámbitos empresariales en el marco de una negociación obrero-patronal.

Es en esa perspectiva que introducimos nosotros la reforma de salud y los resultados del primer gobierno que están a la vista. Se bajó la pobreza de 32% a 20%, la indigencia de 4% a 1,6%, la tasa de desempleo de 15% a 7%, teniendo el menor registro histórico del país. Se recuperaron los salarios reales en un 25% y al mismo tiempo el índice de Gini, el elemento que determina la concentración o la distribución, bajó un 7%, de 45,3% a 43,2% o 0,432. Esta propuesta de crecimiento y redistribución al mismo tiempo tuvo entonces una reforma de la salud con cuatro principios, hoy ya cumplidos: la universalidad (todos tienen acceso a la salud); la justicia social (de cada quién sus ingresos a cada quién sus necesidades, todos aportan en función de su ingreso); basado en la atención primaria de salud (APS); y con participación social, no solo en la parte comunitaria, sino en la conducción. En efecto, el organismo que dirige la reforma de salud tiene usuarios, trabajadores y empresas en su representación.

Tenemos resultados que podemos transmitir a ustedes con mucha convicción. La tasa de mortalidad infantil hoy es de 9,5 por 1000 nacidos vivos, es decir, hemos pasado la barrera de los dos dígitos. La tasa de mortalidad materna ha bajado y queremos anunciar que el número de muertes provocadas por aborto en condiciones de riesgo es de cero, fruto de una política de iniciativas sanitarias que protege, digamos, del aborto en condiciones de riesgo.

Y todo esto en un contexto de cuatro programas que queremos transmitir, como los programas que este segundo gobierno de izquierda, para continuar la reforma de salud iniciada, va a desarrollar: un programa de fortalecimiento de la salud de la niñez, a través de un programa de nutrición y un programa de control de los primeros meses de vida, con visita domiciliaria obligatoria, al que hemos denominado NICO (Nacimiento e Infancia con Control Obligatorio) para todos los prestadores de salud públicos y privados. En segundo lugar, un programa centrado en la adolescencia, que tiende fundamentalmente a continuar la obra del programa de la niñez y que tiene como eje central el tema de las adicciones y el tema de la salud mental, que en ese tramo etario es muy relevante. En tercer lugar, un programa de salud sexual y reproductiva, con una ley aprobada en el país, que obliga a tener clínicas de salud sexual en todos los prestadores de salud y a la distribución universal y gratuita de anticonceptivos. Finalmente, metas asistenciales que se pagan a los prestadores de salud por el cumplimiento de ciertos objetivos en materia de control de salud de los niños y control del embarazo. Eso nos ha llevado a una baja, como expliqué, de la tasa de mortalidad infantil y tasa de mortalidad materna.

Será una gran tarea de este segundo periodo de gobierno de izquierda de Uruguay, un gran programa de salud rural para llevar la salud a los medios más alejados del interior del país, donde todavía algunos de estos derechos que yo anunciaba no han llegado. El programa de salud rural se ha transformado en la prioridad número uno de esta segunda gestión de gobierno. En este sentido, queríamos transmitir estos elementos a ustedes, tener el convencimiento de que, con los niveles actuales que tenemos de mortalidad infantil y mortalidad materna, vamos a llegar en 2014 a los Objetivos del Milenio sin ninguna duda, en la medida que mantengamos, y esa ha sido la decisión política del Gobierno, esta política basada fundamentalmente en la promoción y prevención de salud, con población prioritaria en niñez, adolescencia y mujer. Muchas gracias.

M. MOSSO RAMOS (Cap-Vert):

Monsieur le Président, Mesdames et Messieurs les Ministres, Mesdames et Messieurs, pauvre en ressources naturelles et avec une histoire jalonnée de catastrophes naturelles liées à des sécheresses cycliques, le Cap-Vert a accédé à l'indépendance il y a 35 ans. Grâce à l'effort persévérant de son peuple, à une gouvernance éclairée et sérieuse et avec l'aide de la communauté internationale, le Cap-Vert a réussi un processus de développement intégré qui s'est traduit par l'amélioration du niveau de vie de la population, par l'élévation progressive du revenu par habitant qui est passé de US $200 par an à plus de 2000 aujourd'hui et par l'accroissement de son indice de développement humain. Ces paramètres qui ont contribué à la progression de mon pays dans la catégorie des pays les moins avancés en 2008.

Les indicateurs concernant les secteurs de la santé et de l'éducation reflètent le mieux les progrès enregistrés par mon pays depuis son indépendance. D'une situation de presque désert sanitaire avec un taux de mortalité infantile de 108 pour 1000 naissances vivantes en 1975, il s'est construit un

service national de santé décentralisé et opérationnel qui a réussi, entre autres, à réduire cette mortalité à environ 20 pour 1000 et la mortalité maternelle autour de 14 pour 100 000 naissances vivantes, cela grâce à un programme de protection maternelle et infantile fondé essentiellement sur la prévention. Plus de 80 % des accouchements ont lieu dans des institutions sanitaires assistés par du personnel professionnel. Plus de 75 % de la population a accès en moins de 30 minutes à une structure de santé. Le taux de prévalence du VIH/sida est estimé à 0,8 %. Une enquête réalisée en 2009 a montré que 94 % des enfants de moins d'un an sont vaccinés contre la rougeole et la poliomyélite. Bref, dans le domaine de la santé comme dans d'autres aussi, le Cap-Vert est bien parti pour atteindre les objectifs du Millénaire pour le développement en l'an 2015.

Il faut savoir cependant que, malgré les progrès enregistrés, le Cap-Vert est vulnérable, qu'il s'agisse des risques d'épidémies, de changements climatiques, du crime international organisé ou de la conjoncture économique mondiale. En effet, tout peut être mis en cause compte tenu de la fragilité de ses fondements économiques. C'est ainsi que l'année dernière, une épidémie due au sérotype 3 de dengue a touché plus de 21 000 personnes, provoqué quatre décès, semé la peur et affecté l'économie du pays.

Le Cap-Vert a besoin de l'aide de la communauté internationale pour poursuivre son développement et atteindre de nouveaux paliers de progrès irréversibles. Dans le cas spécifique de la santé, secteur fondamental pour sa croissance, les besoins en ressources sont de plus en plus grands. Pour ne citer qu'un exemple, le Cap-Vert finance avec ses propres ressources le Programme élargi de vaccination. Jusqu'à l'année dernière, le calendrier vaccinal comprenait sept vaccins : contre la tuberculose, la poliomyélite, l'hépatite B, le tétanos, la diphtérie, la coqueluche et la rougeole. La décision, prise cette année, d'inclure d'autres antigènes dans le Programme, parmi lesquels les vaccins contre l'*Haemophilus influenzae* B, la rubéole et la parotidite, implique une multiplication par trois des coûts, ce qui est extrêmement difficile à supporter par un pays comme le nôtre qui ne bénéficie d'aucune aide d'organisations s'occupant de ce type d'activités. D'autre part, suite à l'épidémie de dengue, nous sommes obligés d'admettre le risque imminent d'une épidémie de fièvre jaune au Cap-Vert, étant donné que le vecteur existe dans toutes les îles et que la maladie est endémique dans les pays voisins. Ainsi, nous pensons lancer une campagne de vaccination de la population et introduire le vaccin antiamaril dans le calendrier du Programme élargi de vaccination.

Enfin, le Cap-Vert, comme d'autres pays, subit le double fardeau des maladies transmissibles et non transmissibles et doit prendre ses responsabilités aussi bien vis-à-vis de ses citoyens que par rapport aux recommandations des organisations internationales responsables de la santé. Pour cela, il faut des moyens importants que le pays ne pourra pas mobiliser tout seul. Mais la vérité est que le Cap-Vert ne bénéficie pas de toute l'aide dont il a besoin. Et cela parce que nous ne réunissons pas les critères d'éligibilité comme d'autres pays plus riches en ressources naturelles qui sont acceptés. En fait, ce qui est paradoxal, c'est que mon pays est pénalisé car il présente des indicateurs socio-économiques qui sont le résultat d'une gestion judicieuse de son développement. S'il est permis de se défendre contre cette situation dans ce forum, nous voulons demander que les critères considérés soient révisés pour une question de justice. Je vous remercie de votre attention.

Dr DALIL (Afghanistan):

Mr Vice-President, respected ministers, distinguished delegates, ladies and gentlemen, first of all, I would like to congratulate the President on his election to preside over the Sixty-third World Health Assembly, and to wish him success in this important assignment.

I am delighted to report that investment in the health sector in Afghanistan over the last eight years is bearing results despite the enormous challenges. A decade ago, the health situation of Afghanistan was more than dismal; in early 2002, there were only a limited number of functioning primary health facilities across the country. In fact, one woman died of pregnancy-related causes every 27 minutes. This meant that every week about 370 families became motherless, which was tantamount to a death sentence for small children in Afghan society. Similarly, high maternal mortality, poor nutrition, inadequate hygiene, illiteracy, poverty, and a lack of modern health care combined to produce one of the highest infant and child mortality rates in the world; in 2001, an estimated one in four children died before reaching their fifth birthday. Addressing the poor health status, Afghanistan

took effective strategic steps, including defining a basic package of health services aimed primarily at reducing mortality among rural women and children, and an essential package of hospital services for provincial and regional hospitals. Moreover, the Ministry took on a stewardship role and contracted out the delivery of primary health-care services to nongovernmental organizations. Furthermore, thousands of community-based midwives as well as community health workers were trained and deployed in their own communities. All this subsequently led to about a 25% reduction in child mortality over the past few years. Although we have presumably made progress on Millennium Development Goal 4, our progress on Goal 5 is not evident. All moves were bold and prudent, rationalizing the delivery of health services in a way that is unique in the world and entirely appropriate, given where Afghanistan was in 2002. However, we are still lagging behind global and regional set targets. There is a long way to go in improving the health situation of our country.

We believe that without an effective health system, no programme can be stable and successful. We have also learnt that building health-system elements should be addressed concurrently while the services are scaled up in a post-conflict environment. Currently Afghanistan is focusing on improving access, developing human resources for health, strengthening monitoring and evaluation, integrating health service delivery, and reforming administration and financing. We recognize the importance of the private sector for strengthening the health system. We would like to encourage and support it to expand its services to a wider range. We have significant experience of working with nongovernmental organizations through public–private partnerships and performance-based contract mechanisms, and we are looking forward to sharing it with countries of similar context.

Eradication of poliomyelitis is the biggest global public health initiative. Afghanistan is still one of the four endemic countries with wild poliovirus. We stand fully committed to this cause. His Excellency the President of Afghanistan has on many occasions in the country, and at international forums, expressed his commitment that eradication of poliomyelitis is a priority of our Government. We will do our best not to let conflict stand between our children and the vaccine against poliomyelitis, and to ensure community ownership and an integrated response in order to eradicate poliovirus. We are working for the days of tranquillity in the immunization rounds when our vaccinators can access every child and immunize each child safely. Let me reaffirm our commitment on behalf of the Government of Afghanistan for the eradication of poliovirus in the country, fighting to wipe out the last reservoir in Afghanistan.

I am happy to have shared our progress and challenges with this august gathering. We are thankful to the international community for supporting Afghanistan and that we have translated this support into life-saving critical gains. To keep the pace of progress and to maintain the gains, we are in need of additional and continued support from donors and partners. We are certain that progress in the health sector is an important factor for ensuring socioeconomic development, promoting peace and having a stable and prosperous Afghanistan. A stable and peaceful Afghanistan will nurture stability and progress in the region. Thank you very much.

El Dr. MANZUR (Argentina):

Señor Presidente de la 63.ª Asamblea Mundial de la Salud, señora Directora General, señoras y señores Ministros, distinguidos delegados, amigas y amigos: Hemos dado un paso significativo desde la última Asamblea. El año pasado en esta época, todos los países estábamos frente a la incertidumbre de un evento de salud pública internacional con potencial pandémico. Considero, que a diferencia del año pasado, hoy contamos con muchos más elementos e información, y esto se debe en buena medida a las diferentes iniciativas subregionales, regionales y globales, de foros como el UNASUR SALUD, la Organización Panamericana de la Salud y la propia OMS. En este sentido, nuestra Presidenta, la Dra. Cristina Fernández de Kirchner, ha priorizado la participación en los foros subregionales como MERCOSUR y UNASUR, y la propia participación y relación con los organismos internacionales. Asimismo, la mayoría de nuestros países ya han incorporado la vacuna pandémica. En mi país, a este momento se ha inmunizado ya a más de cinco millones de argentinas y argentinos.

Argentina, como otros países de la Región de las Américas, se caracteriza por tener un perfil epidemiológico en el que se presenta una doble carga de enfermedad. Por un lado debemos responder a las enfermedades transmisibles con la reemergencia de problemas milenarios como han sido la fiebre

amarilla y el dengue. Por otro lado, las enfermedades no transmisibles constituyen la principal causa de muerte en la actualidad, con un marco sostenido de su prevalencia en las últimas décadas.

Argentina se plantea actuar sobre estos dos frentes, con planes intensivos, integrales e intersectoriales de lucha contra las enfermedades no transmisibles, y sobre las transmisibles con la promoción de pautas y estilos de vida saludables, así como con la creación y puesta en marcha de un Instituto Nacional del Cáncer.

En este contexto, consideramos que el mayor desafío que se nos plantea constituye la mejor manera de generar salud para todos los argentinos. Siguiendo las enseñanzas de Alma-Ata, consideramos necesario continuar reforzando la promoción de la salud, involucrando a todas las personas y a las comunidades en el desarrollo de pautas saludables de vida para el cuidado de su propia salud.

Durante la última década, Argentina ha tenido un mejoramiento de los indicadores de salud. En este sentido, podemos mencionar algunas buenas prácticas que hemos implementado y que nos permitieron abordar los Objetivos de Desarrollo del Milenio.

La provisión pública gratuita de medicamentos, que hemos llamado REMEDIAR, ha permitido que los medicamentos esenciales estén en el primer nivel de atención de todos los centros de salud y de atención primaria de la Republica Argentina. Esto ha permitido que 15 millones de personas, incluidas madres y niños vayan a los centros de salud teniendo la certeza de que van a tener acceso al ácido fólico, al hierro, así como a otros medicamentos esenciales para su atención.

A partir de un programa que hemos implementado de médicos comunitarios se formó y se dispuso del recurso humano en salud necesario para atender a la población. El Programa Nacer, que centra su atención en el binomio madre e hijo, propiciando el cumplimiento de los controles durante el embarazo, la asistencia perinatal y el monitoreo de la vacunación de los niños. Argentina ha considerado que para promover la equidad sanitaria es necesario abordarla como una cuestión de justicia social, abordando las cuestiones socioeconómicas. Por eso, la Presidenta Fernández de Kirchner ha implementado una asignación de U$S 45 por cada hijo de desocupado y de empleado no registrado con bajos salarios.

Los Objetivos de Desarrollo del Milenio nos han enseñado que, cuando formulamos objetivos concretos orientados a los problemas sociales y de salud de la población, podemos constituir alianzas estratégicas y desarrollar marcos de cooperación adecuados.

En Argentina hemos adoptado un enfoque de determinantes sociales de la salud, basado en la territorialidad, intersectorialidad e interjurisdiccionalidad, planteando que hay que desplegar respuestas múltiples y combinadas en cada localidad, planteando esfuerzos de empoderamiento y transferencia que buscan sacar a una población de la vulnerabilidad y el letargo, poniéndola en pie para afrontar los problemas de su comunidad.

Considerando la importancia que tiene el contar con sangre segura para los servicios de salud, hemos iniciado un intenso trabajo promoviendo la donación. En este sentido, Argentina ha sido reconocida para ser sede del Día Mundial del Donante de Sangre para el año 2011, siendo la primera vez que un país de las Américas se constituye como sede para este evento.

Siguiendo las enseñanzas obtenidas a partir de los Objetivos de Desarrollo del Milenio, nos propusimos retomar el camino de la planificación, formulando planes y proponiéndonos resultados concretos, y en este sentido el Ministerio de Salud ha dado un paso concreto en sus esfuerzos para lanzar un nuevo Plan Federal de Salud.

Hemos adoptado metas de manera que reflejen las circunstancias y las prioridades de desarrollo, incorporándolas en las políticas nacionales de salud con su apropiación por parte de los niveles provinciales y con el desafío de lograr estrategias de trabajo intersectoriales. Muchas gracias.

Mrs CABRAL (Philippines):

Excellencies, ladies and gentlemen, good morning. At the outset, allow me to congratulate the President on his election. Rest assured of the Philippine delegation's support as you lead us towards a successful outcome of this Sixty-third World Health Assembly.

The Government of the Republic of the Philippines remains fully committed to achieving its targets under the Millennium Development Goals by 2015. The global economic and financial crisis

notwithstanding, the country has persevered in its efforts. Our Department of Health has taken bold steps to reform the health system, focusing on service delivery, regulation, financing and good governance. In the course of our efforts to meet the health-related Millennium Development Goal targets, several key challenges have been identified, and these are being urgently addressed by the Government, through the Department of Health: first, the challenge of reducing maternal, infant and child mortality rates across the regions in our country, across wealth quintiles and between rural and urban areas; secondly, the challenge of balancing population growth with family planning; thirdly, the challenge of mobilizing adequate resources for the public health sector in order to make health services accessible and affordable for all Filipinos; and lastly, the challenge of effectively coordinating national and local government efforts, so as to forge synergies and partnerships among relevant stakeholders, including the private sector, towards achieving the Millennium Development Goals.

Despite these challenges, the Philippines is working hard to meet its commitments under the Millennium Development Goals. We have refused to be hamstrung by limited resources, choosing instead to fund critical health programmes aimed at making an impact on the reduction of maternal, infant and child mortality rates all across the country. Under the Maternal Neonatal and Child Health and Nutrition policy, resources have been put into upgrading the capacities of village health facilities, enabling them to provide basic emergency obstetric and neonatal care, even in remote areas.

We are pushing for the recognition of adequate family planning services as an important tool to achieve the health-related Millennium Development Goals. We have also directed resources for public health programmes such as tuberculosis, malaria and HIV/AIDS, encouraging the active participation of local government units in these health programmes through the Province-wide Investments for Health. At the same time, we have continuously engaged the private sector and civil society in helping craft policies, enhancing service delivery and ensuring good governance. To address the health needs of the poor, our National Health Insurance Program is working for the universal coverage of the indigent population, while the prices of essential drugs and services are being regulated to ensure quality and affordability. Poverty reduction programmes such as the Conditional Cash Transfer Program, also aim to improve the poor's utilization of basic social services such as health and nutrition, while also helping poor women gain access to reproductive health, family planning and maternal health information.

The international community is at an important crossroads in fulfilling the Millennium Development Goals. Five years on, we will be looking back at what we have accomplished and will assess whether we had done enough to uphold our peoples' right to health. We hope that when that time comes, we can all say that we did our utmost. Despite the odds, we are one with all stakeholders in sustaining and enhancing current efforts, while looking for new avenues to improve the efficiency of our services. We must be united in a concerted effort to uplift our respective countries which have lagged behind in the attainment of the Millennium Development Goals. The Philippines thus joins the call to all Governments to increase political and financial commitments to meet the Goals. Five years may seem like a short time for many, but it also represents boundless opportunities to either make or break our efforts. We fervently hope that all of us will make the most of the remaining time we have. Thank you Mr Vice-President and *Mabuhay*!

Ms JURÁSKOVÁ (Czech Republic):

President, colleagues, ladies and gentlemen, the Czech Republic attaches great importance to achieving the Millennium Development Goals defined in the Millennium Declaration of 2000 and reaffirmed at the United Nations World Summit in 2005. At this Summit, the international community again expressed its determination to eradicate extreme poverty, its causes and consequences. We are well aware of how much remains to be done to achieve the Millennium Development Goals, notably in reducing child mortality, improving maternal health, combating HIV/AIDS, malaria and other diseases. I believe that the United Nations General Assembly High-Level Plenary Meeting on the Millennium Development Goals in September of this year will be an opportunity to bring even more coherence to the current initiatives that are taking place around the world, at a national, regional and international level. The global economic and financial crisis has significantly affected economic and social progress achieved during recent decades. Those devastating impacts are being felt worldwide –

both in the developed and developing countries. In the developing countries, the reversed impact is particularly worrisome. Therefore, the consequences of the crisis reinforce the need for particular attention to those Millennium Development Goals and to those regions where the least progress has been made.

The Czech Republic is particularly concerned about the fact that in sub-Saharan Africa, close to 50% of all children and mothers die during pregnancy and delivery. The Czech Republic, as a European Union Member State, holds the firm belief that the Millennium Development Goals and other internationally agreed development goals will not be achieved unless the right to attain the highest standard of reproductive health is promoted and protected. We need to acknowledge that, while certain progress has been made, this right remains unfulfilled for too many women and young girls with devastating and far-reaching consequences. A key factor affecting the progress in achieving the Millennium Development Goals and sustainable development is also education. The reduction of sickness and mortality rates, the empowerment of women, improvement of the quality of the labour force and promotion of democracy can be largely assisted by progress in education. In other words, universal access to education is fundamental to the achievement of internationally agreed development goals, including the Millennium Development Goals.

In conclusion, let me assure you that the Czech Republic, as a European Union Member State, is fully aligned with the European Union's commitments to intensify development assistance, adopted in 2008 and reaffirmed in 2009. The Czech Republic also fully supports the European Union's multi-sectoral approach to combating poverty, which should not be perceived solely in economic terms but also in the broader context of social, environmental and health issues. Thank you for your attention.

The PRESIDENT:

Ladies and gentlemen, it is time to adjourn this morning's session. The meeting is adjourned.

The meeting rose at 12:05.
La séance est levée à 12h05.

FIFTH PLENARY MEETING

Tuesday, 18 May 2010, at 14:45

President: Mr Mondher ZENAIDI (Tunisia)
later: Dr R. SEZIBERA (Rwanda)

CINQUIÈME SÉANCE PLÉNIÈRE

Mardi 18 mai 2010, 14h45

Président: M. Mondher ZENAIDI (Tunisie)
puis: Dr R. SEZIBERA (Rwanda)

1. INVITED SPEAKERS
INTERVENANTS INVITÉS

The PRESIDENT:

The Health Assembly is called to order. Good afternoon, ladies and gentlemen. The Health Assembly will now take up consideration of item 4 of the agenda, Invited speakers. It is an honour for me to introduce our first invited speaker at this Sixty-third World Health Assembly, Her Excellency, Ellen Johnson Sirleaf, President of the Republic of Liberia.

President, Johnson Sirleaf has led a distinguished international career spanning nearly four decades, and began her career in banking and economic and financial management in 1965. In 1992, the President joined the United Nations Development Programme in New York as Assistant Administrator and Director of its Regional Bureau of Africa with the rank of Assistant Secretary General of the United Nations. In 2003, Ellen Johnson Sirleaf returned to Liberia and was elected President of Liberia in January 2006. In 2007, President Johnson Sirleaf was awarded the prestigious Presidential Medal of Freedom. More recently, in April 2010 President Johnson Sirleaf graciously accepted to be the honorary President of the Women's Health Commission for the African Region. Distinguished delegates, please join me in welcoming the President of the Republic of Liberia.

(Applause/Applaudissements)

It is with pleasure that I invite Her Excellency to go to the rostrum. Madam President, you have the floor.

Mrs Ellen JOHNSON SIRLEAF (President of the Republic of Liberia):

Distinguished delegates, Dr Chan, Director-General, other officials of the World Health Organization, ladies and gentlemen. I am here today to join you in asserting that people should not have to die, simply because they are poor. I am here to join in saying that people should not die because treatments common in the rest of the world are not available where they live. I am here today

because I believe that a child should not have to die because a parent has to make the impossible choice between feeding her family, or taking her sick child to the clinic that could have saved her life.

I am delighted, and honoured, to speak to you this morning. Dr Chan, I thank you and I welcome the opportunity to address this important event in the international calendar. WHO has long been an institution of global significance. If anything, it has become ever more vital as the world moves into the twenty-first century.

Pandemics can spread without passports. Diseases don't stop at national borders or checkpoints. Improving the health of our people is not only of fundamental importance to our nations and our citizens themselves; it also has crucial economic and geopolitical implications that reach far beyond the narrow interests of any one country. In a globalized planet, the world's health has to be a shared responsibility. As we face up to the challenge of achieving our Millennium Development Goals, as we strive to save the lives of women and children, and tackle the deadly impact of malaria, of HIV and AIDS, events such as today's Health Assembly help us face up to and shoulder that responsibility together. Because success will make a fundamental difference not only to my country and its people, but also to Africa, the developing world and the planet as a whole.

My message today is simple: individually, and collectively, we are making progress towards achieving the Millennium Development Goals, but we are not making that progress fast enough. To achieve our ambition, we must continue our work together towards improving the health systems of our countries. We must also do more together to remove the barriers that stand in the way of people taking advantage of those systems.

Fourteen years of war will damage a country in multiple ways. In the case of Liberia, my country, the impact of the civil conflict on the country's health system was particularly severe. In 1989, Liberia had 800 practising doctors. By 2003, we had just 50. Clinics and hospitals across the country were destroyed. Even the roads needed to allow people to travel to the few facilities that survived lay in ruins. Less than half our population had access to medical care of any sort! Today, we have renovated and built new clinics, midwifery schools and health training centres. With support from the Swiss Development Corporation, we have renovated and reactivated one of our major rural referral hospitals and a second one is nearing completion with support from China. We have improved general referral services and access to medicines across the country; and we have more than quadrupled the number of facilities offering comprehensive and emergency neonatal care.

We are pleased to have established our "Basic Package of Health Services" in over 80% of the nation's health facilities, ahead of our target date. As a result, more people are receiving free services, and the simple standards set out in the Package give priority to the interventions that will have the greatest benefit to our nation's health. In tackling malaria, without a doubt our country's biggest health problem, we have tripled the distribution of free insecticide-treated bednets which has helped malaria prevalence fall by half in the four years to 2009.

The evidence from our health surveys suggests that we are seeing other results. Our current child mortality rate, for example, has fallen to almost 50% over the last few years. The latest Demographic and Health Survey, conducted in 2007, puts the overall child mortality at 72 deaths per 1000 live births as compared to the 2000 data of 132 deaths to 1000 live births. These are good signs. They show that we can make progress, however challenging the conditions we face.

Unfortunately, not all the news is so positive. The latest figures for maternal mortality in Liberia suggest that nearly one in 1000 women die even as they bring new life into the world – a sharp increase from previous years. This is a shocking statistic, and one reason why I became involved with the Women's Health Commission for the African Region – a WHO initiative, launched last month, in my capacity as Honorary President. The Commission is called upon to produce recommendations on what more can be done to reduce the unacceptable level of maternal mortality in our part of the world. We eagerly await its recommendations. We are also doing all we can to tackle the tragedy of mothers who are dying needlessly. As well as improving emergency obstetrics care and training more midwives to work where they are needed most, we have also adopted the "Reach Every Pregnant Woman" approach, which seeks to ensure that every pregnant woman across the country gets medical attention during pregnancy and delivers her baby at a health facility. We have seen the numbers at these clinics increasing, although the challenges remain awesome – especially as regards increasing

teenage pregnancy. Yet, we know that putting systems in place is not enough on its own. We must do more to allow and to convince our people to take advantage of such systems once they are available.

Distinguished ladies and gentlemen, over 90% of Liberians live on less that US$ 2 a day. In that grim statistic, they are not alone. Around the world, there are millions of people who have so little to live on that any costs required for treatment – no matter how low – are still far too high. That is why, in September last year, a group of countries, including Liberia, committed to extending the principle of free health care to more of our people. Alongside Burundi, Ghana, Malawi, Nepal and Sierra Leone and we announced new ways of allowing those who most need medical help – especially those who are targeted by the Millennium Development Goals – to get the health care they need without having to pay up-front.

Sierra Leone, our neighbouring country, just last month, launched its new programme aimed at mothers and children. Early reports of a huge increase in patients at clinics point to just how many people were not getting the treatment they needed before, simply because of the cost. In Liberia's case, last year I committed to making permanent our temporary suspension of user fees and to providing free health care for all, depending on the continuing support of adequate donor finance to make this possible. Offering free health-care services at all public health facilities has significantly increased out-patient attendance across the country. Similarly, expanding access to health care by building more clinics and health facilities in areas that were previously underserved is making a big difference. In addition, we now have more trained health workers and have implemented various policies aimed at ensuring that health care is equitable.

I understand that there is still debate around the merits of removing user fees – and we must make sure that we go about doing so in the right and sustainable way. But, equally it is clear to me that the people who are least able to pay for their care should not be the ones forced to do so. The implication is clear: often such people simply do not have the money to pay. And often they die as a result. Of course, free health care costs money. If user fees are not to be charged, the money has to come from somewhere.

The initiatives I mentioned were made possible thanks to over US$ 5 billion of investment developed by the High-Level Task Force on Innovative International Financing for Health Systems launched in September 2008 by the former United Kingdom Prime Minister Gordon Brown and World Bank President Robert Zoellick. UNITAID, championed by former French Foreign Minister, Philippe Douste-Blazy, is one of these innovations. In three years UNITAID has raised more than US$ 1 billion to provide life-saving treatments for HIV/AIDS, malaria and tuberculosis patients around the world. These diseases contribute to the death of over 4.5 million people every year. More than 70% of UNITAID finances come from a solidarity levy on airline tickets. Eleven member countries impose the levy today, with others agreeing to contribute in the future. The result of their innovation is that 10 million more women and children will get the medical care they need to save their lives.

We recognize that since the 2000 Millennium Declaration, the total development assistance for health has more than doubled, and this has saved countless lives. The fact remains, however, that more money is still needed if we are to achieve the Millennium Development Goals. It goes without saying that we must use the money that is currently available more efficiently. We have to make the most of every dollar already found, or to be found in the future. We have to target it where it will make the most difference and ensure that our systems are as effective and accountable as they can be.

There is, at the same time, the need to allocate more money – money that needs to come from domestic sources, prioritizing where necessary, but also from our international partners and the various sources of international aid – so that a reliable flow of funds can be targeted at those areas that need change. The stark fact is that unless more is done, and done quickly, some of the Millennium Development Goals could end up being nothing more than well-intentioned ambitions that, ultimately, do not achieve all that they have set out to attain.

My goal, our goal, your goal, must be to do more than this. It must be to build on the good work already done. It must be to continue working together at events like today's to ensure that our mothers, our sisters, our children will not have to pay the price for failure today with their lives tomorrow. You are at the front line of all that we do. You identify the challenges. You lead the change. You make the sacrifices. For that we salute you and I thank you.

(Applause/Applaudissements)

The PRESIDENT:

Thank you very much, Madam President. On behalf of the Health Assembly, I express our sincere thanks for your address today. It is an honour for the Health Assembly to have you here and to hear your views.

I am now very pleased to welcome, on behalf of the Health Assembly, Mr Ray Chambers, the United Nations Secretary-General's first Special Envoy for Malaria. Mr Chambers is a philanthropist and humanitarian, and has been serving as Special Envoy since February 2008. In his capacity, he has committed to achieve the Secretary-General's goal of ensuring universal access to malaria prevention tools in all countries in which the disease is endemic by the end of 2010, with the ultimate goal of achieving near zero preventable malaria deaths by 2015. Most of his other efforts have been directed towards children. He is the Founding Chairman of the Points of Light Foundation and co-founded, with Colin Powell, America's Promise Alliance. Mr Chambers is Co-Founder of the National Mentoring Partnership, and Founding Chairman of both The Millennium Promise Alliance and Malaria No More. Mr Chambers is a member of the President's Council on Service and Civic Participation. It is with pleasure that I invite Mr Ray Chambers to go to the rostrum.

(Applause/Applaudissements)

Mr Chambers, you have the floor.

Mr Ray CHAMBERS (United Nations Secretary-General's Special Envoy for Malaria):

Mr President, Director-General Dr Margaret Chan, Excellencies, ladies and gentlemen, it is an honour and a privilege to have been invited to speak before you today. Just three years ago, you took the decision to create a World Malaria Day to be celebrated on 25 April each year. The following year, in 2008, the Secretary-General of the United Nations, Mr Ban Ki-moon, appointed his first Special Envoy for Malaria. Soon after, he called for all people at risk of malaria to be provided with preventive, diagnostic and treatment measures by the end of 2010 and an end to deaths from malaria by 2015. At the time many thought this overambitious.

As you know, there has been tremendous progress, as recorded in WHO's most recent *World malaria report* presented last December here in Geneva. Thirty-eight countries have recorded declines in cases and deaths by over 50% since 2000; nine of these are in sub-Saharan Africa. The health ministers who have demonstrated such leadership in this fight are to be congratulated.

Of course, this did not happen just because of activities since the Secretary-General's call. However, that call, and its immediate endorsement by the Chair of the African Union, led to a dramatic increase in funding available for malaria. This was primarily from the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank and the United States President's Malaria Initiative as well as from the United Kingdom and other bilateral partners, the Bill & Melinda Gates Foundation, UNITAID, UNICEF and members of the private sector. These commitments, as well as increases in funding from endemic countries themselves, allowed for the rapid scale-up of WHO-recommended malaria-control interventions, primarily in sub-Saharan Africa. The active work of the Roll Back Malaria Partnership under the leadership of Professor Awa Marie Coll-Seck ensured continued advocacy and the development of the comprehensive Global Malaria Action Plan.

The efforts and resources have largely been focused on sub-Saharan Africa to date. Why this focus? As you all know, 85% of the world's malaria cases are found on the continent as well as 90% of the deaths, most of those among children under five years of age. These tragic deaths are entirely unnecessary as the tools exist to prevent them.

In my role of Special Envoy, I concentrate on advocacy, the mobilization of resources, and helping to remove any obstacle in a country's path to achieving the universal coverage target. In order to do this well, my own experience from business tells me that communications have to be brief, focused and clear. We, therefore, used the bednet as the symbol of an action that was immediately

understandable to the lay person, affordable and doable. In the United States we started a campaign to raise both awareness and funds, based on the slogan "US$ 10 buys a net, saves a life." This was picked up in popular television programmes, by many nongovernmental organizations and professional associations and created what the media people call a "buzz" around malaria – particularly that controlling it was achievable. It was extraordinarily successful. By the end of 2009, nearly US$ 4 billion had been committed to the fight against malaria. In 2009 alone, nearly US$ 1.5 billion was disbursed. Much of the funding did indeed go to nets, but by no means all. Much was spent on the life-saving antimalarials – the artemisinin-based combination therapies – as well as on diagnostics and indoor residual spraying. While this increase in funding has been dramatic, we are still far short of the approximately US$ 5 billion per year that is required to scale up these effective tools.

Thirty months ago it was estimated that 700 million people were at risk from malaria in Africa. WHO estimated that one bednet for every two people would be needed to achieve universal coverage. That meant 350 million long-lasting insecticide-treated bednets – approved by WHO's Pesticide Evaluation Scheme – had to be procured and distributed, which would require a tremendous effort from manufacturers, national malaria programmes, and partners involved in distribution and communications. The response has been terrific, and today I can say that over 325 million nets have already been financed, 93% of the originally calculated need. Over 200 million of these have been delivered to countries, and most have either been distributed or are in the process of distribution. The remaining nets are either in the production queue or being delivered.

Therefore, despite the doubts of some, the Secretary-General's goal will be met as far as the delivery of nets is concerned. In its 2009 *World malaria report*, WHO demonstrated that in countries that have achieved high coverage with nets and other malaria-control interventions, the decline in malaria cases and deaths that follows is dramatic, often exceeding 50%. WHO has also shown that in a number of countries, the benefits go beyond malaria, and extend to sharp reductions in overall child mortality. For many countries, the control of malaria will enable the achievement of the Millennium Development Goal of child survival, Goal 4. These declines have the potential to ease the pressure on medical facilities in countries in which the disease is endemic. I witnessed this myself last August when I travelled to Zanzibar, in the United Republic of Tanzania, along with the WHO Director-General – Dr Chan – and Dr Tachi Yamada of the Bill & Melinda Gates Foundation. The 12-bed paediatric ward of the main hospital was empty! Apparently, up to two years before it had been overflowing, often with two children to a bed. These results were achieved through the widespread availability of effective treatment with artemesinin-based combination therapy, the universal distribution of nets, and universal indoor spraying. I know many of you are thinking about the optimal deployment of nets and indoor spraying with a range of insecticides. Clearly a comprehensive approach to control the malaria vector is required to make further gains as well as sustain our current efforts. We must also take care to deploy these and newly developed insecticides and contain the spread of resistance as we will need a full arsenal of all effective insecticides for years to come.

Beyond prevention with nets and spraying, the scale-up of other malaria-control interventions is accelerating, but still lags far behind. Yet there is good news on this front. With regard to treatment, the number of WHO quality artemisinin-based combination therapies has increased and their price has dropped significantly from what it was a few years ago. Nevertheless, we are still seeing the overuse of oral artemisinin monotherapies, and this is dangerous as it may foster resistance to the best available medicines against malaria.

Resistance to artesunate was reported in 2009 at the Thai–Cambodian border, where artemisinins have been used alone as monotherapies for many years, especially in the private sector. When treated with an oral artemisinin-based monotherapy, most patients feel well after two to three days and, for this reason, discontinue treatment. Since they do not take the seven days of treatment required with oral artemisinin-based monotherapy, they may remain with persistent parasites in their blood. Without a second drug given as part of a combination (as is done with artemisinin-based combination therapy), these resistant parasites survive and can be passed on quickly to a mosquito and then another person. These monotherapies are therefore the primary driving force behind the development of resistance by the malaria parasite to artemisinins.

As Dr Chan and Dr Newman, the Director of the Global Malaria Programme at WHO, have stated, the widespread availability of artemisinin monotherapies is one of the most dangerous threats

to our collective efforts. If resistance to artemisinins develops and spreads to other large geographical areas, as has happened before with chloroquine and sulfadoxine-pyrimethamine, we could have a public health disaster. There are currently no alternatives to these life-saving antimalarial medicines, and there will not be one for the treatment of falciparum malaria in the near future.

It is, therefore, imperative that oral artemisinin-based monotherapies be rapidly removed from the market, as was called for in the 2007 Health Assembly resolution on this issue. Progress has been made, but not fast enough. There are at least 37 pharmaceutical companies still involved in the production and marketing of oral artemisinin-based monotherapies, and 29 countries that allow the marketing and use of these compounds. The time has now come for all nations to band together and halt this practice once and for all. Before it is too late.

On the positive side, we have seen a rising use of rapid diagnostic tests which have become increasingly reliable. The increasing availability of quality-assured tests allowed WHO to recently recommend that all persons with suspected malaria receive a diagnostic test prior to the treatment of confirmed cases. Through the use of diagnostic tests, health-care workers are able not only to target artemisinin-based combination therapy to those who actually need it, but also determine which patients have other causes for their fevers – such as pneumonia – and to treat them appropriately. The universal use of diagnostics therefore has the potential not only to diminish the unnecessary use of artemisinin-based combination therapy, and, therefore, save money, but also to improve the treatment of febrile illness, and contribute to continued improvements in child survival.

I know that all of you are deeply committed to building health systems in your countries. I also know that many of you have watched, likely with some amusement, the debate among donors and partners on whether or not to focus on health systems, or whether to control disease. I know you have no choice but to do both, and of course the two are inseparable. There is no doubt in my mind that malaria interventions have boosted health systems development. Whether it is in lowering stress on the system (as in Zanzibar), providing commodities that lead to a more integrated approach to treating sick children (as in Zambia), supporting the development of community health cadres to link communities with health services (as in Ethiopia and Rwanda), or delivering malaria-control services through accredited social health activists (as in India), controlling and reducing malaria has had a remarkably positive and rejuvenating impact on health systems. This can and should go much further. In my visits to countries in which malaria is endemic, health ministers have always reminded me that malaria is a major cause of poor pregnancy outcomes, including maternal mortality. Many countries have programmes targeted at preventing pregnant women from getting malaria. However, this objective should be more assertively pursued. One idea may be to ask local religious leaders to ensure that each couple getting married receives a bednet. Just as WHO has reported a decline in cases and deaths from malaria in many countries, the same tools could be used to reduce the number of complications in pregnancy and child birth in malaria-endemic countries and reduce further the burden on health systems.

I have not yet touched on another issue: the burden malaria puts on the economy. In the past, several figures have been quoted for the annual burden for sub-Saharan Africa. These range from US$ 12 billion to US$ 30 billion. Whichever is more accurate, the economic burden is tremendous. Heads of State and ministers of finance have been keen to see this burden reduced. The recently formed African Leaders Malaria Alliance is currently composed of 27 Heads of State who are particularly concerned about this. They want to see an end to malaria being such a drag on their economies. Three weeks ago, at an event at the World Bank in Washington DC, the Bank's President, Bob Zoellick, and the finance ministers of the Democratic Republic of the Congo, Kenya and Zambia all spoke to this. They see the fight against malaria as an investment, not a cost. I recognize in the audience today someone you know well, Joy Phumaphi, the former Minister of Health of Botswana, who is the interim Executive-Secretary for the Alliance.

On a personal note, I want to thank Dr Chan and her colleagues, particularly Dr Nakatani, Dr Newman, and staff of the Global Malaria Programme, as well as the Regional Director for Africa, Dr Luis Sambo, for their unwavering support to my mission to help achieve the goals set by the Secretary-General. I know they have been struggling for resources, but I can witness the impact of their work. They deserve your increasing financial support as they systematically improve the tools to track, prevent, diagnose and treat malaria and, with that, make a contribution to global health that goes

far beyond the impact on malaria alone. The WHO report I have cited is just one example of the work that is done, much of it away from the glare of publicity. You can be justifiably proud of the way they serve you and your countries.

To conclude, I would like to highlight a number of required actions as we move forward. First, we cannot let up now. We need to sustain the gains and finish the job. This will mean securing stable financing and diversifying the funding base, including with greater domestic commitments. There needs to be greater dialogue between health ministers and finance ministers, particularly with evidence on the return on investment. I cited the recent announcement at the World Bank of an additional US$ 200 million investment with the participation of three African finance ministers. Another recent example is Nigeria's groundbreaking allocation of domestic and debt relief resources to procure and distribute 10 million nets and to invest resources in managing a decentralized malaria programme in the 37 states. As a businessman, I see why finance ministers are captivated by their malaria investments. It is a concrete investment that delivers measurable financial and human returns. The more the linkages between the two ministries can be strengthened, the more confident I am, not only in our ability to finance our existing efforts, but also importantly, in our efforts to continue that financing and avoid a catastrophic resurgence.

Secondly, we need to replace nets as they wear out, closing the gap between net ownership and usage (which is already narrowing but needs sustained advocacy and communications). Thirdly, we must continue to scale up diagnosis, treatment and, importantly, surveillance for malaria. Finally, it is critical that we insist on the banning of the use of oral artemisinin-based monotherapies, and increase our vigilance regarding parasite resistance to antimalarials and mosquito resistance to insecticides.

There is also the hope of new tools on the horizon. For the first time, a malaria vaccine is in the midst of phase III trials in seven countries. In 2015, there will be sufficient data for WHO to review regarding its safety and efficacy, and to make a recommendation regarding whether it should be added to the armamentarium of existing malaria-control tools. Further research is also needed on new insecticides, diagnostics and antimalarial medicines.

Excellencies, progress has been rapid and palpable. We have seen how the Secretary-General's ambitious call is turning into reality. The possibility of having such a positive impact on so many millions of people only comes to us rarely, perhaps once in a lifetime. I am determined to keep the focus so that we will see the impact clearly on reaching the Millennium Development Goals on maternal health, child health, and malaria. If we do that we will also have a major impact on reducing poverty and dramatically improving lives and productivity in malaria-affected countries. The results are within reach but they require determination and constancy to achieve and sustain them. I look to the Health Assembly to monitor this and ensure success. Thank you once more for this opportunity to address you.

(Applause/Applaudissements)

The PRESIDENT:

Thank you very much, Dr Chambers. On behalf of the Health Assembly, I wish to express our appreciation for sharing with us your thoughtful words.

This concludes our consideration of item 4 of our agenda. I would now like to request that delegates remain seated for a few minutes while the Director-General and I bid farewell to our guests. Thank you.

2. ADDRESS BY THE DIRECTOR-GENERAL (continued)
ALLOCUTION DU DIRECTEUR GÉNÉRAL (suite)

The PRESIDENT:

Distinguished delegates, the Health Assembly will now resume its consideration of item 3 of the agenda, concurrent with the third meeting of Committee A. The first two speakers on my list are Congo and Mongolia. May I invite them to the rostrum. I give the floor to the delegate of Congo.

Le Professeur MOYEN (Congo):

Monsieur le Président, Madame le Directeur général, distingués délégués, Mesdames et Messieurs, c'est un honneur pour moi de prendre la parole du haut de cette tribune à la faveur de la Soixante-Troisième Assemblée mondiale de la Santé pour vous présenter la situation sanitaire du Congo. Le Congo, à l'instar des autres pays africains, est caractérisé par des indicateurs sanitaires préoccupants, rendant difficile la réalisation des objectifs du Millénaire pour le développement d'ici à 2015. Pour faire face aux défis qui se présentent à notre système de santé, le Gouvernement congolais, avec à sa tête M. Denis Sassou N'guesso, a pris une série de mesures visant à infléchir les tendances actuelles, à savoir : gratuité de la vaccination systématique dans le cadre du programme national de vaccination ; gratuité du traitement antituberculeux en 2000 ; gratuité du traitement antirétroviral en 2003 ; gratuité du traitement antipaludique pour les enfants de 0 à 15 ans et chez les femmes enceintes en 2008, traitement couplé à la distribution de moustiquaires imprégnées d'insecticide à l'occasion des semaines de santé mère-enfant et lors des campagnes de vaccination intégrée ; gratuité des examens biologiques pour le VIH/sida depuis 2009.

Depuis 2008, nous avons élaboré la feuille de route nationale pour accélérer la réduction de la mortalité maternelle, néonatale et infantile. Sa mise en œuvre a débuté en 2009, renforcée par la mise en place d'un comité de pilotage, d'un comité technique aux niveaux national et départemental, ainsi que de l'Observatoire des décès maternels. À propos de la vaccination, le Congo déploie, sur fonds propres et depuis plusieurs années, des efforts importants qui ont permis l'acquisition régulière des vaccins traditionnels du programme national de vaccination et l'organisation de campagnes de vaccination contre la poliomyélite ; ainsi, malgré les menaces d'importation du poliovirus sauvage, le pays est resté exempt du virus depuis l'an 2000. Avec l'appui des partenaires, notamment l'Alliance mondiale pour les vaccins et la vaccination (GAVI), mon pays a aussi pu acquérir des vaccins sous-utilisés tels le vaccin antiamaril et le vaccin pentavalent, et de nouveaux vaccins tel le vaccin antipneumococcique.

La morbi-mortalité infantile est aussi liée à certaines maladies dont la drépanocytose contre laquelle les premières dames d'Afrique, dont l'épouse du chef d'Etat du Congo, ont engagé une lutte depuis quelques années. En effet, la drépanocytose, dans sa forme homozygote, touche près de 2 % de la population congolaise, et à peine deux enfants sur cinq dépassent l'âge de cinq ans. Les maladies non transmissibles telles que les cancers, les maladies mentales et autres, pour lesquelles les ressources limitées entravent le traitement et la prévention, méritent aussi une attention particulière. Tous ces efforts ne pourront donner des résultats significatifs sans le renforcement du système de santé dans son ensemble. C'est pourquoi, avec l'appui des partenaires, le Gouvernement a mis en place un programme de développement des services de santé qui s'articule autour des points suivants : renforcement du cadre institutionnel et juridique, renforcement des ressources humaines et des capacités de gestion en vue d'assurer une couverture sanitaire totale dans les structures publiques et privées confessionnelles, remise en état et équipement des centres de santé et des hôpitaux de référence, et, enfin, renforcement du paquet de soins essentiels permettant une amélioration qualitative et quantitative des prestations. À terme, nous envisageons de mettre en place une couverture sociale fondée sur la solidarité avec une contribution de l'Etat, ce qui va augmenter le pourcentage du budget de l'Etat alloué à la santé, lequel est actuellement de 7 %.

Tel est le contenu synthétisé du message de mon pays, la République du Congo, qui est engagé à œuvrer pour une intégration sous-régionale et régionale en faveur du système sanitaire. Nous savons compter sur l'appui constant de l'OMS, sous le leadership de Mme le Directeur général, pour atteindre

nos objectifs. Je ne saurais terminer mon propos sans vous féliciter Monsieur le Président et les autres membres du Bureau pour votre élection. Je vous remercie.

Mr LAMBAA (Mongolia):

Good afternoon, Mr President, Director-General, excellencies, distinguished guests, ladies and gentlemen, in order to ensure the successful implementation of the Millennium Development Goals as set out by the United Nations at the beginning of the new millennium, the Parliament of Mongolia defined and approved its own Mongolian-specific "Millennium Development Goals" and "Millennium Development Goals-based Comprehensive National Development Policy". I am grateful for the opportunity given to me to speak about the implementation of the four health-related Millennium Development Goals.

First, with regard to the Goal of reducing the under-five mortality rate by two thirds between 1990 and 2015, the infant mortality rate in Mongolia per 1000 live births has dropped from 64.4 in 1990 to 20.2 in 2009, while the under-five mortality rate per 1000 live births has dropped from 88.8 in 1990 to 23.6 in 2009, both of which reflect a significant reduction. Mongolia has long implemented programmes that target child survival in collaboration with WHO and other international organizations, including the Child Survival Programme, the Maternal and Child Health Programme, the Integrated Management of Childhood Illnesses Programme, the Preventing Childhood Malnutrition Programme, the Micronutrients and Vitamin Deficiency Programme and the Expanded Programme on Immunization. As a result of these programmes, the percentage of the under-five mortality rate caused by preventable diseases has significantly decreased.

Secondly, with regard to the Goal of providing access to required reproductive health services to all individuals of appropriate age, and reducing the maternal mortality rate by three quarters between 1990 and 2015, the Government is currently implementing the State Policy on Population Development, the Third National Reproductive Health Programme, and the second generation of the Strategy to Reduce Maternal Mortality. As a result of these policies and strategies, maternal mortality rates in Mongolia have shown a steady decline since the 1990s. For example, the maternal mortality rate in 2008 was 48.6 per 100 000 live births, which reflects a 250% decrease (in one year alone) compared to statistics in 1990. However, the maternal mortality rate in 2009 experienced a dramatic increase (81.4 per 100 000 live births) as a result of the 17 deaths from pregnancy complications caused by the pandemic (H1N1) 2009. On this note, I would like to express my sincerest gratitude, on behalf of the Government of Mongolia, to WHO for its invaluable assistance in the fight against the pandemic influenza. In order to substantially reduce the maternal mortality rate, the Government of Mongolia has already carried out several major initiatives, such as establishing a monitoring and evaluation framework for the implementation of the Strategy to Reduce Maternal Mortality 2005–2010 and revising the National Strategy to Improve Maternal and Child Health Care to further intensify implementation. In addition, the Government needs to improve medical management and personnel skills of these facilities to provide comprehensive, accessible and good-quality maternal health-care services, and to introduce medical approaches of an international standard in the medical technology and laboratory capacity of these facilities that are applicable to national specifics. Moreover, the health-sector response capacity in times of emergency and disaster-related situations should be significantly improved by setting up a fund for essential medicines and medical supplies, establishing a nationwide prenatal and neonatal care centre, and extending the existing maternity care houses in the rural areas. The Government has been paying due attention to ensuring that the salaries of health professionals have increased, that incentive mechanisms for health professionals have been revised and updated, and that the social welfare services for health professionals have also been guaranteed. It is also important for my Government to target rural and poverty-stricken women who constitute the biggest risk group for maternal mortality, by carrying out intersectoral activities.

Thirdly, with regard to the Goal of combating sexually transmitted diseases and HIV/AIDS, the Government is committed to increasing its efforts to improve HIV/AIDS preventive activities and to limit the prevalence of this disease by 2015. There have been 71 registered cases of HIV infection and HIV/AIDS-related deaths in Mongolia since 1992. In comparison to other countries in the world, the prevalence of HIV/AIDS in Mongolia is quite low. However, closer attention needs to be paid in this

area, as Mongolia's only two neighbours are countries with high prevalences of HIV/AIDS. This effectively puts Mongolia in a high-risk position.

Finally, with regard to the Goal of combating tuberculosis, the Government has committed to reducing the prevalence of tuberculosis by 2015. Tuberculosis accounts for 10.8% of all registered infectious disease cases in Mongolia. Due to the introduction of international standards in diagnosis and treatment, as outlined in the National Agenda for Fighting Tuberculosis, the success rate of tuberculosis treatment has increased to approximately 85%. From 1990 to 1995 there were 119 registered cases of tuberculosis-related mortality. However, this number dropped to 78 between 2002 to 2008. My Government is paying close attention to reducing the prevalence of multidrug-resistant tuberculosis, and provides free treatment for tuberculosis by covering all-related medical expenses for treatment. This policy approach has been one of the main reasons for the significant decrease in the rate of tuberculosis infection in Mongolia.

With cooperation from other governments, nongovernmental organizations and the public, the Government will align the necessary funding with the desired Millennium Development Goal targets, improve the capacity of monitoring and evaluation, improve the effectiveness of the projects being implemented in the rural areas, provide more access to information for the general population, and expand the advertisement campaign for these health issues in order to achieve the Millennium Development Goals. The Government of Mongolia firmly believes in achieving greater health for the Mongolian people and greater development and prosperity in the health sector through close cooperation with United Nations specialized agencies, especially WHO and its Member countries. Thank you very much for your attention.

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

The leadership of WHO, as the world's foremost public health body, is as important as ever. We need WHO if we are to minimize the risks to health from the global financial crisis and tackle the range of health security threats. A healthy population is of course essential to prosperity, security and stability. In contrast, poor health does more than damage the economic and political viability of any one country – it is a threat to the economic and political interests of all countries. I would like to thank the Director-General for her continued leadership and her address that focused on the Millennium Development Goals. I believe that we have a real opportunity to make a difference this week in making progress towards achieving the Goals.

We are pleased to hear of the progress that is being made in reducing child mortality. But we need to strengthen our efforts. We want to ensure that every pregnancy is wanted, every birth is safe and every newborn child is healthy. We must work together to ensure all countries have effective health strategies and strong health systems in this regard.

Each country must decide how to finance its own health system. We support the approach taken by some countries of making critical services free at the point of use for the poorest. This removes a significant barrier for poor people, especially women and children, in accessing health care when they need it most. It is one of the four pillars of the Global Consensus for Maternal, Newborn and Child Health launched during the United Nations General Assembly in New York last September.

We continue to support the Executive Board's resolution to accelerate progress on Millennium Development Goal 4. And here I would like to highlight the importance of the United Kingdom-led resolution on preventing and treating pneumonia, which is coming up later on our agenda. Pneumonia kills more children than any other illness in the world and reducing deaths from pneumonia is crucial if we are to reach Millennium Development Goal 4.

The busy agenda in front of us reminds us of the breadth of work that the WHO Secretariat and its Member States are engaged in – and I would like to pay tribute to the hard work and dedication of the staff. With resources becoming even tighter, it is important that WHO is able to prioritize its work, and we very much welcome the consultation paper that the Director-General recently published, and look forward to playing our part in helping to develop this paper further and implementing it in due course. Thank you, Mr President.

Dr PATSALIDES (Cyprus):

Mr President, allow me to congratulate you and the Vice-Presidents on your election and convey my wishes for a successful and productive Health Assembly. Mr President, Madam Director-General, distinguished colleagues, delegates, first of all, I would like to align myself with the statement made by the Spanish Presidency on behalf of the European Union.

Our focus this year is particularly timely given that we are only five years away from the set target date for achieving the Millennium Development Goals. The fact that the world is in the midst of an economic crisis makes it even more imperative to evaluate now the progress achieved towards that end and ensure that during our national and international efforts to recover from the economic recession, we will not divert our attention from the common commitment of achieving the Goals, no matter how difficult it might be.

Health care and health-related issues were not left untouched by the crisis. Obviously, vulnerable groups are the first to be affected in such situations. Thus, special attention should be paid to monitoring the social determinants of health and reducing health inequalities. Equal opportunities in access to health care are a priority and as such must be promoted through the increased cooperation of all actors involved at the local, national and international levels. After all, a healthy population is both the way to achieve economic prosperity and a key factor for development and economic growth. The way to achieve this is through establishing and maintaining effective health systems. We all know that in order to keep health systems on track a strong sense of direction is necessary, combined with coherent investment in the various building blocks of the health system, so as to provide the kind of services that produce results.

The economic recession is already affecting developing and less developed countries. WHO and the international community in general must be ready to provide maximum assistance to those in need with a view to reducing the impact of the recession on vulnerable populations. Promoting the health-related Millennium Development Goals is a vital prerequisite in efforts to reduce poverty and promote sustainable development, which in turn provides stability and above all healthy societies in all aspects.

Indeed, some progress has been achieved in improving children's nutrition and reducing child mortality, yet a lot more has to be done. In the same vein, a lot of work should be directed towards reducing the unacceptable levels of maternal mortality and improving women's and children's health in many countries. In this respect, Cyprus would like to welcome the WHO report, *Women and health*.

More positive signs are to be observed in the efforts to combat HIV/AIDS, malaria, tuberculosis and other diseases. The Government of Cyprus places high importance on this specific issue and pledged at the end of 2009, despite the challenges posed by the current economic crisis, to support UNITAID, an initiative the importance of which has already been mentioned by the keynote speaker, Her Excellency the President of Liberia. The Cypriot support for UNITAID amounts to an annual contribution of € 400 000 for a period of six years, the largest-ever contribution committed to a specific development initiative by the Cypriot Government.

At the same time, we do recognize that joint concerted action and attention should be directed towards addressing the upward trend of noncommunicable diseases, and we note with appreciation the priority given by the Director-General to this growing health burden. We hope that the action plan for the global strategy for the prevention and control of noncommunicable diseases will prove to be a constructive first step and that the effective implementation of the global strategy will provide an effective tool in combating these diseases.

The last year could be described as a historic one with regard to international public health. We all had to face a common threat – a common challenge. The outbreak of pandemic (H1N1) 2009 has clearly indicated the leading role that WHO has to play in coordinating and managing the global response to health threats. We managed to overcome this crisis with good global cooperation under WHO's leadership. However, there are a lot of lessons to be learnt out of it. The pandemic has demonstrated the usefulness of the International Health Regulations (2005) and provided an opportunity for assessing and evaluating their performance in cases of emergencies. We thus welcome the respective initiative of the Director-General to convene the Review Committee on the Functioning of the International Health Regulations (2005). The experience of the recent pandemic re-established

that indeed viruses do not recognize borders and in this respect an effective response cannot be achieved without international cooperation.

The Millennium Development Goals are mutually reinforcing and closely interconnected and interrelated. They are not a unilateral matter and they cannot be accomplished independently. Progress towards the attainment of the health-related Millennium Development Goals directly affects, and is directly influenced by, progress in the whole framework. International commitment and international cooperation were necessary prerequisites for agreeing on the Goals back in 2000. Equally, and even more importantly, international commitment and international cooperation are necessary prerequisites for achieving them.

The PRESIDENT:

Thank you. I now give the floor to the delegate of Guyana, who will speak on behalf of the Caribbean Community.

Dr RAMSAMMY (Guyana):

Mr President, Director-General, colleagues, all. It is good to be here again and see all of you. At this Sixty-third World Health Assembly, we do have much to be thankful for. We do agree with you, Director-General, that progress in human development has taken place. There can be no doubt that we live longer lives. These can be no doubt that children are protected far more from many diseases than they were previously because we can almost guarantee children access to life-saving vaccines and medicines. There can be no doubt we have reduced maternal and child mortality. We agree that we ought to be thankful. But we cannot yet celebrate because these achievements are uneven within countries and between countries. Equity has been pursued, but we are far from achieving equity in our world. There are still too many communities and too many countries where we are far from achieving longer lives and protecting our children. There are still too many children and poor people who are lacking life-saving medicines, life-saving interventions and who are still undernourished.

This Health Assembly is taking place at a time when the world system continues to wobble under one of the severest economic crises in history. The consequences are still quite severe especially for small developing countries, whose economies are subject to the vicissitudes of external trade and global financial systems that undermine the fabric of social and economic development. We urge that responses by developed countries and multilateral aid agencies to the present economic crisis do not repeat the mistakes of the past, highlighted by the type of structural adjustments for developing countries that led to health deterioration. It is for this reason that on behalf of the 15 member countries of the Caribbean Community which I represent today, I commend the vision illuminated in the address of Dr Chan, WHO's Director-General, in the opening plenary. She highlighted the need for horizontal and vertical approaches, on placing emphasis on coherence and complementarity of programmes, and on targeting the poor as primary beneficiaries of public health services. We in the Caribbean Community fully endorse the clarion call for investing in public health to save lives. We do not make a distinction between health and development, and we have pursued development from the perspective that health is wealth.

As we approach the accountability date of 2015, the focus of the Sixty-third World Health Assembly on the Millennium Development Goals is not only appropriate but pertinent to the intricate links between health and development, as articulated in the Report of the Commission on Macroeconomics and Health, endorsed by this Health Assembly seven years ago. A preliminary assessment of progress towards the implementation of the Goals overall suggests that Member States of the Caribbean Community are on track to meet most of the targets, in particular the Millennium Development Goals 4, 5 and 6, which relate to health.

The recent earthquake in Haiti does pose a tremendous risk for Haiti and we urge that Haiti be provided with the support it needs to meet the Millennium Development Goals, together with her sister nations of the Caribbean Community. In spite of the Haiti setback, the Caribbean Community is proud of its achievement in further reducing child and maternal mortality and undernutrition. We are proud of the gains made in the fight against HIV/AIDS, tuberculosis and malaria.

One of the major reasons for the reduction in child mortality in our region is the proud record of universal access and coverage for life-saving vaccines. Countries provide between 12 and 15 vaccines for children in our region today. Within the last two years, several countries have introduced rotavirus and pneumococcus vaccines, and several are now introducing human papillomavirus vaccines. We believe that vaccines for children must not be negotiable and we share the concern of the Director-General regarding the withholding of vaccines from children because of the reckless doubts about vaccine safety. Countries of the Caribbean Community have pledged to follow a "no child left behind" policy for children's vaccines.

The countries of the Caribbean Community are concerned that, even as we make progress in combating several intractable and poverty-inducing public health scourges, there are others that are threatening to overwhelm us. One such threat is the growing pandemic of noncommunicable diseases. We are proud of the efforts within our region and we appreciate the support from WHO and from other countries to ensure that the challenge of noncommunicable diseases is appropriately addressed. And now with leadership from the Caribbean, we are poised for a Special Session of the United Nations General Assembly on noncommunicable diseases in September 2011. We urge that this opportunity be explored to ensure that a global instrument is crafted for an effective response to noncommunicable diseases.

Mr President and colleagues, we wish to also highlight the great neglect that still characterizes the global response to mental illnesses. At the very least, more than 10% of the disease burden in our region is accounted for by mental illnesses. Globally, WHO estimates a disease burden of more than 14% for mental illnesses. We commend the work of WHO in closing the mental health gap to assist in building capacity in developing countries.

The countries of the Caribbean Community comprehend the benefits of coherence and complementarity to which the Director-General referred. It was after all the Community working with PAHO that became the first region in the world to eradicate smallpox, held the first summit of Heads of Government on the noncommunicable diseases in the world, established the Pan Caribbean Partnership against HIV/AIDS (PANCAP), the first regional network comprising governments, the private sector, nongovernmental organizations and international partners in a network aimed at an accelerated approach to HIV/AIDS, which has been recognized by the United Nations as an international best practice. It is a region that established a CARICOM Single Market (CSM) in 2005 and is moving towards achieving a single market and economy by 2015. This is the flagship of our coherence as the Caribbean Community region.

With the objective of coherence and complementarity, the Member States of the Caribbean Community are engaged in transitioning five regional health institutions into one Caribbean Public Health Agency between 2010 and 2014. This enterprise, referred to as CARPHA, will become fully functional one year ahead of 2015, the benchmark year for the Millennium Development Goals. This is significant because it augurs well for providing the institutional framework to support the technical and operational systems to guarantee the effective outcomes of the health-related Millennium Development Goals.

The Caribbean Community has created a charter, the Charter for Cooperation in Health, the CCH. In the Nassau Declaration of 2001, the Heads of Government established the Charter as an instrument for functional cooperation.

What underscores initiatives such as CARPHA, PANCAP and CCH is the importance of establishing and building partnerships through functional cooperation – regionally, in the hemisphere and internationally – to enhance human capacity, and to mobilize resources to sustain these initiatives. We see functional cooperation as a necessary part of development. In this regard, we are grateful for the support of the Canadian Public Health Agency in assisting us in establishing CARPHA, for the United States' Government and the President's Emergency Plan for AIDS Relief, for the efforts of Cuba to help build capacity for health-care delivery. We are grateful for support received from the United Kingdom of Great Britain and Northern Ireland, the European Union, the World Bank and the Global Fund to fight AIDS, Tuberculosis and Malaria.

Such functional cooperation must be enhanced as our countries confront the severe human resource constraints in health. The Caribbean Community joins our colleagues from Africa and other developing countries to urge for a more ethical recruitment practice by recipient countries for our

nurses and other health-care providers, and we support WHO in the development of a code of practice for recruitment of health-care providers.

Moreover, the Caribbean Community is concerned about the possibility that Round 10 for the Global Fund will be limited, and we are concerned about the restrictions being placed on middle-income countries.

Finally, Mr President, while we were disappointed with the result from Copenhagen, WHO must continue to advocate for mitigation and adaptation interventions in response to the real threats of climate change. This is another area where the Caribbean is leading in advocacy and intervention. For example, Guyana's low-carbon strategy seeks to contribute to the adaptation programme of lowering carbon emissions. Guyana has been recognized for its championing role, and Guyana's President has been awarded a United Nations Environment Programme's Champions of the Earth Award for 2010.

The Caribbean development agenda, colleagues, is premised on the dream of long and productive lives for our citizens. We see functional cooperation with our sisters and brothers everywhere as the instrument to realize this dream. We see "health is wealth" as the basis for realizing this dream.

Professor HOTINEANU (Republic of Moldova):

Madam Director-General, ladies and gentlemen, in 2003, the Republic of Moldova identified the measures to be undertaken for fulfilling the principles of the Declaration and for achieving the Millennium Development Goals. Also, defined were the intermediate indicator levels to be achieved in 2006 and 2010. Indicator monitoring for infant mortality demonstrates that starting with 2000, the level of this indicator in the Republic of Moldova fell by 33.8%, constituting 12.1 cases per 1000 newborns in 2009. Thus, the Republic of Moldova had already achieved the goals for 2010 in 2008.

The mortality rate for children under five decreased by 38.3% during the period 2000–2009 and for the last four consecutive years has constituted about 14 cases per 1000 newborns. However, to achieve the 2015 goal, we still need to improve the quality of cooperation with other social partners (e.g. local authorities and social services). The level of maternal mortality in the Republic of Moldova over the last 10 years displays a sinusoidal curve. For the period 2000–2009, the number of childbirths under a qualified medical personnel's supervision constituted more than 99%. One of the reasons for the high level and unstable character of maternal mortality is the social factor, including late visits to a doctor determined by the migratory character of women's life as well as their work abroad. Monitoring of indicators for the achievement of the Millennium Development Goals relating to mother and child health reveals the risks that negatively impact the measures for achieving the Goals. These risks are as follows: the worsening situation related to pandemic (H1N1) 2009 and the consequences of the world financial crisis.

Despite the fact that the Republic of Moldova has taken a number of measures to improve control of HIV/AIDS morbidity and the tuberculosis mortality level, there has been an increase of these indicators' level. Thus, starting with 2000, the level of HIV/AIDS morbidity increased by 3.3 times, so achieving the goal of 9.6 cases per 100 000 of population by 2010 appears unrealistic. There is no evidence pointing to a positive trend with a decline in the tuberculosis mortality level. In 2009, this indicator constituted 17.9 cases per 100 000 of population. One of the burning issues of tuberculosis control is the high level of multidrug-resistant tuberculosis. In 2009, it accounted for 42.97% of the overall number of tuberculosis patients.

The Republic of Moldova is taking concrete measures to achieve the Millennium Development Goals. In 2010, it initiated the development of national programmes for 2011–2015, such as the National Immunization Programme and National Programmes on HIV/AIDS and tuberculosis prevention and control. However, without external support, particularly in the conditions of the economic crisis, our country will hardly achieve the Millennium Development Goals. In this respect the assistance offered by WHO, Global Fund to Fight AIDS, Tuberculosis and Malaria, and other external partners for development is especially appreciated. Thank you for your attention.

M. BOUDA (Burkina Faso):

Monsieur le Président, Mesdames et Messieurs les Ministres, honorables délégués, Mesdames, Messieurs, c'est un honneur pour moi de prendre la parole au nom du Burkina Faso devant cette auguste Assemblée à l'occasion de la Soixante-Troisième Assemblée mondiale de la Santé. Je voudrais tout d'abord vous féliciter, Monsieur le Président, pour votre brillante élection et le brio avec lequel vous dirigez nos travaux. Je voudrais ensuite faire une mention spéciale à Mme le Directeur général pour la clairvoyance avec laquelle elle dirige notre institution commune et l'attention particulière qu'elle accorde à l'Afrique.

S'agissant de la République de Chine (Taïwan), le statut d'observateur accordé à ce pays en 2009 répare en partie une injustice, et le Burkina Faso souhaite vivement que ce pays puisse accéder au statut de membre à part entière de l'OMS. Permettez-moi de relever également la pertinence du thème du débat général de cette session qui porte sur les progrès accomplis en vue de la réalisation des objectifs du Millénaire pour le développement (OMD) liés à la santé, à l'horizon 2015. En effet, il est tout à fait justifié qu'à cinq ans de l'échéance, nous nous arrêtions pour faire une évaluation du chemin parcouru et des efforts à fournir pour arriver au but.

Pour réaliser les OMD liés à la santé, le Gouvernement du Burkina Faso a adopté une nouvelle politique sanitaire nationale en 2000 ainsi qu'un plan national de développement sanitaire 2001-2010 dans lesquels les OMD liés à la santé occupent une place de choix. Les progrès accomplis par le Burkina Faso vers la réalisation des OMD peuvent se résumer ainsi qu'il suit : pour l'objectif 4, le quotient de mortalité infanto-juvénile est passé de 203 pour 1000 en 1998 à 141,9 pour 1000 en 2006, soit une baisse de 30 %. À ce rythme, le taux serait malheureusement encore de 72 pour 1000 en 2015. Pour l'objectif 5, le taux de mortalité maternelle est passé de 484 pour 100 000 naissances vivantes en 1998 à 307 pour 100 000 naissances vivantes en 2006, soit une réduction de 37 %. Pour l'objectif 6, on note un taux de séroprévalence du VIH à 1,6 % actuellement contre un taux de 7,17 % en 1997. Fin 2009, nous avons enregistré que 26 448 personnes infectées étaient sous antirétroviraux, soit 52 % de notre cible ; ces antirétroviraux sont gratuits depuis le 1er janvier 2010. Les résultats sont encourageants bien que le paludisme reste endémique et que le taux de détection de la tuberculose reste très bas. Ces résultats ont été atteints grâce à la mise en œuvre de mesures comme : la gratuité des soins préventifs en faveur de l'enfant et de la femme enceinte ; la subvention des accouchements et des soins obstétricaux d'urgence à hauteur de 80 % sur le budget de l'Etat ; la délégation des tâches pour les césariennes ; l'élaboration d'une politique nationale de nutrition avec son plan stratégique ; et, enfin, le développement de l'approche contractuelle en faveur des organisations non gouvernementales.

Dans le contexte de pauvreté globale de mon pays, un certain nombre d'obstacles freinent la réalisation des OMD. Pour y faire face, nous allons renforcer notre système de santé par : l'accroissement de la couverture en infrastructures sanitaires ; le développement des ressources humaines pour la santé ; la mise en œuvre des systèmes de partage des coûts de la santé ; et le renforcement de la nutrition par la mise en œuvre de la nouvelle politique nationale. Beaucoup d'initiatives et de partenariats ont été mis en place pour accompagner financièrement et techniquement la réalisation des OMD. Mon pays a bénéficié, entre autres, de l'initiative 20/20, de l'allègement de la dette des pays pauvres très endettés et de l'aide publique au développement. Nous continuerons le plaidoyer pour plus d'alignement et d'harmonisation de l'aide avec les priorités du Gouvernement. C'est dans ce sens que nous venons de signer au cours de cette Soixante-Troisième Assemblée mondiale de la Santé le pacte mondial du partenariat international pour la santé.

C'est pour moi l'occasion de remercier sincèrement tous les partenaires techniques et financiers qui nous accompagnent dans le développement de notre système de santé en général et dans la mise en œuvre des OMD en particulier. Pour le bien-être de son peuple, le Gouvernement du Burkina Faso est plus que jamais engagé à aller de l'avant pour réaliser l'ensemble des OMD en général et ceux qui sont liés à la santé en particulier. Je vous remercie de votre aimable attention.

Dr MYTNYK (Ukraine):
Д-р МЫТНИК (Украина):

Уважаемая г-жа Чен! Уважаемый г-н Председатель, уважаемые делегаты, дамы и господа,

Нас отделяют всего лишь пять лет до того момента, когда будет подведен итог усилиям мирового сообщества по достижению Целей тысячелетия в области развития, определенных Генеральной Ассамблеей ООН в 2000 году.

Сегодня вряд ли кто-нибудь станет отрицать, что основной мерой и критерием достижения основной цели развития является прогресс в отношении здоровья.

Для Украины целями развития в области здравоохранения являются: снижение детской и материнской смертности, снижение распространенности ВИЧ-инфекции/СПИДа и туберкулеза.

Президент и новое правительство Украины определили вопросы здравоохранения приоритетом своей социальной политики – начался процесс реформирования отрасли.

Динамика позитивных сдвигов в области здравоохранения и имеющиеся резервы позволяют нам с оптимизмом смотреть в будущее. Так, на протяжении последнего десятилетия в Украине наблюдается существенное снижение показателей детской и материнской смертности.

Однако несмотря на безусловные успехи, достигнутые в общественном здравоохранении нашей страны, в целом темпы прогрессивных изменений недостаточно высоки для решения в полной мере поставленных задач до 2015 года.

Продолжают вызывать серьезную обеспокоенность темпы распространения эпидемии ВИЧ/СПИДа в Украине. Начиная с 1987 г. в стране официально зарегистрировано более 161 000 случаев ВИЧ-инфекции. В 2009 г. было зарегистрировано наибольшее количество новых случаев ВИЧ-инфекции за весь период наблюдений – 19 840.

Несмотря на то, что усилия государства все еще не обеспечили кардинального перелома в борьбе с эпидемией, успехи на отдельных направлениях этой борьбы дают возможность предвидеть в будущем улучшение ситуации.

Сегодня в Украине профилактика передачи ВИЧ от матери ребенку является единственным профилактическим направлением деятельности, которое достигло значительных успехов. Начиная с 2003 г. уровень охвата добровольным тестированием на ВИЧ среди беременных женщин постоянно превышал 95%. Уровень охвата профилактическим антиретровирусным лечением женщин, которым в течение беременности был поставлен диагноз ВИЧ-инфекции, увеличился с 9% в 1999 г. до 92% в 2007 г. и до 95% в 2009 году. Результатом этой деятельности стало существенное снижение уровня передачи ВИЧ от матери ребенку с 28% в 2001 г. до 6,2% в 2007 году. Однако многое еще необходимо сделать для снижения уровня вертикальной трансмиссии ВИЧ, чтобы достичь уровня целевого индикатора для европейских стран – 2%.

Распространенность ВИЧ-инфекции среди населения в целом увеличивается. Число новых случаев ВИЧ, выявленных в течение календарного года, продолжает расти.

Для успешного противодействия эпидемии ВИЧ-инфекции/СПИДа, для того чтобы реально повлиять на уровень смертности в последние годы, продолжалось создание комплексной системы медицинской и социальной помощи тем, кто в ней нуждается. Чрезвычайно важными были, в частности, мероприятия, ориентированные на проведение беспрерывной антиретровирусной и заместительной терапии, лечения туберкулеза и вирусных гепатитов, уход и поддержку ВИЧ-позитивных пациентов.

Что касается улучшения здоровья матерей, то в Украине наблюдалось снижение материнской смертности с 25 на 100 000 живорожденных в 2000 г. до 15,5 на 100 000 живорожденных в 2008 году. Мониторинговые данные позволяют сделать вывод о прогрессе для достижения поставленной цели.

Благодаря реализации программ планирования семьи и защиты репродуктивного здоровья уменьшилось число случаев материнской смертности, связанных с абортами.

Позитивным является уменьшение доли осложненных родов (с 68% в 2000 г. до 40% в 2008 г.) и увеличение доли нормальных родов, при которых риск для жизни и здоровья матери и ребенка является наиболее низким.

Положительные сдвиги на пути сохранения здоровья матерей и уменьшения числа случаев детской смертности стали возможны благодаря таким мероприятиям в области охраны здоровья детей и матерей, как:

- внедрение современных перинатальных технологий;
- внедрение клинических протоколов оказания медицинской помощи матерям и детям, разработанных на основе доказательной медицины;
- внедрение мероприятий государственной программы "Репродуктивное здоровье нации" на период до 2015 года;
- отраслевая программа "Поддержка грудного вскармливания в Украине" до 2010 года;
- открытие Научно-практического медицинского центра детской кардиологии и кардиохирургии; и другое.

Привлекая ваше внимание к насущным проблемам Украины в отношении достижения Целей тысячелетия, хочу, как и мои коллеги, отметить, что решать эти проблемы приходится в непростых социально-экономических реалиях.

Основным условием достижения Целей тысячелетия мы видим усиление системы здравоохранения посредством ее реформирования при сохранении политических и экономических темпов процесса. Политическая элита и общество в целом должны помнить, что инвестиции в здравоохранение есть вклад в развитие человеческого потенциала.

В этом контексте мы продолжаем возлагать большие надежды на Всемирную организацию здравоохранения, оказывающую неоценимую поддержку государствам-участникам в осуществлении ими эффективной политики для достижения справедливости и прогресса в отношении здоровья.

Благодарю за внимание.

El Dr. UGARTE UBILLUZ (Perú):

Señor Presidente de la 63.ª Asamblea Mundial de la Salud, doctora Margaret Chan, Directora General de la OMS, señores Ministros y Ministras de Salud, señora Directora de la Organización Panamericana de la Salud, señores Representantes:

Reciban un saludo del Ministerio de Salud y del Gobierno del Perú que hacen votos por el éxito de esta 63.ª Asamblea Mundial de la Salud.

Como ha señalado la Directora General, uno de los principales objetivos de esta Asamblea es evaluar el avance hacia los Objetivos de Desarrollo del Milenio relacionados con la salud, sobre todo porque estamos a escasos cinco años para el cumplimiento del plazo que nos hemos propuesto todos los países del mundo.

El Perú viene realizando acciones sostenidas para alcanzar las metas propuestas, reafirmando el concepto de que salud es desarrollo, en el marco de un crecimiento económico continuo durante los últimos diez años y políticas redistributivas con programas sociales orientados a favorecer a los sectores más necesitados.

El Perú viene logrando resultados en la reducción de la desnutrición infantil, a partir de una estrategia de articulación de acciones de salud con otros sectores estatales a cargo de la nutrición, educación, empleo, etc. En 1992 la desnutrición crónica infantil era del 36% en menores de cinco años. Actualmente se ha reducido al 18% y esperamos llegar al 2015 con niveles aún menores. Ya hemos alcanzado la meta de reducción de la mortalidad infantil que el país se había propuesto. Como expresión de una vigorosa política de incremento del financiamiento, de inmunización, de control del crecimiento y desarrollo del niño sano y de promoción, prevención y tratamiento de las enfermedades diarreicas y respiratorias agudas, hemos pasado de una tasa de 57 por 1000 nacidos vivos a inicios de los años noventa a 18 por 1000 nacidos vivos en el año 2008, es decir menos de la tercera parte. Esto significa que hemos evitado 23 400 muertes infantiles cada año aportando a la sociedad peruana la

suma del conjunto de años de vida saludable de estos niños. Ahora queremos reducir aún más el promedio nacional y, sobre todo, acortar las diferencias entre poblaciones urbanas y rurales, así como entre poblaciones con mayores ingresos y menores ingresos. Para ello se han financiado y desplegado en las distintas regiones pobres del país brigadas de profesionales de la salud que nos permiten acceder a las regiones más distantes y más pobres, de manera que podamos llevarles las políticas sociales.

Recientemente la Encuesta Nacional de Demografía y Salud ha comprobado la reducción de la mortalidad materna, de 265 muertes por 100 000 nacidos vivos a principios de los años noventa a 103 en los últimos años. Podemos garantizar que llegaremos a nuestra meta antes del año 2015.

Además estamos profundizando el control de enfermedades transmisibles como la malaria, el dengue, el VIH/sida, la tuberculosis, la enfermedad de Chagas y otras, así como el manejo de enfermedades emergentes como la influenza A (H1N1) pandémica que pudimos controlar adecuadamente durante el año 2009. No tenemos poliomielitis desde el año 1991, no tenemos sarampión desde el 2001, no tenemos rubéola desde el 2006 y estamos próximos a erradicar la rabia humana transmitida por perros.

Para consolidar estos avances hemos iniciado el año pasado el aseguramiento universal en salud, eje de nuestra gestión y reforma fundamental del actual Gobierno, que garantiza el derecho de todos los peruanos y peruanas a acceder de forma oportuna a servicios de salud de calidad. También se ha dado inicio a la reforma del primer nivel de atención, reorientándolo a los objetivos de la atención primaria de la salud e impulsando el proceso de descentralización. Igualmente hemos impulsado la inversión en infraestructura y equipamiento que alcanzó el año 2009 niveles históricos jamás antes alcanzados. Asimismo, venimos impulsando una política de desarrollo de recursos humanos, y de acceso a los medicamentos y uso racional de estos, cuyo objetivo es reducir los precios, hacer un estricto control de calidad y favorecer el acceso de las grandes mayorías.

Para lograr estos objetivos, el Perú valora los espacios de articulación subregional, regional y mundial de salud como son las reuniones de Ministros de Salud del Área Andina, el espacio de UNASUR Salud creado en 2009, el invalorable apoyo de la OPS y por supuesto las orientaciones de la Organización Mundial de la Salud. Muchas gracias, señor Presidente.

El Dr. CHIRIBOGA (Ecuador):

Señora Directora General, ministras y ministros de los Estados Miembros, colegas y amigos: La adopción del modelo de desarrollo económico occidental está asociada con un cambio en el perfil epidemiológico de las llamadas sociedades agrícolas y preindustriales, esto es: resolver las enfermedades carenciales e infectocontagiosas, lo que se traduciría en un incremento significativo de la esperanza de vida; pero este modelo desarrollista, conforme avanza en su consolidación, se asocia con una transición - y finalmente una sustitución - hacia un perfil epidemiológico caracterizado por enfermedades crónicas no transmisibles, trastornos del comportamiento y problemas relacionados con la violencia.

Esta transición está determinada principalmente por cambios estructurales en el medio ambiente, altos niveles de estrés individual y colectivo, sedentarismo, consumo excesivo de calorías procedentes en gran parte de alimentos altamente procesados, con una carga importante de aditivos y toxinas, y un rápido proceso de deterioro del entorno natural debido a una relación extractiva con nuestro planeta.

El modelo de atención de salud prevalente en los países del sur sigue teniendo una fuerte carga curativa, asistencialista y, en general, no ha logrado consolidarse como modelo alternativo.

¿Por qué, a pesar de todos los esfuerzos iniciados desde hace más de 30 años con la Declaración de Alma-Ata, la mayoría de países del sur no hemos logrado despegar en el cambio hacia un modelo basado en la atención primaria de salud?

¿Será tal vez que en el frenesí de la carrera por el desarrollo no nos hemos detenido a meditar sobre el modelo de desarrollo que queremos realmente seguir?

¿Será acaso que el modelo de «desarrollo» pretende ser unidireccional, donde únicamente existen países más o menos desarrollados, de acuerdo a su ubicación en el continuo de una línea recta?

¿Existen modelos alternativos de desarrollo? Yo pienso que sí, y hago un llamado hacia un proceso de meditación profunda: podemos pensar en modelos alternativos de desarrollo que no

significuen una sustitución de las enfermedades infectocontagiosas por enfermedades crónicas, con su consiguiente incremento en la carga económica para el sector de la salud. Podemos también explorar alternativas de desarrollo más armónicas con nuestro planeta, con la inclusión social y económica de toda la población, donde se priorice la promoción y la prevención de la salud y el entorno, donde construyamos un medio ambiente que facilite y promueva la salud física y psíquica de los individuos y de la comunidad, bajo los principios de respeto, empatía y equidad, en la búsqueda de lo que en el Ecuador denominamos en kichwa el «sumak kawsay», que puede traducirse como el «vivir excepcional».

El Gobierno de la República del Ecuador precisamente se encuentra en este proceso, y luego de aprobar una nueva Constitución que coloca a la persona - y no a los intereses económicos - en el centro del modelo de desarrollo, ha concretizado este mandato duplicando el presupuesto para los programas sociales de salud, educación e inclusión económica en la búsqueda de ese «sumak kawsay», a pesar de la crisis económica global.

Este proceso también ha tomado en cuenta los Objetivos de Desarrollo del Milenio porque, en efecto, esos objetivos buscan superar situaciones intolerables de pobreza, exclusión, marginación, en fin, de violación de los derechos humanos; y por esa razón los ODM han sido parte de la estructura que nos ha permitido construir nuestro Plan Nacional de Desarrollo. Sin embargo este plan ha querido superar el formato de ser únicamente una lista de indicadores que deben ser medidos periódicamente, y quiere más bien transformarse en un instrumento que nos recuerde la palabra clave EQUIDAD; quiere que esos indicadores no solamente sean medidas rigurosas de cumplimiento, sino que se transformen en un instrumento que permita el DIÁLOGO con la comunidad; para que la búsqueda de la salud no se limite a la aplicación de un paquete de medidas y recomendaciones impuestas desde arriba, por un grupo de «expertos en desarrollo», sino que se transforme en un verdadero proyecto de so-ciedad.

Invitamos al mundo a unirse en procesos similares, invitamos a pensar en estos modelos alternativos de desarrollo donde se elimine ese enfoque bipolar; en modelos que pongan el centro de la atención en el ser humano y en este planeta que todos habitamos. Muchas gracias.

Mr ZVEKIC (Serbia):

Mr President, excellencies, ladies and gentlemen, it is my pleasure to address you on behalf of the Republic of Serbia and to underscore the importance we attach to the considerations of the Health Assembly on progress towards achieving the Millennium Development Goals. For a country in transition, it is of the utmost importance to place its activities on the public sector reform, including that of the health sector, within the framework of the Millennium Development Goals. This is the case of Serbia.

At the very outset, let me state clearly that the major issue identified through a critical analysis was the lagging behind of vulnerable groups, such as the poor, the refugees and the Roma, especially Roma internally displaced from Kosovo Province since 1999. The estimated mortality rate of the Roma population in camps in North Mitrovica and its surroundings was much higher than the average. We are most grateful to WHO which, since 2005 has provided continued support for improving the situation, and setting up and maintaining specific health interventions to the affected Roma population.

Among other concerns, it should be noted that important progress has been made in the reduction of child mortality, leading to a further expected drop to halve it by 2015. Furthermore, our efforts continue to focus on neonatal and perinatal care. In terms of maternal health, good progress was achieved as well. The Millennium Development Goal framework was used to set up additional national targets as regards child health, and specifically the health of Roma children.

Significant progress was made in HIV/AIDS and tuberculosis control. As regards the former, Serbia is now implementing the third project funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria and has refined the national strategy, targeting primarily groups at risk, marginalized and difficult-to-reach populations. Similarly, the close cooperation between WHO and Serbia for tuberculosis control and the financial support provided by the Global Fund resulted in an effective reduction of the tuberculosis incidence rate from 37 per 100 000 population in 2003 to 24 per 100 000 population in 2009.

Even though national averages for children's and women's health have improved markedly, there are still significant differences within the national territory as well as among socioeconomic groups – the worst situation being that of the Roma population. Serbia is responding to this challenge by adopting a specific "Action Plan for Roma Health" congruent with other sectoral action plans, such as those for employment, education and housing. A National Conference on Roma Health was held in December 2009, in conjunction with WHO, advancing the efforts to address health challenges and to streamline all relevant sectors within the same set of goals within the Millennium Development Goal framework.

Needless to say, the achievement of the health-related Millennium Development Goals is closely linked with a strong health system, good governance and management, human resources, good quality of services delivered and appropriate funding of health services that will ensure that all those in need receive appropriate health promotion, preventative, curative and rehabilitative care services. But, the health-related Goals are to a large extent also related to other Millennium Development Goals such as those for poverty reduction, gender equality and empowerment of women.

We welcome the adoption by the United Nations General Assembly of a resolution on the prevention and control of noncommunicable diseases, which seeks to convene a high-level meeting on the prevention and control of noncommunicable diseases in September 2011 with the participation of Heads of States and Government. It will be a valuable contribution to the achievement of the Millennium Development Goals.

Allow me to thank WHO and other international partners such as UNICEF, the United Nations Office on Drugs and Crime and the European Union for the support provided to Serbia in strengthening the capacity of the Ministry of Health and of the entire Government to perform effectively their stewardship functions. As a global community, we need to ensure continued commitment and funding for the achievement of the Millennium Development Goals in a holistic manner, geographically, politically and health-wise. Serbia is contributing to and participating in this common endeavour, and will continue to do so. I thank you.

Le Professeur HASSAN (Niger):

Monsieur le Président, Mesdames et Messieurs les Ministres, Excellences, Mesdames et Messieurs, permettez-moi avant tout de féliciter M. Mondher Zenaidi, Ministre tunisien de la Santé publique, pour sa brillante élection à la présidence de la Soixante-Troisième Assemblée mondiale de la Santé ainsi que tous les autres membres du Bureau. Je rends également hommage à Mme Margaret Chan pour le leadership remarquable dont elle fait preuve à la tête de l'Organisation mondiale de la Santé et particulièrement en faveur de la santé des populations de l'Afrique.

À mi-parcours de 2015, année cible pour la réalisation des objectifs du Millénaire pour le développement, la santé demeure encore un défi majeur au centre du processus global du développement. Au Niger, le rapport 2009 montre les progrès accomplis, notamment en matière de réduction de la mortalité infanto-juvénile et de la lutte contre le VIH/sida. C'est ainsi que le taux de mortalité infanto-juvénile a été réduit à 17,15 % dans la période 2001-2005, et ce malgré l'impact négatif de la crise alimentaire sur les indicateurs de la santé de l'enfant. Le taux de mortalité maternelle a connu une légère amélioration, passant de 652 décès pour 100 000 en 1992 à 648 décès pour 100 000 en 2006. En ce qui concerne le VIH/sida, l'Enquête démographique et de santé réalisée en 2006 montre une tendance à la stabilisation de l'épidémie, voire une inversion de la tendance de l'infection, passant d'un taux de prévalence de 0,87 % en 2001 à 0,70 % en 2006. Quant à la réalisation de l'objectif 1 relatif à l'élimination de l'extrême pauvreté et de la faim, le Gouvernement dispose d'un cadre de stratégie de développement accéléré et de réduction de la pauvreté ; néanmoins, on évalue à plus de FCFA 6 milliards les ressources nécessaires à la réalisation de ces objectifs.

S'agissant des questions relatives aux endémies, au Niger, le paludisme demeure encore une endémie majeure et constitue la première cause de morbidité et de mortalité dans les groupes vulnérables, en particulier les enfants de moins de cinq ans et les femmes enceintes. Selon une étude du Système national d'information sanitaire, le paludisme a représenté en 2008 au Niger 33,4 % des motifs de consultation. À partir du mois de février 2010, le Niger a été touché par la grippe A (H1N1). Grâce au système de sites sentinelles pour la surveillance des syndromes grippaux et les infections respiratoires aiguës mis en place et la mise en œuvre du Règlement sanitaire international, un total de

49 cas, dont zéro décès a été enregistré. Depuis un mois, le Niger n'a enregistré aucun cas de grippe A (H1N1). À cet égard, le Niger remercie l'OMS et les partenaires internationaux pour l'appui technique et matériel dont il a bénéficié dans la mise en œuvre de son plan d'intervention. L'appui de l'OMS s'est traduit par la fourniture de 220 000 capsules de Tamiflu, le renforcement des sites sentinelles et la fourniture prochaine d'un stock de vaccins contre la grippe A (H1N1) d'environ 1,5 million de doses. En ce qui concerne la lutte antituberculeuse, il est à souligner que le Niger dispose de 602 centres DOTS dont 153 centres de dépistage et de traitement et 449 centres de traitement fin 2006. En outre, le Niger dispose d'un service de prise en charge des cas multirésistants. À l'instar des autres pays en développement, le Niger n'est pas non plus épargné par l'émergence des maladies non transmissibles. Ainsi, la prévalence de l'hypertension artérielle est de 9,9 % et celle du diabète de 4,7 %. Des enquêtes parcellaires ont également montré une prévalence élevée des cancers de l'utérus et du sein, et un taux de 18,22 % de drépanocytaires. Cependant, il faut relever que le tableau n'est pas sombre partout. Le Niger, grâce à un engagement politique fort en faveur de l'éradication de la poliomyélite et la mise en œuvre des stratégies préconisées, est sorti de la liste des pays d'endémie en février 2006. Les effets de l'amélioration de la qualité des activités de vaccination supplémentaire contre la poliomyélite et du renforcement de la vaccination systématique se sont soldés par l'arrêt de la transmission du poliovirus de type 1 en mai 2008. Le poliovirus sauvage de type 3 a pris le relais en octobre 2008 et a été aussi interrompu à partir de mai 2009. Nonobstant les deux cas enregistrés en mars et avril 2010, le Niger est en bonne voie pour l'éradication de la poliomyélite dans un avenir prochain. Le Niger a atteint les objectifs de la Déclaration de Genève de mai 2004 relative à l'éradication du ver de Guinée. En effet, depuis plus de 17 mois, aucun cas de dracunculose n'a été notifié ; par ailleurs, depuis plus de dix ans, le Niger n'a enregistré aucun cas de trypanosomiase humaine africaine. La mise en œuvre des différents plans d'action stratégique d'éradication de la rougeole, ainsi que l'organisation d'activités de vaccination supplémentaire, a permis de réduire la morbidité rougeoleuse de plus de 65 % entre 2000 et 2009.

Devant les multiples défis à relever et l'ampleur de la tâche pour atteindre les objectifs du Millénaire pour le développement, le Niger dispose d'un leadership fort et de stratégies principalement fondées sur : premièrement, la gratuité de la consultation des femmes enceintes, de la planification familiale, de la césarienne, de la prise en charge des enfants de 0 à 5 ans et des cancers gynécologiques ; deuxièmement, la mise en œuvre du Programme national de la santé de la reproduction ; troisièmement, l'opérationnalisation de la feuille de route pour l'accélération de la réduction de la mortalité maternelle et néonatale ; et enfin, quatrièmement, la mise en œuvre de Vision 2020. Tout ceci a permis une légère amélioration des données. Ainsi, le taux de consultations prénatales est de 78 %, le taux d'accouchements assistés par un personnel qualifié est passé de 17 % en 2006 à 29,7 % en 2009. Cependant, malgré toutes ces stratégies, il apparaît clairement que les objectifs du Millénaire seront difficilement atteints sans une mobilisation conséquente des ressources, une meilleure coordination des interventions et le maintien d'une aide publique au développement prévisible.

Enfin, je profite pour saluer et remercier la communauté internationale pour le soutien indéfectible accordé au Niger dans la situation difficile qu'il a connue au cours des derniers mois. Je vous remercie.

El Dr. BENDAÑA (Honduras):

Señor Presidente, es para mi un honor representar al Estado de Honduras en esta Asamblea Mundial de la Salud. Lo felicito por la acertada elección de su persona para conducir los trabajos de esta Asamblea, felicitaciones que extendemos a los demás miembros de la Mesa.

Señor Presidente, señores ministros, distinguidos delegados. Reafirmando la voluntad política de mi Gobierno de continuar impulsando programas nacionales de salud en beneficio de todos los hondureños, quisiera subrayar las acciones concretas que se han implementado en el marco de los Objetivos de Desarrollo del Milenio.

Las metas para el Gobierno de Honduras bajo los ocho Objetivos del Milenio son buscar la reducción de la pobreza extrema y el hambre, y por ende la desnutrición; lograr que todas las personas terminen la escuela primaria; promover la igualdad entre mujeres y hombres y lograr la autonomía de

la mujer; reducir el número de muertes de los niños y niñas; mejorar la salud materna; prevenir el VIH, el paludismo, la tuberculosis y otras enfermedades, y garantizar la estabilidad del medio ambiente.

Quisiera referirme con cierto énfasis al Objetivo 4 «Reducir en dos terceras partes, entre 1990 y 2015, la mortalidad de los niños menores de cinco años».

En Honduras hay avances importantes con una clara tendencia a la reducción de la tasa de mortalidad infantil a nivel nacional desde 1995 a 2006. De 35 muertes por cada 1000 nacidos vivos entre 1991 y 1996, se pasó a 23 entre 2001 y 2006.

Esto significa una reducción de 12 puntos en 15 años, con un ritmo de disminución de 0,8 puntos anuales. Si se mantuviera esta misma tendencia, nos estaríamos acercando a la meta del ODM para el año 2015, que es de 12 muertes por cada 1000 nacidos vivos.

La reducción de la mortalidad neonatal continúa siendo el mayor desafío para el logro del Objetivo 4. La tendencia es hacia la disminución. Se pasó de 20 muertes por cada 1000 nacidos vivos en el periodo 1991-1996 a 14 muertes por cada 1000 nacidos vivos en el periodo 2001-2006. La cobertura de inmunización contra el sarampión en menores de dos años se ha incrementado sustancialmente, del 89,1% en el año 1997 al 99% en 2002 (aumento de 9,9 puntos porcentuales).

En cuanto al Objetivo 5 «Reducir en tres cuartas partes, entre 1990 y 2015, la mortalidad materna», quisiera mencionar que en Honduras el principal problema para monitorear la mortalidad materna a nivel nacional es la falta de un sistema de vigilancia de mortalidad materna que cuente con datos oficiales actualizados. Debido a estas circunstancias, la razón de mortalidad materna nacional se ha obtenido a través de la realización de dos encuestas sobre mortalidad materna, las cuales mostraron una notable reducción entre 1990 y 1997, de 182 a 108 muertes por cada 100 000 nacidos vivos. Esto representó una de las mayores reducciones documentadas en los países en vías de desarrollo en tan corto plazo.

En el Objetivo 6 «Combatir el VIH/sida, el paludismo y otras enfermedades», Honduras logró un descenso notable del número de casos de malaria desde el año 2000. En 2008, Honduras notificó 8225 casos, de los cuales 610 por *P. falciparum*. Así la reducción de la malaria por *P. falciparum* fue del 58%, mientras que la reducción de la malaria por *P. vivax*, ha sido más marcada (77%). Honduras puede cumplir con la meta del ODM 6 con respecto a la malaria.

Los logros en tuberculosis son significativos.

Lograr el objetivo sobre el VIH/sida significa asumir el enorme reto de prevenir la transmisión del VIH; sin embargo, es importante reconocer que las estrategias de prevención todavía requieren un enorme trabajo interno acompañado de una mayor cooperación internacional.

Hemos tenido avances en la consecución de la meta 10: «Reducir a la mitad, para el año 2015, el porcentaje de personas que carezcan de acceso a agua potable y a servicios básicos de saneamiento». En efecto, en el año 2000 el Gobierno adoptó como un compromiso de largo plazo la Estrategia para la Reducción de la Pobreza, instrumento para el desarrollo social y económico que cuenta con el consenso de la sociedad civil y la comunidad internacional. En el marco de la Declaración del Milenio y de la erradicación de la pobreza se considera la asignación de recursos para el sector del agua potable y saneamiento, con un enfoque de beneficiar con servicios de agua salubre y saneamiento, principalmente a la población de escasos recursos.

Honduras ha alcanzado también logros importantes, en el campo de la educación y la provisión de infraestructura básica, lo que evidencia la posibilidad de cumplir algunas metas.

En esta 63.ª Asamblea Mundial de la Salud, mi delegación participa con la confianza de que podremos adoptar las mejores decisiones para beneficio de nuestros pueblos. La agenda es significativa, y considero que sus resultados conferirán mayor y mejor acceso a los medicamentos, a la aplicación responsable del Reglamento Sanitario Internacional, al tratamiento adecuado, al concepto de falsificación de productos médicos, y una decisión consensuada sobre los asuntos técnicos y sanitarios.

Para finalizar, señor Presidente, el Gobierno de Honduras reitera su compromiso y su voluntad política en la importante tarea de velar por que el acceso a la salud continúe siendo un derecho para todos. No obstante, los programas de salud que mi Gobierno tiene señalados requieren cooperación internacional, y es por ello que quisiera hacer un llamamiento a aquellos países y entidades

cooperantes para que continúen apoyándonos con recursos financieros y técnicos. Muchas gracias, señor Presidente.

Dr DIXON (Jamaica):

Mr President, distinguished ladies and gentlemen, Jamaica is honoured to be part of the Sixty-third World Health Assembly. This Health Assembly is taking place as we prepare ourselves for the last five-year lap in the time frame to achieve the Millennium Development Goals. Jamaica supports resolution EB126.R4 and especially the calls to strengthen health systems to deliver equitable health outcomes, reflect health equity in all national policies and to reaffirm the values and principles of primary health care. We look forward to the continued leadership of the Director-General in supporting the work of small and developing nations to retain our health workers who are indispensable to the achievement of the Millennium Development Goals.

This Health Assembly is being held at a time of renewed optimism and hope for a global recovery from what has been a most devastating financial crisis. The challenge that confronts us as leaders is how to move forward without leaving small and vulnerable States behind. The health sectors in many developing countries are struggling to cope with high disease burdens, weak health systems, migration of critical health workers to developed countries, and underinvestment in health. These challenges present extraordinary obstacles to the growth and development of these countries and undermine the achievement of the Millennium Development Goals within the specified time frames.

Jamaica, for its part, has achieved mixed results in the attainment of the health-related Millennium Development Goals. Jamaica is on track to achieve universal access to reproductive health and to halt and reverse the spread of HIV/AIDS, malaria and tuberculosis. In respect of Goal 6 on combating HIV/AIDS, malaria and other diseases, Jamaica has surpassed the target for school attendance among orphans and non-orphans in the 10–14 age group. Between 2004 and 2008, there was a 17% reduction in the number of persons with AIDS and a 40% reduction in the number of AIDS-related deaths. The HIV prevalence rate for the 15–24 age group declined by just over 1% in the last decade. Access to antiretroviral drugs is, at 49%, far below the national target of 75% that was set for 2009.

Slow progress is being made in the reduction of maternal and child mortality. Reported maternal mortality has declined from 120 per 100 000 to almost 95 per 100 000. Reports over various time periods using other methodologies show different figures. We agree with the observation that there is a need for better data collection systems to improve confidence in comparative analyses over time and between countries. The proportion of births attended by skilled health personnel has increased from 81% to 93%. Infant and child mortality rates are 21 and 25 per 1000 live births, respectively, compared to 25 and 28 per 1000 live births 10 years ago. After a decade of slippage in immunization coverage, Jamaica achieved outstanding results last year of 90% coverage, up from an average of 83% over the previous 10 years. The significance of this achievement must be viewed within the context of an environment of declining budgets and the continued migration of our skilled workers.

Jamaica remains committed to the lofty Development Goals of the United Nations Millennium Declaration. We have incorporated these Goals in our national policies and in particular Vision 2030, our National Development Plan. Having regard to our weak economy and the likely impact on the number of persons who could become medically indigent, the Government took the bold move of eliminating user fees in April 2008. The elimination of user fees has resulted in an increase in patient utilization at both the primary and secondary care levels; pharmacy services experienced the highest level of increase at 44% over the period. The drug budget has increased by 100% over the same period. Jamaica's experience is worthy of some consideration in light of Target 8e, which addresses access to affordable and quality essential drugs in developing countries. I urge this Health Assembly and our partners in developed countries to bring resolute leadership to bear on Goal 8. The shift in the disease profile of developing countries, the ageing population and the high incidence of chronic noncommunicable diseases demand immediate and urgent attention as far as access to affordable drugs is concerned.

As we move into the last five-year lap of the Millennium Declaration, I am recommending the following: first, countries should be supported in strengthening data collection and health information

systems; secondly, consideration should be given to including chronic noncommunicable diseases in the Millennium Development Goals, in keeping with our recommendation to the United Nations Economic and Social Council's Annual Ministerial Review last year (we are heartened by the fact that the United Nations resolution on noncommunicable diseases has been adopted); and thirdly, WHO should seek avenues to collaborate more effectively with partners to ensure that developmental support is increased and equitably distributed across countries, including middle-income countries now made more vulnerable as a result of the global financial crisis. Jamaica looks forward to the outcome of this Health Assembly. Thank you.

Mr CAMILLERI (Malta):

Mr Chairman, on behalf of the Maltese delegation, I wish to congratulate you on your election to the Presidency of this Sixty-third World Health Assembly. I would also like to take this opportunity to congratulate Dr Zsuzsanna Jakab on her recent appointment as Regional Director for the European Region. As declared by our Minister on Health, the Elderly and Community Care during Dr Jakab's first official visit to Malta last month, Malta fully supports her declared policy direction for the Region and commits itself to supporting her in the challenging task ahead.

Health over the past years has been facing a number of serious challenges. In her address to the Sixty-first World Health Assembly two years ago, the Director-General presented three major threats to health, namely: food security, climate change and the influenza pandemic. The influenza pandemic caused by the pandemic influenza A(H1N1) 2009 virus was kinder to us than we anticipated. While causing relatively mild health problems, it has led to the development of a number of challenges and criticisms to the response to the infection by the WHO Secretariat and Member States. Although the pandemic is not yet over, Malta feels that a thorough evaluation of our response to the threat as well as a risk assessment of other potential threats are crucial.

Over recent years, there has been a significantly increased awareness of the effects of climate change. Malta feels that not enough emphasis has been placed on the impact of this phenomenon on the health of our people. Malta therefore urges WHO to address this issue in a global, concerted manner and to work towards putting health high on the agenda of the climate change initiative. Malta recently finalized and published a study on the likely effects of climate change on the country, and we will be working towards addressing the issues raised by this study.

When mentioning serious challenges facing the health sector, one cannot ignore the financial crisis that has hit the globe over the past 18 months or so. This has had a major impact on countries' ability to provide for health. The reduction in budgetary allocations, and the social impact of rising unemployment have had a major impact on our capacity for addressing the social determinants of health. It is the most vulnerable that have borne the brunt of these effects, and our efforts in what is now being regarded as the recovery phase of the crisis must be focused in favour of these groups. If we want to effectively address these serious issues, we all need to make a concerted effort to maximize our contribution, under WHO's leadership, to the achievement of the Millennium Development Goals. This can only be achieved if we strongly believe that money spent on health is an investment for wealth.

Malta echoes what was stated earlier by Spain on behalf of the members of the European Union, in that we believe in the leading role of WHO in addressing the tasks before us, and fully support the role and nature of WHO's core business in the rapidly changing global health environment. Within the context of sustainability, Malta also supports the initiative being taken by WHO to establish a global code of practice for the recruitment of health personnel.

This Health Assembly will once again be addressing issues relating to both communicable and noncommunicable diseases. Malta is supportive of the initiatives to address communicable diseases like HIV/AIDS, hepatitis, malaria and tuberculosis as well as the eradication of measles. Over the past years, Malta has seen a steady increase in the incidence of HIV and tuberculosis, primarily due to the arrival of irregular migrants on our shores.

Malta feels that more emphasis should be placed on the implementation of the Global Strategy for the Prevention and Control of Noncommunicable Diseases in order to effectively address the major burden in both developed and developing countries. Only last week, Malta launched a new National

Strategy for the Prevention and Control of Noncommunicable Diseases, setting targets for reduction in a number of risk factors and a reduction in morbidity and mortality from a number of diseases by 2020. We are currently also working on a National Action Plan for Cancer and a National Strategy to address our obesity problem.

In conclusion, I wish to underline Malta's continuing strong support for all the efforts and initiatives being made by WHO, and our commitment to contribute to endeavours to ensure the success of this Health Assembly.

El Dr. GONZÁLEZ GONZÁLEZ (Nicaragua):

Muchas gracias, señor Presidente. Durante esta Asamblea se ha comentado mucho sobre los dilemas de alcanzar los Objetivos de Desarrollo del Milenio. El informe de la Secretaría nos señala que lamentablemente es posible que algunos países no puedan alcanzarlos. Lo que poco se ha discutido son las razones por las cuales algunos países no alcanzarán o no alcanzaremos los Objetivos del Milenio. Nosotros quisiéramos comentar un poco la experiencia de nuestro país, para aportar algo a la discusión sobre este tema. Quisiera decir que Nicaragua vive un segundo momento de una revolución social que comenzó en los años ochenta y que quedó frustrada por fuerzas extranjeras. Nicaragua se ha dado una segunda oportunidad de reconstruir su sociedad y en ese marco estamos tratando de hacer lo mejor posible por nuestro pueblo. Pero, ¿cuáles son los antecedentes del trabajo que estamos realizando? Un trabajo de la FAO y la CEPAL nos dice que en Nicaragua en el 2004 el costo del hambre significaba el 5% del producto interno bruto. Y, ¿por qué esto? Porque el 22% de los menores de cinco años tenían desnutrición crónica y el impacto que esto tiene en el desarrollo del país no es solamente inmediato, sino a largo plazo. Más de 200 millones de dólares perdidos por el país como efecto del impacto del hambre en la productividad comprometen el futuro de nuestros pueblos. En nuestro país recibimos un problema que es que la probabilidad de tener desnutrición es siete veces mayor en los niños más pobres que en los del primer quintil de riqueza de nuestra población. La probabilidad que una mujer pueda parir en una unidad sanitaria es cinco veces más baja si es pobre que si pertenece a la clase más pudiente. En esas condiciones, las políticas del gobierno de reconciliación de unidad nacional no podían limitarse a ver los aspectos de salud desde la perspectiva estrictamente sanitaria y nos lanzamos en ese marco de reconstrucción del país a un enfoque más amplio que tiene en cuenta los determinantes de la salud para transformar realmente la situación sanitaria del país. Desde esa perspectiva hay grandes tareas que se han venido realizando para poder alcanzar los Objetivos del Milenio. Es cierto que hay que dar acceso a la mayoría de la población a la atención primaria. Sin embargo, en ese esquema neoliberal en que el país vivió sumergido durante 16 años, el 40% de nuestras mujeres campesinas eran analfabetas y había que hacer una campaña de alfabetización. Con mujeres analfabetas es muy difícil reducir la mortalidad infantil y la mortalidad materna. En ese esquema los esfuerzos han estado dirigidos a asegurar que la lucha contra la pobreza sea un tanto diferente a los esquemas asistencialistas. Se ha tratado de brindar financiamiento a la pequeña producción para que esas mujeres que son jefas de familia puedan tener la capacidad económica de seguir progresando en el marco de desarrollo del país. Y todo esto porque el plan nacional de Nicaragua cambió su enfoque, dejamos ese enfoque del crecimiento económico para centrarnos en el desarrollo humano. No vamos a esperar hasta que crezca la economía para poder atender los problemas sociales. Hay que atender los problemas sociales porque al final es invertir en el ser humano. En el campo de salud rompimos las barreras económicas. El neoliberalismo, tanto en la educación como en salud, había privatizado los servicios y la barrera económica era la primera barrera que había que destruir. Hemos ampliado los servicios y la cobertura, hemos modificado el enfoque curativo y estamos bajo un enfoque de medicina familiar y comunitaria que centra sus esfuerzos en estrategias de atención primaria y en asegurar que los lugares más recónditos del país puedan tener servicios de salud. ¿Qué hemos venido logrando? Con este enfoque amplio en estos tres años y medio se ha reducido un 20% la mortalidad materna. En cuanto a la reducción de la mortalidad infantil, que es lo más difícil, hemos reducido en un 15% la mortalidad neonatal.

Tenemos bajo control el paludismo, hemos controlado la epidemia que teníamos de tuberculosis y ha comenzado a frenarse el VIH/sida para seguirse manteniendo en una epidemia

concentrada. ¿Cuál es la lección? La lección más importante es que mientras el esquema neoliberal centre su esfuerzo en el crecimiento económico y el ser humano pase a segundo plano, muy difícilmente alcanzaremos los Objetivos del Milenio. Tenemos que cambiar los paradigmas de nuestros países, sus políticas deben concentrarse en la atención al ser humano. Para ello estamos construyendo una democracia directa. Los ciudadanos desde su casa, su hogar, su comunidad, participan en la toma de decisiones junto con el Gobierno para enfrentar estos tremendos problemas que tiene la sociedad. Un elemento importante en este esquema es que necesitamos el apoyo internacional. Es muy importante, pero un apoyo que respalde solidariamente los planes nacionales, que no desvíe la atención de las políticas de gobierno a los aspectos más importantes. Y un último aspecto: el fortalecimiento del sistema. Pero ¿qué significa el fortalecimiento del sistema? Es llevar la salud a todos los ciudadanos, universalizar la salud, romper las barreras económicas, geográficas y culturales que hasta el momento son quizás el obstáculo más importante para alcanzar los Objetivos del Milenio. Muchísimas gracias.

Le Dr GIKORO (Burundi):

Monsieur le Président de la Soixante-Troisième Assemblée mondiale de la Santé, Excellences, chers collègues, Mesdames et Messieurs, c'est un grand honneur pour moi de m'adresser à cette auguste Assemblée au nom de la République du Burundi. Je me permettrai tout d'abord de féliciter le Président de cette Soixante-Troisième Assemblée mondiale de la Santé pour son élection et lui souhaite un plein succès dans cette tâche qui lui est désormais confiée. La République du Burundi, pays situé dans la région des Grands Lacs d'Afrique centrale, vient de sortir d'une guerre civile qui a duré plus d'une dizaine d'années et se trouve actuellement dans une situation fragile de postconflit. Ainsi, la guerre civile fratricide a non seulement emporté des milliers de vies humaines, mais aussi contribué à la paupérisation de la population burundaise qui de surcroît vivait déjà dans des conditions de précarité extrême. Aussi, la plupart des indicateurs de santé se sont progressivement effondrés durant toutes ces années de conflits, hypothéquant de ce fait la réalisation des objectifs du Millénaire pour le développement à l'horizon 2015. Malgré la guerre et surtout après celle-ci, le Gouvernement burundais n'est pas resté les mains croisées, inscrivant la santé de sa population dans ses priorités. En effet, mon pays ayant bénéficié de la remise de sa dette internationale en 2008, a décidé d'affecter une large partie de celle-ci à la promotion de la santé. Le budget de l'Etat alloué au secteur de la santé s'est ainsi considérablement accru, passant de 3 % en 2005 à 9 % en 2010.

C'est dans ce cadre, et dans la perspective d'accélérer les objectifs du Millénaire, qu'une politique de gratuité des soins pour les enfants de moins de cinq ans et les pathologies liées à la grossesse, y compris l'accouchement et les complications du post-partum, a été instituée ; elle complétait une autre liste de gratuité qui existait déjà et qui concernait le traitement antirétroviral et les infections opportunistes du VIH/sida, le traitement de la tuberculose et, plus récemment, le traitement de première intention du paludisme non compliqué. Deux autres réformes majeures ont été mises en place : elles concernaient la décentralisation des services et soins de santé ainsi que la généralisation et l'harmonisation du financement axé sur les résultats, sur tout le territoire national. Avec ces réformes et bien d'autres encore sur lesquelles je ne peux m'étendre, une amélioration nette de la situation sanitaire a été constatée, et je suis heureux de pouvoir vous présenter certains de ces résultats. La couverture vaccinale en DTC3 est remontée jusqu'à un taux de 98 % en 2009, le taux d'accouchements assistés par du personnel qualifié, qui était de 22 % en 2005, est remonté à 60 % en 2009, le taux de séroprévalence globale du VIH/sida se maintient à un taux de 2,9 % selon une étude de 2008. Une mise à niveau de nos interventions, soutenue par une participation de la communauté et des associations de la société civile, est en cours de mise en œuvre. Ces statistiques vont être certainement confirmées par l'Enquête démographique et de santé qui débute bientôt au Burundi, et viendront remplacer les données désuètes figurant dans les statistiques actuelles.

En ce moment même où je suis à cette tribune, une campagne électorale bat son plein dans mon pays et concerne des élections locales, présidentielles et législatives. La précédente législature était issue d'élections pluralistes tenues en 2005 : celles-ci avaient été jugées régulières et transparentes par l'ensemble des observateurs malgré la persistance d'une rébellion encore en activité à cette époque. Avec le retour de la paix, qui est une réalité actuellement, le peuple burundais croit fermement en une

démocratie apaisée qui amènera plus de stabilité politique, plus de prospérité et, partant, une amélioration de sa santé et des conditions de vie. Toutefois, l'accompagnement par la communauté internationale pour soutenir notre Gouvernement reste incontournable pour affronter les trois principaux défis qui découlent finalement du succès de la politique sanitaire en cours, et qui sont la pénurie des ressources humaines en qualité et en quantité ; la remise en état des infrastructures détruites pendant la guerre et la construction de nouveaux centres de soins ; et, enfin, l'insuffisance de l'aide financière internationale. La grande leçon que nous avons tirée de notre expérience est qu'aucune politique de santé ne pourra améliorer durablement l'état de santé de la population sans résoudre les problèmes cruciaux liés à l'ignorance, à l'analphabétisme et à l'illettrisme, et sans relever le niveau socio-économique des populations. Un vaste chantier est en cours au Burundi où nous venons de construire plus de 1000 écoles en moins de deux ans sans aide extérieure, rien qu'avec le concours de la population.

En terminant, Monsieur le Président, je voudrais remercier sincèrement, au nom du Gouvernement burundais, l'invitée spéciale de ce jour, Mme la Présidente du Libéria, qui a bien voulu citer mon pays, le Burundi, parmi les pays qui ont mis en place des politiques innovantes pour accélérer les objectifs du Millénaire pour le développement. Je vous remercie de votre aimable attention.

Dr TENAUA (Kiribati):

Mr President, honourable ministers, distinguished delegates, ladies and gentlemen, on behalf of the Pacific island nations – Cook Islands, Fiji, Federated States of Micronesia, Nauru, Niue, Palau, Papua New Guinea, Samoa, Solomon Islands, Tokelau Tonga, Tuvalu, Vanuatu, and my own country, Kiribati – I would like to extend our warmest greetings. Mr President, I congratulate you on the post you have assumed, and would like to take this opportunity to assure you of our dedication and support.

Let me take this opportunity to acknowledge that, the Director-General, Dr Margaret Chan, has demonstrated strong leadership and guidance that have taken us through these challenging times – pandemic (H1N1) 2009 and meeting our commitments to the Millennium Development Goals in the face of the global financial crisis. To our Regional Director, Dr Shin Young-soo, we thank you for your commitment to improving health in the Pacific.

We all know that each year brings its quota of health problems, some of them new and some of them old ones which refuse to go away. Unfortunately, in the Pacific, we have had our fair share of health challenges over the years. Many of these have been raised by fellow health ministers of the Pacific island countries in their statements to the Health Assembly in previous years. At the mention of the Pacific, most people think of sandy beaches, markets stalls heavy with fruit and vegetables, seas teeming with fish, and happy, smiling people. Very few think of food crisis. And yet that is what is happening right now. Food security is threatened in many ways: declines in traditional food crops and fishing; increased dependence on imported foods; growing vulnerability to climate change; volatility in international commodity prices; and challenges to enact and enforce food safety and quality standards. Collectively, these and other threats are contributing to greater risks of noncommunicable diseases, vitamin and mineral deficiencies, and food diseases in Pacific populations. Malnutrition, chronic obesity, worrying levels of diabetes – these are the everyday realities of life in the Pacific islands. Noncommunicable diseases have now reached epidemic proportions and are the leading cause of death in our Region.

Another huge challenge we face is that of climate change. Climate change figures prominently on the agenda of our meetings in the Pacific and in the Region – and that is not surprising as many Pacific islanders live in coastal zones and atolls that are susceptible to storm surges, coastal erosion, flooding, droughts, high tides and salt-water intrusion. Many countries in the Pacific are literally at risk of disappearing within the foreseeable future. The drivers of climate change are not the small islands of the Pacific, however. We cannot prevent these problems on our own, but only if we work with our neighbours and other countries across the globe.

The public health challenges facing us are beyond the capacity of any of us to address on our own. They are beyond the capacity of the health sector to address on its own. But if we stand together, if we work across the health, trade, agriculture, education and other sectors, we can make real

progress. The Millennium Development Goals are an excellent example of this. The health-related Goals are so closely linked to all the others that these Goals cannot be viewed in isolation. Freedom from poverty and hunger, access to education and gender equality are important determinants of health and maternal, newborn and child health. The health services science required to address the challenges posed by HIV/AIDS, tuberculosis and malaria and protect maternal and child health are well known. The Pacific island countries recognize and value the role of breastfeeding for child nutrition and development, particularly in times of crisis and disasters. However, making these services available and accessible to the people who need them requires robust and equitable health systems. These must be integrated into society as a whole. There must be basic transport and communications networks to support them. And people must be educated as to how to access and use them.

However, the above conditions are not necessarily present in all Pacific island countries. Let us take the case of maternal and child health. All countries have been delivering maternal, child and adolescent health services, though at varying degrees. While targets for Millennium Development Goals 4 and 5 have been met by many Pacific island countries, some still report high maternal mortality ratios. For example, in Papua New Guinea, trends indicate that some targets under the Goals may be challenging to meet. However, the country is taking immediate and urgent action to scale up maternal and child health services. We continue to pay close attention and monitor progress of these two Goals.

Nonetheless, it is not all bad news. I am very pleased to be able to present to you the example of the Pacific islands in acting together to address our common concerns. In November 2008, 15 health ministers signed the Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities 2008–2015. This presents an important opportunity to move forward to translate this policy framework into national plans for actions. In July of last year, we met in Madang, Papua New Guinea at the eighth Meeting of Ministers of Health for the Pacific Island Countries. The Madang Commitment set out a series of bold actions designed to boost interventions to address several critical issues, including maternal and child health, the growing noncommunicable disease burden, human resources for health, health systems, and HIV/AIDS among others. We reaffirmed primary health care, which has been, and continues to be, an organizing principle for strengthening our health systems, and the Health Islands Approach as a model of a holistic approach to achieving our goal of protecting and promoting health in the Pacific. In April of this year, Vanuatu hosted the first-ever Pacific Food Summit to define our common strategy to combat many of the threats to attaining the Millennium Development Goals, such as malnutrition, vitamin and mineral deficiencies, and the increasing epidemic of noncommunicable diseases. The Summit brought together Government officials from health, trade and agriculture ministries, as well as partners in international and regional organizations, development agencies, consumers, the food industry, and a number of other sectors. Finally, a few days ago, we gathered here in Geneva for the first Healthy Islands Forum. The Forum was established as part of the Pacific island countries' effort to strengthen health systems through primary health care and health promotion by revitalizing the Healthy Islands approach. We learnt many valuable lessons from the rich experience in the Pacific, which helped us to understand more fully how truly achieving public health goals would require consistent and strong leadership from senior levels of Government down to engagement and ownership at community levels. We shared good practices for, and practical examples of, delivering concrete actions in achieving the Millennium Development Goals and in response to the increasing threats and burdens due to the rise in noncommunicable diseases and other lifestyle-related issues.

Mr President, in the Pacific we are well aware of the complex challenges we face, and we are united to address them. But to achieve the Millennium Development Goals, we will need to work even more broadly. We fully acknowledge and are forever grateful to our partners who have generously supported us in our efforts to improve the health of our people. The challenges may be great but together we will achieve great things. We thank you for all we have achieved to date, and we look forward to even greater gains. Thank you very much.

Dr Sezibera (Rwanda), Vice-President, took the presidential chair.
Le Dr Sezibera (Rwanda), Vice-Président, assume la présidence.

Mr CHAUDHARY (Nepal):

Mr Vice-President, Madam Director-General, honourable Ministers, distinguished delegates, I feel honoured to represent the Government of Nepal at this Sixty-third World Health Assembly. Let me congratulate you, Mr President, on your election to the Presidency of this Health Assembly. I pledge the full support of my delegation and express confidence that your leadership will guide this Health Assembly towards a successful conclusion. I would like to congratulate Director-General, Madam Margaret Chan, on her leadership of the Organization in this challenging time, and express appreciation for her commitment to work for equitable access to quality health.

The theme of this Health Assembly has special relevance as we look forward to the Review Conference on the status of the Millennium Development Goals later this year. In 2000, when our leaders endorsed a framework for the development in the form of the Millennium Development Goals, they sent a message that we are one world and our development agenda is interconnected. We are fully conscious of our responsibilities in providing equitable health access to our people. Nepal has developed and implemented health-related plans, policies and programmes. The existing Second Long-Term Health Plan prepared with WHO's assistance aims at guiding health sector development for improving the health of our people, particularly those whose health needs are often not met. Nepal has placed priority on public health. Government expenditure on public health has increased threefold in the last five years. Nepal signed the International Partnership for Health Global Compact in 2007, with a view to ensuring predictable funding and aid effectiveness in accordance with the Millennium Development Goals and the principles contained in the Paris Declaration on Aid Effectiveness. Nepal has made significant progress in the direction of achieving the goal on reducing child mortality. Despite several pressing challenges at hand, we are also on the right track to meeting the target on maternal mortality with a remarkable decline in maternal deaths. We have been able to halt and reverse the trend of malaria and tuberculosis. However, in the face of the challenges posed by HIV/AIDS transmission through migrant workers, we need to put additional efforts in reaching this particular target.

Recent studies have shown that least developed countries stand at a high risk of not meeting the Millennium Development Goals. Countries emerging from conflict and those with weak governance are at even higher risk. The Goals are interrelated and cannot be realized without improving the health status of the poorest and most vulnerable people, who are confronting extreme poverty, deprivation, malnutrition, and other health risks on a daily basis. We need to work together in reducing the adverse effects of climate change on the health sector, enhancing the health information system, expanding research on health issues and ensuring access to health facilities.

As the Chair of the Least Developed Countries Group, Nepal strongly appeals to the international community for a scaled-up, strong and sustained level of international assistance in a comprehensive manner for the attainment of the health-related Millennium Development Goals.

The financial crisis of the past few years has adversely affected the national health of developed, developing and least developed countries. The outbreaks of deadly infectious diseases demand that we work collectively to address the challenges of health in relation to poverty, sanitation, education and environment. I express the commitment of my Government to work together with WHO at the national, regional and international levels in promoting equitable access to health care and to make universal health access a reality. Thank you all for your kind attention.

Professor VONGVICHIT (Lao People's Democratic Republic):

Distinguished guests, ladies and gentlemen, on behalf of the delegation of the Lao People's Democratic Republic, allow us to express our warm greetings to the Sixty-third World Health Assembly. On this auspicious occasion, let us express our sincere congratulations to the President and the Vice-Presidents on their elections, and we do believe that under their wise leadership, the Sixty-third World Health Assembly will meet with great success. I am very pleased that the topic of the

health-related Millennium Development Goals was chosen for this meeting, which is timely and relevant to the context of the development and health situation of our country.

In fact, the Lao People's Democratic Republic is a tropical country, which is always exposed to the great risks of communicable diseases. At the same time, noncommunicable diseases are also on the rise. Currently, we are in the final year of the implementation of the Sixth National Socio-Economic Development Plan (2006–2010), aiming at lifting our nation out of least developed status by the year 2020. In this Plan, the health-sector contribution to poverty alleviation consists of ensuring a nationwide health service that is fair and does not discriminate on the basis of gender, age, sex, social rank, tradition, religion, ethnicity or geographic location. Health goals are access and quality; at the same time, the health service is also focusing on prevention. Based on the main achievements and challenges from the implementation of the previous National Socio-Economic Development Plan, the Lao Government has planned to achieve the health-related Millennium Development Goals.

In fact, child mortality and maternal mortality rates are still high in Lao People's Democratic Republic. Every year, hundreds of children in Laos die from preventable causes: illnesses caused by contaminated water, inadequate immunization, injury from unexploded ordinance, high levels of poverty and malnutrition, malaria and tuberculosis. Regarding maternal health, despite considerable improvements in the quality of life over the past two decades, the general health status of the Lao population remains low, particularly for rural communities, and women continue to experience inadequate levels of care in pregnancy and childbirth. Therefore the Lao Government will do its utmost to reduce child and maternal mortality rates by improving living conditions, increasing the immunization rate, ensuring access to safe drinking-water and safe sanitation facilities and increasing women's delivery rate with midwifery attendance.

The combat against HIV/AIDS, malaria and other diseases is also one of our priorities. HIV/AIDS prevalence is still low in Lao People's Democratic Republic, with an estimated adult HIV rate of around 0.06%. There are, however, several risk factors that make the country particularly vulnerable. Half of all new HIV infections are among people aged between 15 and 24 years. By infecting young people disproportionately, the epidemic undermines local and international stability.

We understand that to achieve the Millennium Development Goals, more investment, particularly in the quality of services and better management of health systems, is needed. Lao People's Democratic Republic is committed to working to achieve the Millennium Development Goals and we are aware that international assistance and collaboration are extremely necessary. We are also confident that with our commitment and with the support of international agencies, we will successfully achieve the Goals. On this occasion, on behalf of the delegation of the Lao People's Democratic Republic, I would like to express my gratitude and appreciation to WHO and all development partners for their valuable assistance extended to our country. Finally, I wish the Sixty-third World Health Assembly every success. Thank you very much.

El Sr. MARTÍNEZ (Guatemala):

Señor Presidente, señora Directora General de la OMS, señora Directora de la OPS, honorables delegaciones de los Estados Miembros: Guatemala declaró en 2009 la gratuidad universal de los servicios públicos de salud para ampliar el acceso a la atención médica ambulatoria y hospitalaria. Además, mediante Cohesión Social, otorga transferencias condicionadas a mujeres y familias pobres que demuestren asistencia a las escuelas y cumplimiento de programas de salud. El Congreso Nacional de la República, el Ministerio de Salud Pública y Asistencia Social, la Universidad de San Carlos y el Instituto guatemalteco de Seguridad Social impulsan una nueva ley, basada en el derecho a la salud, orientada a financiar el acceso universal a los servicios. Asimismo, con nuevas normas del modelo de atención buscamos incrementar el acceso de la población pobre, dispersa e indígena, sobre la base de la rectoría, la participación social y la gestión local para reducir la mortalidad materna e infantil y promover los derechos a la salud reproductiva.

El país tiene mayoría de población indígena, y por ello, con el apoyo de la OPS/OMS y de otros socios, creamos en noviembre de 2009 la Unidad de Atención de Salud de los Pueblos Indígenas e Interculturalidad para articular la inclusión del enfoque intercultural en su atención.

Para reducir la desnutrición crónica - el ODM 1 - se ha implementado la Alianza para la infancia, la seguridad alimentaria y la nutrición, focalizada en Totonicapán, departamento mayoritariamente indígena, con altos niveles de analfabetismo, pobreza y desnutrición, para facilitar la prestación integrada de servicios de salud y nutrición a los menores de dos años y generar procesos productivos sostenibles y revalorizar la cultura alimentaria local. Recientemente la inseguridad alimentaria se ha agravado, y el Gobierno se ha visto en la necesidad de declarar el Estado de Calamidad y de hacer un llamamiento al Fondo de Emergencias de las Naciones Unidas. Con el apoyo de la OPS/OMS y de otras agencias se implementaron acciones para salvar vidas, reducir enfermedades y muertes de niños por desnutrición aguda grave, mediante el acceso oportuno a centros de salud y la vigilancia activa para la detección, referencia y atención. Además, el Gobierno y el sistema de las Naciones Unidas lanzaron un llamado internacional humanitario conjunto en marzo pasado por valor de US$ 34,1 millones. Los recursos de la comunidad internacional serán invertidos en salud, nutrición, agua, saneamiento, seguridad alimentaria y recuperación nutricional.

Con respecto al ODM 3, los programas conjuntos «Consolidando la paz mediante la prevención de la violencia y la gestión del conflicto» y «Fortaleciendo la institucionalidad de las mujeres guatemaltecas», denominados «Ventanas de la Paz y de Género», en alianza con los organismos del sistema de las Naciones Unidas y con el apoyo de España, fortalecen la capacidad del Estado para garantizar la vida, la libertad, los sistemas de protección y la igualdad de las mujeres ante la ley, para erradicar la violencia física, psicológica y sexual contra las mujeres, adolescentes y niñas. Se trabaja en políticas públicas y leyes contra el femicidio, la violencia intrafamiliar y la violencia de género, mediante asistencia técnica a operadores de justicia y trabajadores de salud, así como diseño, impulso e institucionalización de protocolos enfocados a la atención de la salud de las víctimas de violencia sexual y la prevención de adicciones.

En cuanto a los ODM 4 y 5, comparando las ultimas encuestas nacionales de salud maternoinfantil del 2002 y 2009, Guatemala mejoró sus indicadores de mortalidad infantil (de 39 a 30 menores de un año); la tasa de fecundidad (de 4,4 a 3,6 hijos por mujer); la prevalencia del uso de métodos anticonceptivos se incrementó (del 43,3% al 54,1%) y la atención institucional del parto (del 42,1% al 51,2%). Sin embargo, estas cifras muestran diferencias importantes en función de la etnia, de la educación de la mujer y del lugar de residencia (rural o urbano). Actualmente se está realizando un estudio retrospectivo de la mortalidad materna del 2007, respecto al 2000 que era de 153 por 100 000 nacidos vivos. Recientemente se presentó el «Plan nacional para la reducción de la mortalidad materna y neonatal y mejoramiento de la salud reproductiva 2010-2015».

Para alcanzar el ODM 6 se han incluido en la agenda nacional de salud las necesidades de los grupos de diversidad sexual con enfoque de derechos y considerando el modelo de atención desarrollado por la OPS/OMS. Se han fortalecido clínicas para su atención y desarrollado campañas de comunicación contra la homofobia conjuntamente con la Red Nacional de la Diversidad Sexual. En materia de tuberculosis, a pesar de los esfuerzos y recursos otorgados por el Fondo Mundial para el programa «Alto a la Tuberculosis», la detección de los casos respiratorios sintomáticos no llega al 40%. La tasa de éxito de tratamiento es del 85%. En comparación con 2008, en 2009 los casos de malaria disminuyeron en un 32%. La vigilancia activa y pasiva continúa. Guatemala ha sobrepasado las metas estipuladas tanto por la iniciativa «Hacer Retroceder el Paludismo », como por el ODM 6.

Es conveniente seguir impulsando acciones de cooperación Sur-Sur, como ha venido haciendo la OPS en estos años, y sistematizar experiencias para difundir las lecciones aprendidas entre los Estados Miembros. Muchas gracias.

Mr HABER (Poland):

Mr Vice-President, excellencies, ladies and gentlemen, I am honoured to address the Sixty-third World Health Assembly on behalf of the Government of the Republic of Poland. Poland fully aligns itself with the statement delivered by the distinguished representative of Spain on behalf of the European Union. This year, the international community is summing up 10 years of the implementation of the Millennium Development Goals, designed to attain sustainable development on a global scale. After the first decade of the twenty-first century, health has more than ever become a serious global challenge. The emergence of new epidemiological threats fuelled by the process of

growing migration has proved that common efforts by the international community are the only way to tackle global health issues. The concern of the international community over the health of the most vulnerable groups, namely children and women, as well as over the threat of communicable diseases, was reflected in the elaboration of the three health-related Millennium Development Goals. While focusing on the health-related Goals, we have to pay special attention to the interdependence between health and poverty, nutrition and access to clean and safe water and sanitation. In view of attaining the best possible living conditions, including health, it is necessary to create a transparent and efficient health system, which is able to deliver treatment and implement effective prevention programmes.

While focusing on health issues in the international development agenda, let me speak briefly on Poland's experience over the past 20 years. The challenging transformation Poland has implemented since 1989 has primarily concerned very profound economic reforms, although special attention has been paid to reforms of health-care systems and the introduction of patient-oriented policies. The Polish Government has prioritized systematic improvement of the quality of medical services provided to children and women, particularly during pregnancy, and spares no effort in tackling communicable and noncommunicable diseases.

Poland has introduced reforms designed to abandon the centralized model and transfer management of the health-care system and ownership of medical facilities to local government bodies, combined with the introduction of universal medical insurance. The process of systemic change coincided with the enhancement of the status of physicians providing basic medical care. At this point, let me emphasize Poland's readiness to share its expertise with the developing countries and countries in transition. One of the priorities of Poland's growing development assistance is the sharing of expertise which Poland has acquired during its systemic transformations, also in the area of health care.

The effective suppression of communicable diseases has been the greatest achievement of Polish public services over the last 50 years. Our success was attained though an overall improvement of hygienic standards, upgrading of hospital hygiene, development of water mains and sewage systems, development and broad use of antibiotics and antiviral drugs, and mass vaccination programmes. Mass vaccination constitutes the most effective example of a public health intervention, producing rapid impacts in the form of health care and a reduction in disease incidence. With reference to communicable diseases, I wish to mention the efforts of the Polish Government in countering HIV/AIDS. The Polish strategy of fighting HIV/AIDS has been based on respect for human dignity and human rights. Ensuring equal access to prevention, treatment and support for the most vulnerable groups is one of the main goals of the Polish Government's strategy. This has resulted in a systematic improvement in the quality of life of persons infected with HIV and suffering from AIDS, as well as enhanced public awareness of the problem.

Poland is involved in the implementation of a growing number of projects in partnership with other countries, particularly with our neighbours. Health care for pregnant women and children is one of the highest priorities of the Polish Government in the health-care area. The main task here is to ensure a proper course for pregnancy and the earliest possible identification of risk factors, making it possible to provide the appropriate assistance. The infant mortality rate has been falling for the past 20 years; last year, it amounted to 5.6 per 1000 live births – a sharp drop from 19.3 in 1990. Medical care in the perinatal period has the objective of ensuring good health of the mother and child with the lowest possible level of medical intervention, though with observance of the relevant safety rules. Safety in this case means care based on proven practices, minimizing risk and error and providing support for the physiological aspect of birth.

We are full engaged in implementation of the Millennium Development Goals, particularly the health-related Goals. Poland believes that sharing best practices from reforms implemented at national level during 20 years of transformation can make a valuable contribution to global health. Thank you for your attention.

Dr KOMBA KONO (Sierra Leone):

Mr Vice-President, I want to take this opportunity to congratulate you and your entire team on your election. I also want to take this opportunity to thank Dr Chan for upholding the image of our beautiful organization, the World Health Organization.

Sierra Leone is in step with the rest of the world as it attempts to reform its health-care system. The Government has identified cost as the biggest barrier to accessing health care in the country. Pregnant and breastfeeding women and young children are by far the largest groups in need of health services, and yet are often excluded from them by cost of referral to health facilities when it is too late. With this major change in policy, the Government and its development partners have removed this barrier, paving the way for greater use of and earlier referral to health services. Moreover, the systemic changes that this new policy will bring about within the provision of health care will produce a stronger, more efficient and effective health service for all Sierra Leoneans.

The alarmingly high maternal mortality ratio of 857 per 100 000 calls for an urgent response from a reformed health care system that works to reduce this high death rate of mothers and children by providing free health services to this fragile population group. It ensures accessibility to health facilities. The present under-five mortality rate of 140 per 1000 is unacceptable and calls for urgent action and commitment to reverse the tide. With this new initiative, pregnant women, lactating mothers and children under five are guaranteed elimination of all user fees in the health facilities within the country. The policy ensures that all medical care to the beneficiary group I have named – that is, pregnant women, lactating mothers and children under five – will be provided free of charge. National awareness and response to this initiative of free health service for pregnant women, lactating mothers and children under five nationwide is reassuring: it reflects an attitude of responsibility for the social welfare of our more vulnerable groups. I am also proud to remark on the increasing response and concern of all health workers nationwide to the initiative and their willingness to make it work. The support of health development partners has been outstanding. They have not only adopted the agenda for change – they promote it, enhance it and work commendably with the administration in districts and towns to improve conditions of service where necessary, ensure sufficient drug supplies, improved care, and as the year unfolds, renovation and upgrading of health facilities and maternity and paediatric wards in Government hospitals. Under the leadership of President Ernest Bai Koroma, the entire population of Sierra Leone accepts the free health-care initiative. The initiative conforms with the President's clarion call for behaviour and attitudinal change. In concluding, I wish to state that President Koroma's dream for Sierra Leone is to ensure that every child is given a chance to reach adulthood and contribute meaningfully to national development. For mothers, President Koroma's dream is to ensure that pregnancy and childbearing brings joy to families. Let me conclude by saying that happiness is considered an index of development. Therefore a happy mother and child in Sierra Leone makes it a happy nation.

Dr JAMEEL (Maldives):

It gives me great pleasure and deep honour to make a statement on behalf of my country at this Health Assembly. My delegation and I bring greetings from the Maldives to all present here. It has been 10 years since we adopted the United Nations Millennium Development Goals. We have no time to lose. We have only five more years to go.

Today, in terms of per capita gross domestic product, the Maldives is one of the richest countries in the region. However, as we emerge from a period of gross mismanagement of our limited financial resources, the present Government is faced with huge challenges and the daunting task of having to deal with huge fiscal and budgetary challenges. Added to this, we know that 2004 brought the tsunami, and we lost about 80% of our gross domestic product. Once again, as the world economic crisis threatens to engulf all nations of the world, our helplessness is further aggravated by the negative effects of the rapidly changing climatic conditions, global warming and the sea level rise. Despite several challenges, we have achieved almost all the Millennium Development Goals. The Maldives has already achieved Goal 1, but there is growing income disparity between the urban and the rural population. Poverty dynamics analysis also showed that many in the non-poor fell back into

poverty and that there is a rise in unemployment among young people. Although we can achieve Goal 2 in time, in halving the proportion of people with hunger, we are faced with the challenge of promoting locally grown food and change the dietary habits of our people. Malnutrition in children is still a public health issue in the Maldives, although a decline is seen in the proportion of underweight, stunting and wasting in children below five years. We have achieved Goal 3 in achieving universal access to primary education, and we are proud to note that our literacy rate of 98 is one of the highest in the world. There is little discrepancy in gender up to secondary education. However, education participation in tertiary level for females varies. Goal 4, to eliminate gender disparity, still needs concerted effort, but today we find that more and more women are engaged in decision-making and even in politics. Goal 5 of a two-thirds reduction of the under-five mortality rate, was already achieved in 2005. However while reducing the maternal mortality rate is on track, accessibility to obstetric care and early detection of high-risk cases in the outer islands are issues that need to be addressed urgently and with new strategies.

We have been able to contain the low prevalence of HIV/AIDS. But the high prevalence of drug use among youth and the increasing use of needles among them is of great concern in maintaining the low prevalence of HIV/AIDS. The Maldives has remained a malaria-free country since 1984 and no indigenous cases have been reported since then. The Maldives remains a tuberculosis low-prevalence country, but the few cases of multidrug-resistance need greater attention. Childhood tuberculosis is considered to be at zero prevalence, which may be linked to almost universal coverage of BCG vaccination in the country.

We have maintained our stand in ensuring environmentally sustainable economic development. We realize that we are among the most vulnerable to climate change. To strengthen our convictions, the Maldives has unveiled a plan to make our country carbon-neutral within a decade. The impacts of climate change are already evident and are affecting the livelihood of the people. Hence the Maldives has led an international initiative to realign this conceptual framework by shifting the world's focus onto the human and social dimensions of climate change. As the honourable Minister from Kiribati said, small island nations are threatened by climate change and international organizations such as WHO should be giving more focus to the small island States.

In developmental efforts, the Government is aspiring to engage private parties in all aspects, including health care. We strongly believe that the social needs of people cannot be left to the markets, yet we need to engage if we are to have sustainability. Our lifestyles are changing, and as in other countries, noncommunicable diseases are increasing. We also have an acute shortage of manpower but we are progressing well with our Millennium Development Goals. We need to strengthen our alliances and support national efforts to move ahead. Building alliances means reaching out to every institution, including civil society.

We would like to urge the Director-General, as I mentioned earlier, to have a special forum for small island nations to discuss the health issues specific to these countries. I thank you for your kind attention.

Mrs HANJAM SOARES (Timor-Leste):

I would like to congratulate the President of the Sixty-third World Health Assembly, the Vice-Presidents and the Chairman of the Committees. I extend my deepest appreciation for the achievements of Madam Director-General. Honourable Ministers and delegates, representatives of international organizations, ladies and gentlemen, Timor-Leste is a young nation with a population of only one million, and is celebrating its eighth year of restoration of independence this week on 20 May 2010. Seven years have passed since the Timor-Leste Demographic Health Survey in 2003, which showed the country as having a very low profile of health and social indicators. Maternal mortality was the highest in the world at 800/100 000 live births; infant mortality was 83 deaths per 1000 live births; 49% of our children were reported as malnourished – all these indicators were very low when compared with other countries of the region. Health infrastructure was also very poor, and the numbers of health workforce were so limited with less than 50 general physicians.

Today, my country considers health as a high priority, the Third National Priority in 2010, and many efforts are being made to overcome health and development challenges. The re-establishment of

health services, the development of basic infrastructure, National Priority No.1 (water and sanitation, human resources development and the strengthening of support systems) have been considered the main priorities during the first phase of improvement. With a total of more than 500 Timorese medical doctors graduating by 2013 and an increase in new undergraduate nurses, midwives and other auxiliary health professionals, the focus has moved now to expanding access and quality of services for both primary health care and hospital care into the second phase. The IVth Constitutional Government has led the development of a long-term national strategic plan where people are the main focus, and the Ministry of Health is using the opportunity to accomplish the necessary development for the sector to improve health and well-being, using the Millennium Development Goals as a guide.

To make progress towards the Goals, the priority focus is now on interventions to reduce maternal and child mortality rates, improve the nutritional status of the population and reduce mortality rates caused by diseases such as diarrhoea, malaria, dengue, tuberculosis and HIV/AIDS. That is why in 2008, the Ministry of Health of Timor-Leste introduced a new approach to health services delivery focusing on community participation and empowerment in health. SISCa, the Integrated Community Health Service, is a preventive care-focused service with special attention to vulnerable groups such as mothers, children, the disabled and the elderly.

The preliminary result of the Timor-Leste Demographic Health Survey from 2009 has indicated significant progress, including a 30% decline in under-five mortality since 2003 with 64 deaths/1000 live births, a 26% decline in fertility since 2003 from 7.8 to 5.7 births/woman; and basic child immunization rates have increased from 35% to 53%, while other key areas such as nutrition need more investment with nearly one in two children (45%) underweight. At the institutional level, reforms are being introduced in both the organizational structure and the support systems necessary for the National Health Strategic Plan. Despite the progress, more support will be required from WHO; and we need the support of our South-East Asia Member countries, Portuguese-speaking countries and other regions. We need to increase information-sharing to better our health system, especially relating to people's right to health care. We hope for donors to maintain the commitments towards health-sector development so as to ensure continuity of care and services to our people. Therefore, I would like to urge all of us here today to put health first in our priorities and enhance WHO's role in leading the global health agenda, as we continue towards our vision for a healthy people in a healthy nation. Thank you very much.

Le Dr BOGUENA (Tchad):

Monsieur le Président, Madame le Directeur général de l'Organisation mondiale de la Santé, Mesdames et Messieurs les Ministres de la Santé et chefs de délégation, Mesdames et Messieurs les ambassadeurs et les représentants des organisations internationales, Monsieur le représentant du Conseil d'État de la République et canton de Genève, distingués délégués, Mesdames, Messieurs, en cette solennelle circonstance de la Soixante-Troisième Assemblée mondiale de la Santé, je vous remercie de m'offrir l'occasion de vous présenter les salutations de M. Idriss Deby Itno, Président de la République du Tchad, chef de l'Etat, ainsi que celle du peuple tchadien. Par la même occasion, au nom de la délégation qui m'accompagne, je tiens à exprimer toutes mes félicitations au Président de la Soixante-Troisième Assemblée mondiale de la Santé pour sa brillante élection à la tête du Bureau des travaux de notre Organisation. Aussi voudrais-je féliciter sincèrement le Dr Margaret Chan, Directeur général de l'OMS, et son Secrétariat pour les efforts inlassables consentis à la bonne préparation de cette auguste Assemblée et surtout au choix judicieux de ce thème relatif aux objectifs du Millénaire pour le développement liés à la santé. Je voudrais par la même occasion, en mon nom propre et au nom de la délégation qui m'accompagne, exprimer toute ma gratitude et tous mes remerciements à M. le représentant du Conseil d'État de la République et canton de Genève pour l'accueil combien chaleureux qui nous a été réservé depuis notre arrivée en ce paisible territoire.

Qu'il me soit permis de souligner que dix ans après l'adoption des objectifs du Millénaire pour le développement, la situation sanitaire de mon pays demeure particulièrement préoccupante en dépit de la ferme volonté et des efforts louables accomplis par le Gouvernement avec l'appui des partenaires au développement. En effet, selon l'Enquête démographique et de santé, au Tchad, le ratio de mortalité maternelle est de 1099 pour 100 000 naissances vivantes et celui de la mortalité infantile est

de 102 pour 1000 naissances vivantes. Après l'enquête nationale de séroprévalence réalisée en 2003, la prévalence de l'infection au VIH/sida s'élève à 3,3 % ; la morbidité et la mortalité liées au paludisme demeurent également une source de préoccupation pour mon pays. Ces indicateurs expliquent bien que nous sommes loin de la réalisation des objectifs mondiaux quand bien même beaucoup d'efforts sont en train d'être fournis. Les actions concrètes réalisées sont l'élaboration de la feuille de route nationale pour la réduction de la mortalité maternelle et néonatale, la construction de plusieurs infrastructures sanitaires, la mise en place de la gratuité des urgences médicales et chirurgicales ainsi que la gratuité des antirétroviraux. Aussi, les progrès sont-ils accomplis selon l'approche « genre » en accordant aux femmes un quota important des postes de responsabilité dans les hautes institutions de l'Etat ; le Gouvernement compte à présent neuf ministres femmes, dont moi-même, plusieurs maires, y compris pour la ville de N'Djaména, la capitale, des préfets et des sous-préfets. Les efforts sont fournis, certes, mais il faut reconnaître que notre système de santé est perturbé par l'afflux des réfugiés et des personnes déplacées à qui le pays et les partenaires ont toujours fourni les soins nécessaires.

S'agissant de la poliomyélite, nous avons ces dernières années revu les stratégies ; cela a permis de réaliser un certain nombre d'activités en vue d'optimiser les résultats de cette lutte. Il s'agit entre autres de la participation de toutes les autorités politiques, administratives, militaires, traditionnelles, confessionnelles, de la société civile et de l'ensemble de la communauté avec à leur tête la participation effective de M. le Président de la République. L'engagement du chef de l'Etat s'est concrétisé en accordant FCFA 4 milliards, soit US $8 millions environ, pour soutenir la lutte contre la poliomyélite au Tchad. De plus, le 12 mars 2010, les gouverneurs des régions réunis à N'Djaména ont souscrit aux engagements pris par le Gouvernement tchadien d'interrompre la circulation du poliovirus sauvage d'ici la fin de 2010 par la Déclaration de N'Djaména sur l'éradication de la poliomyélite au Tchad.

Je ne saurais terminer mon propos sans remercier tous nos partenaires au développement, notamment l'OMS, l'UNICEF, l'UNFPA, MSF, ACF pour leurs appuis multiformes sans cesse croissants et je leur renouvelle ici la gratitude du Gouvernement et du peuple tchadien tout entier. Vive la solidarité internationale, vive la santé pour tous les peuples du monde. Je vous remercie de votre bien aimable attention.

M. SAMBA (République centrafricaine):

Monsieur le Président, je voudrais avant toute chose vous présenter – ainsi qu'à vos Vice-Présidents et Vice-Présidentes – mes chaleureuses félicitations pour votre élection à la tête de cette Soixante-Troisième Assemblée mondiale de la Santé. Je remercie également Mme le Directeur général de l'OMS pour sa constante sollicitude à l'endroit de mon pays. Les objectifs du Millénaire pour le développement (OMD) revêtent une importance capitale pour la République centrafricaine car ils constituent une réponse adéquate aux droits de l'homme essentiels, dont le droit à la santé conformément à la Déclaration universelle des droits de l'homme et la Déclaration du Millénaire, auquel mon pays adhère complètement. Concernant l'objectif 4 relatif à la réduction de la mortalité des enfants de moins de cinq ans, l'évaluation des progrès accomplis par la République centrafricaine vis-à-vis des OMD et des objectifs du Sommet mondial pour les enfants pour la décennie 2001-2010 avait révélé que des acquis importants avaient été obtenus en matière de disponibilité de services sociaux de base avec le concours de la communauté internationale : le taux d'accessibilité aux formations sanitaires dans un rayon de 5 km a augmenté de 45 % à 62 % de 1994 à 2000 grâce à la généralisation de l'Initiative de Bamako à tous les districts sanitaires. Certes, la santé infantile a connu des progrès appréciables, mais ils restent insuffisants. De 1988 à 2006, le taux de mortalité infantile (moins d'un an) a diminué de plus de 26 points de pourcentage, passant de 132 à 106 pour 1000. Le taux de la mortalité infanto-juvénile est passé de 212 pour 1000 naissances vivantes en 1988 à 157 pour 1000 naissances vivantes en 1995, puis à 220 pour 1000 en 2003 pour retomber à 176 pour 1000 naissances vivantes en 2006, avec des disparités importantes entre garçons et filles ainsi que de fortes différences selon les milieux et en particulier entre les milieux ruraux et urbains. Concernant l'objectif 5 relatif à l'amélioration de la santé maternelle, la mortalité maternelle et périnatale continuent de constituer un problème majeur de santé publique en République centrafricaine. Malgré

les efforts consentis par le Gouvernement en matière de santé de la mère et de l'enfant, le taux de mortalité maternelle est en constante augmentation depuis près de 20 ans. Passant de 683 décès pour 100 000 naissances vivantes en 1988, à 948 en 1995, puis à 1355 décès pour 100 000 naissances vivantes en 2003. L'analyse de la situation laisse apparaître un défi majeur, à savoir comment accélérer la mise en œuvre de manière durable des interventions ayant prouvé leur efficacité dans la lutte contre la mortalité maternelle et néonatale afin de les rendre accessibles aux populations et avec leur pleine participation, de sorte que toute femme et tout nouveau-né, en particulier ceux qui vivent en zone rurale, aient accès à des services de qualité. Il faudrait aussi une collaboration effective et un partenariat dynamique entre les principaux partenaires du développement pour que les interventions soient opérationnelles dans le domaine de la lutte contre la mortalité maternelle et néonatale. Face à ces défis, la réponse s'est articulée en deux volets : d'abord, suite aux recommandations du Forum des Premières Dames, organisé à Bamako en 2001, une initiative Vision 2010 de lutte contre la mortalité maternelle et néonatale a été élaborée sous le parrainage de la Première Dame de Centrafrique. Ensuite, en application des recommandations de l'Union africaine et de l'OMS/AFRO et conformément au Programme d'action de la Conférence internationale sur la population et le développement (CIPD+5), réaffirmé dans les objectifs du Millénaire pour le développement, le Gouvernement s'est attelé à l'élaboration d'une feuille de route nationale pour accélérer l'amélioration de la santé maternelle et néonatale ; cette feuille de route a été inscrite à l'ordre du jour du Sommet des chefs d'Etat de l'Union africaine. Concernant l'objectif 6 relatif à la lutte contre le VIH/sida, je peux dire que, malgré l'insuffisance du système de surveillance des infections sexuellement transmissibles et du VIH/sida, tous les indicateurs témoignent d'une tendance à la hausse de l'infection à VIH. Une cartographie du VIH réalisée avec l'appui de l'Institut Pasteur en 2002 a montré une prévalence de 15 % chez les femmes enceintes, et l'enquête MICS 2006 (enquête en grappes à indicateurs multiples) a révélé un taux de prévalence sur le plan national de 6,2 %, ce qui indiquerait qu'environ 260 000 personnes vivent avec le VIH/sida. La vision du Gouvernement centrafricain consiste à contribuer à la réduction du taux de prévalence du VIH de 6,2 % en 2002 à moins de 3 % en 2015 chez les femmes enceintes et à stabiliser la prévalence dans la population générale autour de 6 %. Les options retenues visent à mobiliser les secteurs prioritaires autour des actions de prévention et de prise en charge globale et à renforcer la coordination du suivi et de l'évaluation. L'objectif est d'améliorer la couverture par dépistage du VIH moyennant l'ouverture de services de conseil et de dépistage volontaires dans 74 centres de santé de catégorie A d'ici 2010, c'est-à-dire dans chaque sous-préfecture, de mettre 15 000 personnes vivant avec le VIH sous antirétroviraux d'ici 2012 et d'ouvrir la prise en charge par les antirétroviraux aux organisations confessionnelles telles que l'ASSOMESCA, ainsi qu'aux structures privées.

Monsieur le Président, la délégation de la République centrafricaine suggère que l'on tienne compte de la présence de troubles sociopolitiques qui constitueraient une entrave grave à la réalisation des OMD dans certains pays africains. Je vous remercie pour votre très aimable attention.

Mr TELAVI (Tuvalu):

Mr Vice-President, distinguished delegates, Tuvalu would like to align itself with the statement by the honourable Minister of Health of Kiribati, on behalf of the Pacific island countries. Tuvalu is progressing well towards achieving the health-related Millennium Development Goals. The Expanded Programme on Immunization shows excellent coverage, with an average of 98% for all vaccine-preventable diseases. An effective infant and young child feeding programme is in place, with full implementation of the WHO-recommended Integrated Management of Childhood Illness programme. Over the last five years, Tuvalu has reported a zero maternal mortality rate, with all deliveries attended by a trained midwife in a health facility providing antenatal and postnatal services integrating family planning services, male involvement, counselling services, management of sexually transmitted diseases and HIV referral systems.

Tuvalu is one of the most disaster-prone countries in the Western Pacific Region, with high climate risk and increasing sea levels, rises in temperature and limited adaptive capacity. Since 2007, there have been increasing global and regional discussions on the likely impact that climate change and disasters will have on our tiny atolls in the south Pacific, including Tuvalu. If there is an increase

in the frequency and intensity of disasters as a result of climate change, it is likely that our efforts to achieve the Millennium Development Goals by 2015 may never materialize. This combined interface has the potential to erase decades of developments achieved so far in Tuvalu. We are now two years past the mid-point to the 2015 deadline to reach the Millennium Development Goals; this means less time remains to bridge existing gaps. Now therefore provides a good opportunity for Member States and development partners alike to take stock of progress achieved on the implementation of the Millennium Development Goals as well as the effectiveness of support provided to countries to achieve the Goals.

The volatility of food and fuel prices, the pressing issue of climate change and the looming global economic slowdown are exacerbating the pressures on Tuvalu to accelerate progress towards the Millennium Development Goals and are threatening to reverse some of the gains that have been achieved. Clearly, there is an urgent need to scale up resources, programmes and interventions. In the absence of well-functioning health systems, powerful interventions and the money to purchase them will not be enough to reduce the gaps in health outcomes. Further, a firm commitment is required from WHO, development partners and civil society to put countries on track to accelerate progress towards the Millennium Development Goals over the next six years.

Allow me to congratulate WHO and in particular the International Health Regulations team for responding effectively to pandemic (H1N1) 2009. Tuvalu is now administering vaccines to protect its people from H1N1 and is already part of a regional movement to scale up disease surveillance systems with a focus on early detection and reporting in line with guidelines set forth by WHO.

In closing, I would like to congratulate WHO for granting observer status to Taiwan, an impressive achievement by WHO to bring the world together in participation towards achieving the Millennium Development Goals. Tuvalu is looking forward to other United Nations bodies including Taiwan in their systems. Mr Vice-President, thank you for giving me the opportunity, and thank you, delegates for listening.

Le Professeur TEHINDRAZANARIVELO (Madagascar):

Monsieur le Président, Madame le Directeur général, Mesdames et Messieurs les Ministres et chefs de délégation, honorable assistance, Madagascar adresse ses condoléances aux peuples et aux Gouvernements de Haïti et du Chili ainsi qu'aux membres du personnel de l'OMS morts lors du tragique tremblement en Haïti. Madagascar adresse aussi ses hommages à Mme le Directeur général de l'OMS, et à tous ses collaborateurs, pour son leadership dans la gestion de la lutte contre la grippe pandémique A (H1N1) et pour les thèmes choisis à l'occasion de cette Soixante-Troisième Assemblée mondiale de la Santé. Nous adressons aussi nos vifs et sincères remerciements aux organisations internationales, aux organisations non gouvernementales, aux pays partenaires et à tous les bailleurs de fonds qui ont aidé Madagascar.

Madagascar, bien soutenue par les partenaires techniques et financiers avec un engagement politique jusqu'au plus haut sommet de l'Etat, est sur la bonne voie dans la réalisation des objectifs du Millénaire pour le développement, surtout pour les objectifs 4, 5 et 6. Plus particulièrement, notre réussite dans la lutte contre les grandes endémies, dont le paludisme, nous interpelle pour des interventions continues et beaucoup plus ciblées : nous avons en effet constaté que tout fléchissement sera sanctionné par une résurgence de l'épidémie.

Au travers de cette réussite et à la lumière de notre système national d'information sanitaire, nous avons constaté l'avènement d'une autre endémie qui se singularise, d'une part par son impact direct sur le développement socio-économique de notre pays car elle puise ses victimes dans les ménages, piliers de notre société, à savoir les jeunes adultes et, d'autre part, par la difficulté et la complexité de sa prise en charge : il s'agit des maladies chroniques non transmissibles. Or Madagascar dispose déjà d'une politique nationale de prévention et de lutte contre ces maladies. Grâce à l'attention particulière de Mme le Directeur général de l'OMS et de l'AIEA, Madagascar a pu bénéficier d'une assistance technique qui a permis d'élaborer et de valider cette année notre politique nationale de lutte contre le cancer, notre plan d'action 2010-2015 de lutte contre le cancer et un projet de lutte contre les cancers mammaires et gynécologiques, projet financé à ce jour à hauteur de 30 % par la société civile malgache et notre Gouvernement. Ainsi, nous demandons à la communauté internationale, dans

l'esprit de Doha, de classer les maladies chroniques non transmissibles au même rang que les grandes endémies transmissibles avec une mobilisation financière à la hauteur de leur importance. Par ailleurs, si des partenaires veulent bien nous accompagner, nous ambitionnons de jouer et de servir de site de démonstration et nous nous engageons à valider pour l'OMS les protocoles prévus pour la lutte contre les maladies chroniques non transmissibles, sans réduire notre lutte contre les maladies transmissibles. Je vous remercie de votre attention.

Archbishop ZIMOWSKI (Holy See):

Mr Vice-President, the recent report on monitoring the achievements of the health-related Millennium Development Goals (document A63/7) offers us an appraisal of the successes and challenges. The Holy See delegation would like to join other delegations in acknowledging, among others, the growing success in reducing infant mortality, malaria control, widening of access to antiretroviral therapy for people living with HIV/AIDS, as well as treating and lowering the incidence rate of tuberculosis. There have been positive efforts towards the achievement of some of the set goals. It is true though, that the achievements vary from country to country and from Goal to Goal. On the other hand, my delegation cannot agree with programmes that promote abortion and contraceptives. We need to multiply initiatives that foster the achievement of personal maturity in sexuality and in the mutual love and decision-making that characterize the conjugal relationship in accordance with moral norms. The Holy See considers that abortion and contraceptive methods should not be promoted among targets for the new Millennium.

Furthermore, there are continuing inequities between health-care systems in high-income countries and those of low-income countries, and worse still, those in the so-called least developed countries. Moreover, even in the high-income countries themselves, there are wide gaps in access to health care. Closely related to these problems is the lack of access among poor and marginalized people to medicines and other life-saving technologies because of lack of affordability or the poor health-care infrastructure in their home countries. Resources are badly needed by these poor countries to meet the funding shortfalls and strengthen their health systems.

Pope Benedict XVI, in his recent Encyclical letter *Caritas in veritate,* makes a strong appeal for the "Co-operation of the Human Family". The Holy Father stresses that the development of peoples depends, above all, on a recognition that the human race is a single family working together in true communion, not simply a group of subjects who happen to live side by side. And in order to avoid paternalistic social assistance, which is demeaning to those in need, the solidarity of the rich nations to the poor countries has to be closely linked with the principle of subsidiarity.

Another complicating factor for access to health care is the failure to find a balanced approach to intellectual property rights and the right to make a just profit from investments in research and development for pharmaceuticals and diagnostics vis-à-vis the emergency situation posed to the global community by such pandemics as HIV/AIDS and by major diseases that affect populations in low-income countries. I wish here to reiterate the appeal made by the Servant of God, John Paul II, who in his address to the Conference on Economy and Health, promoted by the Pontifical Council for Health Care Workers, called upon pharmaceutical industries never to let financial gain prevail over the consideration of human values, but to be sensitive to the needs of those who do not enjoy social security, carrying out effective programmes to help the poorest and most marginalized. He said that we must work to reduce and, if possible, eliminate the differences between the various continents, urging the more advanced countries to make available to the less developed their experience, technology and some of their economic wealth.

Lastly, there are growing health concerns today related to climate change, and in the face of established evidence it would be irresponsible not to take the issue seriously. Thus Pope Benedict XVI, in his annual message for the World Day of Peace 2010, called for urgent action to protect the environment, observing that climate change and environmental degradation have a profound impact on the exercise of human rights, such as the right to life, food, health and development. Thank you, Mr Vice-President, and God bless you all.

Professor Chih-liang YAUNG (Chinese Taipei):

Mr Vice-President, health ministers, distinguished delegates, ladies and gentlemen, it is a privilege for me to address this plenary session in my capacity as Minister of Health of Chinese Taipei. Firstly, I would like to extend my congratulations to the President, upon his election to the Presidency of this year's Health Assembly. I would also like to express my sincere appreciation to the Director-General, Dr Margaret Chan, and her capable staff for arranging our participation in this Health Assembly for the second time in 39 years.

Last year, Chinese Taipei's participation in the Health Assembly and incorporation into the International Health Regulations, (2005) framework enabled us to obtain guidance from WHO directly and to take more effective action in handling the pandemic (H1N1) 2009 influenza. Subsequently, we were able to produce our own vaccine and do our part to prevent the spread of the pandemic. Your strong support for our meaningful participation will not go in vain. Moreover, when the earthquake hit Haiti in January this year, our rescue teams were among the first on the spot to assist with the relief work. In the process, we worked closely with teams from Ecuador, El Salvador and the United States of America. We will further join hands with the global community to assist Haiti in rebuilding its public health, medical care and disease prevention systems. These facts illustrate that our participation in WHO not only helps strengthen the global network for epidemic prevention, but also allows more countries to benefit from Taiwan's advanced medical capabilities.

Over the past decade, the global financial crisis, epidemics, earthquakes, blizzards, droughts, floods, and other man-made and natural disasters that have posed serious challenges to mankind. They have also impeded global efforts to realize the Millennium Development Goals 2015. As the deadline for achieving the Goals is drawing near, and considering that health is at the heart of the Goals, it is opportune for us to review where we stand today. To achieve the health-related Millennium Development Goals, WHO has devoted considerable resources to a broad array of projects and has made substantive achievements. Chinese Taipei, likewise, has worked hard and made significant progress in such areas as the prevention of HIV/AIDS and the eradication of malaria as well as other infectious diseases. In addition, we have built a comprehensive medical care system and implemented well-designed public health plans related to women, children, and vaccination. Furthermore, we have established one of the most successful universal health insurance programmes in the world. Because of our endeavours, the health of the general public, particularly women, children and senior citizens, has greatly improved. Chinese Taipei would like very much to share these experiences with the rest of the world, and provide training and resources in a variety of fields to those countries in need. By working together with the international community, we can help achieve the health-related objectives set out in the Millennium Development Goals.

I would like to reiterate that diseases and disasters know no boundaries. Severe acute respiratory syndrome and the H1N1 (2009) have made us all the more aware that only by joining forces can we minimize the impact of cross-border health crises. I therefore call for all countries to join together in support of WHO's policies. We need good use of this important health platform to promote better human security and reach the objectives set out in the Millennium Development Goals.

Mr Vice-President and distinguished health ministers, the continuous participation of Chinese Taipei in WHO's work will not only benefit people in Taiwan, but also help enhance the global system for disease prevention and strengthen the international community's ability to respond to disasters. I cherish this opportunity to take part in deliberations on how to deal with public health challenges, and we very much hope to share our experiences, knowledge and expertise. Last but not least, I wish the Sixty-third World Health Assembly great success. Thank you very much.

Mr SO Se Pyong (Democratic People's Republic of Korea):[1]

Mr Vice-President, Madam Director-General, ladies and gentlemen, on behalf of the delegation of the Democratic People's Republic of Korea, I would like, first of all, to extend warm congratulations to you, Mr Mondher Zenaidi, on your election as the President of the Sixty-third World Health Assembly. I believe that under your able leadership, this session will be a great success.

It is of great significance in improving the health work and promoting the well-being of peoples in the Member States that the Sixty-third World Health Assembly has taken up "the Health-Related Millennium Development Goals" as the theme of the general discussions in the plenary meetings of the Health Assembly to undertake a review of progress and experiences thus far in the implementation of the Millennium Development Goals and consider ways forward to accelerate achievement of the agreed Goals. The delegation of the Democratic People's Republic of Korea greatly appreciates the specific and practical steps and dedicated efforts that Dr Margaret Chan and WHO have made to achieve progress and success and mobilize resources for the implementation of the Millennium Development Goals.

Upholding the leadership of the Songun revolution of the great leader General Kim Jong Il, the Government of the Democratic People's Republic of Korea regards the improvement of the welfare of the people as its foremost principle and provides policy and legal guarantees for rendering equal and good-quality health-care services to all people, ensuring that the State takes full responsibility for their health care. The Government has put forward as its major public health policy preventive health care, universal access to free health care, the household doctor system, training of health professionals according to the needs of the country, improvement of quality of health services and solid building of a self-sustaining pharmaceutical industry. It is steadfastly maintaining the policy of giving utmost priority to the protection of life and the health of the people in line with the nature of human-centred socialist medicine, and is making active efforts to open the gates to a powerful and prosperous country in 2012 and provide a healthier and better life to our people.

Despite the serious difficulties caused by consecutive natural disasters for several years and economic blockage by external forces, the Government of the Democratic People's Republic of Korea has given top priority to the protection and improvement of health of mothers and children and made notable achievements in achieving the Millennium Development Goals by mobilizing all human and material resources in the country. These achievements are most evident in the reduction of the infant mortality rate, the maternal mortality rate and in other health indicators. The Democratic People's Republic of Korea has also established the telemedicine system of linking a central hospital with the provincial hospitals to improve the quality of health care for the people with the support of WHO. The Democratic People's Republic of Korea still has many challenges in the implementation of the health-related Millennium Development Goals by 2015. The health system should be further strengthened, the quality of health services improved and infrastructure reinforced.

In April of this year, Dr Margaret Chan, Director-General of WHO, visited the Democratic People's Republic of Korea. Dr Chan toured various health institutions and discussed the issues of further strengthening health services and implementing the health-related Millennium Development Goals in the country, which marked another important occasion to further strengthen collaboration between the Democratic People's Republic of Korea and WHO.

The delegation of the Democratic People's Republic of Korea takes this opportunity to express its sincere appreciation to the WHO Secretariat, the Regional Office for South-East Asia, other international organizations and donors which have provided support to the country in its efforts to strengthen the capacity of infrastructure, and which provide medicines and other commodities and train health professionals, thus helping the country to implement the health-related Millennium Development Goals.

Last but not least, I assure you, Mr Vice-President, that the delegation of the Democratic People's Republic of Korea will actively cooperate with WHO and Member States to achieve the

[1] The text that follows was submitted by the delegation of the Democratic People's Republic of Korea for inclusion in the verbatim records in accordance with resolution WHA20.2.

health-related Millennium Development Goals, thus making contribution to the improvement of the well-being of humankind.

The PRESIDENT:

This was the last speaker on my list. The Health Assembly has therefore concluded its work on item 3 of its agenda and I wish to thank all delegations which participated in the discussion for their valuable contributions.

It is time to adjourn for the day. The meeting is now adjourned.

The meeting rose at 18:55.
La séance est levée à 18h55.

SIXTH PLENARY MEETING

Wednesday, 19 May 2010, at 09:15

President: Mr Mondher ZENAIDI (Tunisia)

SIXIÈME SÉANCE PLÉNIÈRE

Mardi 19 mai 2010, 9h15

Président: M. Mondher ZENAIDI (Tunisie)

1. EXAMINATION OF CREDENTIALS
VÉRIFICATION DES POUVOIRS

Le PRÉSIDENT:

Je déclare l'Assemblée ouverte. Ce matin, l'Assemblée examinera le rapport de la Commission de Vérification des Pouvoirs qui s'est réunie hier sous la présidence du Dr B. Blaha (Autriche). Le rapport figure dans le document A63/60 que vous avez tous reçu. L'Assemblée souhaite-t-elle faire des observations sur le rapport ?

Je ne vois pas d'objection. Le rapport est par conséquent approuvé.

Outre le présent rapport, j'ai été informé par le Secrétariat que depuis la séance d'hier des pouvoirs officiels ont été reçus de l'Ex-République yougoslave de Macédoine et des Emirats arabes unis qui avaient auparavant présenté des pouvoirs provisoires, comme le reflète le rapport de la Commission. Conformément à la pratique établie, j'ai examiné les pouvoirs officiels de ces Etats Membres et les ai trouvés conformes au Règlement intérieur de l'Assemblée. Je recommande donc à l'Assemblée d'accepter les pouvoirs officiels de l'Ex-République yougoslave de Macédoine et des Emirats arabes unis. L'Assemblée approuve-t-elle cette procédure ?

Je ne vois pas d'objection. Il en est ainsi décidé. Je vous remercie.

2. REPORTS OF THE MAIN COMMITTEES[1]
RAPPORTS DES COMMISSIONS PRINCIPALES[1]

Le PRÉSIDENT:

L'Assemblée examinera à présent le point 8, Rapports des commissions principales.

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[1] See reports of committees in document WHA63/2010/REC/3.

[1] Voir les rapports des commissions dans le document WHA63/2010/REC/3.

First report of Committee A
Premier rapport de la Commission A

Aujourd'hui, nous examinerons le premier rapport de la Commission A, qui figure dans le document A63/58. Le premier rapport contient une résolution intitulée « Préparation en cas de grippe pandémique : échange des virus grippaux et accès aux vaccins et autres avantages ». L'Assemblée est-elle prête à adopter cette résolution ?

Je ne vois pas d'objection. La résolution est par conséquent adoptée et le premier rapport de la Commission A est par conséquent approuvé.

Nous achevons ainsi nos travaux de ce matin. La prochaine séance plénière se tiendra jeudi après-midi à 17 heures. Nous examinerons alors les points suivants : point 7 : Distinctions ; point 6 : Conseil exécutif – Elections ; point 8 : Rapports des commissions principales.

La Commission A se réunira immédiatement après la levée de la présente séance en salle 18 et la Commission B se réunira dans la salle 17. Cet après-midi, à 14 h 30, la septième séance de la Commission A se tiendra dans la salle 18 et la troisième séance de la Commission B aura lieu dans la salle 17. A 17 h 30, le Bureau tiendra sa deuxième séance dans la salle 12 afin de rédiger ses recommandations à l'intention de l'Assemblée de la Santé concernant l'élection annuelle des Membres habilités à désigner une personne devant siéger au Conseil exécutif, et également d'examiner notre programme de travail.

Immédiatement après la levée de la présente séance, la Commission A tiendra donc sa sixième séance en salle 18 et la Commission B sa deuxième séance en salle 17. La séance est levée.

The meeting rose at 09:20.
La séance est levée à 09h20.

SEVENTH PLENARY MEETING

Friday, 21 May 2010, at 17:25

President: Mr Mondher ZENAIDI (Tunisia)

SEPTIÈME SÉANCE PLÉNIÈRE

Vendredi 21 mai 2010, 17h25

Président: M. Mondher ZENAIDI (Tunisie)

1. AWARDS
DISTINCTIONS

The PRESIDENT:

The Health Assembly is called to order. Good afternoon ladies and gentlemen, we shall now proceed with item 7, Awards.

Excellencies, distinguished delegates, ladies and gentlemen, we are assembled here today for the presentation of prizes awarded by the Sasakawa Memorial Health Foundation, the United Arab Emirates Health Foundation, and the Dr LEE Jong-wook Memorial Fund. I have much pleasure in welcoming among us the distinguished winners of these prestigious prizes.

I am also very pleased to greet: representing the Sasakawa Memorial Health Foundation, Professor Kenzo Kiikuni, Chair of the Sasakawa Memorial Health Foundation; representing the founder of the United Arab Emirates Health Foundation, His Excellency, Obaid Salem Saeed Al Zaabi, Ambassador, Permanent Representative to the United Nations Office and other specialized agencies at Geneva; and representing the Dr LEE Jong-wook Memorial Prize for Public Health, Dr Han Kwang-su, President of the Korean Foundation for International Healthcare.

Presentation of the Sasakawa Health Prize
Remise du Prix Sasakawa pour la Santé

Distinguished delegates, ladies and gentlemen, we shall start with the presentation of the Sasakawa Health Prize. I invite Professor Kenzo Kiikuni to address the Health Assembly on behalf of the Sasakawa Memorial Health Foundation. Professor Kenzo Kiikuni, you have the floor.

Professor KIIKUNI (Sasakawa Memorial Health Foundation):

Congratulations, *Zhu he nin*, Dr Du Xueping.

Mr Yohei Sasakawa, the founder and WHO Goodwill Ambassador for Leprosy Elimination, wished to attend this important ceremony but he has to attend a National Day ceremony at Timor-Leste to enhance leprosy elimination, and asked me to address the Health Assembly on his behalf.

The Sasakawa Health Prize was established 26 years ago to enhance the spirit of primary health care in an innovative way. As we all remember, in 1978, 32 years ago, we unanimously agreed to pursue "Health for All", which will be our common objective for our global community, planet earth. And primary health care is the key element to achieve our common goal.

In the past, 45 individuals and institutions became distinguished winners of our award. One of the criteria of the award is not only innovative work to enhance primary health care, but also the future significance of their work looking forward. We ask each awardee how they propose to proceed with their work with our small prize money. We are grateful for excellent selection of this year's award by the selection panel headed by our esteemed President of the Executive Board, Dr Zaramba.

As we all know the People's Republic of China has a pioneering history of development of primary health care ideas. Dr Du is a graduate of Norman Bethune Medical University in northern China. Dr Bethune is the famous Canadian physician who followed Chairman Mao Tse-tung in the Great Leap forward and was one of the founders of modern community health services in China. After graduation, Dr Du spent several years in Inner Mongolia before coming to Beijing's Capital University.

China has made great economic progress in recent years and we are all envious of the great development. I sincerely hope that Dr Du's past achievement of training medical doctors in minority areas of central and western parts of China will lead to a further development of community health services, and we do hope China will be a model of primary health care development, both in developed and developing countries. Thank you and again, congratulations!

The PRESIDENT:

It is with pleasure that I announce that the 2010 Sasakawa Health Prize has been awarded to Dr Du Xueping of China. Dr Du Xueping is Director of the Yue Tan Community Health Service Center of FuXing Hospital, affiliated to the Capital Medical University. She is being nominated by the Ministry of Health of China for contributing, since 1994, in a pioneering manner, to the development of general medicine in China, thus ensuring that it has become an important discipline in the Chinese health-care system. It is now my privilege to present the Sasakawa Health Prize to Dr Du Xueping.

Amid applause, the President handed the Sasakawa Health Prize to Dr Du Xueping.
Le Président remet le Prix Sasakawa pour la Santé au Dr Du Xueping. (Applaudissements)

Dr DU Xueping:

女士们，先生们：

我今天站到这里心情非常激动。我首先感谢世界卫生组织，感谢世川卫生奖的所有评委，也感谢中国政府给了我发展社区卫生服务的机会，他们坐在后边。我从医科大学毕业后已经从医30年了，前15年在大医院的心内科从事心血管急症的救治工作，为我奠定了坚实的临床基础。我当心血管专科医生时，救治了无数的急性心肌梗死病人，有一个病人叫兰英，她十分感谢我的救命之恩，每年中国有一个春节，每年初都来给我拜年，向我问好，说明她还活着。因为专科服务模式是病人病情加重时才到医院来看病，专科医生不随诊。这样

延续了10年，第11年的时候，兰英没有来，替代她的是她的儿子，看到她儿子，我明白了兰英已经病故，临终前嘱咐她的儿子每年春节一定要来看望我。

1995年，也就是我从医30年后的15年，从事了全科医学，转变了服务模式，从被动的提供医疗服务走向预防为主的社区卫生服务——初级卫生保健，从专科走向全科，从医院走向社区，从祖国的东部走向祖国的中西部，从国内走向国外。

在中国政府的支持下，我在北京建立了月坛社区服务中心和下属的10个卫生服务站，为社区13万居民提供初级卫生保健服务，改正了居民的不良生活方式，推创了高血压、糖尿病、脑卒中、老年抑郁障碍的社区管理规范，在我们15年的努力下，许许多多的卧床多年的脑卒中偏瘫的患者站了起来，提高了生活质量，成千上万的高血压、糖尿病患者控制了血压和血糖，减少了并发症的发生，节省了医疗费用，这反映出中国医疗改革走过的路，反映出中国政府关注民生，注重人民健康，建设美好、平等、富强国家的实际行动。

在中国较早开展全科医学教育，培养全科医生，成为全科医学硕士研究生导师。我的一个最初要学习妇产科专业的硕士研究生对我说，从事全科医学其实并不是她的本意，但在学习全科医学的过程中，深深被社区卫生服务事业吸引了，感觉自己就象中了大奖一样幸运，这使我感到十分欣慰！确实，我的越来越多的学生（有大学本科生，也有硕士研究生）已经将毕生精力致力于初级卫生保健事业。

我们在中国中西部贫困地区建立了30多个“手拉手”帮扶社区卫生诊所，帮助他们培养全科医生。印象最深刻的是三年前的一个下午，我带领我的社区卫生服务团队来到中国西部内蒙古鄂尔多斯市的一个社区诊所，看到5个脑瘫患儿在母亲的怀抱中，期待地看到我们这些来自北京的社区专家，我们现场对这些患儿及家属进行了手把手的中西医康复治疗指导。看着几位患儿母亲期待的目光，我更加坚定了帮助中国中西部贫困地区发展社区卫生服务事业的信心。此后，我在北京连续多次开展社区卫生康复技能培训班，继续协助中国中西部十几个省市开展社区卫生服务。我们的工作受到中西部地区以及全科医生的极大欢迎。有一次我带着5名美国威斯康辛家庭医学院教授和2名纽约哥伦比亚大学教授到中国西部甘肃省兰州市讲学，刚下飞机就看到当地的全科医生在机场拉起了一道长长的横幅，欢迎我们的到来，全科医生准备了鲜花，献给我和美国的家庭医生，大家都十分感动，那次授课效果是最好的一次。这也说明中国的全科医学十分需要世界各个国家的专家来传授知识和经验。

我忠心感谢中国政府卫生部对我的支持，感谢世界卫生组织，感谢世川卫生奖的所有评委和世川先生授予我世川卫生奖！它不是我从事初级卫生保健成绩

的终点，而是起点，我愿意和世界上各个国家初级卫生保健事业的专家学者共同搭建世界的初级卫生保健网络，让世界各个国家（包括中国）贫困地区及受灾国家均能享受初级卫生保健，让世界和平、和谐、幸福、安康！我也欢迎各个国家对初级卫生保健事业感兴趣的同仁到我们中国北京，到我工作、生活的月坛社区卫生服务中心参观指导！北京已成功举办2008年奥运会，目前上海举办了世界博览会，中国欢迎你们！

为世界的初级卫生保健事业做出贡献是我毕业的追求！我要将所获得的世川卫生奖的全部奖金用于继续发展中国中西部地区的初级卫生保健事业！

感谢聆听！祝大家愉快！

Presentation of the United Arab Emirates Health Foundation Prize
Remise du Prix de la Fondation des Émirats arabes unis pour la Santé

The PRESIDENT:

We shall now proceed with the presentation of the United Arab Emirates Health Foundation Prize. The members of the Executive Board Selection Panel felt that more than one candidature merited the Prize, and therefore decided that the Prize should be shared between two candidates.

(The speaker continued in Arabic.) **(يواصل المتحدث بالعربية)**

The PRESIDENT: الرئيس:

إنه لمن دواعي سروري أن أعلن عن منح جائزة مؤسسة الإمارات العربية المتحدة للصحة في عام 2010 لكل من:

المركز الوطني للسكري والغدد الصم والأمراض الوراثية (الأردن)

و

برنامج التدخل في مرحلة الطفولة المبكرة التابع للإدارة الإقليمية للصحة في ألينتيجو (البرتغال)

إن المركز الوطني للسكري والغدد الصم والأمراض الوراثية هو أحد المراكز التابعة للمجلس الأعلى للعلوم والتكنولوجيا في الأردن، ويقدم فريقه الرعاية إلى نحو 000 35 مريض.

أما برنامج التدخل في مرحلة الطفولة المبكرة فهو جزء من عملية تنفيذ خطة الصحة الوطنية في ألينتيجو بالبرتغال، ويتجاوب مع عملية إعادة تنظيم النظام الصحي من خلال تجميع مراكز الرعاية الصحية.

وشكراً لكم،

إنه لشرف لي أن أقدم جائزة مؤسسة الإمارات العربية المتحدة للصحة إلى المركز الوطني للسكري والغدد الصم والأمراض الوراثية في الأردن، والذي يمثله الأستاذ كامل عجلوني.

(The speaker continued in English.) **(يواصل المتحدث بالإنكليزية)**

It is my pleasure to announce that the 2010 United Arab Emirates Health Foundation Prize has been awarded jointly to The National Center for Diabetes, Endocrinology and Genetics (Jordan), and the Early Childhood Intervention Programme, Regional Administration of Health of Alentejo (Portugal).

The National Center for Diabetes, Endocrinology and Genetics is attached to the Higher Council for Science and Technology in Jordan, and its team provides care for about 35 000 patients. The Early Childhood Intervention Programme is part of the implementation of the National Health Plan in Alentejo, Portugal, which responds to the reorganization of the health system though grouping health-care centres.

I have now pleasure in inviting His Excellency, Obaid Salem Saeed Al Zaabi representing the United Arab Emirates Health Foundation, to address the Health Assembly.

Mr AL ZAABI (United Arab Emirates Health Foundation):

الزّعبي (مؤسسة الإمارات العربية المتحدة للصحة):

بسم الله الرحمن الرحيم،

سعادة السيد منذر الزنايدي رئيس جمعية الصحة العالمية الثالثة والستين، سيادة الدكتورة مارغريت تشان المديرة العامة لمنظمة الصحة العالمية، أصحاب المعالي وزراء الصحة، أصحاب السعادة أعضاء الوفود، السادة ممثلو المنظمات المشاركة، السيدات والسادة،

السلام عليكم ورحمة الله وبركاته،

يشرفني، باسم مؤسسة الإمارات العربية المتحدة للصحة، أن أتقدم إليكم جميعاً بخالص التهاني بمناسبة الاحتفال السنوي الذي تنظمه منظمة الصحة العالمية لتكريم الأطباء والعلماء والمؤسسات ممن أسهموا في إثراء العمل الصحي وتعزيز دور المنظمة الرائد في المحافظة على صحة الإنسان وسلامته. كما أغتنم هذه المناسبة لأتقدم بجزيل الشكر والامتنان للمجلس التنفيذي للمنظمة للجهود الطيبة التي يبذلها جميع أعضائه بالإعداد الجيد لتكريم الفائزين بهذه الجائزة.

السيدات والسادة،

إن جائزة مؤسسة الإمارات العربية المتحدة للصحة جاءت مجسدة، بثقة وإيمان، القيادة الرشيدة لصاحب السمو الشيخ خليفة بن زايد آل نهيان رئيس الدولة حفظه الله وأخيه صاحب السمو الشيخ محمد بن راشد آل مكتوم نائب رئيس الدولة، رئيس مجلس الوزراء حاكم دبي حفظه الله وإخوانه معه، أصحاب السمو حكام الإمارات حفظهم الله لتعزيز ودعم العمل النبيل لمنظمة الصحة العالمية في كافة بلدان العالم.

إن التطور الذي شهده القطاع الصحي في دولة الإمارات العربية المتحدة خاصة خلال السنوات القليلة الماضية يعكس بوضوح فعالية الاستراتيجيات التي انتهجتها الدولة في هذا المجال حتى أصبحت تضاهي مثيلاتها في كثير من دول العالم المتقدم. فمع النهضة الاقتصادية والاجتماعية المتسارعة التي تشهدها دولة الإمارات بادرت وزارة الصحة من جانبها إلى اتخاذ خطوات حثيثة لتطوير استراتيجيات قادرة على تقييم المشاكل الصحية بصورة علمية ودقيقة تستوعب التقنيات والمعارف الحديثة المتاحة حتى تلائم الظروف والطموحات الوطنية.

ومن أهم معالم هذه الاستراتيجيات، أيضاً، تطوير برامج شاملة لمكافحة الأمراض المعدية والمزمنة على حد سواء، حيث تم إطلاق البرنامج الوطني لمكافحة داء السكري. كما أن لاستئصال مرض شلل الأطفال والإشهاد على خلو دولة الإمارات من الملاريا دوراً هاماً في تعزيز برامج الترصد الوبائي للأمراض المعدية والأمراض المستجدة. ومما ساهم في تفعيل برامج الترصد، حسب منظمة الصحة العالمية وبعد دخول اللوائح الصحية الدولية حيز التنفيذ في أيار/ مايو 2007 رفعت كافة الدول قدراتها للتأهب والاستعداد للتدخل فور حدوث أي مشكلة صحية ناتجة عن مرض معد.

السيدات والسادة،

إنه لشرف لي أن أعلن من هذا المقام وبموافقة المجلس التنفيذي لمنظمة الصحة العالمية منح جائزة مؤسسة الإمارات للصحة لهذا العام مناصفة إلى كل من برنامج التدخل للطفولة المبكرة التابع للإدارة الإقليمية للصحة بمنطقة أليننتيجو في البرتغال، والمركز الوطني لمرض السكري والغدد الصم والوراثة بالأردن.

يقدم برنامج التدخل للطفولة المبكرة التابع للإدارة الإقليمية للصحة في البرتغال خدمات مميزة للمستفيدين منه وذلك من خلال تقييم الأطفال الذين يعانون اضطرابات فيما يتعلق بنموهم وتقييم احتياجاتهم

باعتماد مبدأ مشاركة الأسرة والمجتمع وجميع الموارد المحلية المناسبة وضمان التواصل الجيد بين جميع الأطراف المعنية، مما يدل على شراكة سليمة بين مؤسسات التعليم والرعاية الصحية ونُظم الرعاية الاجتماعية ومؤسسات التضامن الاجتماعي الخاص، فضلاً عن التعاون مع السكان لنجاح البرنامج.

أما المركز الوطني لمرض السكري والغدد الصم والوراثة بالأردن فإنه يقدم الخدمة المتكاملة لمرضى السكري ومضاعفاته ورفع مستوى الخدمات المقدمة لهؤلاء المرضى حيث بلغ عدد المرضى المستفيدين من هذه الخدمة منذ عام 2006 حوالى 000 35 مريض. وقد تميز المركز بالبحوث العلمية حيث نشر العاملون فيه ما يزيد على 120 بحثاً متخصصاً في مجالات علمية كالسكري والاختصاصات ذات العلاقة. ويقوم المركز، بالتعاون مع الجامعة الأردنية، بالتدريب المهني الأكاديمي للأطباء والممرضات وأخصائيي التغذية السريرية والإرشاد الوراثي والقدم السكرية ويمنح هذا البرنامج درجات الدبلوم والماجستير في الطب السكري والتمريض المتخصص بالسكري وممرض أو فني متخصص بالسكري والقدم السكرية والتغذية السريرية وأخيراً التثقيف الصحي. كما يقوم المركز بتأهيل الاختصاصيين الباطنيين بتخصص الغدد الصم والسكري والاستقلاب بعد دراسة وتدريب لمدة ثلاث سنوات.

السيدات والسادة،

إن دولة الإمارات العربية المتحدة بإسهامها في منح جائزة الإمارات للصحة تتطلع إلى حث العلماء والباحثين والمؤسسات العلمية والمنظمات والجمعيات ذات النفع العام في جميع أنحاء العالم على بذل مزيد من الجهد لمواكبة التطورات المتسارعة التي يشهدها عالمنا اليوم وذلك للتوصل إلى أساليب أكثر فعالية للتغلب على المشاكل والتحديات الصحية التي تواجهها والتي أدت إلى معاناة كبيرة خاصة في الدول القليلة الموارد مما يشكل عبئاً إضافياً على تطور وتنمية خدماتها الصحية.

وأخيراً، لا يسعني إلا أن أتوجه لجمعكم الكريم هذا بالشكر والتقدير والتهنئة القلبية للفائزين بجائزة هذا العام. كما أؤكد مرة أخرى مواصلة سعينا إلى تقديم كل ما من شأنه أن يعود بالخير على البشرية جمعاء.

والسلام عليكم ورحمة الله وبركاته.

الرئيس: The PRESIDENT:

شكراً لكم،

إنه لشرف لي أن أقدم جائزة مؤسسة الإمارات العربية المتحدة للصحة إلى المركز الوطني للسكري والغدد الصم والأمراض الوراثية في الأردن، والذي يمثله الأستاذ كامل عجلوني.

(يواصل المتحدث بالإنكليزية) **(The speaker continued in English.)**

It is now my privilege to present the United Arab Emirates Health Foundation Prize to the National Center for Diabetes, Endocrinology and Genetics of Jordan, represented by Professor Kamel Ajlouni.

Amid applause, the President handed the United Arab Émirates Health Foundation Prize to Professor Kamel Ajlouni.

Le Président remet le Prix de la Fondation des Émirats arabes unis pour la Santé au Professeur Kamel Ajlouni. (Applaudissements)

Professor AJLOUNI:

الأستاذ عجلوني (المملكة الأردنية الهاشمية):

بسم الله الرحمن الرحيم،
السيد الرئيس، السيدة المديرة العامة، أصحاب المعالي والعطوفة ممثلو الدول كافة المحترمون، سيداتي سادتي،

إنه لشرف عظيم لي أن أقف بين ظهرانيكم مساء هذا اليوم الطيب لأتسلم جائزة الإمارات العربية المتحدة عام 2010 لأفضل الخدمات الصحية على مستوى العالم ممثلاً للمركز الوطني للسكري والغدد الصم والوراثة في عمّان، الأردن لتقديم خدمات مميزة وعلى مستوى تشهد المؤسسات الأكاديمية والمهنية به مشاركة مع برنامج التدخلات الخاصة ببداية مرحلة الطفولة التابع للإدارة الإقليمية للصحة في مقاطعة ألينتيجو، البرتغال.

إن فوز مركزنا بهذا التقدير من مؤسستكم العتيدة له معان سامية في تقدير بلدنا الأردن صاحب الموارد المالية الشحيحة وصاحب الأعمال الكبار في خدمة الإنسان والإنسانية التي لا حدود لها ضمن إمكانياتنا وهو إنجاز ما كان ليحدث لولا دعم الجهات المعنية في بلدي وعلى رأسها وزارة الصحة الأردنية ممثلة بمعالي الدكتور نايف الفايز وكليات الطب في جامعتنا الأردنية التي نفخر بها ومؤازرة المؤسسات العديدة التي تعنى بالخدمات الصحية في بلدنا. ولذا لابد من شكرها في هذا اليوم المبارك على تعاونها وما أدى إليه هذا التعاون معها من نتائج مثمرة وكبيرة آملين أن نستمر في هذا الإطار مثالاً للتعاون والإنجاز. ولابد، هنا، من الاعتراف بفضل المكتب الإقليمي لمنظمة الصحة العالمية وعلى رأسه المدير الإقليمي الدكتور حسين الجزائري الداعم للتفوق والتميز.

السيد الرئيس، السيدة المديرة العامة، سيداتي سادتي،

إن منطقتنا تحتاج إلى الكثير من العمل الجاد الدؤوب لخدمة إنسانية الإنسان ليعيش هذا الإنسان حريته وآماله بصحة جيدة ولن يتسنى ذلك إلا إذا عولجت المشاكل وعلى رأسها القضية الفلسطينية لإعادة حقوق الشعب الفلسطيني مما سيجنب منطقتنا الكثير من الدمار والإرهاب والحروب وما يتبعه من آثار سلبية على صحة الإنسان وسلامته. وما العراق وأفغانستان إلا مثالان حيّان نأمل أن تنتهي هذه المآسي إلى سلام دائم وشامل وعادل.

من على هذا المنبر وبكل اعتزاز أقول لكم إن جائزتكم هي جائزة لكل العاملين في المركز الوطني للسكري والغدد الصم والوراثة في الأردن من الأطباء وأصحاب المهن المساعدة والمساندة والإداريين. فباسمهم جميعاً أقول لكم، قبل تسلمي لجائزتكم الكريمة وبعد ذلك، شكراً لكم على هذا التقدير الذي يزيد من مسؤوليتنا ويحفزنا لمزيد من العمل الجاد لنكون دائماً عند حسن الظن بنا. ولا يفوتني هنا أن أتقدم بالشكر لدولة الإمارات العربية المتحدة التي تدعم التميز ليس فقط في بلدها ومنطقتها العربية بل وعلى مستوى العالم فلها كل الشكر والعرفان والامتنان والسلام عليكم ورحمة الله وبركاته.

The PRESIDENT: الرئيس:

شكراً لكم،
إنه لشرف لي أن أقدم الآن جائزة مؤسسة الإمارات العربية المتحدة لبرنامج التدخل في مرحلة الطفولة المبكرة التابع لإدارة الصحة في ألينتيجو بالبرتغال والذي تمثله السيدة روزا فالنتي دي ماتوس زورينيو.

Amid applause, the President handed the United Arab Emirates Health Foundation Prize to Dr Rosa Valente de Matos Zorrinho.
Le Président remet le Prix de la Fondation des Émirats arabes unis pour la Santé au Dr Rosa Valente de Matos Zorrinho. (Applaudissements)

Dr VALENTE DE MATOS ZORRINHO:

Good afternoon. The main goal of the Early Childhood Intervention Programme is to ensure development conditions for children between 0 and 6 years, with disability or at risk of serious development delay, as well as supporting their families. This support delivery takes place within children's natural life context and actively engages their care providers, boosting developmental capabilities, in order to enhance full social inclusion. Dr Cristina Miranda is the responsible officer in Alentejo.

The Programme, which is based on several partnerships, was implemented in Alentejo in 2000; by the end of 2008, it covered the entire region (47 municipalities). It is locally guaranteed by 42 Direct Intervention Teams, made up from different professionals (early childhood educators, therapists, psychologists, nurses and social workers), and has 38 vehicles at its disposal. In 2009, the Early Childhood Intervention Programme provided support to 2349 children and their families. On behalf of the Regional Administration of Health of Alentejo, the professionals working in the Early Childhood Intervention Programme and, especially, the children and families, I would like to thank WHO and the United Arab Emirates Health Foundation for such an honourable distinction. Thank you.

(*Applause/Applaudissements)*

Presentation of the Dr LEE Jong-wook Memorial Prize for Public Health
Remise du Prix Dr LEE Jong-wook pour la Santé publique

The PRESIDENT:

We will now proceed with the presentation of the 2010 Dr LEE Jong-wook Memorial Prize for Public Health. It is my pleasure to announce that the 2010 Dr LEE Jong-wook Memorial Prize for Public Health has been awarded to Action for Aids, Singapore, represented by its President, Professor Roy Chan. Action for AIDS Singapore is a voluntary, community-based organization, formed in 1998, and registered as a charity since 1994. I shall now invite Dr Han Kwang-su, President of the Korean Foundation for International Healthcare to address the Health Assembly on behalf of the Dr LEE Jong-wook Memorial Fund.

Dr HAN Kwang-su (Korean Foundation for International Healthcare):

Honourable Chair, Madam Director-General, honourable delegates from the Member States, representatives of Action for AIDS Singapore, this year's award recipient, distinguished guests, ladies and gentlemen.

As President of the Korean Foundation for International Healthcare, I am honoured to stand before you today to pay tribute both to our late great leader, Dr Lee Jong-wook, and to this year's recipient of the Dr LEE Jong-wook Memorial Prize for Public Health, Action for AIDS Singapore.

Already, four years have passed since Dr Lee died. Despite the enduring sadness of Dr Lee's premature passing, we take optimistic pride in the fact that Dr Lee continues his noble work, even in death, through the Prize in his name. Moreover, we are confident that his ideals continue to be championed and realized by his dearest friend, colleague and successor, Dr Margaret Chan, Madam Director-General, the tireless members of WHO, and all those who follow in his footsteps.

This brings us to Action for AIDS Singapore, this year's Prize recipient. While Action for AIDS Singapore's work is ostensibly focused on Singapore at this time, we are confident that their achievements and ongoing efforts will set an example – the standard – to be followed by others in the region, as well as the rest of the world.

On behalf of the Korean Foundation for International Healthcare and the Dr LEE Jong-wook Memorial Prize for Public Health, I ask you, the 193 Member States of WHO, to congratulate Action for AIDS Singapore and to follow their lead – not just with respect to HIV/AIDS but with all diseases

and the marginalized people suffering from them, not just for the sake of your nation and your people but for the sake of everyone in this world.

Dr Lee Jong-wook would have accepted nothing less. Thank you.

The PRESIDENT:

Thank you. It is with great pleasure that I present the 2010 Dr LEE Jong-wook Memorial Prize for Public Health to Action for AIDS Singapore.

Amid applause, the President handed the Dr LEE Jong-wook Memorial Prize for Public Health to Action for AIDS Singapore.
Le Président remet le Prix Dr LEE Jong-wook pour la Santé publique à Action for AIDS (Singapour). (Applaudissements)

Professor Roy CHAN:

Mr President, Madam Director-General, distinguished delegates, in 1986, a group of concerned individuals started a committee to address a new infectious disease called AIDS. We felt that a community-based perspective to education, awareness, prevention and support was urgently needed to meet the challenges presented by AIDS in a traditional and conservative society.

Action for AIDS was formed and registered in 1988. From the outset, because we were nongovernmental and privately and locally funded, our programme content, delivery and strategies were frank and largely free from censorship.

In the area of awareness and education, we pushed the message of condom promotion and safer sex. This often attracted criticism from conservative groups and media. But we stuck to our mission and goals. Public education was communicated through mass media, as well as programmes through clubs, group meetings and street- and venue-based events. We enlisted the help of pop stars, artists and celebrities to promote safer sex. We utilized drama, pop concerts and music, organized walks, runs and marathon bicycle rides to create public awareness and to spread the message. Aware of our limited resources, we concentrated our efforts on those at highest risk and, in Singapore, these include men who have sex with men, street-based sex workers and clients of sex workers. We have also been targeting out-of-school youth and especially young men who have sex with men who are the most vulnerable.

We raised funds to import and pay for expensive medications – starting in 1990 with aerosolized pentamidine and influenza vaccination. When zidovudine (AZT) was introduced, our buyers' club hand-carried AZT from Australia. The buyers' club has now grown to help poor patients obtain generic antiretroviral medications. We started a medication assistance fund to assist needy patients, including pregnant mothers, to access highly active antiretroviral therapy. We coordinate three peer support groups and have just opened a positive living centre. In order to promote HIV testing, we started the anonymous testing service in 1991, which has provided over 100 000 tests to date. Three years ago, we started free and anonymous venue-based testing in clubs and saunas for men who have sex with men, and are now planning for a mobile testing van service. We have fought HIV-related discrimination on many fronts, including burial rights and right of abode of HIV-infected foreign spouses of citizens. We have worked towards universal access to affordable antiretroviral therapy, increased access to education and prevention, and have argued for the repeal of the law that criminalizes homosexual sex in Singapore.

Over the last 22 years, we have enjoyed the support and generosity of a very large number of individuals, businesses and organizations. We now also receive significant support and recognition from the Singapore government. None of our achievements would have been possible if not for the dedication and effort of volunteers, many of whom were and are HIV-positive. Our volunteer Governing Board has provided guidance and direction, and our tireless staff and volunteers have laboured to transform that into action. It is for all of them, and for the people of my country, that I proudly and at the same time very humbly receive this award. On behalf of Action for AIDS Singapore, I would like to thank the Singapore Ministry of Health for nominating us, the Awards

Committee of the Dr LEE Jong-wook Memorial Prize for Public Health and the Korean Foundation for International Healthcare for this great honour. Thank you very much.

The PRESIDENT:

Thank you Professor Chan. This concludes our consideration of item 7 of our agenda. I would now like to request that delegates remain seated for a few moments while the Director-General and I bid farewell to our guests. Thank you.

2. EXECUTIVE BOARD: ELECTION
CONSEIL EXÉCUTIF: ÉLECTION

Le PRÉSIDENT:

Mesdames et Messieurs, nous allons passer à l'examen du point 6 : Conseil exécutif – élection. J'attire votre attention sur la liste des 12 membres figurant dans le document A63/61 établi par le Bureau conformément à l'article 100 du Règlement intérieur. De l'avis du Bureau, ces 12 membres réaliseraient, s'ils étaient élus, un Conseil comportant dans son ensemble une distribution équilibrée. Ces membres sont, dans l'ordre alphabétique français, les suivants : Arménie, Barbade, Chine, Equateur, Etats-Unis d'Amérique, Maroc, Mongolie, Mozambique, Norvège, Seychelles, Timor-Leste et Yémen. L'Assemblée est-elle prête, conformément à l'article 78 du Règlement intérieur, à élire ces 12 membres comme le Bureau le propose ? Je ne vois pas d'objection. Je déclare donc ces 12 membres élus.

Cette élection sera dûment consignée dans les actes officiels de l'Assemblée. Puis-je saisir cette occasion d'inviter les membres à tenir dûment compte des dispositions de l'article 24 de la Constitution lorsqu'il désigne une personne devant faire partie du Conseil exécutif.

3. REPORTS OF THE MAIN COMMITTEES[1] (continued)
RAPPORTS DES COMMISSIONS PRINCIPALES[1] (suite)

Le PRÉSIDENT:

Nous allons maintenant passer à l'examen du point 8 de l'ordre du jour: Rapports des commissions principales.

Second report of Committee A
Deuxième rapport de la Commission A

Aujourd'hui, nous examinerons le deuxième rapport de la Commission A tel qu'il figure dans le document A63/59. Veuillez ne pas tenir compte de la mention « projet » puisque le rapport a été adopté par la Commission sans amendement.

Le rapport contient une résolution intitulée « Situation sanitaire dans le territoire palestinien occupé, y compris Jérusalem-Est, et dans le Golan syrien occupé ».

L'Assemblée de la Santé est-elle prête à adopter cette résolution ? Je ne vois pas d'objection. La résolution est donc adoptée et le deuxième rapport de la Commission A est par conséquent approuvé.

Les Etats-Unis d'Amérique demandent la parole.

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[1] See reports of committees in document WHA63/2010/REC/3.

[1] Voir les rapports des commissions dans le document WHA63/2010/REC/3.

Dr DAULAIRE (United States of America):

Thank you, Mr President. My delegation requests that the records of this meeting reflect that this resolution was adopted in committee by a recorded vote and is not a consensus text. Thank you.

Le PRÉSIDENT:

Je vous remercie Monsieur. L'Arabie saoudite a la parole.

Dr MEMISH (Saudi Arabia):

الدكتور ميمش (المملكة العربية السعودية):

سيدي الرئيس،
إن المملكة العربية السعودية تود ضم صوتها إلى صوت الدول التي أيـدت القـرار بـشأن "الأحـوال الصحية في الأرض الفلسطينية المحتلة، بما فيها القدس الشرقية وفي الجولان السوري المحتل".
وتؤكد المملكة على تسجيل موقفها في هذا الخصوص.
شكراً سيدي الرئيس.

Le PRÉSIDENT:

Merci. Est-ce qu'il y a une autre demande d'intervention ? La résolution est donc adoptée et le deuxième rapport de la Commission A est par conséquent approuvé.

Third report of Committee A
Troisième rapport de la Commission A

Examinons à présent le troisième rapport de la Commission A tel qu'il figure dans le document A63/63. Le rapport contient une résolution intitulée « Promotion d'initiatives en faveur de la sécurité sanitaire des aliments ». L'Assemblée de la Santé est-elle prête à adopter cette résolution ? Je ne vois pas d'objection. La résolution est donc adoptée et le troisième rapport de la Commission A est par conséquent approuvé.

Ce qui nous amène à conclure nos travaux pour aujourd'hui. Immédiatement après la levée de la présente séance, la Commission A tiendra sa dixième séance et la Commission B sa sixième séance, respectivement dans les salles 18 et 17. Demain matin, vendredi 21 mai à 9 heures, la Commission A tiendra sa onzième séance et la Commission B sa septième séance. L'Assemblée tiendra sa prochaine séance plénière après la conclusion des travaux des deux Commissions. La séance est levée.

The meeting rose at 18:10.
La séance est levée à 18h10.

EIGHTH PLENARY MEETING

Friday, 21 May 2010, at 20:40

President: Mr Mondher ZENAIDI (Tunisia)

HUITIÈME SÉANCE PLÉNIÈRE

Vendredi 21 mai 2010, 20h40

Président: M. Mondher ZENAIDI (Tunisie)

1. REPORTS OF THE MAIN COMMITTEES[1] (continued) RAPPORTS DES COMMISSIONS PRINCIPALES[1] (suite)

Le PRÉSIDENT:

Je déclare l'Assemblée ouverte.

First report of Committee B
Premier rapport de la Commission B

Nous sommes réunis ici cet après-midi pour examiner le point 8 de notre ordre du jour – Rapports des commissions principales. Examinons à présent le premier rapport de la Commission B tel qu'il figure dans le document A63/62. Le rapport contient huit résolutions et une décision. La première résolution est intitulée « Rapport financier et états financiers vérifiés pour la période 1er janvier 2008-31 décembre 2009 ». L'Assemblée est-elle prête à adopter cette résolution ? Je ne vois pas d'objection. La résolution est donc adoptée.

La seconde résolution est intitulée « Barème des contributions 2010-2011 ». L'Assemblée est-elle prête à adopter cette résolution ? Je ne vois pas d'objection. La résolution est donc adoptée.

La troisième résolution est intitulée « Sûreté et sécurité du personnel et des locaux ». L'Assemblée est-elle prête à adopter cette résolution ? Je ne vois pas d'objection. La résolution est donc adoptée.

La quatrième résolution est intitulée « Plan-cadre d'équipement ». L'Assemblée est-elle prête à adopter cette résolution ? Je ne vois pas d'objection. La résolution est donc adoptée.

La cinquième résolution est intitulée « Rapport du Commissaire aux Comptes ». L'Assemblée est-elle prête à adopter cette résolution ? Je ne vois pas d'objection. La résolution est donc adoptée.

La sixième résolution est intitulée « Traitement du personnel hors classes et du Directeur général ». L'Assemblée est-elle prête à adopter cette résolution ? Je ne vois pas d'objection. La résolution est donc adoptée.

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[1] See reports of committees in document WHA63/2010/REC/3.

[1] Voir les rapports des commissions dans le document WHA63/2010/REC/3.

La septième résolution est intitulée « Partenariats ». L'Assemblée est-elle prête à adopter cette résolution ? Je ne vois pas d'objection. La résolution est donc adoptée.

La huitième résolution est intitulée « Accords avec des organisations intergouvernementales ». L'Assemblée est-elle prête à adopter cette résolution ? Je ne vois pas d'objection. La résolution est donc adoptée.

Mesdames, Messieurs, honorables délégués, je vais vous demander si nous pouvons suspendre la séance pour quelques minutes parce que nous attendons un rapport qui n'est pas encore prêt. Je vous remercie de votre compréhension.

The meeting was suspended at 20:45 and resumed at 20:50.
La séance est suspendue à 20h45 et reprend à 20h50.

Second report of Committee B
Deuxième rapport de la Commission B

Le PRÉSIDENT:

Mesdames, Messieurs, honorables délégués, nous reprenons notre séance.

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

Let us now consider the second report of Committee B, which is contained in document A63/65. The report contains one resolution. The resolution for your consideration is entitled "Availability, safety and quality of blood products". I understand that an amendment was approved by the Committee. Is the Health Assembly ready to adopt this resolution? I see no objection. The resolution is therefore adopted and the second report of Committee B is therefore approved.

Fourth report of Committee A
Quatrième rapport de la Commission A

Now we will consider the fourth report of Committee A. This is contained in document A63/64. Please disregard the word "draft" as the Committee approved the report without amendments. The report contains four resolutions, which I will read out one at a time.

First, there is a resolution entitled "Strategies to reduce the harmful use of alcohol". Is the Health Assembly ready to adopt this resolution? I see no objection. The resolution is therefore adopted.

The second resolution for your consideration is entitled "Marketing of food and non-alcoholic beverages to children". Is the Health Assembly ready to adopt this resolution? I see no objection. The resolution is therefore adopted.

The third resolution for your consideration is entitled "Monitoring of the achievement of the health-related Millennium Development Goals". Is the Health Assembly ready to adopt this resolution? I see no objection. The resolution is therefore adopted.

The fourth resolution is entitled "International recruitment of health personnel: draft global code of practice". Is the Health Assembly ready to adopt this resolution? I see no objection. The resolution is therefore adopted.

The four resolutions are therefore adopted as amended, and the fourth report of Committee A is therefore approved.

Fifth report of Committee A
Cinquième rapport de la Commission A

Now we will consider the fifth report of Committee A. The report will contain 13 resolutions, which I will read out one at a time.

First, there is a resolution entitled "Birth defects". I understand that an amendment was approved by the Committee. Is the Health Assembly ready to adopt this resolution? I see no objection. The resolution is therefore adopted.

The second resolution for your consideration is entitled "Viral hepatitis". I understand that an amendment was approved by the Committee. Is the Health Assembly ready to adopt this resolution? I see no objection. The resolution is therefore adopted.

The third resolution for your consideration is entitled "WHO HIV/AIDS strategy for 2011–2015". I understand that an amendment was approved by the Committee. Is the Health Assembly ready to adopt this resolution? I see no objection. The resolution is therefore adopted.

The fourth resolution is entitled "Chagas disease: control and elimination". I understand that an amendment was approved by the Committee. Is the Health Assembly ready to adopt this resolution? As I see no objection, the resolution is adopted.

The fifth resolution for your consideration is entitled "WHO's role and responsibilities in health research". I understand that an amendment was approved by the Committee. Is the Health Assembly ready to adopt this resolution? I see no objection. The resolution is therefore adopted.

The sixth resolution for your consideration is entitled "Human organ and tissue transplantation". I understand that an amendment was approved by the Committee. Is the Health Assembly ready to adopt this resolution? I see no objection. The resolution is therefore adopted.

The seventh resolution for your consideration is entitled "Accelerating progress towards achievement of Millennium Development Goal 4 to reduce child mortality: prevention and treatment of pneumonia". I understand that an amendment was approved by the Committee. Is the Health Assembly ready to adopt this resolution? I see no objection. The resolution is therefore adopted.

The eighth resolution is entitled "Substandard/spurious/falsely-labelled/falsified/counterfeit medical products". I understand than an amendment was approved by the Committee. Is the Health Assembly ready to adopt this resolution? I see no objection. The resolution is therefore adopted.

The ninth resolution for your consideration is entitled "Improvement of health through safe and environmentally sound waste management". I understand that an amendment was approved by the Committee. Is the Health Assembly ready to adopt this resolution? I see no objection. The resolution is therefore adopted.

The tenth resolution for your consideration is entitled "Improvement of health through sound management of obsolete pesticides and other obsolete chemicals." I understand than an amendment was approved by the Committee. Is the Health Assembly ready to adopt this resolution? As I see no objection, the resolution is adopted.

The eleventh resolution is entitled "Strengthening the capacity of governments to constructively engage the private sector in providing essential health-care services". Is the Health Assembly ready to adopt this resolution? I see no objection. The resolution is therefore adopted.

The twelfth resolution for your consideration is entitled "Establishment of a consultative expert working group on research and development: financing and coordination". I understand that the draft resolution was prepared during the deliberations of the Committee, read out in its entirety and approved in this form by the Committee, with two amendments. Is the Health Assembly ready to adopt this resolution? I see no objection. The resolution is therefore adopted.

The thirteenth resolution for your consideration is entitled "Infant and young child nutrition". I understand that an amendment was approved by the Committee. Is the Health Assembly ready to adopt this resolution? I see no objection. The resolution is therefore adopted, and the fifth report of Committee A is therefore approved.

2. SELECTION OF THE COUNTRY OR REGION IN WHICH THE SIXTY-FOURTH WORLD HEALTH ASSEMBLY WILL BE HELD
CHOIX DU PAYS OU DE LA RÉGION OÙ SE TIENDRA LA SOIXANTE-QUATRIÈME ASSEMBLÉE MONDIALE DE LA SANTÉ

Le PRÉSIDENT:

Je souhaiterais appeler l'attention de l'Assemblée de la Santé sur le fait que, conformément aux dispositions de l'article 14 de la Constitution, l'Assemblée de la Santé, lors de chaque session annuelle, choisit le pays ou la Région dans lequel se tiendra sa prochaine session annuelle, le Conseil en fixant ultérieurement le lieu et la date. Je considère donc que l'Assemblée décide que la Soixante-Quatrième Assemblée mondiale de la Santé se tiendra en Suisse. En l'absence de toute objection, il en est ainsi décidé.

3. CLOSURE OF THE SESSION
CLÔTURE DE LA SESSION

Le PRÉSIDENT:

Nous allons maintenant examiner le dernier point de notre ordre du jour : point 9, Clôture de l'Assemblée de la Santé. Je souhaiterais inviter le Dr Masato Mugitani, du Japon, Président de la Commission A, à venir à la tribune et à s'adresser à l'Assemblée de la Santé pour faire la synthèse des travaux de la Commission A. Docteur Mugitani, vous avez la parole.

Dr MUGITANI (Japan) (Chairman of Committee A):

Mr President, your excellencies, distinguished delegates, Dr Margaret Chan, ladies and gentlemen, it is with great pleasure that I present to you this report of the work of Committee A during this Sixty-third World Health Assembly. The work of Committee A concentrated on technical and health matters. The list of agenda items was extensive and some of the discussions were vexatious, yet the Committee managed to proceed with 20 resolutions and we remained friends and colleagues because we shared a common unified ground and an unwavering commitment to the promotion and protection of public health.

The following 19 resolutions on technical and health matters were adopted: Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits; Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan; Advancing food safety initiatives; Global strategy to reduce the harmful use of alcohol; Marketing of food and non-alcoholic beverages to children; Infant and young child nutrition; Birth defects; WHO HIV/AIDS strategy for 2011–2015; Monitoring of the achievement of the health-related Millennium Development Goals; Viral hepatitis; WHO Global Code of Practice on the International Recruitment of Health Personnel; Chagas disease: control and elimination; WHO's role and responsibilities in health research; Human organ and tissue transplantation; Accelerating progress towards achievement of Millennium Development Goal 4 to reduce child mortality: prevention and treatment of pneumonia; Improvement of health through safe and environmentally sound waste management; Improvement of health through sound management of obsolete pesticides and other obsolete chemicals; Strengthening the capacity of governments to constructively engage the private sector in providing essential health-care services; and Establishment of a consultative expert working group on research and development: financing and coordination. A decision was also adopted on Substandard/spurious/falsely-labelled/falsified/counterfeit medical products.

Here are just some of the memorable highlights. First, a drafting group of Committee A worked for over 30 hours until 04:30 on Thursday morning to obtain a consensus text of the resolution on international recruitment of health personnel. Splendid! A special thanks go to Dr Tangcharoensathien

from Thailand for chairing this group. Secondly, the delegates exhibited great restraint and discipline in coming together and finally adopting a resolution on alcohol. And thirdly, there were times when consensus seemed unobtainable, such as when we tackled the issues of substandard spurious, falsely-labelled, falsified counterfeit medical products. It indeed felt like, as one delegate lamented, we were waiting for Godot to provide us with an easy solution. My huge appreciation goes to Dr Ahmadi from Iran for stepping up to the plate and accepting the most difficult task of chairing the drafting group. The group showed flexibility and adopted a spirit of compromise All the above, we did because we know that our Health Assembly resolutions will provide a robust and effective framework to tackle the myriad health issues that our populations face, and they are the ones that are directly affected by the decisions made by this august Health Assembly.

By the resolutions we have adopted, we are showing that our preparations matter, that we do care. It has been an honour and a privilege to serve as Chairman of Committee A, both for myself and my country Japan. It was inspiring to observe how all of you made efforts to find common ground in such a constructive spirit of cooperation and solidarity so that we all can address the pressing public health needs of our constituencies. I would also like to acknowledge my fellow officers in Committee A for their most competent assistance, Vice-Chairmen, Mr Udo Scholten (Germany) and Dr David Chiriboga (Ecuador) and as Rapporteur Dr Praveen K. Mishra (Nepal); thank you dear colleagues. And of course all Committee A's work would not have been possible without the tremendous support and professional assistance we all received from the secretariat of Committee A. I would like to thank Dr Monir Islam, Secretary, Committee A, and his team for ensuring that the work of the Committee could proceed smoothly and fruitfully.

I thank you Mr President for your most competent and resourceful leadership, which was instrumental in achieving the objectives of this Health Assembly. I would also like to thank the Vice-Presidents and the Rapporteurs for their superb support in making this Health Assembly as successful as it has been. And to you, Director-General, I would like to extend my personal appreciation and utmost regard. Mr President, and all other offices and delegates, I wish you good health, peace and well-being in the interim time until we meet again next year here in smoke-free Geneva. Thank you.

(Applause/Applaudissements)

Le PRÉSIDENT:

Je vous remercie, Dr Mugitani. Permettez-moi de vous féliciter chaleureusement de l'excellent rapport que vous avez présenté et aussi de la qualité remarquable de votre prestation en tant que Président de la Commission A.

J'invite à présent le Vice-Président de la Commission B, le Dr George J. Komba Kono, du Sierra Leone, à venir à la tribune et à faire la synthèse des travaux de la Commission B. Docteur Komba Kono, vous avez la parole.

Dr KOMBA KONO (Sierra Leone) (Vice-Chairman of Committee B):

Mr President, distinguished delegates, Madam Director-General, ladies and gentlemen, it is with pleasure that I present you this final report of the work of Committee B during this year's Health Assembly on behalf of our Chairman, the distinguished Dr Wimal Jayantha, Deputy Director-General, Planning, in the Ministry of Healthcare and Nutrition of Sri Lanka.

Since most of the information on our work has been shared through the daily reports and the journal I am only going to present an overview. At the outset, we would like to compliment the work of the Programme, Budget and Administration Committee and to say that the work of the Committee has facilitated Committee B, which has benefited greatly from the reporting of the issues discussed during the Programme, Budget and Administration Committee. We concentrated our efforts on items pertaining to programme and budget matters, financial matters, audit and oversight matters, staffing matters and management and legal matters.

Our Committee worked effectively and completed the discussion of most of these agenda items in advance. We were able to accomplish the approval of eight resolutions and one decision. Having

advanced well, we were able to deal with six additional items on technical and health matters transferred to us from Committee A, and we approved one additional resolution on the availability, safety and quality of blood products.

This year the agenda item on the election of the Director-General of WHO brought on a very long and arduous debate in which almost all the delegations became actively engaged. This is a testimony to the very high level of interest and attachment that delegates feel for this Organization.

It has been an honour and privilege for me to serve as Vice-Chairman of Committee B. I would like to pay tribute to the leadership of our Chairman, Dr Wimal Jayantha, and to all the delegations who participated very actively in all the discussions in a spirit of goodwill. I would like to thank my colleagues, the other Vice-Chairman of Committee B, Dr Nasr El Sayed (Egypt) and the Rapporteur Dr Arne-Petter Sanne (Norway) for their good work throughout the deliberations of Committee B. I thank you, Mr President, for taking the work of this Health Assembly to a constructive and successful finish.

Finally, on behalf of our Chairman and all the participating delegations I would like to thank warmly the Director-General and all the members of the Secretariat who assisted and supported us in our work. We look forward to meeting again next year. In the meantime we take forward the recommendation of this Health Assembly to our countries so that they can contribute to the improvement of the health and well-being of our people. I thank you all. Actually, I would like to pay tribute to the members of Committee A for the complementarity that existed between us. Because of that complementarity we were able to do each other's work when the going got tough on the other side. I thank you.

(Applause/Applaudissements)

Le PRÉSIDENT:

Je vous remercie pour ce rapport complet et salue la manière dont le Président, Dr Jayanta du Sri Lanka, le Vice-Président, Dr Nasr El Sayed de l'Egypte et vous avez dirigé les travaux de la Commission B.

À présent que les commissions principales ont achevé leurs travaux, y compris l'examen des rapports du Conseil exécutif, nous pouvons officiellement prendre acte de ces rapports. Compte tenu des observations qui ont été faites, je considère que l'Assemblée souhaite féliciter le Conseil pour le travail accompli et exprimer ses remerciements pour le dévouement dont il a fait preuve pour s'acquitter de la tâche qui lui était confiée. En l'absence de tout commentaire, il en est ainsi décidé.

Le Directeur général souhaiterait ajouter quelques mots. Docteur Chan, vous avez la parole.

The DIRECTOR-GENERAL:

Mr President, honourable ministers, excellencies, distinguished delegates, ladies and gentlemen, you faced a challenging agenda, with a large number of items to discuss, including some surrounded by complex and potentially divisive issues. The Chairmen and officers of the two Committees have been working extremely hard, and you have just heard the outcome. I thank them for seeing us through an important, demanding and ultimately very difficult agenda.

Hard work can bring a big payback, as long as it does not delay progress or disrupt the strong spirit of international cooperation for better health that has been growing in recent years. We have just seen two examples, shall I say, "hot off the press", of this spirit of collaboration and consensus-building. Thank you for finding a way forward on the issues of research and development financing, and substandard, spurious, falsely-labelled, falsified, counterfeit medical products. You reached agreement on some very important items that are a real gift to public health, everywhere. Thanks to some all-night efforts, we now have a Code of Practice on the International Recruitment of Health Personnel.

In addition, you have given public health a policy instrument and guidance for tackling one of the world's fastest-growing and most alarming health problems. This is the rise of chronic noncommunicable diseases, like cardiovascular disease, cancer, diabetes and chronic respiratory

disease. Many of these diseases develop slowly, but lifestyle changes that increase the risk are taking place with stunning speed and sweep. We know that the harmful use of alcohol and unhealthy diets are two of the four risk factors for these diseases.

As several of you noted, the global strategy to reduce the harmful use of alcohol is a true breakthrough. This strategy gives you a large and flexible menu of evidence-based policy options for addressing a problem that damages health in rich and poor countries alike. The strategy sends a powerful message: countries are willing to work together to take a tough stand against the harmful use of alcohol.

Your resolution on the marketing of food and non-alcoholic beverages to children responds to an astonishing statistic. This is a world in which some 43 million pre-school children are obese or overweight. Think of what this means in terms of life-long risks to their health. Think about the life-long demands for care at a time when most health systems are already overburdened, underfunded, and dangerously understaffed. I believe we all welcome the news that the United Nations General Assembly will be addressing noncommunicable diseases in a high-level meeting in September of next year.

Ladies and gentlemen, I have given you some personal impressions about a few items on your agenda. But this Health Assembly had a second dimension, expressed as your unwavering commitment to the health-related Millennium Development Goals. I witnessed first hand your great desire to cooperate internationally, and with other sectors, in reaching these Goals. The spirit I personally witnessed was one of great optimism, solidarity, and a can-do attitude. The technical briefings on the Millennium Development Goals have given the Secretariat some solid and inspiring guidance. I thank you for this guidance and want to assure you that we will be taking your arguments, views, experience, and enthusiasm forward at the United Nations summit on the Millennium Development Goals later this year.

I want to close by thanking the President and the Vice-Presidents for the guidance they have provided. I was particularly impressed by the efficient manner in which, Mr President, you conducted the plenary sessions, and of course by the multilingualism so well demonstrated by you, our able President. Thank you, and to all of you, honourable members and delegations; I thank you for all the support and your very active participation, and I wish you a safe journey home.

(Applause/Applaudissements)

The PRESIDENT:

Thank you, Dr Chan.

(The speaker continued in Arabic.) (يواصل المتحدث بالعربية)

The PRESIDENT: الرئيس:

السيدات والسادة نواب رئيس جمعية الصحة، السيدة مارغريت تشان المديرة العامة لمنظمة الصحة العالمية، أصحاب المعالي والسعادة، السادة المندوبين، السيدات والسادة،

يسعدني في ختام أعمالنا، أن أعرب مجدداً للبلدان الأعضاء عن فائق التقدير على الثقة الغالية التي حظيت بها تونس من خلال ترؤسها لجمعية الصحة العالمية الثالثة والستين راجياً أن تكون بلادي قد توفقت في أداء هذه المهمة الجسيمة على الوجه الأكمل وبما يخدم تطلعاتنا المشتركة إلى تحقيق مزيد من الرفاه لكافة شعوب المعمورة.

وينبع اعتزاز تونس برئاسة هذه الدورة من الأهمية البالغة التي مافتئت توليها لميدان الصحة الذي بوأه سيادة الرئيس زين العابدين بن علي مكانة بارزة في إطار مقاربته الرائدة لمقتضيات التنمية الشاملة والمستديمة والتي تجعل من الإنسان محور التنمية وغايتها.

ويطيب لي بهذه المناسبة أن أعبر عن جزيل الشكر وصادق الامتنان لوفود البلدان الأعضاء على مشاركتها الحثيثة في أعمال هذه الدورة وهو ما يتجلى من خلال المناقشات الثرية والجادة صلب اللجنتين الرئيسيتين "أ" و"ب" متوجهاً في هذا الصدد بفائق التقدير إلى رئيسي اللجنتين ومساعديهم.

ولا يفوتني في نفس الإطار أن أعرب مجدداً عن فائق التقدير للمديرة العامة الدكتورة مارغريت تشان وكافة مساعديها في أمانة المنظمة وكذلك للمترجمين وكافة الموظفين والأعوان على الجهود الدؤوبة والقيّمة التي بذلوها قصد تهيئة الظروف المثلى لسير أعمال هذه الدورة.

ويقيني أن ما توصلنا إليه من قرارات هامة، في إطار التوافق بين الدول الأعضاء حول أغلب النقاط المدرجة في جدول الأعمال، قد عكس مجدداً ما يحدونا من عزم مشترك على الخروج بنتائج ملموسة تُسهم في مزيد الارتقاء بأداء منظمتنا وخلق نقلة جديدة في النظام الصحي الدولي تكرس المزيد من العدل والمساواة بين كافة سكان المعمورة في العيش الكريم والاستفادة من حقهم المشروع في الصحة.

ويتطلب تحقيق هذه الأهداف النبيلة الإسراع بتحويل ما توصلنا إليه من نتائج خلال هذه الدورة إلى واقع ملموس. وهو ما يحتاج منا إلى نفس طويل ومثابرة جادة لدفع الجهد المبذول من كافة الأطراف الفاعلة ولاسيما المنظمة والبلدان الأعضاء والجهات المانحة وذلك انطلاقاً من رؤية شاملة للتحديات المطروحة والآليات الملائمة للارتقاء بالوضع الصحي في كافة أنحاء العالم.

ويطيب لي، في هذا الإطار، أن أجدد دعوة تونس إلى إرساء تضامن دولي فاعل في الميدان الصحي بوصفه شرطاً أساسياً للحد من الهوة الصحية المتعاظمة بين شطري العالم والإسراع في تحقيق التقدم المنشود على درب تجسيم المرامي الإنمائية للألفية ذات الصلة بالصحة، والقضاء على كل مظاهر الفقر والتهميش في كافة أرجاء المعمورة.

وأود، في ختام هذه الكلمة، أن أعرب لكم مجدداً جميعاً عن فائق الشكر على تعاونكم راجياً لكم عودة ميمونة إلى بلدانكم على أمل أن يتجدد لقاؤها خلال الدورة القادمة، والسلام عليكم ورحمة الله وبركاته.

(يواصل المتحدث كلامه بالفرنسية)

(يواصل المتحدث بالفرنسية) **(L'orateur poursuit en français.)**

Mesdames, Messieurs, honorables délégués, je déclare officiellement close la Soixante-Troisième Assemblée mondiale de la Santé.

The session closed at 21:30.
La session est close à 21h30.

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 ÉTATS MEMBRES
DELEGATIONS OF MEMBER STATES

AFGHANISTAN – AFGHANISTAN

Chef de délégation – Chief delegate

Dr S. Dalil
Ministre intérimaire, Santé publique

Délégué(s) – Delegate(s)

M. O.K. Noori
Chargé d'affaires, Mission permanente, Genève

Dr A.J. Naeem
Directeur général, Politique et Planification, Ministère de la Santé publique

Suppléant(s) – Alternate(s)

Dr A.S. Salehi
Directeur, Santé, Département de l'Economie et des Finances, Ministère de la Santé publique

Dr A. Mashkoor
Chef du HMIS, Ministère de la Santé publique

Dr S.A. Gawhary
Assistant technique, Ministère de la Santé publique

Dr H. Ahmadzai
Directeur, Relations internationales, Ministère de la Santé publique

M. A. Javid
Troisième Secrétaire, Mission permanente, Genève

AFRIQUE DU SUD – SOUTH AFRICA

Chef de délégation – Chief delegate

Dr P.A. Motsoaledi
Minister of Health

Délégué(s) – Delegate(s)

Mr J.M. Matjila
Ambassador, Permanent Representative, Geneva

Ms M.K. Matsau
Deputy Director-General, International Relations, Health Trade and Health Production

Suppléant(s) – Alternate(s)

Mr L. Ndimeni
Deputy Permanent Representative, Geneva

Dr M.P. Mahlati
Deputy Director-General, Human Resources and Management Development

Ms N.C. Dladla
Health Attaché, Permanent Mission, Geneva

Professor M.C. Freeman
Cluster Manager, Non-Communicable Diseases, Department of Health

Ms M. Hela
Cluster Manager, Medicines Regulatory Authority

Dr R.E. Mhlanga
Cluster Manager, Maternal Child and Women's Health, Department of Health

Ms P. Pardesi
Chief of Staff, Office of the Minister of Health

Ms T.G. Mnisi
Director, South-South Relations, Department of Health

Mr J. Van Wyk
Counsellor, Economy and Development, Permanent Mission, Geneva

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