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FORTIETH WORLD HEALTH ASSEMBLY — 5 May 1987

QUARANTIEME ASSEMBLEE MONDIALE DE LA SANTE — 5 mai 1987

СОРОКОВАЯ СЕССИЯ ВСЕМИРНОЙ АССАМБЛЕИ ЗДРАВООХРАНЕНИЯ — 5 мая 1987 г.

40ª ASAMBLEA MUNDIAL DE LA SALUD — 5 de mayo de 1987

جمعية الصحة العالمية الأربعون — ٥ أيار / مايو ١٩٨٧

第四十届世界卫生大会 — 1987年5月5日

PROVISIONAL VERBATIM RECORD OF THE
FOURTH PLENARY MEETING
Tuesday, 5 May 1987, at 14 h 35
Palais des Nations, Geneva
President: Dr J. VAN LONDEN (Netherlands)

COMPTE RENDU IN EXTENSO PROVISOIRE
DE LA QUATRIEME SEANCE PLENIERE
Mardi 5 mai 1987, 14h35
Palais des Nations, Genève
Président : Dr J. VAN LONDEN (Pays-Bas)

ПРЕДВАРИТЕЛЬНАЯ СТЕНОГРАММА ЧЕТВЕРТОГО
ПЛЕНАРНОГО ЗАСЕДАНИЯ
Вторник, 5 мая 1987 г., 14 ч. 35 м.
Дворец Наций, Женева
Председатель: д-р VAN LONDEN (Нидерланды)

ACTA TAQUIGRAFICA PROVISIONAL
DE LA CUARTA SESION PLENARIA
Martes 5 de mayo de 1987 a las 14.35 horas
Palais des Nations, Ginebra
Presidente: Dr. J. VAN LONDEN (Países Bajos)

محضر حرفي مؤقت
للجلسة العامة الرابعة
الثلاثاء ٥ أيار / مايو ١٩٨٧ ، الساعة ١٤٫٣٥
قصر الأمم ، جنيف
الرئيس : الدكتور ج. فان لندن (هولندا)

第四次全体会议
发言临时逐字记录
1987年5月5日14：35时（星期二）
日内瓦 万国宫
主席：J·范·朗登博士（荷兰）

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就执行委员会第七十八届和第七十九届会议的报告及总干事所作世界卫生组织一九八六年工作的报告进行讨论（续）

The PRESIDENT:

The Assembly is called to order. I invite the next speaker on my list - the delegate of Congo - and at the same time I call on the delegate of San Marino to come to the rostrum.

M. COMBO-MATSIONA (Congo) :

Monsieur le Président, Monsieur le Directeur général, distingués délégués, Mesdames, Messieurs, la délégation de la République populaire du Congo que j'ai l'honneur de conduire à cette auguste Assemblée et moi-même joignons nos voix à celles des orateurs qui nous ont précédés pour vous présenter, Monsieur le Président, nos sincères félicitations, pour votre brillante élection à la présidence de cette Assemblée. En vous souhaitant plein succès dans l'accomplissement des lourdes tâches qui viennent de vous être confiées par la communauté sanitaire internationale, nous voulons formuler les voeux les plus ardents pour que, sous votre présidence, et malgré le malheureux incident survenu tout au début de cette Assemblée, nos travaux se déroulent dans un esprit serein de compréhension et de strict respect des traditions établies depuis de longues années au cours des Assemblées.

Nous adressons également nos remerciements et nos félicitations au Dr Hamzeh, Ministre de la Santé de la Jordanie et Président de la Trente-Neuvième Assemblée de notre Organisation, pour la clairvoyance, la compétence, l'esprit de suite et la fermeté avec lesquels il a su diriger les travaux de cette Trente-Neuvième Assemblée de la Santé.

Nos remerciements vont aussi à l'endroit d'un homme dont le courage, la perspicacité et le dévouement à la cause de l'humanité souffrante forcent notre admiration. Monsieur le Directeur général, cher Docteur Mahler, au moment où l'humanité entière traverse l'une des crises économiques les plus graves de son histoire, les yeux du monde de la souffrance et de la misère nous encouragent à aller de l'avant dans cette voie pour la lutte pour la survie de l'homme. A vous et à tous ceux qui, de près ou de loin, nous aident dans l'exécution de cette tâche difficile mais combien exaltante, nous disons merci, simplement. Enfin, nous saluons tous les délégués présents à cette Assemblée de notre Organisation.

En choisissant comme thèmes principaux d'orientation générale des travaux de cette Assemblée des questions aussi complexes que celles du soutien économique pour les stratégies nationales de la santé pour tous et de la coopération, l'Organisation mondiale de la Santé, fidèle à sa définition traditionnelle d'institution spécialisée des Nations Unies responsable de la direction de la coordination des problèmes sanitaires mondiaux, a voulu, une fois de plus, nous inciter à la réflexion en vue, d'une part, de susciter chez les décideurs politiques nationaux une volonté capable de permettre une meilleure compréhension des problèmes sanitaires et, d'autre part, de rechercher une voie de coopération plus efficace, plus sincère, plus respectueuse des cultures des partenaires en présence et, par voie de conséquence, plus humaine, parce que basée pour l'essentiel sur des actions empreintes de plus de dévouement, de plus de compréhension et de plus d'humanisme.

Nous situant en effet, Monsieur le Président, distingués délégués, à une époque essentiellement caractérisée par une grave crise économique - à laquelle aucune nation du reste, fût-elle

développée, ne paraît en mesure d'échapper - aucun autre thème de réflexion ne pouvait mieux convenir aux travaux de cette Assemblée qui se tient, faut-il le rappeler, dans une conjoncture qui interdit à la plupart de nos économies nationales, malgré notre bonne volonté, de consacrer plus de ressources à la solution de nos problèmes de santé.

A cette situation économique préoccupante, qui frappe avec plus d'acuité les pays en développement, il faut malheureusement ajouter les conséquences de nombreux foyers de tension allumés et entretenus çà et là dans le monde, et qui ne permettent pas la promotion et le développement d'une action sanitaire à la hauteur des besoins réels des populations victimes.

Il est clair, Monsieur le Président, que dans ces conditions, la plupart de nos pays solliciteront longtemps encore l'intervention des ressources extérieures, dans le cadre d'une coopération avec des organisations internationales, des organismes de coopération bilatérale et des organisations non gouvernementales.

La République populaire du Congo, notre pays, a toujours apprécié l'importance de la coopération, à quelque niveau qu'elle se situe. Ainsi, qu'il s'agisse du redimensionnement de notre système de santé basé sur les soins de santé primaires, et que nous avons en 1986 conçu de manière trop ambitieuse, ou qu'il s'agisse de l'exécution de nos projets spécifiques dans le domaine sanitaire de la réalisation de notre campagne nationale de vaccination contre les six maladies les plus meurtrières de l'enfance, nous avons bénéficié d'un appui direct et effectif de l'OMS, du FISE et des organisations non gouvernementales. Pour toutes ces manifestations de la volonté de ces institutions à coopérer avec notre pays à la promotion et au développement de notre action sanitaire, nous exprimons ici tous nos sentiments de profonde gratitude.

Cependant, Monsieur le Président, honorables délégués, qu'il nous soit permis de manifester quelque inquiétude quant à l'avenir de cette coopération que nous appelons de tous nos voeux et, par conséquent, de poser concrètement le problème de la redéfinition d'un nouveau cadre de coopération où donateurs et assistés acceptent, librement, de mettre en commun leurs efforts, en vue d'une action concertée qui tienne compte des besoins réels et des objectifs fixés par le plan global de développement socio-économique du pays bénéficiaire. De même, toute attitude paternaliste frise une nouvelle forme d'aliénation et doit être considérée comme contraire à l'idéal d'entraide que nous animerons.

Par ailleurs, beaucoup d'assistances prennent souvent des caractères marginaux par rapport à nos priorités sanitaires. Mieux, certaines d'entre elles contribuent à démobiliser les forces vives nationales au lieu de les amener à prendre leurs responsabilités qui ne sauraient être assumées par d'autres.

Enfin, dans un domaine aussi complexe que celui de la santé, où nos priorités demeurent la lutte contre les maladies transmissibles, l'hygiène du milieu, la formation du personnel national et le développement des structures, nos pays doivent savoir que le progrès ne peut et ne saurait venir constamment du dehors, que l'aide extérieure ne peut et ne doit être considérée que comme un appui à l'effort national, et que la plupart de nos problèmes sanitaires doivent trouver leurs solutions d'abord par nos propres efforts. Et il est encourageant de noter que nombre de pays en développement, malgré les conséquences de la crise, ont consenti et acceptent de consentir encore d'importants efforts dans le domaine de la santé.

Monsieur le Président, honorables délégués, je ne puis me permettre de terminer mes propos à cette tribune de la Quarantième Assemblée de notre Organisation sans évoquer un phénomène nouveau envahissant, préoccupant : le syndrome d'immunodéficience acquise. Nous pensons très sincèrement que peu importe de savoir quelle est en définitive l'origine du mal. L'important, en effet, est de savoir que le mal est constant, présent et qu'à tout moment, il peut frapper à la porte de n'importe quelle nation, quoi qu'elle fasse. Nous voulons par conséquent, Monsieur le Président, stigmatiser l'attitude de certains Etats Membres de notre Organisation qui ont pris des mesures discriminatoires et vexatoires qui n'ont d'efficace que la forte teinte raciste qui les caractérise.

Voilà, Monsieur le Président, le message que la délégation du Congo laisse à cette quarantième session de l'Assemblée mondiale de la Santé.

M. GHIOTTI (Saint-Marin) :

Monsieur le Président, Monsieur le Directeur général, Excellences, Mesdames et Messieurs, je voudrais tout d'abord vous transmettre les salutations de la République de Saint-Marin que j'ai l'honneur de représenter au sein de cette honorable Assemblée, en tant que Ministre de la Santé et de la Sécurité sociale.

La santé et la sécurité sociale ont toujours représenté pour mon pays le support même du développement, le centre des préoccupations politiques et le point sur lequel ont porté les efforts économiques les plus importants. Depuis plus de trente ans, notre système sanitaire octroie gratuitement à tous les citoyens l'assistance et les soins médicaux : cela signifie que notre système a constitué et constitue encore aujourd'hui une conquête sociale irréversible.

La République de Saint-Marin, membre actif de l'Organisation mondiale de la Santé, a orienté sa propre politique sanitaire conformément aux règlements et programmes de l'OMS.

La santé pour tous d'ici l'an 2000 constitue une tâche importante à laquelle la République de Saint-Marin peut et veut apporter sa contribution. Au plan interne, nous nous sommes engagés dans la voie de la modernisation du système et des structures mêmes des services sociaux, afin de les adapter en permanence aux exigences nouvelles qui évoluent dans leur nature, leur nombre et leur forme. Nous avons récemment approuvé la loi sur l'hygiène et la sécurité sur les lieux de travail, qui vient compléter des dispositions juridiques antérieures et qui répond aux transformations constantes du monde du travail. D'ici peu, nous apporterons d'autres compléments aux instruments législatifs existants en ce qui concerne l'hygiène des aliments et des boissons ainsi que l'hygiène du sol et de l'habitat. Il convient de noter que ces lois constituent des instruments utiles en vue d'une action efficace dans le domaine de l'éducation sanitaire et dans le cadre d'une phase de prévention préparatoire. Le programme d'adaptation et de modernisation de notre système sanitaire implique également les travailleurs de la santé. Dans ce contexte, nous reconnaissons la nécessité de sortir d'un schéma d'opération rigide qui conditionne actuellement leur profession, et nous nous efforçons de créer les conditions les plus favorables, au plan conceptionnel et opérationnel, pour assurer des services à la fois de grande qualité et de grande efficacité.

Notre structure sanitaire actuelle est constituée par les différents services suivants : médecine de base; service hospitalier et spécialisé; service pharmaceutique; service de l'hygiène de l'environnement; service socio-sanitaire qui comprend un atelier-maison familiale pour les handicapés, un service à distance et un service à domicile pour les personnes âgées, enfin, un service neuropsychiatrique. Tous ces divers services sont dotés d'un personnel qualifié, d'infrastructures et d'appareillages modernes, appropriés aux besoins de nos communautés. Dans le cadre de ces mêmes services, nous accordons une attention particulière aux problèmes relatifs à l'insertion des handicapés dans le monde du travail, à l'assistance aux personnes âgées, sous différentes formes, ainsi qu'à la récupération des toxicomanes - cette dernière catégorie étant relativement limitée.

Nous pouvons également considérer avec satisfaction la prévention exercée dans notre pays en ce qui concerne le phénomène important du SIDA et nous féliciter d'avoir eu assez de chance jusqu'à présent dans ce domaine. Notre pays, qui compte 23 000 habitants, possède à l'heure actuelle 1700 donneurs de sang. Depuis 1985, l'ensemble de ces donneurs ont été soumis au test de vérification de la séropositivité; aucun n'a été positif, et nous nous en félicitons. Ce résultat constitue une donnée encourageante et un indice extrêmement révélateur.

Le rôle joué par la République de Saint-Marin ne se limite pas seulement au plan interne. Nous adhérons également aux organismes internationaux, conscients à la fois de notre identité de petit Etat et de l'importance primordiale de la coopération. A plusieurs reprises, nous avons été les promoteurs de congrès et de réunions dans le secteur de la santé et de la sécurité sociale, avec le soutien scientifique et technique des organisations internationales, et nous en avons retiré des éléments utiles pour notre propre développement.

En novembre 1986, sous l'égide du Conseil de l'Europe et avec la collaboration du Bureau régional OMS de l'Europe, nous avons concrétisé dans notre pays un projet de coopération européenne par la mise en place du Centre européen pour la Médecine des Catastrophes (CEMEC); ce centre, auquel participent à ce jour avec nous l'Espagne, la France, la Grèce, l'Italie, le Luxembourg, Malte, le Portugal et la Turquie, s'occupe des problèmes que posent la prévention et l'intervention immédiate en cas de catastrophe et de désastre naturel ou technologique. Au programme de cette année sont inscrits des cours de formation, de recherche, de diffusion des résultats, et d'organisation des secours en cas de catastrophe. Nous espérons que ces services seront, dans un proche avenir, aussi à la disposition des pays en développement, pays qui sont malheureusement les plus menacés par de telles catastrophes. Nous sommes redevables de la réalisation de ce centre à la collaboration précieuse et irremplaçable du Dr William Gunn, du Professeur Michel Lechat, associés depuis longtemps aux interventions de l'OMS en cas de catastrophe, ainsi qu'à notre représentant permanent auprès de l'OMS, l'Ambassadeur Dieter Thomas. A tous ceux-ci et au Directeur régional pour l'Europe, le Dr Asvall, s'adressent nos plus vifs remerciements et la gratitude de mon pays.

Je voudrais confirmer une nouvelle fois, au nom de mon pays, notre adhésion à la politique de l'Organisation en vue de la réalisation de la santé pour tous d'ici l'an 2000. Je voudrais, par ailleurs, adresser mes plus vives félicitations au Directeur général pour le contenu de son discours, auquel mon pays s'associe entièrement.

Je formule également le souhait que cette Assemblée apporte une contribution importante à la poursuite des progrès accomplis sur la voie de la coopération, en vue d'aboutir à une politique de santé qui soit efficace pour tous les pays et qui tienne compte de la situation réelle de tous les peuples et des plus hautes valeurs de justice et de solidarité humaines.

Mr PATHMANABAN (Malaysia):

Mr President, honourable Vice-Presidents, Mr Director-General, distinguished delegates, ladies and gentlemen, I join my friends in congratulating you, Mr President, on your election to the high office of the presidency of the Fortieth World Health Assembly. I am confident that under your wise leadership this Assembly will achieve its objectives. My congratulations also go to the five newly elected Vice-Presidents.

Next year we shall be celebrating the fortieth anniversary of the founding of WHO. We can be justifiably proud of our Organization's achievements over the past 40 years. It has been able to mobilize international resources and support for health programmes at global, regional and country level and to focus attention on problems of common concern. The forum that WHO has provided for discussing international health issues has acted as an effective catalyst for fresh approaches and new directions to our national programmes. But, as in any other organization, the strength of WHO is derived from the support of its individual members and the resources it can muster. From its past record, we believe WHO is worthy of the full and unwavering support of all nations of the world.

We shall be debating in this Assembly the Organization's budget for 1988-1989. We shall also be discussing the topic of "Economic Support for National Health for All Strategies" in the Technical Discussions. Our discussions on both these subjects are taking place at a most opportune and critical juncture.

We have previously considered in this Assembly the impact of the world-wide economic recession on health. The review indicated reduced economic growth for many countries, and even negative growth for others. Mounting foreign debts, made worse by the erosion of exchange rates, burden many countries. Unemployment will increase, and countries may adopt extreme measures in an effort to induce a spurt to their own lagging economies. This would necessarily mean diverting more resources for economic activities, and that much less allocations for much needed social services.

The pall of economic uncertainty continues to hover over many countries and indeed over our own WHO. The current unfavourable economic climate calls for a much more critical look at the manner in which we manage our affairs. The entire national resources will have to be mobilized in the face of dwindling external assistance, and steps taken to increase productivity and cost containment. We must certainly be prepared to abandon traditional activities which have outlived their usefulness and to embark on new directions and approaches which seem more relevant and cost-effective. Intersectoral coordination needs to be stepped up, as the real solution to many health matters lies outside the health sector. A concerted and coordinated effort is needed if we are to reach our ultimate goal of health for all.

The Seventh Report on the World Health Situation clearly shows how much still needs to be done and the severe difficulties that are already being faced. International comparisons indicate what can be done, or what is possible. The difference between needs and what can in reality be achieved represents the magnitude of the health gap that is the challenge before us at this Assembly. Our discussions on the budget will be an answer to this challenge.

The message and tone of the Director-General in his Introduction to the programme budget for 1988-1989 and the report on the work of WHO in 1986 cannot miss any of us.

We have a serious liquidity crisis arising principally as a result of a delinquent shortfall in income from assessed contributions to the Organization. The need for us at this Assembly is to press for this situation to be corrected. All Member States must be obliged to demonstrate greater commitment and adherence to their constitutional obligations, instead of allowing the delinquency and the decisions of a few to detract from the most basic of our aspirations that WHO represents - that is, to advocate and work towards policies and programmes that bring greater social justice, within nations and globally, through better health for all.

We cannot be, and indeed are not, indifferent to this unprecedented crisis. We are and must be concerned. Nevertheless, the malaise that we face in WHO is reflective of crises elsewhere in international relations. We need to address the crises here and elsewhere and would urge the Director-General to do the same.

In addressing ourselves to these issues, I would only make two points.

First, the Organization as well as its regional representatives and ministers must go beyond problem characterization, which many of us unfortunately tend to indulge in. We must build the elements of a better management strategy and style that makes maximum use of people and resources. In the entire reorientation that is proposed, I find the concentration on an effective primary health care and referral system at the district level to have the most promising start. Evaluation of ongoing programmes and the building of a viable, self-sustaining health system focused at this level is perhaps one medicine that will bring better cures to the problems of health programmes in the developing world. This will help to keep the focus of WHO's contribution national in character.

Second, in redirecting the advocacy and national contact roles of WHO, it would be a serious mistake to relegate national ministries of health to a secondary role. The suggestion that WHO should be allowed to deal direct with other national institutions and centres, bypassing ministries of health, will only weaken their coordinating role at national level and perhaps sow the seeds of a crisis at a different level - a crisis this time of confidence towards the national ministries of health!

Within the Western Pacific Region of WHO, from which we come, a wide diversity of health achievements is evident. Life expectancy, infant and maternal mortality, coverage of health infrastructure, and immunization, sanitation and safe water availability, as well as the ratio of health expenditure to GNP, vary from very poor to very good.

Though the comparisons are gross, their ranges are significant. Obviously, we are far from our goal of health for all. Missionary zeal alone is not enough, because many genuine efforts have been thwarted by the decisions or actions of others and other forums. For some the quality of life is the paramount target, but for many others it is still the basic question of survival. Equity must still be our objective target. It is a question of the most for all rather than the best for the privileged few. The redistribution process must necessarily start at country level, but similar steps are needed internationally if the global equity aspects of the health-for-all Strategy are to be achieved.

In spite of the tremendous advances in medicine and ready availability of effective technologies, in many countries health programmes continue to be uneven in coverage and low in level and quality. In many parts of the world, health services have not reached the rural and urban poor; or the services provided are grossly inadequate or unreliable. There is imbalance between curative and preventive programmes. As a result, health problems which can be controlled or avoided still persist and pose a serious challenge.

Lack of commitment or poor planning and improper utilization of resources contribute to the current inequity in health care. Another important factor is the perception of the medical profession with regard to their role in health care. Modern medicine has definitely improved the prospects for better diagnosis and treatment of illnesses; but unfortunately the emphasis appears to be more on curing rather than caring, more on disease rather than health, and more on technologies rather than patients. The catch phrase "partners in health" appears to have lost its significance and relevance as the medical profession, armed with the latest equipment and drugs, moves in to occupy the centre stage, whilst the bewildered patients willingly and trustingly surrender the responsibility for their own health to doctors and nurses. This disturbing current trend is incompatible with the Global Strategy for Health for All. There has to be balance between cure and prevention or promotion, as well as the commitment and actions that go with it.

Since a substantial proportion of the cost of health care can be attributed to the decisions of doctors, their ability as planners, managers, diagnosticians or therapeutists is increasingly coming under scrutiny. The need to instil cost awareness among doctors has never been greater than now, when many countries are facing shortages of resources and when the medical world is flooded with so-called improved technologies, new models or new drugs, the superiority of which may be only marginal or have yet to be tested fully. The practice of medicine without due regard to cost, whether paid for by patients or by other parties, cannot be defended in the health-for-all Strategy. Whilst we agree that doctors should do their best for their patients, the best should be for all and therefore within the context of what is acceptable with what is available.

If we accept the concept of ill health as the consequence of an aberration in the relationship between individuals and their total environment, the current disease-cure model in medical education and medical practice is obviously out of place. Some basic changes are clearly required in medical education.

It is in this spirit that we welcome the proposed international conference on medical education next year. It is our firm belief that a doctor has many more roles than what he traditionally practises. He is also a systems analyst of a much bigger system than the human body and a manager of resources, the bulk of which are not his. If we can reorientate his

education to fulfil these roles as well, we would like to believe that many of the issues raised at this year's Technical Discussions on economic support for national health-for-all strategies can be more easily resolved.

We are of the view that our biggest challenge today is in the area of management. There is increasing realization that many current weaknesses and shortfalls in health programmes are due to poor management. Availability of resources cannot guarantee good coverage or effectiveness of programmes unless they are properly managed. Planning and organizational skills are needed if resources are to be put to optimum use. Managing is more than rules and procedures. Among others, it is about people, effective team-building and communication; it is concerned with supervision and monitoring; and above all it is about problem-solving, training and staff development. Many managers do not possess these important skills, whilst others put into positions of management attempt to learn by trial and error. Clearly, there is a need to focus on management training and development. Those intending to become managers must be given the opportunity to learn these basic skills and acquire the needed reorientation, and the relevant educational programmes must include elements of management in their curricula. Health for all can be achieved only through effective management and skilful managers.

I join my colleagues in complimenting the Director-General on a clear, balanced and informative report, and on his single-minded pursuit of the objective of the health-for-all Strategy. The Malaysian delegation wishes him well in this pursuit and looks forward very much to the proceedings of this Assembly.

Sr. GARCIA VARGAS (España):

Señor Presidente, señor Director General, distinguidos delegados, señoras y señores: Me felicito por la oportunidad que se me brinda de poder dirigirme a los distinguidos componentes de esta Organización, que en 1988 cumplirá 40 años desde el inicio de su funcionamiento. Asimismo, como hoy se ha dicho, se cumple este año un decenio desde la Conferencia sobre Atención Primaria. Durante estos diez años, España ha partido en todas sus actuaciones sanitarias, de la consideración de la salud como un derecho humano fundamental, compartiendo plenamente las resoluciones de la 30ª Asamblea Mundial de la Salud.

Ese marco de Salud para todos ha favorecido en mi país una preocupación mayor por conceptos como una nueva organización de la atención primaria, los sistemas de gestión, la participación comunitaria, la equidad en el acceso a los servicios, el medio ambiente y la modificación de los hábitos de vida.

Con una amplitud cada vez mayor, se extiende en España la convicción de que las verdaderas plagas de esta segunda mitad del siglo XX - como son los accidentes de tráfico, las enfermedades cardiovasculares, el tabaquismo, el alcoholismo y algunas formas de cáncer - están estrechamente relacionadas con nuestra forma de vida y nuestras costumbres sociales. También comienza a imponerse la reflexión sobre la responsabilidad que tienen los individuos y la sociedad en la conservación de la salud.

Todo ello ha quedado reflejado en los principios generales que inspiran la Ley General de Sanidad de 1986, en la que se afirma que las actuaciones de las administraciones sanitarias estarán orientadas a la promoción de la salud y a mejorar la autorresponsabilidad y el interés individual, familiar y social por la salud.

Por otra parte, durante estos años, la política exterior española en materia sanitaria, ha reconocido en todo momento el papel coordinador de la Organización Mundial de la Salud y la necesidad de la cooperación técnica internacional, imprescindible para el logro de los objetivos del Octavo Programa. Mi país ha sido consecuente con el hecho de que algunos de los problemas sanitarios más candentes sólo pueden abordarse y resolverse en este marco. Entre esos problemas cabe destacar el del SIDA, las drogodependencias, la contaminación en el continente europeo y en el mar Mediterráneo.

Por ello, hemos apoyado también iniciativas concretas, como el Plan General sobre Necesidades Prioritarias de Salud en América Central y Panamá, que ha dado lugar a siete áreas prioritarias de actuación, presentadas a la comunidad internacional durante la Conferencia de Madrid-Contadora sobre Salud para la Paz en Centroamérica y Panamá, en noviembre de 1985. Dos años más tarde, se ha elaborado un acuerdo entre el Ministerio de Sanidad y Consumo de España y la Organización Panamericana de la Salud para profundizar en esta dirección. También se han apoyado programas concretos para Guinea Ecuatorial, el Magreb y la subregión andina.

Esta nueva política sanitaria parte, en lo que se refiere a su aplicación en el interior de España, de una situación favorable. En las últimas dos décadas se han producido cambios muy notables en la mortalidad, natalidad y esperanza de vida. La tasa de mortalidad ha descendido desde un 8,41 por 1000 en 1970 a un 7,72 en 1983. En el mismo periodo, la mortalidad infantil ha pasado de 26,3 por 1000 nacidos vivos a 12,3 y la esperanza de vida ha aumentado más de cuatro años, siendo de 78 años para mujeres y de 72,5 para hombres. Al mismo tiempo se ha producido un cambio radical en la tasa de natalidad, que ha pasado del 19,6 por 1000 en 1970 al 12,5

por 1000 en 1984. Este cambio en la demografía está produciendo variaciones marcadas en la estructura por edades y en las prioridades sanitarias de la población española. La proyección para 1990 indica un estrechamiento en la base de nuestra pirámide, y un aumento de la cúspide.

Como consecuencia del progresivo envejecimiento de la población, las enfermedades crónicas y degenerativas han pasado a ocupar un papel estelar en las causas de muerte: en 1980 las enfermedades del corazón fueron causa del 45,8% de las muertes, los tumores del 20,2% y las enfermedades respiratorias del 9,3%.

El envejecimiento de la población, el incremento de nivel de vida, tienden a modificar los hábitos de la población haciéndolos en algunos casos más perjudiciales para la salud. Los accidentes de tráfico siguen incrementando su importancia como causa de muerte, el consumo de tabaco sigue creciendo suavemente por su extensión entre las mujeres y el de alcohol sólo ha disminuido en muy escasa medida. Persisten diferencias entre la ciudad y el campo en cuanto a la accesibilidad a asistencia sanitaria, aunque ya muy paliadas por el programa de construcción de hospitales comarcales. Persisten también ciertas enfermedades infecciosas características del área mediterránea y han aparecido otras como el SIDA, con 357 casos declarados hasta ahora, equivalente al 9,2 por millón.

En resumen, las prioridades en atención sanitaria son ahora muy similares a las de los países de la Comunidad Económica Europea, con algún rasgo específico. La política sanitaria del Gobierno español se inscribe pues en el marco definido por la nueva Ley General de Sanidad aprobada en 1986. Al tiempo, queda enmarcada por la integración en la Comunidad Económica Europea, la puesta en práctica de las actuaciones derivadas de la Estrategia de Salud para todos en el año 2000 y la voluntad política de desarrollar una cooperación técnica sanitaria en áreas geográficas definidas.

En el mismo plano, se ha ampliado la cobertura de la asistencia sanitaria pública a la práctica totalidad de la población, a partir de la cual se está desarrollando un Programa de Cooperación entre España y la Oficina Regional para Europa de la OMS, con objeto de aplicar especialmente 23 de los 38 objetivos de la Salud para todos.

Se está avanzando también en el proceso de descentralización de la gestión del sistema de prestación de cuidados a los Gobiernos Regionales.

En concreto nuestra reforma se está haciendo mediante la consecución de los siguientes objetivos:

potenciación y transformación de la atención primaria a través de equipos de atención primaria, ubicados en centros de salud y compuestos por 8 ó 10 médicos y otros tantos diplomados de enfermería. El objetivo es que la atención primaria recupere importancia frente a la hospitalaria y preste con carácter general servicios de prevención y promoción de la salud y planificación familiar;

mejora de la coordinación entre la atención primaria y la hospitalaria, que se alcanza en un nuevo espacio sanitario, que es el Area de Salud. La población que comprende este área es de 200-250 000 personas;

gestión profesionalizada de los hospitales públicos, con la participación de los profesionales sanitarios y los usuarios;

la aplicación de un nuevo sistema retributivo a los sanitarios que prime la dedicación más exclusiva al sector público;

la consecución de la accesibilidad a la misma calidad asistencial a todos los españoles, estén donde estén, aunque pertenezcan a los grupos sociales más desfavorecidos. Por ello estamos dirigiendo las inversiones a donde existen mayores déficits, llevando los centros sanitarios cerca de donde viven los ciudadanos;

constitución de un Sistema Nacional de Salud, compuesto por los servicios de los 17 Gobiernos Autónomos. Este sistema integrará las redes públicas, que están siendo concentradas en una sola, complementándose con los centros privados concertados;

mejora del dispositivo informativo para el seguimiento de las enfermedades de mayor prevalencia;

impulso a programas específicos de donación de órganos y trasplantes, lucha contra el tabaquismo, planificación familiar, uso racional de los medicamentos, salud bucodental y salud mental;

un nuevo papel de la enfermería está introduciéndose paulatinamente, a pesar de las resistencias que suscita entre otros profesionales;

también, desde noviembre de 1985, se está aplicando un Plan Nacional contra la Droga que está permitiendo la implantación de una red de centros privados y públicos para el tratamiento de toxicómanos;

una propuesta de programa de un Plan Nacional contra el SIDA se presentó a las Comunidades Autónomas el 18 de febrero pasado. Dicho Plan se está llevando a cabo con especial incidencia en campañas de educación y prevención entre la población reclusa en prisiones y drogodependientes. También se están realizando campañas entre la población en general;

particular importancia se ha dado a la educación sanitaria. Madrid ha sido recientemente sede de la 1ª Conferencia Europea de la Unión Internacional de Educación Sanitaria.

En definitiva, nuestra política apuesta por un sistena nacional de salud que garantice una asistencia igual para todos los ciudadanos. Este sistema se ha demostrado internacionalmente como el más justo, así como el menos costoso. Dicha política sigue una estrategia global que integra los objetivos para el año 2000 de la Oficina Regional para Europa de la OMS.

Su perfeccionamiento está encontrando, como en otros países, problemas financieros que se derivan de la crisis económica. El gasto público sanitario en España con respecto al PIB se mantiene en torno al 4,5%. No obstante, existe una voluntad de aumentar los recursos dedicados a esta función y mejorar las prestaciones.

Nuestra política favorece además - y con esto termino, señor Presidente - un aumento inmediato de la cooperación sanitaria internacional para incidir en los hábitos de conducta de los ciudadanos, amenazados por intereses de muy diversas naturalezas, y para evitar los riesgos de enfermedades como el SIDA, que se extienden por todo el mundo. Para evitar la propagación de esta enfermedad, España propicia una acción intensa por parte de esta Organización dirigida a advertir a toda la población, aunque respetando las convicciones individuales. En esta acción puede jugarse el destino de muchas personas de este planeta.

Dr. ANTELO (Cuba):

Señor Presidente, señor Director General, excelentísimos señores: Deseo expresarles, en mis primeras palabras, el fraternal saludo de mi pueblo a los señores delegados a esta 40ª Asamblea Mundial de la Salud, de forma especial al Dr. Mahler, Director de nuestra Organización Mundial de la Salud, así como la felicitación al señor Presidente por su elección.

Resulta verdaderamente alentador para mi delegación, tener esta oportunidad de compartir experiencias y de conocer a los dirigentes que llevan sobre sí el compromiso fundamental de salud para todos, por lo que estamos seguros que estos días alejados de nuestros países serán aprovechados en esta gran escuela que es la Asamblea Mundial de la Salud.

Señores delegados: El trabajo por la salud de nuestro pueblo continúa ocupando un lugar preferente en los esfuerzos por el desarrollo socioeconómico de Cuba. La dirección principal del trabajo del sistema nacional de salud ha sido el impulso decidido a todas las tareas que forman parte de la estrategia de desarrollo de la salud pública cubana, definida por nuestro Presidente, el Comandante en Jefe Fidel Castro. Esta estrategia tiene un carácter integral y sus múltiples indicaciones van encaminadas a un objetivo científicamente fundamentado: el incremento ininterrumpido del bienestar y la felicidad de nuestro pueblo, sólo alcanzable con voluntad política, audacia operativa, acendrado humanismo e incorporación de los últimos adelantos de la ciencia y la técnica. Constituye un salto cualitativo en la concepción organizativa de la salud pública, pues se dirige al fortalecimiento de la atención primaria con un enfoque eminentemente preventivo y de promoción de salud, al introducir el médico de familia, que articulado con el sistema de salud, se nutre de los adelantos del acelerado desarrollo científico-técnico.

El médico de familia, en nuestra concepción de "guardián de la salud" del individuo, de la familia y de la comunidad, se abre paso exitosamente en todo el país. Sirviéndose de un planteamiento clínico, epidemiológico y social de los problemas de salud, tiene como objetivo informar y educar para alcanzar la autorresponsabilidad de la comunidad por la salud, aprovechando al máximo las posibilidades ilimitadas que se abren para la propia formación científica y humana, en contacto directo con la comunidad y en íntima relación con el pueblo.

Actualmente están incorporados a este programa 2473 médicos que ofrecen atención al 13,8% de la población en zonas urbanas, rurales y en las montañas. En un futuro no lejano habrá 20 000 médicos de familia, junto a 5000 más, que prestarán sus servicios en fábricas, escuelas y otros centros y que mediante un programa de formación de postgrado de tres años se convertirán en especialistas de medicina general integral, nueva especialidad que constituye la base fundamental de las acciones preventivo-curativas en la atención de salud a la población. En 1986 ya se graduaron los primeros 28 especialistas de medicina general integral y este curso 676 residentes realizan sus estudios de especialización.

Señor Presidente: La ejecución de la política de salud pública se revierte en el mejoramiento constante del estado de salud de la población. Los indicadores de salud considerados a nivel mundial como los más importantes, mejoran en el país ostensiblemente. Así, tenemos que la esperanza de vida actualmente pasa de los 74 años. Es significativo que del total de la mortalidad nacional sólo el 21% muere con menos de 50 años y, de ellos, el 4,4% con menos de 5 años. Al entrar en la década de los años setenta, cuando ya se habían obtenido grandes éxitos en la salud pública, aún el 37,5% de la población moría con menos de 50 años y, de ellos, el 23,7% eran menores de 5 años.

Otro indicador de importancia es la proporción de muertes por causas infecciosas y parasitarias, pues en su mayoría estas causas son evitables si se toman diversas medidas. De más del 13% de las muertes que se ocasionaban por estas causas en los primeros años de la Revolu-

ción, hemos descendido en 1986 al 1,5%, la tasa más baja de nuestra historia. Podemos destacar que la mortalidad infantil ha sido reducida en 11 años al 50%; o sea, de 27,5 por 1000 nacidos vivos en 1975, a 13,6 en el año 1986.

El programa de inmunización ha continuado su marcha ascendente; la reciente campaña nacional de la vacuna triple vírica (sarampión, parotiditis y rubéola) alcanzó una cobertura del 95% en el grupo de 1 a 14 años. La cobertura de las cuatro vacunas del programa ampliado de inmunización alcanzó cifras mayores del 90% en el grupo de niños menores de 1 año.

Se mantiene el país libre de poliomielitis, paludismo autóctono, difteria, rabia humana y tétanos infantil. La tuberculosis bajó su incidencia de 8,3 a 6,4 por 100 000 habitantes.

Tales hechos, por citar algunos ejemplos, tan contundentes como irrebatibles, son un ejemplo de cómo en Cuba se asegura de manera real y para toda la población, sin distinción de razas, posición social y lugar de residencia, uno de los derechos humanos fundamentales: el derecho a la salud.

Señor Presidente, señores delegados: El Consejo Ejecutivo ha pedido a los jefes de delegaciones que traten el tema de la cooperación mundial entre los Estados Miembros con miras a alcanzar la meta de la Salud para Todos en el año 2000. Somos conscientes de que no se podría alcanzar una meta social de esa magnitud si no fuésemos capaces de desarrollar la cooperación entre los países. El mundo subdesarrollado no puede por sí solo enfrentar la enorme tarea del desarrollo, insoslayable realidad que, quizás, se pueda rehuir en un discurso pero que la vida se encargaría de presentar en cada minuto en su dramática magnitud.

A nuestro juicio la cooperación mundial no puede responder a consideraciones de ningún tipo que la condicionen, o que resulten en dependencias políticas o económicas. Esta cooperación tiene que estar matizada por lograr el mayor desarrollo de las capacidades nacionales de quienes por sus necesidades recibirían los beneficios de la misma. En el plano ético, la cooperación la comprendemos como un mecanismo más para satisfacer el derecho del hombre al bienestar, independientemente de las fronteras donde viva, de su régimen social, de sus consideraciones ideológicas o de las riquezas de sus suelos. La sola razón de haber aprobado la estrategia de Salud para todos, ha venido posibilitando el análisis de los problemas que inciden en los países en desarrollo para alcanzar la meta y se ha ido despejando un grupo de esos problemas que no tendrán solución sin el diálogo y el entendimiento, que son, precisamente, fundamentales pilares de la cooperación internacional.

Para nosotros la necesidad de la paz y del desarrollo se encuentran dentro de los más acuciantes problemas ante los cuales se encuentra la humanidad. Es un axioma que sin paz no habrá desarrollo; pero es también un axioma que sin desarrollo para las ocho décimas partes de la población mundial, no puede haber paz. Si las grandes potencias militares de los países desarrollados vieran desaparecer la pesadilla de un holocausto nuclear, que por supuesto nos alcanzaría a todos, sería legítimo que los pueblos del Tercer Mundo conciban la esperanza de ver desaparecer también la pesadilla del holocausto por hambre, por enfermedad, por desamparo, por falta de techo, de trabajo y de las más elementales condiciones de vida, que ya cientos de millones de sus niños, sus jóvenes, sus mujeres, sus hombres y sus ancianos están sufriendo.

Señores delegados: Cuba ha hecho un esfuerzo por expresar de manera concreta su solidaridad y ofertar su cooperación con otros pueblos que lo necesiten. Más de 22 000 jóvenes del Tercer Mundo realizan gratuitamente sus estudios en nuestro país. En el campo de la salud hasta 1986 estudiaron carreras de nivel medio y superior alumnos de 88 países y ese modesto aporte ha posibilitado graduaciones de 1100 médicos, 132 estomatólogos, 634 técnicos y más de 200 que concluyeron sus estudios de especialización. En 35 países, más de 2000 trabajadores de la salud, actualmente prestan sus servicios en las zonas donde son requeridos. Entre ellos, un grupo de nuestros profesores laboran como docentes en cinco países que ya han construido sus facultades de medicina, lo que nos llena de legítima satisfacción.

Estos ejemplos no pretenden mostrar la magnitud de la cooperación que modestamente podamos ofrecer. Su mayor importancia radica en que demuestran la enorme potencialidad de nuestros países, la extraordinaria reserva con que contamos, incluso siendo países en desarrollo, y el torrente de voluntad e inteligencia que permiten confirmar que Salud para todos no es un sueño de unos cuantos bien intencionados.

Si en verdad todos queremos ser consecuentes con Salud para todos en el año 2000, todos, en el grado que su desarrollo y riquezas lo permitan, debemos sentirnos obligados moralmente con este compromiso con la historia y actuar en consecuencia. Utilicemos la cooperación mundial para que el derecho del hombre a la salud sea reconocido como un deber insoslayable de toda la humanidad.

Dr BENGZON (Philippines):

Mr President, Mr Director-General, distinguished delegates, honoured guests, ladies and gentlemen, the Government and the people of the Philippines extend their best wishes to the Fortieth World Health Assembly. Our President, President Corazon Aquino, extends her warm felicitations to the World Health Organization.

In the past year the Philippines has tried to advance over a broad front in the field of health. We have strengthened our Ministry of Health organizationally. We have placed health as a central concern in our new Constitution. Our Government has strongly supported health in its budget. We are revitalizing our public health programmes and we are improving our hospital services. We are expanding and deepening our collaboration with nongovernmental agencies and other government offices. Our Ministry of Health, and the whole Philippine health sector, is greatly encouraged and highly enthusiastic. Even with limited resources, we in the Philippines feel that in health many initiatives are possible, many advances can be obtained and many benefits can be achieved. Within the Government's framework of democratic restoration, continued pursuit of peace and economic recovery, and social restructuring, health has secured its place as a goal of national effort and as a means for attaining other national goals.

Despite this optimism, we have no illusion that the achievement of health for all is a matter preordained by faith or rendered automatic by circumstances. No, we are hopeful, but not unrealistic. There are still many obstacles. We are familiar with these many obstacles to real, sustained and substantial advance of health programmes. These obstacles fall under three basic categories. Many obstacles fall under one category, which is the lack of clarity and focus in policy. Under this class fall such problems as confusion, ignorance, bias, shortsightedness, expedience, technical defects and lack of direction. This type of problem is peculiar in that one does not easily recognize that one's policy is misdirected. Many other obstacles fall under the second category of lack of resources. Under this class fall such problems as deficient budgets, unpredictable cashflow, and rigidities in resource allocation and utilization. These problems are endemic in health sectors - so much so that we are devoting this year's Technical Discussions to the vital issue of economic support for primary health care. The final category of obstacles concerns problems of people. Such problems as personality differences, demoralization, intrigue, unhealthy competition, dishonesty and excessive pride fall under this category. We normally underestimate the damage of this type of problem; but many errors and much waste have occurred because of the "people problem".

In the context of grappling with these obstacles I would like to discuss two major issues that I believe will critically shape the way our country will surmount its difficulties in health. I shall discuss the issue of political governance as a basic underpinning of health initiatives and the issue of a public and open health ministry as a basic approach in health-for-all strategies.

I am convinced that the domestic political climate presents fundamental opportunities and constraints for health. Politics is a means to clarify society's goals and is a tool for organizing efforts towards these goals. The political system has to take health goals as society's own before the vast arsenal of resources necessary for health progress can be mobilized. In this regard policy formulation and administration in health has to be politically active. One of the recurring tragedies in health is the continued dichotomy between those who have mastered health technology and those who exercise the levers of political powers. This is tragic because of the neglect and waste that has resulted as well as the disaffection it has caused among leaders in health. Health leaders have to be political leaders. If they are unwilling to do so, then health leaders must have the patience, the energy and the attention to transform their political leaders into persons who understand and support health. These efforts will greatly assist in clarifying policy, in assuring resources for health and in managing personalities. Incidentally, a key issue in political governance is the tug of war between control and initiative. This issue permeates the debate in health policy and administration. In the Philippines, we have learned that opening up public debate on policy helps clarify directions, although with some loss of control. Participative management and consultative decision-making increases available resources but makes their efficient allocation and utilization more challenging and more difficult. No approach is perfect, but in any case leaders of goodwill and sound judgement are a necessity. I am sure many are familiar with the phenomenon I shall describe. If one goes to a community, analyses its health problems and makes people aware of these problems and their roots, one sees that resources become available. People are mobilized and problems get solved. If this happens in a community, surely it can happen in a country. If this happens in a state, surely this can happen in the world. Except for magnitude, complexity and extent of intervention required, those situations are parallel and the approaches should be similar.

With these assumptions, I would like to argue for a more open and publicly conducted ministry of health. I believe health leaders must openly communicate with the people. They must creatively and effectively thrust health issues in the centre stage of national debates. They must use information and technology to bring problems and possible solutions to those most affected - the people themselves. In this role, the credibility of health leaders

becomes a critical issue. Our constituents, which is to say the people who are beneficiaries of our services and policies, should be able to regard us as competent, honest and forward-looking, since these are the hallmarks of credible leadership. These efforts to influence people via a publicly expressed leadership should be directed not simply towards greater awareness, but, beyond that, towards greater health-supportive behaviour. Here the field is wide, and wide open for innovation and demonstrated successes. I have seen too many studies in health where high levels of public awareness were not matched by equivalent levels of appropriate behaviour.

In the Philippines, we are moving steadily forward. We had tremendous problems, but the future is hopeful. We shall continue to articulate health concerns in political arenas and we shall seek to build a publicly constructed consensus for health initiatives. Many people still die unnecessarily, so we do not have the luxury of a stately pace. Rest assured, distinguished delegates, we join the rest of the world in pursuing great goals despite little time and much less resources.

Mrs SIGURDSEN (Sweden):

Mr President, Mr Director-General, distinguished delegates, never before has the World Health Organization been more important than at present. We have little more than a decade to go before the goal we have set up - health for all by the year 2000 - is to be attained.

The report of the Director-General to this World Health Assembly gives a clear picture of the Organization's strong support to Member States in implementing the health-for-all Strategy. However, it is clear that, despite tremendous efforts made nationally and internationally, the health status of a large proportion of the world's population remains precarious. Many countries face economic constraints which threaten their health budgets. On the positive side it can be noted that almost all countries have some form of strategy for health for all and that a wide range of technology already exists for the implementation of the essential elements in primary health care.

As the Director-General underlines in his Introduction to the budget proposal, it is now important to support the establishment of sound health infrastructures and capacities for better health management. The Organization's impact on health development in all countries is self-evident. Sweden has certainly received great benefits from the use of the World Health Organization. Unfortunately, over the last years many efforts have had to be devoted to devising contingency plans and designing budget cuts, because some Member States have not met their financial obligations towards WHO. This is just not acceptable. We have a collective responsibility to see to it that WHO can work with those matters it is supposed to deal with - namely health matters. A prerequisite for this is of course that each Member State pays its contribution in full and on time.

The world is now facing one of the most severe health risks of this century - AIDS. Once again, WHO is there when we need it. Without delay, the Organization pools its resources of knowledge, skill and dedication and rises to meet this formidable challenge - an epidemic which was virtually unknown a couple of years ago. To meet new problems like AIDS we must have a strong and efficient WHO, an organization which can concentrate its efforts on what we want it to do - to improve world health.

AIDS is already a pandemic; 101 countries representing all continents have reported cases. It is a severe - and growing - global health problem, affecting both developed and developing countries. In Sweden we have up to now had 106 cases of AIDS and there are 1400 known cases of HIV infection in a population of eight million. Like many other countries, Sweden has started a nationwide campaign against AIDS. The goal is to inform everyone on how to avoid the infection. Epidemiological surveillance and the active tracing of HIV transmission are other important parts of our overall community effort to combat the spread of AIDS. The most effective preventive strategy will of course vary somewhat from country to country and have to be adapted to cultural and social patterns. But at present, and for years to come, information that leads to changed behaviour will be the only "vaccine" available. For developing countries already afflicted with severe health problems, AIDS imposes an additional heavy burden. The personal, social and economic costs of the HIV epidemic are enormous. It is the productive 20- to 40-year-olds that will die. And once again children are at special risk - both of getting the infection from the mother, and of losing parents or other family providers.

The need for international cooperation to combat the AIDS pandemic is self-evident, as is the crucial task of WHO to coordinate preventive measures, research and technical assistance. The Swedish Government is prepared substantially to raise its assistance to developing countries for measures against AIDS, and our bilateral assistance will be undertaken in close cooperation with WHO. The Swedish support of WHO's programme on AIDS is 1.8 million dollars for the fiscal year 1986-1987, and it will be 15 million dollars for the fiscal year 1987-1988. Approximately 10 million dollars of this amount will be multilateral support for the special programme and 5 million dollars bilateral support.

The societal impact of AIDS - personal, social and economic - will be increasingly profound. There are widespread fears and apprehensions among the general public. What will be the impact of the disease on our societies? It is clear that we must fight all tendencies of stigmatization of groups, discrimination, social isolation and hostility towards infected persons. In all our measures to combat the spread of AIDS our common basis must be to preserve the societies we have built up on the foundations of solidarity, humanism and respect for human dignity. Knowledge that one is infected with HIV virus is a heavy burden for the person concerned and for his or her family. This calls for support and assistance, and for the provision of education and psychosocial support to health personnel.

While I strongly support the general outline of the new programme on AIDS, I would like especially to underline some aspects. Firstly, donor and recipient countries have a collective responsibility for the policy and implementation of the AIDS programme. Secondly, the need for special measures against AIDS, as well as intersectoral activities involving several of the WHO programmes, should be duly reflected in the budget. To achieve profound results, more than a special AIDS programme is needed. For instance, anaemia sometimes resulting in a need for blood transfusions can be avoided thanks to malaria prophylaxis. Prevention and treatment of other sexually transmitted diseases as well as drug abuse lessen the risk of HIV infection. What we really need is most of the essential elements in the health-for-all Strategy: a functioning health infrastructure, primary health care, mother and child health care, health education, family planning, vaccination programmes, etc., and whenever possible sound intersectoral approaches.

In conclusion, Mr President, in times of financial restrictions and urgent needs to tackle severe health problems, of which AIDS is currently the most dramatic example, it is important that we unite our efforts and that we safeguard our common organization's work for health for all.

Mr Hai Won LEE (Republic of Korea):

Mr President, Director-General, distinguished delegates, ladies and gentlemen, on behalf of the Government of the Republic of Korea, I wish to extend my sincere congratulations to you, Mr President, on your unanimous election to the presidency of the Fortieth World Health Assembly. I would also like to take this opportunity to express my deep appreciation to the Director-General and his staff for their unswerving endeavours to achieve health for all.

Mr President, on this occasion please allow me to briefly introduce efforts and progress made in the Republic of Korea in line with the goal of WHO, that is to attain health for all by the year 2000.

The overall health situation in the Republic of Korea has been remarkably improved for the last several years, with rapid economic and social development through the successful implementation of the five consecutive Five-Year National Economic and Social Development Plans.

My Government has placed emphasis on social development as well as economic development to enhance living standards. Consequently, we have been able to promote the health of the people through balanced progress in the fields of health and medical services as well as other related areas, such as farming, education, safe water supply, housing, and social security.

In the field of immunization activities, an area of great importance prompted by WHO, as declared in this year's World Health Day theme, we have been able to maintain a high percentage of coverage of children, with the active voluntary participation of parents through a better understanding of the matter. Furthermore, my Government has provided free immunization services to all children to prevent childhood infectious diseases, thereby reducing the infant mortality rate.

In primary health care, my Government has launched a very ambitious programme, with major emphasis on the provision of health personnel and facilities, on community involvement and on reducing the financial burden to the people. As a result of this, we were able to eliminate doctorless areas in 1983, and the assignment of primary health care workers to the village primary health posts was completed for the whole country last year.

Mr President, the promotion of environmental health cannot be overlooked in the promotion of health. In order to preserve a healthy environment the Environmental Protection Law was promulgated in 1977 and the Environment Administration was established in 1980 at the national level. Air and water pollution, created in the course of rapid industrialization, has been checked by the constant efforts of the Government with the help of industries and all citizens. We were able therefore to successfully host the Asian Games under pleasant environmental conditions last year.

On the occasion of the Seoul Asian Games we made every effort to improve food and environmental sanitation. Continuous efforts in such areas as drug control, maternal and

child health, including family planning, health services for the senior citizens and rehabilitation of the handicapped are also noteworthy.

Mr President, apart from these accomplishments, I would like to touch on the subject of our National Medical Protection Programme which is one of the major social security programmes. Presently, a little over half of the Republic of Korea's total population are beneficiaries of one of the three programmes: the National Medical Insurance Programme, the Medical Aid Programme or the Medical Assistance Programme. My Government has decided to expand the National Medical Protection Programme to all the rural population by 1988 and all the urban population by 1989. In addition we have amended the relevant law to include the Republic of Korea's traditional medicine in the medical insurance scheme effective from this year.

Mr President, now I would like to add a few comments on international cooperation among Member States to ensure the attainment of health for all by the year 2000, emphasizing the ever-increasing role of WHO. The Republic of Korea has accumulated much experience of implementing various pilot projects for the promotion of health, in close collaboration with international organizations such as WHO and UNICEF. We are ready to share this valuable experience with other developing countries. My Government is willing to participate in the field of technical cooperation, such as the production of drugs and medical technology, to help those countries which need such assistance. I also believe that the experience with the Saema-ul Undong (New Community Movement), which has been a successful community development movement in the Republic of Korea, would provide a good example to other developing countries in relation to the implementation of primary health care.

Lastly, I would like to express my appreciation of WHO's action to control AIDS, clearly shown in the Director-General's report. Virtually all nations are facing the serious AIDS problem. However, considering the fact that the possibility of AIDS spread due to infected travellers is very high in some countries, I propoe that WHO should initiate affirmative action to control the spread of HIV, including the HIV screening of international travellers, and to strengthen scientific research on AIDS.

Mr President, I am proud to report that all preparations, including health care services and environmental sanitation, are progressing properly for the great event of the 1988 Seoul Olympic Games. These preparations will ensure a memorable stay in the Republic of Korea for all the participating athletes and tourists during the Games. I would like to solicit your cooperation to make this great festival successful. I can also say with great confidence that the Seoul Paralympics next year will be a very meaningful gathering to provide hope and courage to the handicapped, supported by all your concern and cooperation.

Mr President, I would like to conclude my remarks by extending my best wishes for the happiness and prosperity of all the distinguished delegates.

Thank you.

Dr MARANDI (Islamic Republic of Iran)

In the name of God, the Merciful, the Compassionate, it gives me great pleasure to congratulate you, Mr President, on your election to the presidency of the Fortieth World Health Assembly, and wish you all success in conducting the work of the Assembly.

Mr President, the Government of the Islamic Republic of Iran, inspired by the Islamic ideology, attaches great importance to the attainment of the noble goal of health for all by the year 2000. In this regard, high priority is given to the rural underserved areas, as a result of which thousands of kilometres of rural roads have been constructed, thousands of villages are provided with electricity and millions of people have enjoyed the rural literacy campaign. In 1986 alone 1400 health houses and 200 rural health centres were established, while safe drinking-water was provided for 424 more villages.

Further to a new law passed by the Parliament in October 1985, the former Ministry of Health was reorganized in the Ministry of Health and Medical Education, being expected to play a major role in the planning of health programmes as well as the training of manpower based on the actual needs of the country. To that end, while nine new medical schools have been established and the number of annual admissions of medical students has been increased from 3000, which was the case in the past, to 5000 at the present time, an increasing number of the teachers of medical schools are involved in the health planning process and competent public health officers of the Ministry of Health are being considered as potential teachers for medical schools.

In pursuance of the national seminar regarding the role of medical schools in health for all, a national workshop on strengthening and reorientation of the departments of community medicine towards health for all was held in Saravan, a remote district in the south-eastern part of the country in March 1987. It was personally attended and chaired by myself, and actively participated in by chancellors of universities of medical sciences and the professors of the departments of community medicine.

We are confident that, in the near future, our universities of medical sciences will realize the ardent desire of universities being actual partners with health sectors in the attainment of the goal of health for all by the year 2000. Needless to say that in this connection the support of the World Health Organization as well as the cooperation of interested Member States would be needed and very much appreciated.

Believing in the fact that like many other developing countries we are lacking the critical resources in managerial expertise, a national workshop on the managerial process for national health development was held in Zanjan in September 1986 and was followed by eleven similar regional workshops.

Mr President, bearing in mind that close cooperation between developing countries is an undeniable necessity for attaining health for all, the Government of the Islamic Republic of Iran believes that true international collaboration based on mutual goodwill and appropriate partnership can be supportive to the implementation of the respective countries' national strategies for health for all. On the other hand, one cannot ignore that still many countries of the world today are suffering from exploitation, hunger, illiteracy and war, which makes it almost impossible for them to reach the goal of health for all by the year 2000. Unfortunately, Mr President, my country has been suffering from the imposed war for nearly seven consecutive years, as a result of which thousands of innocent people have been killed due to the use of chemical weapons and heavy bombardment of residential areas by the Iraqi regime.

To mention as an example, early in the year, in a period of less than two months, the Iraqi bombers raided the residential areas of our cities and villages 236 times. As a result of this criminal action, about 4000 people were killed....

The PRESIDENT:

There is a point of order. The delegate of Iraq has raised his hand. You have the floor, Sir.

Dr AL HADAWI (Iraq):

Mr President, this is a civilized forum. This is not an impertinent forum, whereby none other a Minister belittles himself to indulge the Organization in redundance, irrelevance and lack of tact. May I add please ...

The PRESIDENT:

I am sorry to say this is not a point of order. You have the right to make a point of order and you have the right to make a reply. Yes, you have the floor, Sir.

Dr AL HADAWI (Iraq):

I wish to make a point of order and then I will take my right of reply at a later stage. Thank you, Mr President.

Dr MARANDI (Islamic Republic of Iran):

Thank you, Mr President. I was saying, to mention as an example, early in the year, in a period of two months, the Iraqi bombers raided the residential areas of our cities and villages 236 times. As a result of this criminal action, about 4000 people were killed, around 12 000 people were seriously injured and more than 60 hospitals and health centres were destroyed.

Continuous use of chemical weapons by ...

The PRESIDENT:

You have a point of order, Sir? The delegate of Iraq.

Dr AL HADAWI (Iraq):

Thank you, Mr President. Mr President, the Minister of Iran should be put to order. I appeal to you for a second time, Mr President. There is no point in raising issues that have no bearing on the substance of this meeting. This is not a political institution. This is the World Health Organization. Mr President, I wish you to uphold the point of order, lest you force me again to interrupt, which I hate very much to do. Thank you, Mr President.

The PRESIDENT:

You have the right to reply. I shall give you the floor at the end of the afternoon session. Again, Sir, you have asked for that and I ask now the delegate of Iran to continue his speech and to take into account what has been asked.

Dr MARANDI (Islamic Republic of Iran)

Continuous use of chemical weapons by the felonious regime of Iraq is a well known tragedy to everyone. Regretfully, this regime has also used chemical weapons against our civilians and even hospitals, frequently, victimizing many doctors, nurses and other health personnel.

Mr President, distinguished delegates, despite the imposed war, we have been able to develop our health system based on primary health care so that, at present, more than 55% of the rural population have access to primary health care, while safe drinking-water has been provided for 60% of the rural population, and 75% of children under one year of age have been fully immunized against six EPI target diseases; and the infant mortality rate has dropped from 104 to 50.7 per thousand.

Nevertheless, we are not satisfied with what we have achieved so far, and I am confident that while my Government is determined to reach the goal of health for all, our people will work hard in order to accelerate its attainment.

In conclusion, Mr President, I would like to congratulate the Director-General for his excellent report and wish him all success in realizing the goal of health for all by the year 2000.

Thank you very much, Mr President.

Le Dr DIALLO (Guinée) :

Monsieur le Président, Messieurs les Vice-Présidents, Monsieur le Directeur général, honorables délégués, la délégation de la République de Guinée souhaite plein succès aux travaux de la Quarantième Assemblée mondiale de la Santé. Il convient de dire que mon pays, malgré la crise financière que connaît notre Organisation, accorde toute sa confiance au Directeur général de l'OMS, le Dr Mahler.

La Guinée apprécie l'esprit de consensus qui a permis aux membres du Conseil exécutif de prendre des décisions harmonieuses lors de sa soixante-dix-neuvième session et souhaite que les travaux de la présente Assemblée se déroulent dans le même esprit de compréhension mutuelle. Ma délégation appuie les mesures d'urgence adoptées par le Directeur général pour faire face aux difficultés budgétaires. Mon Gouvernement, malgré les contraintes de la phase de restructuration et d'ajustement monétaire, a fait des efforts louables pour s'acquitter de ses contributions de l'exercice 1986-1987.

Le Ministère de la Santé et des Affaires sociales a, durant le biennium 1986-1987, axé ses efforts sur le renforcement institutionnel, la formation des cadres (surtout en gestion), l'inventaire des ressources disponibles, l'élaboration d'un document de politique générale de la santé avec un plan quinquennal de développement sanitaire (1987-1991) ainsi que sur la préparation de projets de mise en oeuvre du programme national de soins de santé primaires. Certaines activités, telles que la lutte contre l'épidémie de choléra de 1986, les journées de vaccination de Conakry (de décembre 1986 à février 1987) ont permis au Département de renforcer sa collaboration avec d'autres ministères, avec les organisations internationales gouvernementales et non gouvernementales, ainsi que de bénéficier de l'aide d'urgence de plusieurs pays amis dont la France, la République fédérale d'Allemagne, l'Italie, l'Algérie, le Maroc, l'Egypte, la Bulgarie, la Hongrie, l'Union des Républiques socialistes soviétiques, les Etats-Unis d'Amérique, le Japon, la République démocratique allemande.

Depuis le 3 avril 1984, le Ministère de la Santé et des Affaires sociales a réussi à renforcer la coopération avec les organisations internationales (OMS, FISE, CEE, PNUD, BAD, Banque mondiale), ce qui a permis la préparation des projets suivants : le projet programme élargi de vaccination/soins de santé primaires avec le FISE, le projet de développement des services de santé avec la Banque mondiale, le renforcement institutionnel et la préparation de projets avec la Banque africaine de Développement, le programme de médicaments essentiels avec l'OMS. La politique de décentralisation du Gouvernement a créé un cadre propice à la collaboration avec les organisations non gouvernementales (ONG), ce qui a permis au Département de la Santé d'avoir sur le terrain six ONG, et deux autres protocoles d'accord sont en préparation. Une réunion d'information sur la Guinée a pu se tenir sous l'égide de l'OMS/Genève, à l'intention des organisations non gouvernementales, en marge des travaux de l'Assemblée annuelle des ONG des Communautés européennes à Bruxelles en avril 1987. Il faut noter que tous les projets

sont basés sur la mise en oeuvre des activités intégrées au niveau des préfectures et des centres de santé de sous-préfecture, avec la fourniture de médicaments essentiels et le recouvrement des coûts.

Les échanges d'expériences ainsi que les concertations à travers la Commission mixte de Coopération se poursuivent avec plusieurs pays, aussi bien d'Afrique que d'autres continents. En somme, la Guinée accorde une importance primordiale à la coopération internationale dans le domaine de la santé. Le Gouvernement fait aussi de gros efforts pour l'augmentation du budget alloué à la santé ainsi que pour la motivation du personnel par la décision récente d'augmenter les salaires.

Le thème des discussions techniques revêt une grande importance pour la mise en oeuvre des stratégies nationales, qui ont réellement besoin d'un appui suffisant et constant. Cet appui doit permettre de mobiliser toutes les ressources, intérieures et extérieures, budgétaires et extrabudgétaires. A l'heure où l'Organisation est frappée de plein fouet par la crise financière, les pays en développement, notamment ceux de la Région africaine de l'OMS, ont besoin de tout le soutien de la communauté internationale dans la recherche de ressources extrabudgétaires nécessaires à la mise en oeuvre des programmes nationaux de soins de santé primaires.

La délégation guinéenne appuie les programmes OMS de lutte contre le SIDA et contre les maladies diarrhéiques, et approuve le projet de huitième programme général de travail (1990-1995). Néanmoins, il convient d'attirer l'attention sur la nécessité de rechercher suffisamment de fonds pour certains programmes encore prioritaires en Afrique : le paludisme, la tuberculose, la trypanosomiase, la lèpre, l'onchocercose, la santé des travailleurs.

Dr PELEKANOS (Cyprus):

Mr President, on behalf of the Cyprus delegation and myself I would like to congratulate you on your election as President of the Fortieth World Health Assembly and wish you every success in your difficult task. May I also extend our congratulations to all the other officers who have been elected to assist you in the deliberations of this Assembly. On this occasion, I would like to express my thanks and appreciation to the Director-General, Dr Mahler, and the Executive Board for their efficient work over the last year, which aimed towards again achieving better health for all. In Cyprus, further progress in obtaining health for all has been made over the last year, despite the tragic events of 19874 and the continuing displacement of one third of our population. The health infrastructure system has been strengthened in order to improve not only the quantity but also the quality of care. The health indicators show that progress is sustained. Infant mortality, for example, has been refused to twelve per one thousand live births. This, however, by itself cannot be comforting. The whole issue of health for all does not end at looking at health indicators alone. Even under the best circumstances new health problems will arise. A clear example is the AIDS epidemic. This is why the Government of Cyprus keeps a continuous watch on the development and spread of this dreadful epidemic. In this respect we have introduced special measures in order to protect our population. Prevention of AIDS is the only safe way to contain this killer disease. In this national prevention programme, health education, screening of blood donors and high risk groups and the introduction of legislative measures are the main elements.

In the meantime other preventive and health promotion programmes were launched or continued. Those include cardiovascular diseases and accident prvention. The strengthening of the health infrastructure system has been possible through adequate government funding and the general support of UNHCR for those projects that are directed towards the service of the Cypriot refugees. Furthermore, the contribution of the private sector has been very significant. This sector continued to supplement for those services that are either not in the priorities of the national strategies for health for all, or to provide primary services on a broad and accessible basis, mainly in the urban areas. The establishment of medical foundations, namely non-profit organizations, is another way of financing health care, particularly tertiary level care, that appears to be developing in Cyprus. In this respect, we mobilize and utilize all the available resources to support our national health-for-all strategies. Despite these facts, we have to continue the assessment and evaluation of our efforts in achieving the goal of health for all by the year 2000. This reappraisal is partly made possible through the WHO technical input, and I take this opportunity to thank the WHO technical staff for their contribution. I would also like to express our special thanks to Dr Hussein Gezairy, Regional Director for the Eastern Mediterranean, for his cooperation and positive response to our collaborative programmes with WHO. We also extend our special thanks to UNHCR for its inputs in our refugee health programmes.

Before leaving the floor, I would like to reiterate the commitment of the Government of Cyprus to health for all and express our appreciation that the main theme of the technical discussions this year is Economic Support for National Health-for-all Strategies, an issue that is bound to concern all Member States. Resources are not unlimited but it is certain that there is always a better way of using them.

Thank you, Mr President.

Mrs BELLEH (Liberia):

Mr President, Director-General, distinguished delegates, permit me, Mr President, on behalf of my delegation to congratulate you and your officers on your election to the high offices of the Fortieth World Health Assembly. We trust and believe you will guide this august body to a successful conclusion of the deliberations before it. In this regard, we assure you of our support and wish you and all of us success.

We have very carefully studied the Director-General's very informative and clear report on the work of WHO in 1986, on which I intend to make some brief observations shortly. Prior to my observations, I wish to heartly thank our hardworking Director-General and his Secretariat for the efforts made in the implementation of our collective decision during the year under review. We have, with some relief, noted the progress report on the Global Strategy for Health for All by the Year 2000. I also would like to seize this opportunity to sincerely thank our Regional Director, Dr Monekosso, for his constant and unfailing support and guidance he continues to make available to us in the implementation of our various health programmes. I therefore would like to assure both the Director-General and the Regional Director for Africa of my Government's continued support for their commendable and relentless efforts in the implementation of our collective decisions.

We are all gathered here once again to deliberate the health issues affecting the wellbeing of us all wherever we may be. This Fortieth World Health Assembly is a very significant and at the same time a special one. It is significant in that the accumulated 40-year experiences of successes and failures of WHO will be carefully used to re-map and strengthen our efforts for health for all by the year 2000, and it is "special" because it is said that life begins effectively or more actively at "40". We hope for a brighter future for our Organization in this regard.

Although some global gains have been made in the overall health situation in Africa, some have equally been lost due to various factors, some of which, like the economic recession, natural disasters etc. are beyond our control. These difficulties have had a negative influence on the successful implementation of our various health programmes, especially so in Liberia. The health demands of our people seem to outstrip the available limited resources. And this immediately brings me to the rational utilization of the national, bilateral and international resources, which has been a constant subject for this Assembly's resolutions. Admittedly, we in Liberia, like those in other developing parts of the world, are going through a period of serious economic constraints, and that is one reason why my country welcomes the development and implementation of the accelerated primary health care at the district level, with particular emphasis on the community level.

Since we adopted this strategy in Liberia in collaboration with WHO, UNICEF, and USAID and other bilateral agencies we are happy to positively state that we continue to make efforts in that direction. It will, perhaps, suffice to mention that in collaboration with WHO, five countries have been selected for the implementation of primary health care activities. Prior to that, we carried out a survey on the overall health situation on the basis of which a district primary health care action plan is being formulated.

In an effort to improve and strengthen the decentralized managerial process for effective primary health care implementation, an analysis of various systems was conducted which enabled us to formulate a national policy for implementation. A national revolving fund system aimed at ensuring the availability of essential drugs and medical supplies at the various levels at a reasonable cost has been developed and is being implemented in some countries and districts. We had also directed our efforts at developing, through training courses and workshops, primary health care leadership with particular emphasis on the national and community levels. We consider this leadership to be a crucial element and requirement for an effective decentralized primary health care system, especially at the district level. It is here again, that we would like to request the Director-General and the Regional Director for Africa to continue to assist in mobilizing the necessary resources for these very important activities. Support for both nationally and internationally recruited associate professional officers would greatly ease the tasks of primary health care implementation at the district level.

Before concluding my statement, I should like to thank the Director-General for the efforts being made to contain the deadly disease AIDS. Although to date, we have had only one clinically known case of AIDS, we appreciate and thank the Organization for the means and support being made available to us. No doubt the control and final elimination of the disease, as was the case with smallpox, will require much closer collaboration among us all. This, of course, is in conformity with the principles of technical cooperation between developing countries.

Once again, Mr President, I pledge my country's support for the many efforts being made by WHO as we strive to achieve our objectives of health for all by the year 2000 and to wish all of us success in our efforts.

Mr MOMIN (Brunei Darussalam):

Mr President, Director-General, honourable ministers, ladies and gentlemen, may I take this opportunity on behalf of my Minister and my delegation to congratulate you on your election to the high office of President of the Fortieth World Health Assembly and extend out best wishes to other elected officer-bearers. I am confident that with your leadership and experience and that of our colleagues you will continue to harness the deliberations of this Assembly towards further significant impacts on policy in the health-for-all movement.

Throughout the world we have seen substantial progress being achieved in the health status of the people. Since the Alma-Ata Declaration in 1978 all nations have accepted the primary health care approach as the best means to achieve health for all. Major childhood communicable diseases have either disappeared or their incidence has been drastically reduced in most countries. In all fields of research WHO has acted as a catalyst, and must sustain continuous support and encouragement as new problems like AIDS emerge to threaten our progress towards health for all by the year 2000. Health policy and strategies based on the primary health care approach are oriented towards this goal in Brunei Darussalam. I must state that His Majesty the Sultan Dan Yang Di Pertuan of Brunei Darussalam himself has recognized and emphasized the important role of a healthy environment and community participation in influencing the everyday activities of the people. In this connection His Majesty created a new and separate Ministry of Health in October last year.

It is therefore a great privilege and a singular honour to my country and my delegation to have been given this opportunity to address this august Assembly today.

Brunei Darussalam is a small country with a small population and has health norms which compare favourably with most developed countries with an infant mortality rate of 11.97 per 1000 live births, a perinatal mortality rate of 12.3 per 1000 births and life expectancy at birth of 70.2 years for males and 72 years for females.

In the context of national targets for health for all, we are proud to state that we have already achieved universal immunization with almost 90% immunization coverage for three doses against diphtheria, poliomyelitis, pertussis and tetanus and in equally high coverage for tuberculosis and measles. Vaccination against hepatitis "B" will become a national programme in the very near future. We have also successfully eradicated malaria and controlled the vector of dengue haemorrhagic fever. The last indigenous case of malaria was in 1970. We are hopeful of receiving WHO certification for malaria free status before the end of the year. Programmes of health education are given priority, and it has been integrated into all ongoing health programmes as well as in teaching and training institutions. In order to promote self-reliance and encourage participation, primary health care pilot projects have been started throughout the State. Village health committees have been formed and we intend to extend these activities to more villages before the year 2000, particularly in the remote areas. Recognizing the role of intersectoral collaboration for health for all as an essential component, a national workshop for senior staff will be conducted in Brunei Darussalam this year. This will be the first of its kind involving government, non-government sectors and the community. Essential drugs are available and accessible to the whole population. Reorientation and re-training of existing staff at all levels in the primary health care approach is a high priority. The reorientation of community nurses has been initiated and this will be extended to other grades of staff eventually. Training of the trainers will be undertaken by a WHO consultant late this year. Village health volunteers are trained in simple health care and returned to the community. This programme is being received well and we hope to have a team of trained volunteers in at least 75% of the rural and remote villages by the year 2000.

A great deal of the success of our health care delivery and achievements of health-for-all targets is due to the socioeconomic, financial and political stability of my country and the generous allocation of funds to the health services by His Majesty's Government.

Medical care is free for all citizens and heavily subsidized for others working and living in the State. The expenditure of government health services is financed entirely from government revenue on a direct budget basis. Health costs are also shared by other relevant ministries. The demand for sophisticated technology in hospitals continues to absorb a major portion of the health budget. It is difficult to divert capital away from these institutions and this therefore leaves very little for preventive care, health promotion and primary health care development. This imbalance is being looked into. The Ministry intends to carry out an in-depth study to find long-lasting and cost-effective solutions in health economics. Our present financial planning has the following objectives:

- to rationalize existing services in order to reduce cost;
- to encourage rational use of pharmaceuticals;
- to develop maximum coverage of the population in order to make expenditure cost effective.

The main obstruction to our attaining the health-for-all goal rapidly is the acute shortage of manpower at all levels, inadequate training facilities and the under-utilization of existing trained health personnel. Problems of middle-level management have also hindered progress. To this end we are collaborating with WHO to assess and develop various aspects of our health services.

ASEAN's collaboration has facilitated technical cooperation in many fields of medico-social welfare between countries of different regional blocks in WHO in Asia and the Western Pacific.

Training programmes for health personnel from Brunei Darussalam in Singapore, Malaysia and Thailand have been further strengthened recently. Countries in the Commonwealth, such as the United Kingdom, Australia and Canada, continue to cooperate with my country to provide places for higher medical education and training for our students and health personnel abroad.

Since the Alma-Ata Declaration 1978, the global economic crisis has hit the economies of all countries, particularly the developing countries, whose limited resources have already been stretched to the limit. Added to this, substantial cuts in health budgets, which are usually inadequate to begin with, have resulted in the disintegration of health and social welfare services and created shortages of drugs and medical equipment. The so-called arms race continues to escalate. Even a non-violent nuclear accident last year has affected and indeed is still affecting our delivery of health services.

I am therefore particularly glad to note that the topics for the Technical Discussions this year are related to policies in financial planning and health economics.

Mr President, I have no doubt that with your able guidance and astute discretion our deliberations and recommendations will not only benefit all of us at management and policy-making levels, but will also be appreciated by our counterparts in the budgeting sectors. Allow me in conclusion to express the hope that the necessary support will be forthcoming from all delegates at this Assembly to assist the Committee to develop strategies to overcome major health problems currently facing many of our countries.

I would like to place on record that we share and appreciate the sentiments and reservations expressed by the Director-General, Dr Mahler, during his address to the Assembly this morning. May I also express our sincere appreciation of the support we have received from the Regional Director, Dr Hiroshi Nakajima and the staff of the Regional Office for the Western Pacific.

On behalf of my Government, my Minister and my delegation, may I express our confidence that the deliberations of the Fortieth World Health Assembly will be productive, and extend our best wishes for the continued success of the work of the World Health Organization.

Dr MAKENETE (Lesotho):

Mr President, honourable ministers, Director-General, distinguished delegates, ladies and gentlemen, please allow me on behalf of the delegation of the Kingdom of Lesotho, to take this opportunity to congratulate you, Mr President, and your bureau on your election. You have the important task of guiding the deliberations of this august body. We have full confidence in you and your bureau, and assure you of our support.

This Fortieth World Health Assembly is noteworthy in that our deliberations will focus special attention on worldwide cooperation among Member States to ensure attainment of health for all by the year 2000. It is at this time that we need to stand together as nations to survive and to continue to have faith in a future which promises good quality of life and social wellbeing for all.

The memories of natural calamities in the recent past are still very fresh in our minds, for example, drought, earthquakes, nuclear accidents, to mention but a few. All these, coupled with the worsening economic crisis, cannot be dealt with by any single nation. No

country is likely to stand alone in dealing with these issues because many of the conditions which threaten our resolve to achieve health for all by the year 2000 recognize no boundaries.

Lesotho is one of the countries being strangulated by the present economic crisis at a time when it has not recovered from the negative impact of the prolonged drought. We have to deal with the question of reducing the national debt while at the same time addressing overall national development. Social indicators including health, are showing warning signs which cannot and should not be ignored.

It is for these and other reasons that my delegation particularly welcomes the special attention being given to worldwide cooperation to ensure the attainment of health for all. Not so long ago the Director-General, Dr Mahler, reminded us that the count-down to the target year has begun. We are now left with only 12 years.

The Government of Lesotho remains fully committed to the goal of health for all. The new administration in Lesotho is also committed to a policy of peace, reconciliation, equitable distribution of the national resources, priority being given to the hitherto underserved and rural infrastructures. The Government has set up decentralized mechanisms in the form of development councils in order to draw on the community initiative and participation in planning, implementation and monitoring of development programmes. An intensive programme of training in leadership roles for the council members has been initiated and continues.

The Lesotho Government is also conscious of the fact that decentralized administration has more credibility if it is accompanied by decentralized authority including decision-making and budgeting, it is for this reason that each district has been provided with some budget for their priority development programmes. We are encouraged to see the enthusiasm with which the districts are assuming this responsibility. For the implementation of the health-for-all strategy, we in the health sector see this process offering a number of very important opportunities. In particular: (1) it offers communities a chance to plan, set priorities and implement, for their common benefit; (2) it offers them the opportunity to monitor and be accountable for their programmes; (3) it improves local capabilities in the organization and management of programmes; and (4) it lays down the basis for the development of a critical mass for health-for-all leadership.

We do not think the health personnel is over optimistic in making the above assessment, especially because we have accepted the fact that health is an integral part of the overall development process. Lesotho is a recipient of significant donor assistance, but it also has very resourceful people (an inheritance of our past history for survival as a nation). It is therefore essential and important to reach a proper mix of the two, that is, donor support and goodwill, and local human resourcefulness, the main aim being to move towards more self-sufficiency.

A number of primary health care programmes are currently being implemented through the assistance of various donors; however, there are a number of areas still requiring further inputs of various types.

The following are just a few of the major programmes which still require assistance:

(1) Drinking water and sanitation, under which donors still have to be identified for three of the 10 districts.

(2) The food and nutrition programme is receiving some attention aimed at achieving national food security. The health sector is primarily concerned about household food security and its effects on the nutritional status of the population. This is important considering that 60% of households live below the poverty line and about 4% of the people are landless. Nutrition surveillance is ongoing, but its usefulness is limited by lack of well-established interventions; this is an area where a lot of assistance is still required.

(3) Immunization and control of diarrhoeal diseases have benefited reasonably from a well-coordinated approach from both the health sector staff and the public. We wish to register our appreciation to the donor community for the support which has been given to the Universal Child Immunization Programme (UCI/1990). We however must point out that a lot of work still needs to be done to strengthen organizational and management aspects to ensure full coverage.

(4) Child spacing as a component of maternal and child health services is being promoted vigorously. Joint action with the local nongovernmental organizations and women's voluntary organizations is proving to be very useful in this effort.

(5) The essential drugs programme based on local manufacture of drugs and a reliable procurement, storage and distribution system is benefiting both Lesotho and neighbouring sister countries.

We thank the donors who are supporting this venture; however, it is important to point out that there are still a number of areas requiring donor assistance, such as training of personnel and improvement of facilities.

We wish to take this opportunity to thank each and everyone of our donors for having contributed in so many ways towards our efforts on the difficult but gallant goal of health for all. That WHO continues to offer strong direction even when faced with very difficult constraints is commendable. Indeed, we expect no less from it as a leader in international health. We must also commend our dedicated and dynamic leader, Dr Mahler, who has a heavy responsibility within the Organization and sometimes has to tread a lonely path.

May I take a moment again to thank Dr Monekosso, Regional Director for Africa, who has assumed leadership responsibility of that Region at a most difficult time of its development. He has presented us with a three-year scenario for the acceleration of the implementation of the health-for-all strategy which we have accepted. We must now work together to realize our joint expectations. In 1985, for our Region an average of 20% immunization coverage was given for the eligible infant population. In one year, following the Declaration of 1986 as the African Year for Immunization, we increased this average to 30%; this has raised our hopes, and we look forward to a significant reduction of infant mortality, which has hitherto been unacceptably high.

In conclusion, Mr President, we realize that the deliberations of this Assembly are focusing on the worldwide cooperation for health for all, certainly the most challenging theme since Alma-Ata. With frank and open discussions and goodwill all round, the attainment of health for all by the year 2000, is still a reality.

Ladies and gentlemen, thank you very much for your attention.

The PRESIDENT:

I thank the distinguished delegate of Lesotho. I now give the floor to the last speaker in the general debate of this afternoon's meeting, the delegate of Brazil, following which I shall give the floor to the delegate of Iraq, who has asked for the right of reply.

I give the floor to the delegate of Brazil.

Dr SANTOS (Brazil):

Mr President, Excellencies, ladies and gentlemen, on behalf of his Excellency Dr Jose Sarney, President of the Federal Republic of Brazil, and on behalf of the Brazilian delegation, I have pleasure in greeting the President and Vice-Presidents of this Fortieth World Health Assembly, wishing them full success in their work.

I also extend to Dr Halfdan Mahler, Director-General of WHO, my most cordial greetings and renewed congratulations for his efficient work at the head of this Organization.

The far-reaching political and administrative changes which have been set in motion in Brazil since March 1985, and to which we referred in our presentation at the Thirty-ninth World Health Assembly, have been maintained at a steady pace. In November of last year, elections were held for the appointment of a new Congress in charge of adopting a new Constitution. At the same time, the country is deeply involved in overcoming its economic problems and accelerating the pace of social progress, which President Sarney described as the most salient feature of his presidential mandate.

When it took over, the present Government found a situation of rampant inflation and tried to contain it through a price-freeze policy together with a number of additional measures which yielded excellent results throughout most of 1986. In spite of the major economic difficulties, Brazil netted a positive trade balance of US$ 9.5 billion, a figure surpassed only by Japan and West Germany. At the same time, the per capita income grew over two years by 11.5% and the industrial product by 12%. However, a number of underlying problems, and more specifically the crucial one of the financial commitments resulting from the foreign debt, gave rise in 1987 to renewed inflation and lower growth rates.

In a context of political renovation and serious economic difficulties, President Sarney remained true to his initial pledge towards the more destitute members of the population, as witnessed by the increasing budget allocations in the area of health. At the same time, major steps were taken in the political and administrative area, aiming at a thorough reorganization of health services at federal, state and municipal level, including a reallocation of existing resources and the quest for additional financial means. In the coming months I think we can count on a consolidation of these reforms which should allow for a better use of existing resources for the promotion, preservation and restoration of health in Brazil, summed up in the process of health reform concentrating on primary health care.

In the specific area of public health, the year that has elapsed has been fairly propitious in various health policy fields, as will be seen from the following examples:

(1) AIDS (acquired immunodeficiency syndrome)

Throughout 1986, public opinion became increasingly aware of AIDS as a public health problem. The population at large and the media showed special interest in the measures

adopted by the authorities and health professionals. The programme launched by the Brazilian Health Ministry and closely observed by WHO specialists was essentially based on a massive educational campaign waged with the help of the media, highlighting the nature of the disease, paths of transmission and means available to contain its progression. This campaign was both innovative and courageous in its outlook, to the extent that it dealt with problems which had never been discussed so openly. It was well received by the public. The Ministry is now carrying out an evaluation of its impact on the general public and on high-risk groups.

The disease was first diagnosed in Brazil in June 1982. As at March 1987 a total of 1542 cases had been notified, with a death rate of 54%. Homosexuals and bisexuals account for 65%, haemophiliacs 4%, users of injectable drugs 2%, non-identified 6%, and 22% of cases are still under investigation. The hospitalization of serious cases gave rise to a number of problems which had to be overcome. Considerable resistance was initially found in auxillary staff. But this reluctance is gradually disappearing, thanks to an educational effort on transmission of the disease and to simplified isolation techniques of patients in general hospitals.

One of the major problems has been the availability of kits for large-scale testing of potential blood-donors for various therapeutic uses at reasonable cost. With the help of WHO/PAHO, Brazil is importing large quantities of such kits and is now working on the domestic production of such equipment, as part of a wider programme for self-sufficiency in the manufacturing of immunobiological products.

(2) Malaria

Malaria remains the major challenge for the Brazilian authorities in the area of the main endemic diseases. Malaria is essentially prevalent in the Amazon region, where ecological conditions hamper the fight against the vector. The number of cases has increased as a result of the strong migratory currents of the past 10 years, with migrants coming from other regions of Brazil to the forest areas in quest of new mining and agricultural or cattle farming activities.

As the conventional means of control did not avert a rise in the incidence of the disease nor the emergence of Plasmodium falciparum strains resistant to the most commonly used drugs, the Health Ministry decided to implement a special "crash" programme from October to December 1986. This campaign involved the participation of 2000 technicians dispensing chemotherapy in the hyperendemic areas and covered a total population of 550 000. At the same time, the vector control programme was intensified in the hope of reducing the rate of transmission of the disease in extremely adverse conditions. The initial results of these measures proved to be rewarding inasmuch as they actually did help to slow down the rate of increase of the disease.

(3) Aedes aegypti

In March 1986, dengue fever was diagnosed in the metropolitan area of Rio de Janeiro, where high indices of Aedes aegypti concentration had been registered.

Attack on the vector was launched massively with the help of 2800 field workers (for larva control) and the use of numerous spraying machines for the eradication of adult A. aegypti.

Shortly thereafter, two new foci broke out, although in smaller proportions, in the cities of Fortaleza and Maceió, in North-East Brazil. They were successfully put down thanks to the methods described above.

Early in 1987, in the summer season, a further increase in the number of cases was diagnosed in the Rio de Janeiro urban area. The new outbreak, which was less serious than the previous one, has been visibly declining in the last weeks.

Up to now none of the dengue cases proved to be serious or to produce sequellae. Throughout this period, urban areas were closely monitored for possible outbreaks of urban yellow fever, but no cases have so far been detected.

Throughout these efforts Brazil received considerable support from WHO/PAHO.

In June 1986, Aedes albopictus was identified for the first time in Brazil. Detection of the insect was then organized in various regions and its possible role in the transmission of viruses was investigated. Brazil once again turns to those countries where A. aegypti and A. albopictus had been identified and urges them to intensify their efforts towards the control or even the eradication of these vectors.

(4) Family planning

In mid-1986, Brazil officially defined, through the Health Ministry, its position with respect to family planning, thereby dispelling the doubts which had emerged in some sectors of Brazilian society. Based on this definition, a programme was set up within the comprehensive mother and child welfare programme, and has rapidly met with considerable success. In keeping with the above-mentioned principles, the guidelines given below govern public health measures for the female population

- The concept of comprehensive care should be present at all times in clinical and gynaecological practice. A new attitude is thus expected of health staff, and new criteria are being applied to the selection and recruitment of health personnel.

- The concept of comprehensive care implies a didactic approach: the recipients of medical care should be taught the basics of self-care and a better control of their own health.

- Family planning comes as a supplemental activity in the mother and child welfare programme. The motivation of the Brazilian Government in suggesting effective measures in this area are based on principles of equity - equal access to information and means of fertility control for all the population - as well as medical principles, such as pregnancy risks. In no way should it be construed as a coercive measure for families resorting to their services.

To sum up, if such a programme, of which we gave a few topical examples, is to be extended to a population of 140 million inhabitants in a poor country such as Brazil, enormous financial resources are necessary, as is well-known by one and all, including WHO officials. This is why we consider as excessive the additional burden resulting from a surprising 30% increase in Brazil's contribution to this international body. We do not question the need for WHO to find financial resources, nor the excellent quality of its services. But we believe that it would be appropriate to improve the integration of some WHO programmes; improving the complementarity of programmes whilst cutting down costs is vital for countries which have to meet heavy external financial commitments.

We believe that if this effort towards better integration is incorporated in WHO activities this will be of immense help in achieving the goal of health for all in the year 2000.

The PRESIDENT:

I thank the distinguished delegate of Brazil and give the floor now to the delegate of Iraq to exercise his right of reply. I would, however, recall that Rule 59 of the Rules of Procedure of the World Health Assembly states that in exercising this right the delegate should attempt to be as brief as possible, and I remind you, too, of my announcement this morning that we have an informal meeting at 17h30 which is on AIDS: the Director-General will give an introduction on AIDS at 17h30.

I give the floor to the delegate of Iraq.

Mr HADAWI (Iraq):

Thank you, Mr President. In exercising my right of reply to what the Iranian Minister of Health has said in deliberately trying to mislead this august Assembly I shall let facts talk for themselves. As early as 28 September 1980 the Security Council adopted resolution 479, which was the first to deal with the war which Iran has launched against my country. The resolution ...

The PRESIDENT:

Excuse me, sir, the delegate of Iran wants to make a point of order.

Mr HOSSEINI (Islamic Republic of Iran):

In the name of God, the Merciful, the Compassionate. Mr President, when the Minister of Health of the Islamic Republic of Iran was giving his speech to this august Assembly the Iraqi representative asked for point of order and said this is not a political Assembly. Now he himself is trying to politicize the Assembly. I suggest you, Mr President, stop him from doing so. Otherwise sir, I would like to reserve my right of reply.

The PRESIDENT:

Thank you. I ask the delegate of Iraq to continue his statement, and I ask him to be as brief as possible. I remind the delegate of the Islamic Republic of Iran that he has a right to reply.

Mr HADAWI (Iraq):

... The resolution appealed to both countries to end the war and settle the dispute by peaceful methods. Shouldering its international responsibility, Iraq heeded the appeal, for Mr Saddam Hussein, President of the Republic of Iraq, immediately delegated envoys during October 1980 to scores of heads of state or government to convey to them the sincere desire of Iraq to conclude peace with Iran in accordance with international law and the Security Council resolution I referred to. This initiative, however, came from a position of

strength. Iran on the other hand rejected the resolution and refused to accept the Iraqi invitation to peace.

The Security Council so far has adopted half-a-dozen resolutions on the same issue. Chief among them were resolutions 540, 582 and 588. All were rejected by Iran and all were welcomed by Iraq.

The President of Iraq has furthermore enunciated a project of peace which he repeatedly addressed to both the Iranian people and their rulers, but to no avail. The project comprises the following elements: (1) complete, comprehensive and unconditional withdrawal by both parties to the internationally recognized borders; (2) comprehensive exchange of prisoners of war; (3) non-interference by either party in the domestic affairs of the other; (4) cooperation by both countries to ensure peace, stability and prosperity for all nations of the region; (5) the signing of a peace and non-aggression accord between the two countries. Iran, however, has rejected this offer again because the Iranian regime assigned to itself the overthrow of Iraq's sociopolitical system as a basic task which is considered to be a divine duty and an unquestionable right. Indeed, Iran started the war against Iraq for one reason and only for one reason: namely, to accomplish its aggressive expansionist policy and the export of the so-called Iranian revolution. Iran on the other hand embarked on a policy of selectivity. In other words, the Iranian rulers, although they show indifference, albeit contempt to the Security Council, they always choose aspects or parts of Security Council resolutions that seemed to be most beneficial to them and ignored the substance. Or they insist on selective conditions to serve their final purposes - short, of course, of ending the war and re-establishing peace.

In his statement the Iranian Minister of Health once again resorted to the familiar style of diverting attention from the main issue and raising irrelevant subjects (which only yesterday the General Committee dismissed) - the Minister of Health of Iran, who by resorting to lies has not only demeaned himself but also further scandalized the already scandalized regime which proved itself notorious ...

The PRESIDENT:

I am very sorry to interrupt you, sir. May I kindly remind you of my request to be as brief as possible? You may continue, and be as brief as possible.

Mr HADAWI (Iraq):

Thank you, Mr President, it will take me half a minute, maybe less. I said the Minister of Health of Iran, who by resorting to lies has not only demeaned himself but also further scandalized the already scandalized regime which proved itself notorious by sending little children to unearth mine-fields, by killing and mutilating our prisoners of war, bombarding our towns by unguided long-range missiles and refusing to accept peace. Such a regime is the last ...

The PRESIDENT:

I have again to interrupt you, sir; the delegate of Iran has asked for the floor on a point of order.

Mr HOSSEINI (Islamic Republic of Iran):

Sir, may I ask you kindly to stop this gentleman. Thank you.

The PRESIDENT:

I have already asked the delegate of Iraq to be as brief as possible.
Perhaps you can conclude now, sir.

Mr HADAWI (Iraq):

Thank you, Mr President, two seconds only.
Such a regime is the last to enjoy a seat as a Member in this august Assembly of WHO.

The PRESIDENT:

I now give the floor to the delegate of the Islamic Republic of Iran, for he has asked to exercise his right of reply to the statement made by the delegate of Iraq. In accordance with Rule 59 of the Rules of Procedure I would request also him to be as brief as possible.

Mr HOSSEINI (Islamic Republic of Iran):

Thank you, Mr President. In the name of God, the Merciful, the Compassionate!

Mr President, distinguished delegates, peaceful settlement of disputes and inadmissibility of force are the basic principles of the United Nations Charter and international humanitarian law. The root of the present conflict is the violation of these principles by the Iraqi aggression regime.

The Iraqi regime waged the total war of aggression against the Islamic Republic of Iran on 22 September 1980. You all know about the time of aggression, and here we do not have time to elaborate more on that - it is a lie made by the Iraqi representative when he mentioned another date for the aggression.

Immediately after the time of aggression we asked for peace, ladies and gentlemen, distinguished delegates, we asked for peace; we asked for a ceasefire; we asked the Iraqis to return their forces of aggression to the internationally recognized borders. But President Saddam Hussein, being proud of his "victorious" aggression, rejected our proposal of peace and continued his aggression with the intention to destroy our Islamic revolution and to annex part of the country to Iraq.

Then our heroic Moslem people fought against the aggressors and pushed them back to their own border. After being defeated by Moslems, by our people, now the regime is asking, is crying, is begging for peace! What type of peace could this be? You invade a country and destroy thousands of villages, killing thousands of innocent people, and now you ask for peace? Iraqi conduct in the course of the imposed war has been indeed an open challenge to the raison d'être of the fundamental rules of international law governing armed conflict. The repeated use of chemical weapons, which is in clear violation of the 1925 Geneva Protocol, and was announced and condemned by the Security Council of the United Nations, as well as bombardment of purely civilian areas and threatening international civil aviation - these all illustrate the acts of lawlessness and brutality of the Iraqi regime. With these crimes, I am surprised that these gentlemen, this delegation, are asking for peace and wasting the time here of this august Assembly.

After a minute, I think I will finish, Mr President.

The Islamic Republic of Iran has always reiterated the point that as long as the international community does not master the necessary political will to take a clear, just and unequivocal position on the all-out military aggression initiated by Iraq, the cessation of hostilities remains inapplicable. As the respected United Nations Secretary-General, His Excellency Xavier Perez de Cuellar mentioned in his statement at the recent session of the Islamic Conference: "After six years it seems to be futile simply to repeat appeals for peace." This is exactly what Iraq is doing: after being defeated, after those military and material and human losses, now they are asking for peace. In this connection, the position of the Islamic Republic of Iran is to achieve a lasting, durable and just peace. We are seeking a just peace. We want peace, of course; everybody wants peace, but a just peace, not the peace they are talking about. This can be obtained by the elimination and removal of the root of aggression who is President Saddam and his gang.

The PRESIDENT:

If the delegate of Iraq wants the floor ...? I am afraid I have to adjourn the meeting now; if you want to have the right to reply I can give you the possibility to reply tomorrow. You want it now? Half a minute? Then, yes, but before giving the floor to the delegate of Iraq - I am prepared to give you the floor, but I have to say that after your statement, which has to be as brief as possible, I will not authorize any other speakers to take the floor on this subject, and we will adjourn this meeting after the delegate of Iraq has spoken.

Mr HADAWI (Iraq):

Mr President, the Iranian delegate pretended that his Government during the course of the war asked for peace or offered Iraq peace. I wish the distinguished representative of Iran to produce the document showing the time when such an offer was made, but I will be patient with him until the end of the World Health Assembly session. Thank you, sir.

The PRESIDENT:

Thank you, sir. The meeting is adjourned.

The meeting rose at 17h35.
La séance est levée à 17h35.
Заседание заканчивается в 17 ч. 35 м.
Se levanta la sesión a las 17.35 horas.
رفعت الجلسة في الساعة ١٧ر٣٥ .
会议于17：35时休会。

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