World Health Organization
Organisation mondiale de la Santé

FORTY-NINTH WORLD HEALTH ASSEMBLY

COMMITTEE A

A49/A/SR/3
22 May 1996

PROVISIONAL SUMMARY RECORD OF THE THIRD MEETING

Palais des Nations, Geneva
Wednesday, 22 May 1996, at 9:00

Chairman: Professor B. SANGSTER (Netherlands)

CONTENTS

THIRD MEETING

Wednesday, 22 May 1996, at 9:00

Chairman: Professor B. SANGSTER (Netherlands)

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

Mrs EIGHABSHAWI (Sudan) said that economic and social reconstruction had been made particularly difficult by 10 years of warfare, and international aid was needed to help rebuild and foster development. The setting up of 26 provincial health ministries in Sudan had been costly in terms of both human and material resources, at a time of other economic pressures and a reduction in foreign aid. In 1993, a policy of economic liberalization had been introduced and the private sector was now participating in the funding of health care. There were presently over one million immigrants in the country, which placed enormous pressure on health institutions. Diseases and epidemics were being combated even in parts of the country controlled by rebels. Health was regarded as an essential human right and charters and declarations of the United Nations organizations working in the area of health were respected, as illustrated by support for programmes on malaria and tuberculosis, poliomyelitis and AIDS. The emergence of chloroquine resistance had re-established malaria as a priority disease. The importance of women in relation to the health of the family and of children was also recognized.

Sir Kenneth CALMAN (United Kingdom of Great Britain and Northern Ireland) wished to emphasize four points. Firstly, that health was one of the best indicators of development. Secondly, that WHO had a key leadership role, particularly in establishing partnerships. Thirdly and most importantly, that future development should be based on a six-point framework, and fourthly, that the importance of both resource issues and continued reform should be stressed. If WHO was to continue to be the premier world health organization it would need support.

Dr KÖKÉNY (Hungary) affirmed that the theme of *The world health report 1996* had particular relevance for countries living through a period of overall economic and social transition with the contingent adverse effects on health. Throughout Central and Eastern Europe life expectancy was continuing to decrease and cases of infant and maternal mortality to rise. Deaths from cardiovascular disease, cancer, accidents and violence were also increasing. At the same time, there had been a breakdown in the public health system and the re-emergence of communicable diseases such as tuberculosis. The Regional Office for Europe had established the EUROHEALTH programme to support health development in those countries and two-thirds of regional resources had been reallocated in their favour. Nevertheless, needs still continued to exceed diminishing resources. At its session in 1995, the Regional Committee had expressed the view that the European Region should receive a larger share of the total regular budget to reflect realities in the Region.

As part of the reform process, the examination of the WHO Constitution was a significant step forward. Priority was being given to WHO's mission and function, but there were many other topics suitable for review. In any case, important matters concerning the future of WHO, including a better balance of resources within the Organization, should be discussed in the governing bodies in an open, democratic way, rather than through press statements.

Hungary cooperated closely with WHO and other partners, such as the European Union and the World Bank, in formulating and implementing national health care policies and reforms aimed at disease prevention and health promotion.

Dr ARAFAT (Palestine) speaking at the invitation of the CHAIRMAN, welcomed *The world health report 1996*. The twin goals of peace and health for all by the year 2000 had been generally accepted. All

obstacles to peace must be removed; the long-standing blockade had had a negative impact on the health of the Palestinian people, especially among vulnerable groups. The Palestinian health authorities were committed to providing health services and thanked WHO and all those countries and international and nongovernmental organizations that had provided assistance in that regard. The health authorities were currently cooperating with those of Israel to develop health services for the two peoples. He welcomed the agreement signed by countries in the Region and by Palestine for joint action against cancer, with support from the Government of the United States of America.

Mr TCHEUL (Democratic People's Republic of Korea) regretted that people should still be vulnerable to new, emerging and re-emerging diseases that ranged from diarrhoeal diseases to Ebola and AIDS. It was unacceptable that those diseases were on the increase as a result of war, drug abuse and unemployment, as well as a lack of coordination and planning in the provision of health care services and cooperation in the public health sector. He therefore supported the three priorities set out in *The world health report 1996* which should contribute to coordinated action by the international community. Diseases could only be tackled through international cooperation based on firm determination and reliable resources. WHO should therefore concentrate on reforming its own internal structure to enable it to help Member States to make the necessary improvements to domestic infrastructures. An international conference on fighting common diseases might contribute towards mobilization on a global scale. The Democratic People's Republic of Korea would continue to cooperate with WHO in carrying out programmes directly linked to improving people's chances of survival. In conclusion, he thanked WHO and all countries which had offered emergency assistance to flood victims in the Democratic People's Republic of Korea in 1995.

Dr ADAMS (Australia), welcoming *The world health report 1996*, said that WHO would undoubtedly be remembered for eliminating a number of diseases, including yaws and smallpox, from the planet, but other threats, such as Ebola, BSE, tuberculosis and iodine deficiency diseases, remained. WHO still had a vital role to play in a number of areas: responding to emergencies, developing early warning mechanisms for emerging and re-emerging diseases, modernizing the International Health Regulations and drawing attention to the link between communicable diseases and cancer. If progress was to be made in health development, however, WHO would have to join forces with other bilateral and multilateral organizations. In view of its restricted budget, the Organization would also have to rethink its role and priorities which might mean dropping some of its present programmes and concentrating on contemporary major public health issues.

Mr JUI MENG CHUA (Malaysia) said that his country's rapid development was creating new health challenges. Although good programmes were in place, there was a need for development in new areas of concern. Both communicable and noncommunicable disease problems were present. The diseases in the first priority area defined in *The world health report 1996* were under control as a result of immunization and good cold-chain maintenance, but diseases in the second priority area, especially malaria and tuberculosis, required active WHO programmes to combat them. Diseases in the third priority area were particularly important for Malaysia, since dengue and dengue haemorrhagic fever were spreading, and appropriate research, including behavioural research, would be important in developing effective strategies to control them.

There was a great need to improve the health information system and collaboration at country, regional and global levels. He therefore welcomed the institution of WHONET for the global surveillance of bacterial resistance to microbial agents, and hoped that such an innovative use of information technology could be extended to the surveillance of communicable diseases. In a world in which large-scale international travel spread viruses and bacteria across frontiers, WHONET, the Internet and the development of telemedicine together would change the way in which the world viewed health care delivery. However, total community involvement would be required. For that purpose Malaysia had evolved a policy providing for interaction by the public sector, the private sector and nongovernmental organizations. Assistance from the latter was particularly important for combating the new "lifestyle" diseases, as had been shown in the "healthy lifestyle" campaigns carried out since 1991, targeted on diseases such as heart disease, AIDS and diabetes.

Malaysia looked forward to greater collaboration with WHO, to whose work it was fully committed, believing that despite the criticism levied against the Organization and despite some of its failings it remained the best hope in the fight against diseases old and new.

Professor LE NGOC TRONG (Viet Nam) said that as the twenty-first century approached, the world was confronted by political, social and economic changes never experienced before. The discrepancy between the rich and the poor was widening, and rapid population growth and urbanization, the aggravation of health gaps between the developed and least developed countries, worldwide environmental destruction and the mass migration of refugees afflicted by natural or man-made disasters were all affecting the international health situation. Viet Nam was therefore looking at health and environment problems from a somewhat different perspective, focusing on consideration of the environment as a factor in all stages of development.

The dynamic development of the Western Pacific had not always had a positive impact on health or the quality of life. Viet Nam was therefore taking a fresh look at its development priorities and was reorienting national strategies through programmes to eradicate poverty in remote mountain areas, special initiatives to ensure tangible benefits for vulnerable groups, and programmes to combat vaccine-preventable diseases and social diseases such as malaria and endemic goitre. It was endeavouring to improve living conditions, to rehabilitate schools, health clinics and roads, and to provide clean water and sanitation.

Economic development, education, poverty alleviation, environmental policy and agricultural activities were all key factors influencing the health status of individuals and the population in general. The relationship between health and development proved to be stronger in the case of women and children. Development generated growth, but the fruits of growth must also be distributed equitably. His Government hoped that WHO, which it fully supported, would continue to provide the necessary leadership in achieving health for all by the year 2000.

Dr IVANOV (Belarus) said that his country shared WHO's concern regarding the communicable disease problem, which had a very important impact on socioeconomic development. Communicable diseases were especially important for Belarus, which, on account of its geographical situation, hosted a large number of legal and illegal migrants from the Community of Independent States, the Middle East and Asia. His country was most grateful to WHO, UNICEF and the International Committee of the Red Cross for their help in controlling communicable diseases, especially through the provision of vaccines and improvements in the cold chain.

At present the Government of Belarus, with the assistance of international organizations, was engaged in a campaign to vaccinate the whole population against diphtheria. Also, a special programme had been prepared to protect the population against viral, bacterial and parasitic diseases. Belarus, which had the laboratories and structures required to carry out research with highly pathogenic biological agents, was willing to cooperate with other countries with regard to problems such as microbial resistance to antibiotics and the control of poliomyelitis.

The comprehensive campaign against communicable diseases should be coordinated in terms of the provision of information, the preparation of standardized approaches to research, and the prevention of infection, and training. Appropriate national programmes should be formulated, and national and international coordinating centres should be designated and fitted out with up-to-date equipment. Belarus had offered to establish a WHO coordinating centre for the control of communicable diseases at its Institute for Epidemiological and Microbiological Research.

In addition, integrated research should be carried out on endemic and other diseases in areas subjected to radioactivity as a result of the Chernobyl disaster, the aftermath of which was continuing to affect Belarus. Unfortunately the funds available for remedying the effects of the disaster had been reduced. Belarus could not cope with all the problems on its own, and it was therefore necessary to continue the International Programme to mitigate the Health Effects of the Chernobyl Accident (IPHECA) and the international "thyroid" project. His delegation hoped that the Health Assembly would adopt a resolution on the subject and that WHO would find funds. In turn, Belarus was willing to share its tragic but unique experience with the rest of the world.

Mr SIDIBE (Mali), speaking on behalf of Benin, Burkina Faso, Burundi, Cameroon, Chad, Congo, Côte d'Ivoire, Gabon, Guinea, Madagascar, Mali, Niger, Senegal and Togo said that the health situation in those countries was still a source of concern and there was still a need to promote health as a sector that contributed to economic growth and well-being. In view of the scarcity of resources, it was necessary to establish rigorous priorities that took account of endemic diseases, diseases in epidemiological transition, and emerging and re-emerging diseases. The outbreak of cerebrospinal meningitis in which 10 000 persons in the West African subregion had died had been mastered thanks to international solidarity. The economic and social costs of malaria were becoming increasingly severe, while acute respiratory infections, diarrhoeal diseases, cholera, measles, trypanosomiasis and Ebola haemorrhagic fever were endangering development and shattering fragile health systems. The spread of the HIV/AIDS pandemic would, it was hoped, be checked with the establishment of UNAIDS, whose activities should go beyond prevention and, in the name of equity, also cover the problem of AIDS patients' access to medicines. Meanwhile, the world population was constantly growing, in association with a galloping urbanization that was having harmful consequences on the health of city dwellers, particularly women and children. In order to meet those challenges, innovative strategies had to be adopted and health systems strengthened by stressing the importance of integration at different levels, and of improved organization and health service management. Water supply and a clean environment also had to be taken into account, while mental disorders and infections of the oral cavity could not be overlooked. In that context the countries on whose behalf he was speaking were determined to continue the reform of their community- and individual-centred health systems, since only in a comprehensive and integrated health system sustained by vigorous community commitment would it be possible to combat disease effectively. They called upon their partners to match those reforms.

There was also a need to further improve cooperation among States, especially in emergencies. Many countries had established mechanisms for preventing and responding to emergencies through the constitution and pre-positioning of stocks, the creation of a crisis committee and the formation of teams for emergency prevention and management, but generally those arrangements were dependent on an epidemiological surveillance and early warning systems which needed to be reinforced. What was now required was a real pooling of all health resources in a regional strategy for the prevention and control of communicable disease epidemics. Furthermore, in view of the size of forced population displacements, there was a need for mechanisms to ensure good quality health services for all in full security. In any case, WHO was effectively supporting the health programmes and systems of the countries on whose behalf he was speaking, and its mandate must therefore be preserved. The international community should therefore place at its disposal sufficient resources, which should, however, be managed with greater rigour and relevance.

Mr DUGASSE (Seychelles) recalled that delegates had left the Forty-eighth World Health Assembly with a clear understanding of the need for broad consultation within their respective countries in order to raise awareness of the need to place health high on the political agenda among the general public, political leaders, ministries and other partners concerned with social and economic development. A comprehensive study and a series of consultations had been launched in the Seychelles soon afterwards, with the prime objective of reviewing the country's health policy and strategies. The study had shown that, despite changing perspectives, health for all remained a valid and realizable policy, and primary health care a very effective and appropriate strategy. Decentralized primary health care services would continue to be made available to the population free of charge, based on actual needs and not on ability to pay. There was, however, a fast-growing private medical sector. The recent review had strengthened the Government's conviction that primary health care required an unswerving political commitment and that governments must continue to play a central role in the planning, organization, provision and monitoring of health care services.

Following the review, health policies and strategies had been not only revitalized but also prioritized and translated into practical measures. For example, the Ministry of Health had succeeded in obtaining an increase in its share of the national budget. A commitment had been made to redress the imbalance that existed in the allocation of resources between hospitals and primary health care. The Government had also recognized that human resources development was central to sustainable development and was reviewing development of the managerial capacity required at all levels of health care. In addition, progress had been made in building up greater awareness of health among individuals and in the community. A stronger

partnership was being fostered with governmental and nongovernmental organizations through, for example, a strengthening of collaboration in schools and with those involved in community level social services. The Government was also enhancing community participation and promoting the concept of individual responsibility for health. It was anxious to sustain and upgrade the high quality of health care delivery and would therefore include quality assurance among the indicators for the provision of health care.

When Seychelles had gained its independence in 1976, its health budget had been tiny and its health indicators dismal. Now, 20 years later, it had recorded significant gains in all major health indicators, which were comparable to those of many developed countries. Its current aim was to sustain the gains and improve on them. There was no doubt that, throughout the process of health development, Seychelles had been inspired and guided by WHO, whose support at the country office, regional office, and headquarters levels it appreciated. It had learnt from and adapted the experience of other countries and now sought new ways of cooperating with its partners and friends in the years ahead. In any event, Seychelles wished to renew its commitment to the cause of health for all and to its partnership with WHO.

Dr MADUBUIKE (Nigeria), speaking on behalf of the Member States of the West African Health Community (Gambia, Ghana, Liberia, Nigeria and Sierra Leone), said that all the countries of the Community (WAHC) faced the same challenges in the health sector, including high maternal and infant mortality rates, the pressure of a soaring population, forced migrations resulting from natural and man-made disasters, and communicable diseases such as HIV/AIDS, tuberculosis, yellow fever, cholera, Ebola haemorrhagic fever and Lassa fever. An epidemic of cerebrospinal meningitis was currently affecting some countries of the subregion. WAHC was grateful to international donors for their assistance in combating the epidemic. Malnutrition and micronutrient deficiency played a major part in premature death, disease and disability. However, it was hoped that dracunculiasis would soon be eradicated, and a programme of salt iodization had begun with the aim of eliminating iodine deficiency disorders by the year 2000.

A number of other problems were of concern to WAHC, including the rising incidence of cardiovascular diseases and accidents, and tobacco smoking. Better water and sanitation services would have an immediate impact on people's health - also an area where more help was needed from the international community. Some members of WAHC had suffered civil strife which had adversely affected many sectors, including health, and it was to be hoped that matters would improve when the conflicts were over. The continuing problem of fake and substandard drugs made it more important than ever to enforce WHO's essential drugs policy.

Although many countries were undertaking health sector reforms, economic crisis and structural adjustment programmes had adversely affected people's health, and both local and foreign resources must be mobilized in order to meet the urgent health needs of the people. WAHC supported WHO's budgetary reforms, which were intended to increase allocations to country programmes and give countries more control over their country budgets.

Human resources development continued to be a major concern of WAHC. Nurses and midwives made up the majority of health personnel, and he welcomed the new focus on strengthening nursing and midwifery as an integral part of health development. More training was needed for medical and nursing staff who worked to rehabilitate disaster victims and displaced persons. Specialist medical personnel were being trained at in-country or regional training centres in order to improve the capacity and quality of health care at all levels, and more efforts were being made to increase training in specialist areas. The assistance of the international donor community in that endeavour would be appreciated. Management training for senior-level and middle-level health personnel was also important, since management problems had been blamed for most of the failures experienced in the implementation of policies and programmes. He welcomed the new emphasis on workplace health programmes, although only a small proportion of adults in the WAHC countries worked in the formal sector. It was important to address the needs of all workers.

Dr VASSALLO (Malta) said that while *The world health report 1996* provided a balanced view of successes and failures in the fight against the world's major health problems, it failed to mention the regrettable reduction in the number of WHO's public health specialists, including those experienced in tropical diseases. The pharmaceutical industry should consider intensifying its research in that field, which was

assuming greater importance. WHO was making a great effort to raise awareness about the deteriorating situation in the communicable disease field, and he welcomed the creation of the new Division of Emerging and other Communicable Diseases Surveillance and Control. It was essential to make the International Health Regulations, currently under review, more helpful to countries.

WHO must not lose sight of the massive burden of ill-health caused by noncommunicable diseases such as uncontrolled infections, heart disease, diabetes and cancer. Many countries were vulnerable to unhealthy lifestyles and glamorous advertisements for harmful substances. WHO's future programmes of work should strive for an appropriate balance between communicable and noncommunicable disease activities. However, any relegation of priorities should be approached with caution.

Malta had always supported health efforts at the global, regional and subregional levels. It was currently exploring the feasibility of a coordinating strategy and action for a number of Mediterranean countries, involving WHO headquarters, the European, Eastern Mediterranean and African Regions and individual countries, as a contribution to the global review of the health-for-all strategy.

He supported the conclusions and action plan as set out it document A49/3 and appealed for concerted international action and solidarity in support of WHO initiatives.

Dr IBRAHIM (Brunei Darussalam) said that the control of communicable diseases had become a very serious problem, particularly in the face of increasing drug resistance and factors such as poverty, economic and social crises and people's increasing mobility, which exacerbated their spread. The changing patterns of diseases demanded a fresh approach to health planning and management on a global scale.

In general, noncommunicable diseases were more of a problem in Brunei Darussalam than communicable diseases. However, there was concern that diseases such as tuberculosis, malaria and HIV/AIDS might become more serious in the future because of changing lifestyles, an expected influx of guest workers and increased tourism and trade.

Dr PALACIO (Ecuador) said that health problems respected no frontiers and must be tackled at the global level. Radical political change was required in order to reform the structure and financing of WHO. Despite its many achievements in the past, WHO was only now beginning its most vital task - the creation of a new world health order which would define more clearly the relationships between national health systems and the various economic and cultural processes taking place in the world. Above all, the new order must address the issue of human reproduction in a healthy world.

The current administrative restructuring of WHO was not enough: ideological changes were also needed in order to foster people's links with nature and with human organizations. Important issues, such as the impact of cities on people's health and the potential economic power of the health sector, must not be ignored. One example of a specific problem was the fact that almost all the pharmaceuticals produced in the world were consumed by the rich minority in the north rather than the poor masses of the south.

He urged WHO to establish a global health system whose main objective would be the health of future generations and which would involve all social, economic and political sectors. The new system should incorporate health into all national cultures and provide a way of freeing the world from underdevelopment and ill-health.

Dr OPOLSKI (Poland) said that the situation of communicable diseases, with old diseases re-emerging and new ones arising, paralleled the world's health problems as a whole. Many Member States were reforming their health care systems to respond to the growing expectations of their population and to the financial constraints on health expenditure. WHO, too, had begun a reform process in response to global change which had had to be accelerated in recent years because of severe financial constraints. WHO needed to consider all possible options for maintaining and improving the effectiveness of its work: the role of the Regional Offices in that task was particularly important.

Poland was currently reforming both its socioeconomic and its political system. It had come to realize that appropriate utilization of available resources was the main problem in health care service delivery, rather than a lack of infrastructure or human resources, as had been thought in the past. The Government's main

function was one of management, even though it also acted as an employer or producer of consumable commodities, as well as fulfilling social, educational and political functions.

Dr BARAKZAI (Afghanistan) said that, in 17 years of war, his country had lost 75% of its health infrastructure. Infant and maternal mortality rates were high, and life expectancy, at 43, was low. Tuberculosis, malaria, leishmaniasis, gastroenteritis, acute respiratory infections, other communicable diseases, and iodine and vitamin A deficiency disorders gave particular cause for concern.

Despite its economic difficulties, Afghanistan had extended its Expanded Programme on Immunization to achieve a coverage of 70%-80%. It hoped to receive increased funding in that area and for the planned water chlorination programme. A mass immunization campaign against poliomyelitis was also planned, and Afghanistan acknowledged the assistance of the Regional Office for the Eastern Mediterranean, UNICEF and the Islamic Republic of Iran in poliomyelitis control activities. Many communicable diseases affected more than one country in the Region, and his Government had suggested the formation of a joint committee to coordinate the fight against those diseases. The fight against iodine deficiency diseases would require intersectoral cooperation between the Government, economic agents, the legislature, the media and educationalists. He called upon WHO to assist in the supply of iodized salt.

Because of the effects of the war, the cities of Afghanistan were far from being "healthy cities": they did not have electricity or water supplies and their children, their most precious asset, were living in an unhealthy environment without schools or play areas. Children in Afghanistan were undernourished and mentally distressed, and under constant threat from the land mines left over from the war. He appealed to all participants in the Health Assembly to provide the funding, technicians and designers needed for the construction of a truly healthy city which could act as a model for the reconstruction of the whole country.

Mr ANGATIA (Kenya) said that the process of reforming the health sector in his country was based on the development of a new health policy framework paper and explored alternative financing mechanisms, capacity-building and rationalization of personnel working in the sector, and improvement in the delivery of health care services. The main health challenge was to prevent and control communicable diseases, of which malaria remained the most significant. Kenya had recently launched a five-year programme of action on malaria control for whose implementation it would require the support of WHO and other international as well as bilateral organizations. The approaches to be adopted were multi-pronged and included vector control, environmental management, chemotherapy and the monitoring of drug resistance trends. Kenya was implementing a national drug policy but, like other countries in the Region, was beginning to experience problems relating to the counterfeiting and import of substandard drugs. Those problems required the concerted attention of the pharmaceutical industry, regulatory boards and government departments, under the guidance of WHO. In addition, Kenya was dealing with the challenge of new, emerging and re-emerging diseases; WHO's role should be strengthened to assist Member States to be in a state of readiness to contain those diseases when they occurred, with minimal suffering and loss of life. WHO should also play a crucial role in working out strategies to link the coordinating efforts of UNAIDS in the fight against AIDS and sexually transmitted diseases with what was being done in the prevention, control and treatment of tuberculosis. Kenya devoted special attention to child survival and development programmes; since the beginning of 1996 the country had recorded no cases of poliomyelitis and had every reason to believe it would achieve its eradication. A similar trend applied to dracunculiasis.

Mr NUMBI (Zaire) said that despite the current difficulties his Government still gave real priority to health: health expenditures ranked second in the country's budget and Zaire had paid all its arrears of contributions to WHO. Health coverage in Zaire had improved significantly, with the activities of the Expanded Programme on Immunization, the National Bureau for Tuberculosis, the Central Bureau for Trypanosomiasis, and the National Bureau for Onchocerciasis, the fight against iodine deficiency disorders by banning the sale of non-iodized salts, improvement in the quality and effectiveness of health care through infrastructure rehabilitation and partnership with the private sector and local nongovernmental religious organizations. Nevertheless, the situation overall remained precarious, with the unprecedented socioeconomic crisis being made worse by the breakdown in structural cooperation and successive waves of refugees. He

wished to draw the attention of the international community to the disastrous effect that massive population movements had on the spread of HIV; in Zaire prevalence had soared from 6% to 18% in only two years. The fight against HIV infection should take that into account. Zaire welcomed the friendly overtures being made by a number of countries regarding structural cooperation. Finally, Zaire was preparing draft resolutions on HIV and trypanosomiasis, which he hoped could be submitted for consideration in due course.

Dr MAKUMBI (Uganda) said his Government had increased the financing of its health sector by over 50% since 1993, and that effort had been enhanced by strategies designed to attract back those professionals who had left the country during the civil turmoil prior to 1986. The Government was restructuring the workforce, introducing a conducive working environment and improving remuneration for health professionals. The Ministry of Health was carrying out a study of 39 districts to identify the priority communicable diseases, formulate cost-effective interventions, and carry out a detailed analysis of the sources and expenditure of funds at each district level to enable resources to be allocated rationally and flexibly. Alongside that, every effort had been made to improve early diagnosis and prompt case management, vector control measures, the development of early warning systems and surveillance mechanisms to prevent epidemics as well as the spread of new pathogens. Activities included the sharing of information, and the fostering of a better understanding of the constraints that hindered the effective control of epidemics and a better collaboration between neighbouring countries and districts. Uganda had drastically reduced the incidence and prevalence of both dracunculiasis and poliomyelitis, and was stepping up its efforts to control measles, onchocerciasis, AIDS, tuberculosis and malaria. Uganda welcomed national and international collaboration to combat newly emerging diseases, as well as operational research on their prevention, treatment and control. Trypanosomiasis was on the increase in Uganda, and its Government was grateful for WHO's efforts to ensure that the production and delivery of melarsoprol would resume. Finally, he wished to inform the Health Assembly that Uganda had hosted the Ninth International Conference on AIDS and sexually transmitted diseases in Africa in December 1995, attracting nearly 4000 participants from all over the world.

Mr MARQUES DE LIMA (Sao Tome and Principe) said that *The world health report 1996* presented a number of causes for concern, yet the means were available to solve some of the problems. For example, there were effective vaccines for a number of communicable diseases, and malaria mortality could be reduced by earlier diagnosis and the use of impregnated mosquito nets. Furthermore, efforts should be made to deal with the threatened increase of emerging diseases by improving human resource training, improving working conditions, pursuing research at national, regional and interregional levels and applying the results of that research with determination. International solidarity should be ever present.

Dr DASHZEVEG (Mongolia) said that in recent years his country had conducted large-scale campaigns to combat communicable diseases which had long been the main cause of morbidity and mortality. The Expanded Programme of Immunization including immunization against hepatitis B was being organized with the support and assistance of WHO and UNICEF and with the active participation of a number of donor countries, including Japan and France. Since 1993 Mongolia had been organizing twice-yearly national vaccination campaigns as a result of which there had been no cases of poliomyelitis or neonatal tetanus for the past three years and no deaths from measles in children; the number of hepatitis B cases had fallen by one-third from 1991 to 1995. Widespread vaccination and treatment had put a halt to outbreaks of meningococcal infection and diphtheria in 1993 and 1994. However, communicable diseases, including plague and tuberculosis, were on the increase. The International Health Regulations should be reviewed as part of the fight against communicable diseases; they should take account of global changes in disease patterns and the current demands of the world community. A technical working group should be set up for that purpose. It was essential to provide the world medical community with full information about new diseases and about the emergence of atypical pathogens. It was also very important to establish bilateral and multilateral cooperation within regions. Mongolia was currently undergoing a severe economic crisis and, at the beginning of 1996, had suffered from more than 270 separate forest and steppe fires - 25 of which were still ablaze - which had affected seven provinces and 73 districts causing much material damage, and even

loss of life. He thanked all the countries and international organizations, including WHO and especially the Western Pacific Regional Office, which had given the Mongolian people material and moral assistance in overcoming their difficulties.

Mr FEKADU (Eritrea) said his was the newest nation in Africa, and was on the eve of celebrating its fifth year of liberation. Eritrea was rapidly emerging from the crises caused by 30 years of war through rapid relief and rehabilitation measures; the country was now fully engaged in the development process, and cooperating with its neighbours in the Horn of Africa. It was implementing several nationwide health programmes in spite of financial and human resource constraints, and, through a national health policy based on primary health care, was seeking to make basic health services available to the majority of its population. Considerable progress had been made in a short space of time in the rehabilitation and construction of health facilities. Eritrea had developed a primary health care policy and guidelines, a national AIDS control programme, a strengthened national malaria control programme, an Expanded Programme of Immunization at national and regional levels, iodization of all salt supplies with the aim of eliminating iodine deficiency disorders by the year 2000, a national drug policy and drug quality control laboratory, a pharmaceutical production plant, a health financing scheme and the introduction of private practice, a restructured and streamlined Ministry of Health, and decentralization of health services to the regional level.

Eritrea believed that WHO should continue to play the leading role in all health matters, but for it to be able to discharge its obligations it should improve its managerial performance with the assistance of all Member States. Eritrea regretted the steps being taken to reduce WHO's budget in certain priority areas, but at the same time believed that developing countries should try to make their programmes sustainable from their own resources. Regional or subregional cooperation played a significant role in the development of health services, and the countries of the Horn of Africa had already begun to promote the coordination of health intervention in border areas, especially with the aim of combating communicable diseases.

Dr SOLARI (Uruguay) said that the demographic and epidemiological situation and increasing social exclusion in Uruguay compounded the problems arising from new, emerging and re-emerging communicable diseases. In addition, the prevalence of cardiovascular diseases, malignant tumours, various kinds of rheumatism and other chronic illnesses associated with an aging population placed a heavy burden on the health care services. Uruguay had responded to the challenge by focusing on high-technology therapeutic services. To date, however, it lacked properly planned and funded preventive projects aimed at such risk factors as tobacco, excess weight and lack of exercise that were conducive to chronic illness. The lack of an explicit medical training policy was another major shortcoming. Keen competition among a very large number of doctors made for over-specialization, so that only 10% of doctors were general practitioners.

As a result, although Uruguay devoted 9.5% of its gross domestic product to health services, its performance in terms of health indicators was relatively poor. It would need WHO's support to change its approach in the interests of efficiency, equity and quality and to counteract the forces originating in developed countries (medical specialization, pressure from the pharmaceutical industry and the spread of advanced technology) which made it difficult for moderately developed countries such as Uruguay to strike a proper balance between, on the one hand, the adoption of costly technologies and, on the other, the promotion of health and the prevention of disease.

Mr ESKOLA (Finland) said that while the strong emphasis on communicable diseases in *The world health report 1996* was justifiable on the grounds that the least developed countries were most severely affected, it might also be viewed as a narrowing of scope and a move towards vertical methods of work. The emphasis in the 1995 report on improving equity as a crucial means of achieving better health should remain a key principle of WHO policy in the years ahead. Population development, urbanization and changing lifestyles had led to an increase in noncommunicable diseases in the developing countries. The increase in maternal mortality figures was an example of their "double burden" in terms of lack of equity. Improved and widely accessible primary health care held the key to a reversal of recent trends. More information was needed concerning social and cultural aspects of the spread of communicable diseases and their impact on the community. It was essential that WHO should be actively involved in existing regional and global plans

for intensifying the surveillance and control of such diseases. While renewing strategies and improving management, the Organization should continue to promote the values of equity, solidarity and health as basic human rights, adopting a horizontal and integrated approach.

Mr AL MIDFAA (United Arab Emirates) said that efforts to prevent the spread of new infectious diseases were impeded by such modern phenomena as a highly mobile international labour force and mass tourism and also by the failure of some countries to report recent outbreaks.

Basic health indicators in the United Arab Emirates had in some cases exceeded the targets set in 1981. The country's performance in terms of life expectancy, low infant and child mortality rates, high vaccination rates and the proportion of the budget devoted to health services was comparable to that of developed countries. Technical guidance had been sought for the implementation of WHO health strategies such as the global malaria strategy and programmes such as the Expanded Programme on Immunization.

The Ministry of Health viewed primary health care, based on the principles of participation and accessibility, as the key to the entire health system. Existing services incorporated a referral system for specialist treatment.

In 1993, the Government had donated US$ 1 million to WHO to institute an annual award for outstanding achievements in the field of health by individuals or organizations. The Executive Board had subsequently approved the establishment of the United Arab Emirates Health Foundation Prize.

The DIRECTOR-GENERAL, responding to the debate on *The world health report 1996*, commended the representatives of Member States on the discipline they had displayed under the restrictive conditions imposed and on the quality of their comments and recommendations, which would be extremely useful not only for future planning and priority-setting but, more importantly, for underlining the importance of health for socioeconomic development and peace. He had been particularly gratified by the reaffirmation of WHO's key role in world development. To fulfil that role, the Organization must combine increased cost-effectiveness with unremitting hard work.

The report had been issued on the recommendation of the Executive Board Working Group on the WHO Response to Global Change. Reform was a continuous process. The different issues dealt with from year to year in the report formed part of the continuous process of implementing WHO's vision and basic goal. The issue of bridging the health gap between rich and poor dealt with in the 1995 report was related to the priority-setting exercise undertaken in the current report.

The Secretariat greatly appreciated the active participation of Member States and pledged to continue its work to enhance the status of health worldwide, bearing in mind the principles of solidarity, equity and full participation by all.

The CHAIRMAN took it that the Committee wished to commend the Director-General on *The world health report 1996* and express its satisfaction with the manner in which the programme of the Organization was being implemented.

It was so agreed.

2. IMPLEMENTATION OF RESOLUTIONS (PROGRESS REPORTS BY THE DIRECTOR-GENERAL): Item 17 of the Agenda (Document A49/4)

Improving technical cooperation among developing countries (Resolution WHA43.9)

Dr ANTELO PÉREZ (representative of the Executive Board) said that a lively exchange of views had taken place in the Executive Board on the document containing the Director-General's report on the implementation of resolution WHA43.9. In the context of rapid globalization, increasing poverty and criticism of international organizations for failing to tackle development issues, technical cooperation among

developing countries (TCDC) promoted solidarity for sustainable development through individual and collective self-reliance. WHO had supported many innovative TCDC initiatives, especially at the subregional and regional levels and on behalf of the neediest countries. The Non-Aligned Movement had called for an international network of solidarity against poverty. Such an initiative would provide a unique opportunity to include TCDC in the human development framework, stressing the relevance of the primary health care strategy for poverty alleviation. The Executive Board had called for a critical analysis of the role of WHO and its regional offices in improving the effectiveness of TCDC, which would identify the major obstacles impeding such cooperation in the field of health.

Professor BERTAN (Turkey) noted that, where health was poor and there were social problems, TCDC was one of the most promising and perhaps most cost-effective tools for coping with specific needs. Each region could develop documents describing the areas in which technical cooperation might be useful (such as disease prevention and control, research, management, human development and resource generation) and on how such cooperation could be brought about, including successful case studies. WHO should catalyse and disseminate the TCDC concept and monitor and report on how it was practised. Strengthened WHO collaborating centres could provide guidance on the identification of specific needs and the implementation of technical cooperation. Successful cooperation would encourage both provider and recipient countries to collaborate further.

Dr MOREL (Brazil) suggested that WHO collaborating centres could play a much more active role in TCDC.

Dr KHOJA (Saudi Arabia) endorsed the views of the Executive Board. An information system was needed to ensure cooperation among the countries of all regions, and not only among developing countries. WHO should undertake joint regional studies to reinforce cooperation for health development and should set up a committee in each region that would serve as a catalyst. Exchanges of experience should be encouraged by cooperation among experts throughout the regions. WHO should also encourage joint activities in developing countries in order to reinforce programmes that were experiencing difficulties, such as those for health for all and for combating chronic, endemic, and infectious diseases.

Dr DAULAIRE (United States of America) stressed the importance of technical relationships among equal partners. However, the report had not clearly addressed the issue of improving TCDC. Electronic communication and conferencing could make such cooperation more feasible, less expensive and more regular. PAHO had held a useful seminar in November 1995 on the subject "Rethinking technical cooperation in health", the results of which might be useful to the WHO Secretariat and to the regional offices.

Dr BIHARI (India) noted that the recent realignment of global political and economic relationships laid greater emphasis on market-based economies and democratic reforms, stressing individual rights and responsibilities for basic needs such as health, food, housing and education. Those changes had, however, been accompanied by others, including environmental degradation and pollution, rapid population growth, unplanned urbanization and mass migration, which had significantly affected health status and disease patterns, such as the spread of the AIDS pandemic and the re-emergence of diseases like tuberculosis and malaria. Furthermore, the rate of economic growth had not kept pace with the rising cost of health care, especially as technical advances in medicine and expanding awareness of health had created higher expectations with regard to the level and quality of health care; at the same time, there was no substantial increase in national funding for the health sector in developing countries. As those issues transcended national boundaries, well-coordinated inter-country intervention was required, in the form of technical cooperation among developing countries. It would ensure not only the pooling of resources for health but also the sustainability of health programmes and would contribute to social and economic development.

The fact that India had the second largest population in the world meant that it had the largest reservoir of trained health manpower; it also had developmental capacity and expertise. A number of joint ventures had been started to share those resources with neighbouring countries. For instance, India had evolved a joint

strategy for controlling malaria and other vector-borne diseases along its borders with Myanmar, Bangladesh and Nepal; the members of the technical committee of the South Asian Association for Regional Cooperation (SAARC) had decided to conduct a common "pulse polio immunization" day; and the ministers of health of the countries of the South-East Asia Region had identified eight areas for technical cooperation: control of diarrhoeal diseases, immunization, family planning, maternal and child health, nutrition, control of epidemics, essential drugs and training of human resources in health.

Dr MILEN (Finland) commented that few of the examples of TCDC given in the report appeared to be supported by WHO. The usefulness of north-south cooperation for human development tended to be overestimated, often at the expense of south-south cooperation. The experience of countries with similar characteristics in analysing, solving and modelling problems should be shared more effectively. WHO should actively support such cooperation and ensure exchange among experts in developing countries; it should also provide more support to regional collaborating centres. She concurred with the delegate of the United States that new approaches were needed to use experience gained in developing countries, as stated in resolution WHA43.9 adopted some six years previously.

Professor PICO (Argentina) said that WHO and the regions should promote horizontal cooperation among countries with similar histories, cultures and problems. Subregional initiatives were also important, such as Mercosur, the trade group of four South American countries which had adopted WHO's requirements for good manufacturing practices for pharmaceutical products. TCDC should be coordinated by ministries of health in order to avoid duplication of efforts. Limited resources should be used as efficiently as possible so as to provide more and better treatment, and new strategies were needed to avoid the types of errors that had been committed previously.

Mr CHAUDRY (Pakistan) recognized the efforts of WHO in fostering TCDC. Pakistan had taken several steps to improve such cooperation in the South-East Asia Region in forums such as SAARC; it had also advocated more collaboration during the conference on Population and Development held in Cairo in 1994 and the conference on Women and Development held in Beijing in 1995.

Dr DOTRES MARTÍNEZ (Cuba) said that technical cooperation was important not only for countries facing difficulties in developing health programmes but also for the spirit of the Organization and for the achievement of health goals. Health problems were not distributed equally throughout the world or within countries but had to be resolved by the international community. Country- and region-specific strategies should be supported at the country level, which should ensure optimum use of resources, and should make use of the experiences and complement those of other countries and regions. A number of agreements that Cuba had with other countries in the Region, including exchanges of medical personnel and technical information, had allowed Cuba to optimize its health resources and to increase its experience and efficiency, by focusing on problems of common interest.

Mr YANG (Republic of Korea) noted that the alleviation of poverty was a vital factor in controlling communicable diseases in developing countries. The experience of developed countries in incorporating health policies and programmes into social and economic systems could be used by developing countries. Mechanisms were needed for the exchange of such information once bilateral and multilateral cooperation practices had been monitored and compared by international organizations such as UNDP. WHO should expand TCDC in collaboration with other international and nongovernmental organizations. The Republic of Korea wished to strengthen technical cooperation in the field of health with the less developed countries of the Western Pacific Region.

Dr ANTELO PÉREZ (representative of the Executive Board) noted that delegates' comments had been consistent with the discussions of the Executive Board, especially with regard to the need for new methods and new regional strategies. The comments had been most useful and would be taken into consideration in the report by the representatives of the Executive Board at the Forty-ninth World Health Assembly.

Dr KONE-DIABI (Assistant Director-General) noted further that the comments had been in keeping with the spirit of the recommendations of the PAHO seminar in November 1995 on the subject "Rethinking technical cooperation in health".

The DIRECTOR-GENERAL commented that the ministers of health of the Non-Aligned Movement would meet during the Health Assembly, as they had in 1995. WHO regulations existed for study and scientific groups, collaborating institutions and other mechanisms of collaboration (*Basic documents*, 40th ed., pp. 107-114). In view of the useful comments that had been made, he could review those regulations in order to ensure that they reflected global change and would report to the Executive Board and the World Health Assembly, if the delegates so wished.

The CHAIRMAN asked whether he might take it that the Committee wished to note the report of the Director-General and the progress made.

It was so decided.

The meeting rose at 12:30.

= = =