World Health Organization
Organisation mondiale de la Santé

FORTY-NINTH WORLD HEALTH ASSEMBLY

COMMITTEE A

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21 May 1996

PROVISIONAL SUMMARY RECORD OF THE FIRST MEETING

Palais des Nations, Geneva
Tuesday, 21 May 1996, at 9:00

Chairman: Professor B. SANGSTER (Netherlands)

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1. **ELECTION OF VICE-CHAIRMEN AND RAPPORTEUR (RULE 36):** Item 16 of the Agenda (Document A49/37)

The CHAIRMAN expressed gratitude for his election and welcomed those present. He then drew attention to the third report of the Committee on Nominations (document A49/37), in which Dr Ana Maria Alfaro de Gamero (El Salvador) and Dr M. Dayrit (Philippines) were nominated for the offices of Vice-Chairmen of Committee A and Dr J. Singay (Bhutan) for that of Rapporteur.

Decision: Committee A elected Dr Ana Maria Alfaro de Gamero (El Salvador) and Dr M. Dayrit (Philippines) as Vice-Chairmen and Dr J. Singay (Bhutan) as Rapporteur.

2. **ORGANIZATION OF WORK**

The CHAIRMAN suggested that the normal working hours be from 9:00 to 12:30 and from 14:30 to 17:30.

It was so agreed.

3. **REVIEW OF THE WORLD HEALTH REPORT 1996:** Item 10 of the Agenda (*The world health report 1996* and document A49/3)

Dr MAZZA (Argentina) noted that *The world health report 1996* covered the important aspects of population health and the role of the Organization in the face of global change. It defined the current situation with regard to communicable diseases, their spread, the difficulty of controlling them, and the burden they represented; it indicated how combating disease fostered development. New social and demographic realities, including urbanization and easier communications and international travel, affected epidemiological profiles. The appearance of emerging and re-emerging diseases, such as AIDS and tuberculosis (which was an example of the constant microbial adaptation that raised new challenges in the control of communicable diseases), would oblige health systems to adapt to new morbidity patterns and to the rising costs of medical care. Eradication or elimination before the year 2000 of nine target diseases - leprosy, dracunculiasis, Chagas disease, onchocerciasis, poliomyelitis, measles, neonatal tetanus, brucellosis and urban rabies - would constitute a triumph for humanity. The situation with regard to those diseases should be examined within each region, subregion and country, in order to take account of local differences; for instance, in his country, there was no dracunculiasis or onchocerciasis, poliomyelitis and urban rabies had been eradicated, and the control of the other target diseases were at different stages of control, which he outlined.

With firm political resolve, the set goals could be met with the available technological means. The programmes of the Organization should be restructured centrally, regionally and at the country level in order to achieve health for all as soon as possible; horizontal cooperation between countries would be of fundamental importance. If communicable diseases were not controlled, they might re-emerge, as had tuberculosis, vitiating previous efforts. "Old" diseases such as malaria and tuberculosis were also priorities

for new research activities, epidemiological surveillance, early diagnosis and proper treatment. Short- and medium-term activities against all emerging and re-emerging diseases should be systematized, and early-warning systems should be developed to control epidemic outbreaks.

Mr BALDOCCI (Italy), speaking on behalf of the Minister of Health of the country that held the presidency of the European Union, noted that the Health Council of the Union had discussed some of the problems raised by the Director-General in *The world health report 1996*. The ministers of health of the European Union considered that bovine transmissible spongiform encephalopathy was a public health problem; it would be necessary to extend surveillance to all countries of the Union, to ensure continuous review of scientific information on the causes and transmission of Creutzfeldt-Jakob disease and to conduct further studies on the two diseases. Close collaboration between countries was needed for the control of communicable diseases. A joint task force of the European Union and the United States of America had been set up to establish an effective, global, early-warning system and response network for communicable diseases, which would collaborate with WHO to take into consideration the needs and policies of developing countries and would encourage scientists from those countries to work in European Union and United States research programmes.

The European Union assisted developing countries both bilaterally and multilaterally. Reorganization of health services, of pharmaceutical policy, of disease prevention and health promotion were included in its PHARE and TACIS programmes for the countries of central and eastern Europe and the newly independent states of the former Union of Soviet Socialist Republics. Programmes on cancer, on AIDS and on other communicable diseases were designed specifically for the countries of central and eastern Europe. Disease prevention and health protection were integrated into humanitarian operations carried out within the programme of the European Community Humanitarian Office (ECHO).

He supported the principles on which WHO's reforms were based - equity, solidarity, efficiency and accountability - and the priorities selected to meet the most pressing health needs: health emergencies, the poorest countries and most vulnerable groups, major causes of death, suffering and disability, and major impediments to social and economic development. Careful analysis and planning were necessary in order to avoid fragmentation or duplication of efforts at the country level. It was also essential that the technical expertise of WHO remain of the highest quality, despite the budgetary restraints adopted in the programme budget for 1996-1997. The countries of the European Union had continued to pay their assessed contributions regularly, despite tight budgetary constraints, and had encouraged international agencies to make savings, set priorities carefully, undertake transparent budgeting, and ensure cost-effectiveness.

The dramatic worldwide escalation of communicable diseases called for increased surveillance and control. Adequate health infrastructures, health promotion, primary health care, the availability of essential drugs and a sound environment were still of importance, however, and it was possible that communicable diseases were emerging or re-emerging because those issues had not been tackled vigorously enough.

The eradication of smallpox had been a great achievement. At least three other goals could be reached by the year 2000: the eradication of poliomyelitis, the elimination of leprosy as a public health problem, and the eradication of dracunculiasis.

Dr AL-MUHAILAN (Kuwait) said that new modalities would be necessary in order for WHO to fulfil its responsibilities materially and morally. Many emerging global problems could be combated only by WHO. Although the cost of drugs had become prohibitively high, WHO should ensure that all people received the necessary treatment. His country had implemented legislation against smoking in public places and advertising of tobacco products, and was combating endemic diseases and causes of death related to behaviour, such as cancer, drugs of abuse, obesity, cardiovascular diseases and traffic accidents. A long-term strategy, to be completed by the year 2010, aimed at the provision of treatment for all citizens and residents of Kuwait. Modern hospitals, new technology and telemedicine were already available.

Dr SANSINGKEO (Thailand) said that an important seminar held very recently in Thailand to discuss national plans up to the year 2020, had concluded that policies aimed at stimulating economic growth should be designed in such a way as to ensure sustainable human development through respect for the balance of

nature, the health of the people and their quality of life. With regard to health development, a conference entitled "Health Science and Health Care for the Twenty-first Century: Problem, Challenge and Opportunity", cosponsored by the Ministry of Public Health and WHO, would take place in Bangkok in February 1997.

As a contribution to the effort of international cooperation to create a healthy planet, WHO's goal should be the eradication of certain diseases from all regions of the world. Emerging and re-emerging diseases such as bovine spongiform encephalopathy, plague, Ebola haemorrhagic fever, tuberculosis and malaria, as well as HIV/AIDS, were adversely affecting the global community. WHO had a vital role to play in promoting health development that corresponded to its own definition of health, not just as the absence of disease, but as a state of complete physical, mental and social well-being.

The time had also come for governments to encourage greater participation in the provision of health care by the private sector, which was often more efficient than the government sector.

Dr ONO (Japan) commended *The world health report 1996* on the concrete measures it proposed for dealing with three types of communicable diseases: those, like poliomyelitis, that would be eradicated or eliminated in the near future; those that exhibited resistance to antimicrobials, such as tuberculosis and malaria; and those, like Ebola haemorrhagic fever, that were newly emerging.

In view of the volume of people and goods crossing national boundaries, Japan was collaborating fully in WHO's preparations for revising the International Health Regulations.

With regard to the Organization's immunization programmes, he was pleased to note that poliomyelitis was on the verge of eradication from the Western Pacific Region. Within the policy coordination framework, of the Japan-US Common Agenda, Japan had contributed significantly to international measures related to HIV/AIDS, population, and children's health. In respect of HIV/AIDS, Japan would continue to support the measures carried out jointly by WHO and UNAIDS and would expand training programmes for those responsible for HIV/AIDS policies in Asia.

The WHO Centre for Health Development established in Kobe in March, placed its major emphasis on urbanization and health and should contribute significantly to the control of infectious diseases related to rapid and uncontrolled urbanization. In addition to its vital role in coordinating international health work, WHO should also be strengthening its normative function, particularly in relation to standards for pharmaceuticals and food safety.

In addition to its assessed budget contribution, Japan would make a voluntary contribution despite its own stringent financial situation in order to demonstrate its commitment to WHO's health-for-all strategy.

Under the Director-General's leadership WHO had made a genuine effort to counterbalance the conflicting demands of increased health care needs and a dwindling budget and its endeavours should be supported in the future.

Dr SHALALA (United States of America) expressed concern over the difficulties of meeting the challenges presented by the emergence and re-emergence of infectious diseases with ever-diminishing resources, both nationally and internationally. For WHO to survive as an effective instrument for promoting and protecting global health in the twenty-first century, it must concentrate on the global community's most urgent health problems and deepen its commitment to reform, including greater budgetary transparency and restraint. The United States of America was deeply committed to the success of WHO, and President Clinton and she herself had fought hard and successfully for agreement for payments to international organizations. Without genuine reform, however, that substantial support for WHO would not be sustainable.

WHO must focus on what it did best: exerting global leadership in health; mobilizing global resources to respond to health emergencies and prevent their future occurrence; setting standards, and providing countries with the information and tools to promote health and development.

Women's health would be a major challenge in the next century. The commitments made - with the help of effective WHO leadership - at the United Nations Conference on Women in Beijing in September 1995 to promoting and safeguarding women's rights had to be put into practice. The time had come to show in the clearest possible way that violence against women and girls was unacceptable, and that an end must be put to the inhuman practice of female genital mutilation. Women should be provided with proper nutrition, education and prenatal and reproductive health care to enable them to reach their full potential and

to protect both themselves and their families from environmental toxins, from drugs and tobacco and from potentially deadly diseases.

In spite of many important accomplishments in the control of communicable diseases - not least the eradication of smallpox and the possible elimination of poliomyelitis - increased international cooperation was still needed. In that respect the creation by WHO of the Division of Emerging and other Communicable Diseases Surveillance and Control was a welcome step. She also expressed strong support for the Joint United Nations Programme on HIV/AIDS (UNAIDS) and for WHO's continued coordination with that programme.

Mr DINGWALL (Canada) said that the information in *The world health report 1996* was a cause for concern: one-third of all deaths in the world were due to infectious diseases, yet most such deaths were preventable. Greater international cooperation and a more dynamic WHO could contribute to reducing that burden.

Canada, maintaining its tradition of supporting international action for health, would be hosting the XI International Conference on AIDS in July in order to advance a common understanding of HIV/AIDS.

The preparation of WHO's imminent new global health policy provides an opportunity for redefining the Organization's role. Canada considered that WHO should seek common solutions to the collective problems of its Member States, that its normative functions should be clarified and perhaps expanded in strategically-focused areas, and that it should provide countries with specialized technical cooperation in a limited range of priority areas in which its capacity to deliver was recognized. Its role in national health development, however, needed clarifying.

Despite WHO's success in eradicating smallpox and virtually eliminating poliomyelitis, it had lost its momentum and was no longer the primary reference point for international health issues. The Organization therefore needed effective programming, focused on priority areas to meet the real needs of Member States; it needed strengthened and fully transparent management, which was vital for public institutions; it needed to eliminate overlap and duplication within the international system; and it needed to respect fiscal realities.

Mr GAYMARD (France) said that the serious health consequences of international events in the past year profoundly affected the work and the future of the Organization. Communicable diseases were once again becoming a major priority, as the report showed so clearly. Health indicators were disturbing throughout the world, and in the European Region the economic crisis was affecting immunization programmes in the Newly Independent States, resulting in the maintenance of poliomyelitis incidence and the outbreak of the recent diphtheria epidemic. The re-emergence of such diseases demonstrated the need for a collaborative effort, coordinated by WHO, to combat them.

Reforms were needed to reduce the rise in expenditure on social services, but that should not be permitted adversely to affect the most vulnerable sections of society. It was the duty of both WHO and the wealthier countries to ensure that the necessary resources were made available to those most in need in order to improve the health situation throughout the world. WHO's ability to do so would depend on its ability to concentrate its human and financial resources on the areas where the need was greatest.

The very serious global threat posed by HIV/AIDS warranted concerted action by the United Nations and its programmes and agencies; for that purpose UNAIDS had started operating in January. He hope that WHO would continue to play a leading role in its work.

The European Union had recently instituted a policy for the development of orphan drugs. In addition, some drugs for the treatment of parasitic diseases were no longer effective, and the European Union was seeking ways to remedy that situation. The Union also favoured a more widespread use of generic drugs in order to reduce costs and France was encouraging their development.

The process of reform initiated by WHO should enable the Organization to deal with emerging diseases such as bovine spongiform encephalopathy and to frame policies based on equity and solidarity. In view of budget constraints, it was important to meet such challenges through synergy and cooperation within the United Nations system and with such entities as the European Union.

Mr YEO (Singapore) said that East Asia was going through an economic and social transformation on a scale never seen before. Overall poverty levels had come down drastically, and in the twenty-first century large parts of East Asia would be definitely middle class. The rapid growth that had started in Japan was now gradually encompassing all South-East Asia and China, causing a fundamental change in the structure of the health care sector in various countries. While the problems of communicable diseases and malnutrition would still be present for many years, they would increasingly give way to new problems of providing for the more complex health care needs of middle-class societies.

Thus a rapidly growing health-care industry was emerging in East Asia to serve the new middle classes. Public health care systems set up to meet the basic needs of fundamentally rural societies were no longer adequate. Many national systems were being reformed to meet new needs and to provide a better balance between the public and private sectors. In fact, the health care industry in East Asia would be one of the fastest-growing industries in the world. Private capital would become more important, with the result that there would be a growing difference in the quality and range of health care facilities available to the rich and to the not-so-rich, which in turn would create political tensions.

Contrasting with the rapidly growing health care industry in East Asia was the mature health care industry in North America and Western Europe. In the United States of America it amounted to 14% of the gross national product, a burden no society could bear for long. Thus there was an excess of health care resources in North America and Western Europe and an under-supply in East Asia, providing a great opportunity for mutually beneficial transoceanic transfers. In East Asia, whatever role the state played, responsibility for health care and healthy living should remain firmly anchored in individuals and their families. The Government at both municipal and national levels should bear part of the burden, but never most or all of it. To anticipate the growing problems of urbanization and aging, governments should avoid excessive subsidization when populations were young because it was never easy to reduce the level of subsidy in any society. There must always be a circumspect view of third party payment. Holistic medicine, which was an important part of the East Asian heritage, should be harnessed. If the systems were well designed, they would be politically sustainable over a long period and would enable the economic growth of East Asia to continue well into the next century, in turn creating enormous opportunities for the health care industries in North America and Western Europe.

Singapore tried to strike a balance between individual responsibility, family responsibility and group responsibility. It required every individual to build up his own medical savings for himself and his family; the employer shared some of the burden. Singapore was also facilitating the scientific development of traditional Chinese medicine and was encouraging the private sector to expand, both to meet the needs of Singaporeans and to service the region. It was also working with WHO with a view to cooperating and exchanging experience with other countries.

Mr NARASINGHA (Nepal) said that in the current times of severe financial constraints it was necessary to impress upon countries and the international community the need to maintain health and human beings at the centre of development goals and to recognize the crucial contribution that improved health made to fostering development and economic growth by reducing production losses caused by worker illness, by permitting the use of natural resources that had been inaccessible because of disease, by increasing the enrolment of children in school and making them better able to learn, and by freeing resources that would otherwise have to be spent on treating illness. The South-East Asia Region could be proud of the steady improvement in the health status of its people, particularly with regard to life expectancy, infant morbidity and mortality, and immunization coverage. Furthermore, it was expected that poliomyelitis and neonatal tetanus would soon be eradicated. In that connection, Nepal would undertake national immunization days for poliomyelitis during December 1996.

However, despite the progress achieved, infant and maternal mortality rates remained unacceptably high. The incidence of old and new communicable diseases was on the rise, the advent of resistant strains of the causal agents of diseases such as malaria and tuberculosis was creating additional difficulties, and despite widespread health infrastructure development and the increased production of human resources for health, there were significant gaps in health services coverage, especially so far as the poor and the most vulnerable groups were concerned. To continue to foster development and economic growth and to ensure that all

segments of the population enjoyed the benefits of development, political commitment and financial support were essential. Consequently, while appreciating the financial constraints facing Member States, he hoped that the Health Assembly's deliberations would not be guided simply by economic concerns but would be tempered by an appreciation of health care needs, particularly the need to bridge the gap between those who enjoyed the benefits of the health care system and those whose health needs were often not met. As the Health Assembly sought to devise effective strategies to fight disease and foster development, it should not abandon or diminish its commitment to the health-for-all principles and should ensure that the poor and most vulnerable groups were not neglected.

Dr AL BAATH (Syrian Arab Republic) said that his country gave high priority to preventive medicine and to human resources development in the areas of health care, nutrition and environmental protection. An immunization programme incorporating seven vaccines had attained 93% coverage of Syrian children in 1995. The number of clinics, hospitals and hospital beds had increased dramatically over the previous 25 years and many hospitals were using information technology. Local drugs factories met 83% of the country's needs and their products were carefully monitored. Average life expectancy had increased from 53 years of age in the early 1970s to over 67 in 1995. Infant mortality had declined to 30 per 1000 live births.

In view of the importance of a reliable water supply for the health of the individual and society, it was incumbent on international organizations to work towards the equitable distribution of safe water according to appropriate international criteria.

WHO had an important role to play in narrowing the gap between the developed and developing countries through the transfer of health technology and techniques and in creating the requisite infrastructure for attainment of the goal of health for all.

He condemned the recent brutal attack on Lebanon and its people by Israel, culminating in the deliberate massacre of over 100 civilians who had sought refuge at Qana with the United Nations Interim Force in Lebanon (UNIFIL). The Syrian Arab Republic condemned all forms of terrorism, whether perpetrated by individuals or States. It supported the right of peoples to resist occupation and was committed to a just and comprehensive peace based on the principles established at the Madrid Peace Conference on the Middle East and on United Nations resolutions.

Dr MARTINEZ (Cuba) said that the application of adjustment measures resulting from neoliberal policies had made life much more difficult for the world's poor, especially with regard to the effects of ill health. In fact, in many countries health systems had collapsed or had not yet even been created. The developing countries therefore had to make an effort to advance their political, economic and social development. For equity, solidarity, ethics, health care development and social justice to be made effective, a real flow of international cooperation from the developed to the developing countries was required.

At present, Cuba was endeavouring to readjust its economy to a crisis resulting from the loss of its traditional economic ties and the strengthening of the blockade, in such a way as to guarantee the country's public health achievements. It would maintain the principle of a fully State-funded health system and the free provision of services for all. In the field of communicable diseases, the country was free of 12 vaccine-preventable children's diseases, poliomyelitis had been eradicated in 1962, diphtheria in 1979, and neonatal tetanus and tuberculous meningitis in 1972. Since no case of measles had been reported for the past three years, Cuba wished to be declared free of that disease too. Malaria had been eradicated in 1967, and dengue in 1981.

The country's present strategy was based on reorienting the health system towards primary health care and the family doctor and nurse. Approximately 96% of the population had access to the programme. In Cuba there was one doctor for every 194 inhabitants, and the Government continued to emphasize family medicine without neglecting hospital care and advanced technology for the people. It was grateful to WHO and to peoples, governments, organizations and individuals for their support in the present difficult times. For the past 33 years Cuba had provided technical cooperation to 61 countries and was willing to continue with that task.

Mr CHAUHAN (India) said that for a country of its size, India had progressed significantly in health matters. Indeed, one of its component states - Kerala - had achieved birth, death and infant mortality rates which compared extremely well with countries having much more favourable economic indices. One of the country's most positive gains had been the immunization against poliomyelitis of 87 million children in a single day, followed shortly afterwards by that of another 93 million. The same exercise would be repeated annually until poliomyelitis was eradicated. Furthermore, a massive AIDS-control programme had been launched; a leprosy-control project had succeeded in reducing the number of leprosy patients from 4 million in 1981 to 500 000 in 1996, thereby indicating that the target of eliminating leprosy by the year 2000 could be achieved; a project for conducting 21 million sight-restoring cataract operations in seven years had been taken up, and a tuberculosis-control project was at an advanced stage of appraisal by the World Bank. A new malaria-control project was being formulated; for the first time bio-environmental methods were being considered through the use of medicated bednets, biocides and larvivorous fish, with the full involvement of local village bodies. An important district health system project seeking to strengthen the organizational structure of the health machinery by integrating primary health services with first-referral hospitals was currently being implemented in four states. In addition, a major thrust was being given to the programme for the control of iodine deficiency disorders.

Since India relied heavily on its systems of traditional medicine and homeopathy, more than 50 institutions had been financed to develop the production of medicinal herbs and to improve cultivation techniques.

WHO had rightly encouraged the adoption of a global programme to combat hepatitis B, but it must also take up the issues of vaccine availability, production possibilities, cost reduction and the organization of efficient operational systems. The Organization's move to step up consultation on the renewal of the health-for-all strategy to meet national and sub-national needs was welcome, and its documentation had been circulated in India to all state governments and key officials in the Ministry of Health and Family Welfare. The time had come when health had to be seen in conjunction with the work of other departments, agencies and organizations that wittingly or unwittingly created unhealthy situations which subsequently became the responsibility of the health sector. Health risk assessments ought to be made an integral part of the formulation and implementation of all development projects and programmes. In that connection WHO should prepare a mandate adopted by the Health Assembly which health departments in every country could insist upon.

Mr BUTALE (Botswana), speaking also on behalf of the 11 Member States of the Southern African Development Community, said that although steady improvements continued to be made in health, many health problems and the incidence of diseases such as HIV/AIDS and other sexually transmitted diseases, malaria and tuberculosis were increasing, as was microbial resistance. Many of those problems were preventable, while some, such as tobacco-related diseases and diseases related to environmental degradation and increasing violence, were man-made. Nevertheless, the battle against disease could still be won and development fostered if effective and successful approaches could be found that were protective of human rights, well managed, adequately resourced and founded on active community commitment.

Most of the cost of combating HIV/AIDS was being borne by governments, whose main constraints included a shortage of skilled manpower. It was therefore to be hoped that technical expertise in that area would be made available.

As family members became sick and died, the family became poorer because of lost opportunities and increased costs. In most cases the health problems concerned affected people who were at the most productive stage of their lives; many of them had benefited from many years of investment in training, and their death resulted in a disruption of production. However, with a renewed commitment to the health-for-all strategy victory was possible. The countries of the Southern African Development Community had recorded tremendous successes in the fight against vaccine-preventable diseases such as poliomyelitis, neonatal tetanus and measles and through strategies such as the safe motherhood initiative, the integrated programme on the sick child, and Joint United Nations Programme on HIV/AIDS, as well as through the integration of information, education and communication into all relevant programmes.

It would be appreciated if special funding could be found in the regular budget to assist with various programmes in Africa that were in danger of collapsing because of lack of resources. The US$ 25 billion allocated to the Special Initiative on Africa gave no promise of new resources, and the attitude of the countries in the northern hemisphere and of WHO's headquarters to Africa was a cause for concern. Greater transparency and accountability were required, particularly in budget allocations, contributions, and the employment of Africans from southern Africa in the Organization. The gender issue was a matter of particular concern, since the number of women experts from Africa employed by WHO left much to be desired.

Mr WU Jianmin (China) said that the Chinese Government made considerable efforts to control infectious diseases by measures such as its Infectious Diseases Control Law and the vigorous promotion of the Expanded Programme on Immunization. In a three-year campaign, 400 million children under four years of age had received supplementary vaccination against poliomyelitis, and no new cases of infection with wild polioviruses had been reported in 1995. The average coverage rate for vaccination of the newborn against hepatitis B had reached 85% in urban areas; it was hoped that the rate in rural areas would reach 60% by the year 2000. However, with a population of 1.2 billion, and about 70 million people living in poverty, China faced many problems in the development and financing of its health services. He hoped that WHO would urge the developed countries to support poorer countries in their efforts to improve health conditions.

The communicable diseases which caused concern were not only new diseases, such as AIDS and Ebola haemorrhagic fever, but also familiar diseases, such as tuberculosis, which had previously been considered to be under control. China endorsed the three priorities for international action set by WHO for the coming five years (*The world health report 1996*, p. 110) and would play its part in international activities to promote health throughout the world.

Dr AKTUNA (Turkey) welcomed the report's emphasis on controlling disease in order to promote development. Most countries now sought to prevent ill-health and enhance the quality of life, rather than merely to reduce mortality. Turkey had made significant progress in the control of specific diseases, and it was hoped that poliomyelitis would soon be eradicated following the success of the first national immunization day in Turkey and neighbouring countries in 1995. However, many people of all ages were still suffering and dying because they lacked access to safe water, sanitation and basic drugs. Turkey was also concerned about the rising incidence of communicable diseases such as tuberculosis, malaria, hepatitis B, diphtheria and sexually transmitted diseases.

International action had successfully reduced infant mortality rates throughout the world. It was now time to give higher priority to women's health, an area in which WHO could play a unique normative role by providing cost-effective and innovative technical tools such as the mother-baby package.

Increasing urbanization had made the campaign to create healthy cities even more important. The forthcoming Second United Nations Conference on Human Settlements (Habitat II) - to be held in Istanbul - would explore all aspects of urbanization and its effects on health within the context of sustainable development.

Since the 1980s, Turkey had been working on a programme of health reforms, covering quality of care, health financing and the reorganization of the Ministry of Health. The reform programme was intended to ensure equity and quality of care and improve the efficiency of family practitioners as well as universal health insurance coverage.

Dr SEIXAS (Brazil) said that, despite the advances achieved in certain areas, there was increasing inequity in health matters throughout the world. If health for all were to be achieved, it would require a real commitment from all countries and a thorough reassessment of the way that WHO interacted with Member States. The health-for-all strategy should become a unifying strategy, integrating health promotion and sector reform as the basis for healthier communities in an environmentally conscious world.

Governments had an ethical duty to work towards the control of diseases such as cholera, malaria, leprosy, tuberculosis, Chagas disease, filariasis and dengue. The Brazilian Government had recently approved

a wide-ranging programme for the eradication of the disease-carrying mosquito *Aedes aegypti*, which had already been endorsed by 10 countries of the region.

The Brazilian Government believed that it would be possible to find the additional resources so desperately needed to promote health. It was introducing a new tax on financial transactions which would substantially increase the public funds allocated to the health sector. A similar tax on international financial transactions, coupled with reform of health systems and their financing mechanisms, would be an ethical means of promoting equity in health services, throughout the world.

The structure, role and functions of WHO itself were in need of thorough review. WHO needed a more catalytic role, which would reinforce its technical, normative and information functions and encourage national leadership and self-reliance. Recent advances in computer and communication technology would replace the current practice of sending technical experts around the world, which would increase WHO's efficiency and help to relieve the financial crisis.

Mrs WAZIR ALI (Pakistan) said that WHO's celebrated successes in the fight against communicable diseases were under threat. A new global strategy was needed, which would focus on surveillance and control of infectious diseases and the development of new and effective drugs. That would require real decentralization of power and responsibility to the regional and country levels to ensure a prompt response to epidemics and more reliable data about disease patterns. Another problem which concerned her Government was the increasing marginalization of the poor throughout the world, millions of whom died of diseases that were preventable and curable. WHO and other international agencies could play a pivotal role in redressing the situation.

Pakistan's health problems were, in many respects, the problems of poverty and under-development, caused by illiteracy, malnutrition and a lack of human and financial resources. The Government had now introduced a comprehensive programme to provide better health care and increased access to education, with emphasis on environmental issues and population planning. In the past two years the health budget had quadrupled, with 75% of it devoted to primary health care. The nationwide network of health facilities was being strengthened, and the basic minimum needs approach had been adopted in two provinces. A total of 32 000 village-based women health workers had been trained to deliver primary preventive and promotive health services, and their number was expected to increase to 100 000 by 1999. The number of cases of poliomyelitis had fallen to below 450 in 1995, and dracunuliasis had been completely eradicated. Programmes of salt iodization and the provision of other nutritional supplements were being implemented. Medical education was being adapted to a more community-based approach.

As a result of the above policies, infant and maternal mortality rates had declined, and life expectancy in Pakistan had risen from 59 to 62 years. Much however, remained to be done.

Pakistan greatly valued WHO's cooperation and support, but felt that it was time to review the Constitution and functions of the Organization and enhance its ability to respond to new challenges and responsibilities. Pakistan strongly endorsed the 30% target for women's representation at senior levels in WHO and measures to ensure equitable geographical representation in the Organization's staff.

Mrs WALLSTRÖM (Sweden) said that her country was a firm believer in the United Nations system, but it saw the need to strengthen and realign global health cooperation. As a newcomer to the Health Assembly, she had been surprised to see so many agenda items referring to internal WHO affairs, rather than the substantive work of the Organization. There was a strong contrast between the bleak picture painted in *The world health report 1996* and the lack of action proposals on the agenda. The Secretariat had done much to reform the structure of the Organization, at the request of the Executive Board and the Health Assembly, but it had mainly addressed managerial issues; the future mission, mandate and functions of WHO remained to be defined. The fact had to be faced that at present WHO lacked a common vision to meet the challenges of today and tomorrow.

To take the example of reproductive health, *The world health report 1996* mentioned the occurrence of some 333 million new cases of sexually transmitted diseases in 1995. However, it made no mention of other vital factors, such as unsafe abortions, teenage pregnancies, maternal mortality and morbidity, and the quality of contraceptive services. WHO should use its traditional biomedical expertise in a productive

partnership with other international players in order to overcome the obstacles raised by cultural, religious and social differences.

Sweden and other countries were conducting a study on ways of strengthening international cooperation in health. WHO must not face criticism by retreating into defensiveness. It was essential to restore its pride and enthusiasm for further improvements in health in the years to come. The responsibility for doing so rested entirely with its Member States, though strong support from the Secretariat would be needed. She pleaded with other Member States, from North and South alike, to join in formulating a reform of WHO that could be adopted by consensus in 1998, on the occasion of the Organization's fiftieth anniversary.

Dr SNEH (Israel) said that *The world health report 1996* described the emergence and re-emergence of new and old communicable diseases, whose effects were aggravated by poverty, economic and social crisis, migration and environmental degradation. It was very difficult to decide which sectors should receive priority, even without the current budgetary constraints.

Despite the persistent political and security problems in his country, cooperation in the field of health between Israel and the Palestinian health authorities had continued, covering educational activities and joint committees dealing with such matters as immunization, communicable diseases, and quality control of pharmaceutical products. A joint Palestinian-Israeli medical centre was planned for the area between the Gaza Strip and Israel, which would care for the Palestinian population of Gaza as well as other patients from all over the Middle East. He hoped that other Member States of WHO would support that endeavour.

On the previous day, the Ministers of Health of Cyprus, Egypt, Israel, Jordan and the Palestinian Authority had signed an agreement establishing a Middle East cancer consortium. Turkey was to sign the agreement soon. The parties to the agreement would collaborate on cancer research, epidemiology and treatment: the consortium had been initiated by the National Cancer Institute in the USA as part of the United States efforts to promote peace in the Middle East. The consortium was an extraordinary example of regional cooperation in a spirit of peace and reconciliation.

Although Israel was a developed nation, its population came from highly diverse backgrounds. In 1995-1996, Israel had shared its experience with 25 states on four continents, providing training, technical assistance, establishment of medical facilities and capacity-building. His country was willing to collaborate with WHO and Member States to advance the health of people throughout the world. The leadership role of WHO in bringing people together through collaborative effort could not be overestimated.

Mr DEMBA (Mauritania) said that his country attached great importance to health and especially to the health problems resulting from the population explosion, declining rates of growth in the developing world, and the lack of food and of safe drinking-water. Mauritania had emphasized basic health needs, notably maternal and child health. There were immunization programmes to eradicate poliomyelitis and measles and to combat diarrhoeal diseases. Mauritania had tried to provide mothers with proper health care and to encourage them to space their births. Health education programmes had been incorporated in school curricula, and a charter had been adopted on the health implications of the environment and urbanization. There was a plan for the purchase of pharmaceuticals and the strengthening of their local production, as well as for ensuring coverage with essential drugs for the whole country. Mauritania tried to focus on the vulnerable sectors of the population, in cooperation with WHO, governmental and nongovernmental organizations and other partners. Nevertheless, health problems persisted and required greater efforts, notably with respect to tuberculosis, malaria and diarrhoeal diseases. Greater efforts also had to be made to implement national and international strategies; Mauritania's cooperation with WHO was becoming stronger, and it was certain that the Organization would do all it could to provide it with the resources it needed. Meeting the goal of health for all presented a difficult challenge which depended on equitable action and an international environment of peace and stability. It was important to ensure that WHO was an organization for all who suffered from diseases due to wars and conflicts so that health for all could really be achieved by the year 2000.

Mr LEE (Republic of Korea) said that despite past and expected achievements in disease control and eradication, the picture presented by *The world health report 1996* was not an optimistic one. Preventable

and even curable infectious diseases were not being properly treated for reasons of poverty and were causing a large number of deaths in the less developed countries, which found themselves in a vicious cycle where poverty led to poor disease control which in turn reduced productivity and further hampered economic development. Even in the developed countries infectious diseases such as tuberculosis, cholera and malaria, which once seemed to have been mastered, were again on the increase and becoming more difficult to control. The case of bovine spongiform encephalopathy, which had caused a severe trade conflict, had demonstrated how a disease could lead to world panic. Epidemiological findings on the causes of diseases and the development of medical technologies to control them did not of themselves lead to their conquest; many socioeconomic factors, including the alleviation of poverty, better education and the improvement of diet and nutrition, had to be taken into account, and it was in that context that he wished to suggest potential reforms and directions for WHO.

WHO should firstly integrate its efforts in dealing with human health problems with the United Nations, its specialized agencies and related international organizations, and should enhance its leadership role in its relations with all of them. Secondly, WHO's ability to respond promptly to outbreaks of unexpected or new diseases should be greatly strengthened, and the Organization should distribute updated information based on epidemiological investigations without delay to Member States through an established international surveillance network between WHO and designated focal points in Member States. Thirdly, in view of the fact that infectious diseases were directly related to poverty, WHO and its Member States needed to make greater efforts to aid the less developed countries without heed of ideology, race and social standing.

Mr THAN NYUNT (Myanmar) said his Government had established national immunization days for the eradication of poliomyelitis on which children under the age of 5 years were vaccinated on a community basis with the participation of national and international nongovernmental organizations. The programme would be continued until the year 2000, by which time it was expected that eradication would have been achieved. With improving security in many border areas, health facilities were being extended so that previously deprived segments of the population would enjoy standards of health care similar to those obtaining elsewhere in Myanmar. A community cost-sharing system for health care expenditure would be providing the community with readily available and effective essential drugs at an affordable cost; the community involvement in that mechanism would reduce the burden on the State and increase community self-determination and self-reliance. The backbone of primary health care in Myanmar was midwifery, and in that area there were many training opportunities. Three medical schools had been upgraded to institutes, and a fourth, responsible for training basic health workers, would be similarly upgraded in the near future. Communicable diseases were still a major problem in his country: malaria was the leading cause of both morbidity and mortality, and basic health workers were trained in microscopy to assist in its early diagnosis. Pulmonary tuberculosis, one of the leading causes of mortality, was posing the greatest threat to the community since the emergence of HIV/AIDS infection. In the fight against HIV/AIDS emphasis was placed on public education, control of drug abuse, rehabilitation centres for drug addicts and the control of sexually transmitted diseases. Condoms had been distributed to high-risk groups, which had also been given counselling. Health workers and both national and international nongovernmental organizations were actively involved in HIV/AIDS prevention in a multisectoral effort.

Mr TSAREGORODTSEV (Russian Federation) said that *The world health report 1996* rightly emphasized the issue of combating diseases, especially infectious and parasitic diseases. Serious problems were being caused for many countries by diseases - such as tuberculosis and malaria - which seemed to have been conquered but were now re-emerging and affecting wide sections of the population. There was the separate problem of newly emerging infectious diseases such as HIV/AIDS, Ebola haemorrhagic fever and diseases caused by hantaviruses. Socioeconomic factors were slowing progress against such diseases; it was therefore important to strengthen WHO's coordinating role so that the entire world could be involved in the work. The Organization had done an enormous amount to coordinate efforts to solve global problems and to provide technical assistance to Member States. The Russian Federation was particularly grateful for WHO's participation in its efforts to combat diphtheria, poliomyelitis and tuberculosis. He also emphasized the importance of WHO's work in controlling diarrhoeal diseases, respiratory diseases and viral infections

in infants and young children. It had done much to promote health education among adolescents and to promote health care among the working population, the elderly and women. Its cooperation with UNDP, the World Bank and UNICEF on environmental matters was greatly appreciated, notably in developing ways of involving people in overcoming problems relating to the supply of safe drinking-water and sanitation, the extension of the Healthy Cities Network and the plan to promote health and health education. The organization and management of health care, health reforms and the legislative framework should remain within the purview of WHO, and standardization should continue to be given priority attention.

Health care reform in the Russian Federation was being undertaken on the basis of specific legislation, decrees and government decisions, and was focused on the demarcation of competence between federal, territorial and local levels, decentralization of management and the transfer of the management, financing, procurement and training functions to the territorial level, the determination of financing mechanisms from federal, territorial and local budgetary sources, federal and territorial compulsory insurance funds, enterprise and company resources, charitable and social funds, private institutions and the personal resources of citizens themselves. The reforms brought together state, municipal, social, charitable and private health care institutions into a single health service system, providing free access to primary health care, emergency medical care and specialized hospital treatment within a framework of compulsory medical insurance, and a basic prevention and treatment programme. The achievement of a high-quality medical service was an inalienable principle for the Russian Federation which defined its priorities by using WHO's strategy for achieving health for all. Pre-diploma and post-diploma training for professional medical staff was being improved, and much was being done to support medical science, research and training, and to ensure that generally accepted ethical standards for medical service were observed.

In spite of its difficult economic situation, the Russian Federation was continuing to pay off its arrears of assessed contributions to WHO, and during the current year had transferred US$ 10 million to the Organization; by the end of the year it planned to transfer a similar sum.

Dr MORÓN (Bolivia) said that a country such as his, with a 75% poverty rate, was a fertile breeding ground for infectious diseases, particularly tuberculosis, malaria and Chagas disease. Rapid urbanization forced millions of people to live in overcrowded and unhygienic conditions.

In view of the heavy toll of human life taken by infectious diseases and the emergence of 29 new diseases in the last 20 years, his delegation viewed with concern the evident lack of political will and resources, both nationally and internationally, to establish and maintain systems for the detection and containment of such diseases. WHO and its regional offices must therefore take resolute action in the areas of prevention, information and promotion of new technologies for disease control and must alert governments and international organizations to the importance of economic development and higher living standards for the eradication of infectious diseases.

Despite the vital importance of international cooperation, economic resources and technology, Bolivia had opted for a decentralized approach to the analysis and solution of health problems, with community participation and shared responsibilities, especially in combating malaria, Chagas disease and tuberculosis.

Dr MARANDI (Islamic Republic of Iran) said that with the emergence of such diseases as AIDS and Ebola haemorrhagic fever and the re-emergence of some of the known communicable diseases such as tuberculosis, disease control demanded the cooperation of all countries in a global mission. Comprehensive disease surveillance systems should be established and expanded through national, regional and global networks, disseminating data and information; the present International Health Regulations should also be revised. An important approach to enhancing disease control and surveillance was community-oriented medicine; medical students should be trained not only in hospitals but throughout the health care system and in the community. In his country medical education and the health care system had been integrated for the past 10 years, and medical education was the responsibility of the Ministry of Health; his country was prepared to share its extensive experience in that regard with others. It was also expected of the World Health Organization that it should encourage and facilitate collaboration in applied research as a vital instrument for effective disease surveillance and control. WHO should benefit from the support of all Member States, in particular the developed countries, which should take on more responsibilities for the

provision of its financial needs. All WHO Member States should ensure that the Organization remained a technical and specialized entity. Social equity, including equity of the sexes, should always be at the forefront of all decisions and of the implementation of health-related programmes. Many countries were rapidly privatizing their health sectors, and that phenomenon could be more beneficial when it was in line with the development of national health insurance schemes and social security systems aimed at achieving and securing social equity.

Mr MORENO ROJAS (Colombia) said that his country in reforming its social security system, was endeavouring to consolidate a new model based on health promotion and disease prevention. It was also undergoing a process of social transformations, many of which conditioned the health situation. For example, the proportion of males in the population had been declining since 1985 as a result of the violent deaths of adolescents and young men. Since 1950 rapid urbanization had taken place. The population growth rate was falling, despite the increase in life expectancy, which was 69.2 years. The population over 65 years of age would increase to 12.8% of the total by 2025, from 5.6% for 1980, resulting in a higher incidence of chronic noncommunicable diseases and injuries. Violent death was the foremost cause of mortality in the country, with a murder rate of 80 per 100 000 inhabitants. There was an increase in chronic and degenerative diseases, and in communicable diseases such as tuberculosis, leprosy and leishmaniasis, while malaria was still a health problem. In addition, diseases such as Venezuelan equine encephalitis, cholera, dengue and yellow fever had reappeared, and certain new diseases, such as some associated with HIV, had emerged. The difficulties experienced in the control of communicable diseases, especially tuberculosis, were increasing, giving rise to a need for multilateral plans with specific goals and effective assistance for those lacking sufficient means.

The control of communicable diseases required a strong political commitment. Many countries were currently engaged in restructuring their health systems, and there was evidence that in that process strategies for the control of communicable diseases were being weakened. The countries concerned must therefore make a special effort to maintain control of such diseases, particularly through immunization and education. Colombians could testify that that could be done, since in the past 30 years infant mortality had been reduced from 100 to 24 per 1000 live births. Poliomyelitis had recently been eradicated and in a few years time it would be possible to say the same of measles, leprosy, neonatal tetanus and onchocerciasis. Nevertheless, action at the country level alone was not sufficient to produce results. Consequently, the campaign against communicable diseases required a concerted international effort that would be given concrete shape in multilateral plans. The world plan being proposed should take into account support mechanisms for possible emergencies, financial incentives for commercially unfashionable disease research, and the strengthening of organizations engaged in the dissemination of knowledge.

The communicable disease problem was compounded by lack of safe drinking-water, malnutrition, low immunization coverage, wars and poverty, which governments and communities needed to overcome through appropriate development policies and models. Education, in particular, required a number of changes, since mere health instruction was not sufficient to achieve satisfactory results. The development of healthy lifestyles should be encouraged. Moreover, at present the use of antibiotics and other therapeutic agents could not be considered to be a matter solely for health professionals, since their misuse worsened the communicable disease problem. Colombia was developing a model that guaranteed basic health services, immunization, safe drinking-water and health promotion and which provided the necessary tools through intersectoral action.

Technology was a major factor in the campaign against communicable diseases. The world required treatments and vaccines of low cost and broad application. For that purpose it was essential that research should be supported and diversified, especially in areas where it was still inadequate. Malaria and tuberculosis were obvious examples, and Colombia was making a valuable contribution to the control of one of them through vaccine development and amelioration. As a result of improper use deriving from inappropriate marketing policies and professional ignorance, many antibiotics had generated resistance. Moreover, the high cost of drugs was becoming an insurmountable obstacle for many people. Governments should therefore try to ensure that drugs were made available to all and to prevent their misuse. Information campaigns targeted on women in poor countries would be very effective and would cost only a small

percentage of the sums spent on defence. If health and environmental conditions were improved, if malnutrition and poverty were reduced and if new technological and scientific elements were developed, accompanied by judicious epidemiological surveillance, it should be possible to achieve well-being, development and a better level of health for everyone.

Mr HERNES (Norway) said that the frustrations of modern medicine, and of the World Health Organization as well, were generated by the increasing divergence between what was within reach and what could actually be grasped. The possibilities of medicine had never been greater, yet *The world health report 1996* made it clear that the state of the world's health was a cause for grave concern. There was an increasing mismatch even in the richest countries between rapidly advancing medical knowledge and what health systems could afford. There were growing demands for access, efficiency and quality, but the capacity to deliver was undermined by unemployment, uncertainty and dire financial straits. Despite what was known about the links between disease, poverty, lifestyles and the environment, health care systems remained tailored to dealing with medical specialities and not intersectoral complexities. Never before had there been such a divergence between ambitions and accomplishments.

Adding to that frustration was the mismatch between the importance of WHO's mission and the feebleness of its actions. Norway had frequently expressed its concern about the lack of direction of WHO in recent years, and was now repeating with even stronger urgency its call for clearer leadership, a more explicit strategy and a keener sense of mission. The Organization could not afford to lose time and waste resources on vague goals and nebulous priorities. Instead of responding in fundamental ways to those problems, the WHO reform process had been issue-oriented and piecemeal. It had been fragmented rather than focused. It had serious problems in establishing real priorities, and did not have good enough mechanisms to link regular and extrabudgetary funds in strategic discussions and operational planning. Progress was still slow and fumbling on those critical issues.

Only by sharpening the focus of WHO's mission could measures to reform the Organization from within be tested according to whether they contributed to results where results mattered. The time had come for clear guidance on priority functions, and for WHO to make explicit the normative tasks that lay at the core of its mission. The Organization could not do everything everywhere. The task called for intellectual leadership, for authority that was based on medical knowledge fused with conceptual skills and humane commitment. The independent study that was being conducted of WHO programmes at country level should contribute constructively to the debate on the Organization's decentralized functions and partnerships with other agencies. Unless duplication and waste between agencies at national and international levels were reduced, global health would not be improved. Unless WHO became more efficient in its own operations, specialized in key functions and utilized its network more strategically, it would not serve as the instrument that was now needed. That called for organizational leadership which generated loyalty based on the skills in coping with diverse needs without losing focus and credibility among the many actors jointly facing rapid change. WHO could not expect its budget to grow while social budgets in the Member States themselves were cut. The best way of generating support for further allocations, even increasing allocations, was for the intellectual and organizational leadership to be matched by creative economic leadership that convinced Member States that they could not make any better use of the allocated funds than to spend them at WHO.

There were signs of hope and new opportunities in world health. The eradication of smallpox was a classic example, and another was the poliomyelitis eradication campaign. During the first quarter of 1996 Europe had been free from poliomyelitis for the first time in its history, and similar efforts in Asia and Africa were promising: that showed WHO at its best.

The officers of an organization were there to promote its goals; an organization was not there to promote the ambitions of its officers. If Norway was impatient, that was because it did not see in the documents presented to the Health Assembly the kind of creative thinking that alleviated frustrations, took up opportunities, and kindled hopes. It was a time for accomplishment, not for complacency; for initiative, not for inaction; for leadership, not for laggardness. It was the common challenge and obligation to the many millions who had put their faith and hopes in WHO.

Professor SHBOKSHI (Saudi Arabia) said that international cooperation to control communicable diseases should focus on the following activities: dissemination of up-to-date information on the epidemiology of emerging diseases; improvement of the capacity to respond to medical emergencies and epidemics; enhancement of awareness to promote healthier lifestyles; technical cooperation and pooling of experience among all States.

Primary health care services in Saudi Arabia were available to 98% of the population. There were special projects on noncommunicable diseases, mother and child care, and psychological and social health. A child immunization programme covering nine diseases, including hepatitis B, had led to a sharp decline in the morbidity rate.

During the Pilgrimage (*hajj*), which brought over 2 million pilgrims to Saudi Arabia, the Kingdom had shown its ability to respond effectively to various kinds of health emergencies.

He proposed that the Organization should play a prominent role in developing a comprehensive strategy for the control of re-emerging communicable diseases on the lines of the anti-tobacco, HIV/AIDS and environmental health strategies. It should continue to develop the International Health Regulations and promote cooperation among Member States in the dissemination of epidemiological and other information and in lowering the costs of health services while preserving their quality. It should provide more effective support to Member States for the training of national health professionals and should give high priority to occupational health and prevention of accidents in the workplace.

Mr COLLA (Belgium) said that vulnerability to disease was heightened by social and urban exclusion and the associated phenomena of poverty, unemployment and homelessness. He therefore welcomed the Organization's more realistic approach to its tasks in the years ahead, as reflected for instance in the updating of the International Health Regulations.

WHO should preserve its principal role as the reference point for advice, expertise and recommendations in public health - for example, establishing international standards for foodstuffs and biological and pharmaceutical products.

Most of the Organization's human and financial resources should continue to be directed to the assistance of the poorest countries, focusing on the reorganization of basic health structures. WHO should convince its partners in other sectors and institutions that health was a prerequisite for sustainable development and that the health dimension should be integrated into all planning and decision-making. In that connection, he praised the Organization's chemical safety and health legislation programmes.

Comprehensive health data were an essential tool for the formulation of health policies and the history of AIDS had shown the importance of a sound epidemiological surveillance system for health planning. In Belgium, a network of physicians collected basic data for surveillance of communicable diseases with the voluntary collaboration of private laboratories. His country was more than willing to share its experience in tropical diseases with the international community. In that connection, he mentioned that an international conference on the Ebola virus would be held in Antwerp, Belgium, in September 1996.

WHO should be more active in promoting the delegation of responsibility to grassroots communities in the area of health.

Health policy should be geared to new urban environments, particularly in terms of action against pollution, noise and other nuisances. He advocated an in-depth evaluation of experience gained from the Healthy Cities Network.

Priority should be given to the containment of violence and trafficking in human beings, particularly women and children.

Dr WILLIAMS (Cook Islands), also speaking on behalf of Fiji, Kiribati, Federated States of Micronesia, Nauru, Palau, Papua New Guinea, Samoa, Tonga, Tuvalu and Vanuatu, said that the signing by the United States of America and France of the treaty of Rarotonga banning nuclear testing in the Pacific had been welcomed by the governments and peoples of the region. The small island nations of the Pacific commended the President of France for taking the initiative and the President of French Polynesia for his assistance.

In his part of the world, communicable diseases were no longer the leading causes of death. Improved overall socioeconomic status and changing lifestyles had led to the increased prevalence of such

noncommunicable diseases as diabetes, hypertension, coronary heart disease and cancer. Control and eradication efforts had focused on case-detection and case-holding and on surveillance. Health education programmes were aimed at all sectors of the community and in particular at high-risk populations.

Stressing the pivotal role that immunization programmes played in the prevention and eradication of infectious diseases, he expressed concern at the suggestion that organizations should redirect their immunization funding and leave governments to meet the cost. He supported the continued provision of free vaccines.

He welcomed the Director-General's call for a strategy to improve surveillance systems, strengthen laboratory services and respond rapidly to public health problems. Laboratory services in the island nations were inadequate and more sophisticated technologies were needed.

He suggested that the WHONET information system should be expanded to make all information relating to WHO activities available to the small island nations of the Pacific. Diseases such as poliomyelitis, leprosy and tuberculosis had almost been eradicated in some of those nations but newly emerging diseases such as HIV/AIDS and dengue fever would undoubtedly cause havoc.

If scientists' predictions of global warming were to be believed, many Pacific islands were doomed to disappear beneath the ocean. He asked the Health Assembly to reflect on what action might be taken to prevent such a disaster.

The meeting rose at 12:50.

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