A38/VR/7

THIRTY-EIGHTH WORLD HEALTH ASSEMBLY — 9 May 1985

TRENTE-HUITIEME ASSEMBLEE MONDIALE DE LA SANTE — 9 mai 1985

ТРИДЦАТЬ ВОСЬМАЯ СЕССИЯ ВСЕМИРНОЙ АССАМБЛЕИ ЗДРАВООХРАНЕНИЯ — 9 мая 1985 г.

38[a] ASAMBLEA MUNDIAL DE LA SALUD — 9 mayo de 1985

جمعية الصحة العالمية الثامنة والثلاثون — ٩ مايو/أيار ١٩٨٥

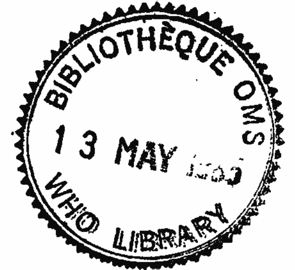
第三十八届世界卫生大会 — 1985年5月9日

PROVISIONAL VERBATIM RECORD OF THE SEVENTH PLENARY MEETING

9 May 1985, at 9h10

Palais des Nations, Geneva

President: Dr S. SURJANINGRAT (Indonesia)



BIBLIOTHÈQUE OMS
13 MAY
WHO LIBRARY

COMPTE RENDU IN EXTENSO PROVISOIRE DE LA SEPTIEME SEANCE PLENIERE

9 mai 1985, 9h10

Palais des Nations, Genève

Président: Dr S. SURJANINGRAT (Indonésie)

ПРЕДВАРИТЕЛЬНАЯ СТЕНОГРАММА СЕДЬМОГО ПЛЕНАРНОГО ЗАСЕДАНИЯ

9 мая 1985 г., 9 ч.10 ч.

Дворец Наций, Женева

Председатель: д-р S. SURJANINGRAT (Индонезия)

ACTA TAQUIGRAFICA PROVISIONAL DE LA SEPTIMA SESION PLENARIA

9 de mayo de 1985, a las 9.10 horas

Palais des Nations, Ginebra

Presidente: Dr. S. SURJANINGRAT (Indonesia)

محضر حرفي مؤقت للجلسة العامة السابعة

٩ مايو/أيار ١٩٨٥ ، الساعة ١٠ر٩ صباحا

قصر الأمم ، جنيف

الرئيس : الدكتور س. سوريانانجرات (اندونيسيا)

第七次全体会议发言临时逐字记录

1985年5月9日上午9时10分

日内瓦万国宫

主席：S·苏雅宁格拉特博士（印度尼西亚）

<u>Note</u>: In this provisional verbatim record speeches delivered in Arabic, Chinese, English, French, Russian or Spanish are reproduced in the language used by the speaker; speeches delivered in other languages are given in the English or French interpretation. The final verbatim records will subsequently be issued in separate English, French, Russian and Spanish versions.

This record is regarded as <u>provisional</u> because the texts of speeches have not yet been approved by the speakers. Corrections for inclusion in the <u>final</u> version should be handed in to the Conference Officer or sent to the Records Service (Room 4013, WHO headquarters), in writing, before the end of the session. Alternatively, they may be forwarded to Chief, Office of Publications, World Health Organization, 1211 Geneva 27, Switzerland before 1 July 1985.

<u>Note</u> : Le présent compte rendu in extenso provisoire reproduit dans la langue utilisée par l'orateur les discours prononcés en anglais, arabe, chinois, espagnol, français ou russe, et dans leur interprétation anglaise ou française les discours prononcés dans d'autres langues. Les comptes rendus définitifs paraîtront ultérieurement dans des documents distincts en anglais, espagnol, français et russe.

Ce compte rendu est considéré comme un document <u>provisoire</u>, le texte des interventions n'ayant pas encore été approuvé par les auteurs de celles-ci. Les rectifications à inclure dans la version <u>définitive</u> doivent, jusqu'à la fin de la session, soit être remises par écrit à l'Administrateur du service des Conférences, soit être envoyées au service des Comptes rendus (bureau 4013, Siège de l'OMS). Elles peuvent aussi être adressées au Chef du Bureau des Publications, Organisation mondiale de la Santé, 1211 Genève 27, cela avant le 1er juillet 1985.

<u>Примечание</u>: В настоящем предварительном стенографическом отчете о заседании выступления на английском, арабском, испанском, китайском, русском или французском языках воспроизводятся на языке оратора; выступления на других языках воспроизводятся в переводе на английский или французский язык. Впоследствии стенограммы заседания будут изданы отдельно на английском, испанском, русском и французском языках.

Настоящий протокол является <u>предварительным</u>, так как тексты выступлений еще не были одобрены докладчиками. Поправки для включения в <u>окончательный</u> вариант протокола должны быть представлены в письменном виде сотруднику по обслуживанию конференций или направлены в Отдел документации (комната 4013, штаб-квартира ВОЗ) до окончания сессии. Они могут быть также вручены до 1 июля 1985 г. заведующему редакционно-издательскими службами, Всемирная организация здравоохранения, 1211 Женева 27, Швейцария.

<u>Nota</u>: En la presente acta taquigráfica provisional, los discursos pronunciados en árabe, chino, español, francés, inglés o ruso se reproducen en el idioma utilizado por el orador. De los pronunciados en otros idiomas se reproduce la interpretación al francés o al inglés. Las actas taquigráficas definitivas aparecerán posteriormente en versiones separadas en español, francés, inglés y ruso.

La presente acta tiene un carácter <u>provisional</u> porque los textos de los discursos no han sido aún aprobados por los oradores. Las correcciones que hayan de incluirse en la versión <u>definitiva</u> deberán entregarse, por escrito, al Oficial de Conferencias o enviarse al Servicio de Actas (despacho 4013, sede de la OMS) antes de que termine la reunión. A partir de ese momento, pueden enviarse al Jefe de la Oficina de Publicaciones, Organización Mundial de la Salud, 1211 Ginebra 27, Suiza, antes del 1 de julio de 1985.

<u>ملاحظة</u> : فى هذا المحضر الحرفى الموًقت تسجل الكلمات التى تلقى بالأسبانية أو الانجليزية أو الروسية أو الصينية أو العربية أو الفرنسية بنفس اللغة التى يستخدمها المتحدث • أما الكلمات التى تلقى بلغات أخرى فان هذا المحضر يورد ترجمتها الانجليزية أو الفرنسية • وسوف تصدر المحاضر الحرفية النهائية فيما بعد باللغات الأسبانية والانجليزية والروسية والفرنسية كل على حدة •

ويعتبر هذا المحضر <u>موًقتا</u> نظرا لأن نصوص الكلمات لم تعتمد بعد من السادة المتحدثين • وتسلّم التصويبات المراد ادخالها فى النص <u>النهائى</u> الى المسوًول عن خدمة الموًتمر أو ترسل كتابة الى دائرة المحاضر (الغرفة ٤٠١٣ بالمقر الرئيسى للمنظمة) قبل نهاية الدورة • وفى الامكان أيضا أن ترسل الى رئيس قسم المنشورات ، بمنظمة الصحة العالمية ، ١٢١١ جنيف ٢٧ ، سويسرا ، وذلك قبل ١ يوليو/تموز ١٩٨٥ •

说明：

凡是阿拉伯文、中文、英文、法文、俄文或西班牙文的发言，将以发言人所用的语种在本临时逐字记录中刊印；其他语种的发言，将以其英文或法文的译文刊印。最后的逐字记录将随后分别用英文、法文、俄文和西班牙文出版。

本记录属临时性质，因为发言稿的文本未经发言人审阅。需要列入最后文本的修改，应在本届会议结束以前书面提交会务官员或送记录办公室（世界卫生组织总部４０１３室），或者在一九八五年七月一日以前寄给瑞士1211日内瓦２７，世界卫生组织出版办公室负责人。

CONTENTS

Page

1. Announcement.. 5
2. Debate on the reports of the Executive Board on its seventy-fourth and seventy-fifth sessions and on the report of the Director-General on the work of WHO in 1984 (continued).. 5
3. Presentation of the Sasakawa Health Prize.. 28

SOMMAIRE

Page

1. Communication.. 5
2. Débat sur les rapports du Conseil exécutif sur ses soixante-quatorzième et soixante-quinzième sessions et sur le rapport du Directeur général sur l'activité de l'OMS en 1984 (suite).. 5
3. Remise du Prix Sasakawa pour la santé.. 28

СОДЕРЖАНИЕ

Стр.

1. Объявление 5
2. Рассмотрение докладов Исполнительного комитета о работе его Семьдесят четвертой и Семьдесят пятой сессий и отчета Генерального директора о работе ВОЗ в 1984 г. (продолжение) 5
3. Вручение премии Фонда здравоохранения Сасакавы 28

INDICE

Página

1. Communicación.. 5
2. Debate acerca de los informes del Consejo Ejecutivo sobre sus 74ª y 75ª reuniones y del informe del Director General sobre las actividades de la OMS en 1984 (continuación).. 5
3. Entrega del Premio Sasakawa para la Salud.. 28

المحتويات

الصفحة

١ـ تبليغ ٥
٢ـ مناقشة تقريرى المجلس التنفيذى عن دورتيه الرابعة والسبعين والخامسة والسبعين وتقرير المدير العام عن أعمال المنظمة فى عام ١٩٨٤ .... ٥
٣ـ تقديم جائزة ساساكاوا للصحة ٢٨

目　　录

页数

1. 通知 5
2. 就执行委员会第七十四届及第七十五届会议报告和总干事所作世界卫生组织一九八四年工作报告的辩论（续） 5
3. 颁发 Sasakawa 奖 28

1. ANNOUNCEMENT
COMMUNICATION
ОБЪЯВЛЕНИЕ
COMUNICACION
تبليغ
通知

The PRESIDENT:

The meeting is called to order.

I wish first to make an important announcement concerning the annual election of Members entitled to designate a person to serve on the Executive Board.

Rule 101 of the Rules of Procedure reads:

At the commencement of each regular session of the Health Assembly the President shall request Members desirous of putting forward suggestions regarding the annual election of those Members to be entitled to designate a person to serve on the Board to place their suggestions before the General Committee. Such suggestions shall reach the Chairman of the General Committee not later than forty-eight hours after the President has made the announcement in accordance with this Rule.

I therefore invite delegates wishing to put forward suggestions concerning these elections to do so not later than Monday morning, 13 May, at 10h00, in order to enable the General Committee to meet the same day, at noon, to draw up its recommendations to the Assembly regarding these elections.

Suggestions should be handed to the Assistant to the Secretary of the Assembly.

2. DEBATE ON THE REPORTS OF THE EXECUTIVE BOARD ON ITS SEVENTY-FOURTH AND SEVENTY-FIFTH SESSIONS AND ON THE REPORT OF THE DIRECTOR-GENERAL ON THE WORK OF WHO IN 1984 (continued)
DEBAT SUR LES RAPPORTS DU CONSEIL EXECUTIF SUR SES SOIXANTE-QUATORZIEME ET SOIXANTE-QUINZIEME SESSIONS ET SUR LE RAPPORT DU DIRECTEUR GENERAL SUR L'ACTIVITE DE L'OMS EN 1984 (suite)
РАССМОТРЕНИЕ ДОКЛАДОВ ИСПОЛНИТЕЛЬНОГО КОМИТЕТА О РАБОТЕ ЕГО СЕМЬДЕСЯТ ЧЕТВЕРТОЙ И СЕМЬДЕСЯТ ПЯТОЙ СЕССИЙ И ОТЧЕТА ГЕНЕРАЛЬНОГО ДИРЕКТОРА О РАБОТЕ ВОЗ В 1984 г. (продолжение)
DEBATE ACERCA DE LOS INFORMES DEL CONSEJO EJECUTIVO SOBRE SUS 74[a] Y 75[a] REUNIONES Y DEL INFORME DEL DIRECTOR GENERAL SOBRE LAS ACTIVIDADES DE LA OMS EN 1984 (continuación)
مناقشة تقريرى المجلس التنفيذى عن دورتيه الرابعة والسبعين والخامسة والسبعين وتقرير المدير العام عن أعمال المنظمة فى عام ١٩٨٤ (تابع)
就执行委员会第七十四届及第七十五届会议报告和总干事所作世界卫生组织一九八四年工作报告的辩论（续）

The PRESIDENT:

We shall now continue the debate on items 10 and 11, and I call to the rostrum the first two speakers on my list, the delegates of Bulgaria and of Norway and I give the floor to the delegate of Bulgaria.

Проф. ПОПИВАНОВ (Болгария)
Professor POPIVANOV (Bulgaria)

Уважаемый г-н Председатель, уважаемый заместитель Генерального директора, г-н профессор Ламбо, дамы и господа, для меня большое удовольствие от имени болгарской делегации поздравить Вас, г-н Председатель, и вас, господа заместители Председателя, с единодушным избранием на эти ответственные посты и одновременно с тем выразить нашу уверенность, что под вашим умелым руководством Ассамблея успешно выполнит стоящие перед ней задачи.

Позвольте мне также выразить нашу благодарность д-ру Малеру и сотрудникам Секретариата и региональных бюро за многостороннюю деятельность, проделанную за истекший год в соответствии с программами Организации, а также по реализации национальных стратегий достижения общей цели. Мы высоко оцениваем эту деятельность не только по причине возрастающих результатов, но и в связи с тем, что Организация является двигателем сотрудничества в области здравоохранения между странами с различными социально-экономическими системами, что активно содействует возрастанию доверия и дружбы между народами, разрядке во всем мире.

Еще в самом начале я хочу отметить, что делегация НРБ поддерживает усилия ВОЗ, направленные на предотвращение ядерной катастрофы. В этой связи мне бы хотелось высказать наше удовлетворение установившимися официальными отношениями между ВОЗ и движением "Врачи мира за предотвращение ядерной войны".

В апреле месяце в НРБ сделан углубленный анализ-оценка выполнения национальной стратегии достижения здоровья для всех на основе отчетов органов здравоохранения страны перед населением. Эти отчеты были откровенным диалогом с людьми не только об успехах, но и о проблемах и путях их решения. Результаты выполнения комплекса мероприятий национальной стратегии в области здравоохранения, осуществленных на базе динамичного социально-экономического развития страны при активном участии населения, показали возрастающую тенденцию к улучшению уровня здоровья населения. Они свидетельствуют об эффективности проводимой правительством политики в области здравоохранения, направленной на обеспечение более высокой степени здоровья, трудоспособности и творческого долголетия каждого члена нашего общества.

Сейчас в нашей стране идет подготовка пятилетнего плана развития страны на период 1986-1990 гг. Он предусматривает дальнейшее развитие и усовершенствование здравоохранения на основе национальной стратегии достижения здоровья для всех.

Мы приветствуем предложение Исполнительного комитета об "Оптимальном использовании ресурсов Организации в поддержку стратегии". Так как документ ВОЗ по этому вопросу будет обсуждаться отдельно, мне бы хотелось сейчас высказать лишь только принципиальные соображения. Мы согласны с необходимостью внести ясность в использование ресурсов Организации на национальном уровне, но для этого следовало бы искать наиболее подходящую форму, которая бы учитывала право на суверенитет и невмешательство во внутренние дела стран-членов.

К использованию ресурсов Организации наша страна всегда относилась ответственно. Вопрос о кадровых ресурсах рассматривался в двух аспектах: использование экспертов для потребностей нашего здравоохранения по предварительно подготовленным программам их работы и для обучения кадров, преимущественно из развивающихся стран, на курсах, организованных у нас совместно с ВОЗ в рамках Генерального меморандума о сотрудничестве.

Что касается весьма скромных финансовых ресурсов, предоставляемых из регулярного бюджета Европейского регионального бюро, то они используются преимущественно для повышения квалификации кадров в других странах по приоритетным для здравоохранения и медицинской науки проблемам. Эти проблемы определяются высококомпетентным органом. Кандидатам предъявляется требование иметь возможно максимальные знания о достижениях в соответствующей области с тем, чтобы наиболее рационально использовать время, предоставленное им для специализации. Небольшая доля средств используется для развития экспериментальной модели медицинского обслуживания населения.

Мне бы хотелось отметить, что существуют резервы улучшения использования ресурсов Организации. Считаем, что одной из таких возможностей является более справедливое распределение представительства стран-членов в различных научных встречах ВОЗ, являющихся прямым каналом, по которому знания достигают своих потребителей. С другой стороны, наверно, та экономия, которая достигается путем ограничения рабочих языков на некоторых форумах, ведет к снижению возможностей стран участвовать в них, а это, со своей стороны, ограничивает возможности широкого использования накопленных знаний и опыта. Опоздание с некоторыми публикациями - техническими докладами, монографиями, результатами научных исследований также имеет отрицательное значение.

Сегодня человечество отмечает 40-летие Победы антигитлеровской коалиции над нацизмом и фашизмом, 40 лет со дня окончания самой жестокой и кровопролитной войны и 40-летие создания ООН. Искренние чувства благодарности и уважения мы испытываем к народам Советского Союза, которые вынесли на своих плечах основную тяжесть войны и потеряли в ней свыше 20 млн. человек. Антифашистское боевое единство стран позволило заложить основы послевоенного мира. А мир - это труд и здоровье, созидательная деятельность во имя жизни и прогресса, во имя будущего человечества. Благодаря ей зажило много тяжелых ран войны.

В области здравоохранения и медицинской науки достигнуты большие успехи. Существуют, конечно, и проблемы, но возможности сегодняшней медицины обнадеживающие. Коллективными уси-

лиями мы создали стратегию - стратегию здоровья и жизни. Однако без мира она не может быть реальной. Мир после войны выдержал много испытаний, сейчас он вновь в опасности. Решение ООН объявить 1986 год - Годом мира встречается с надеждой и одобрением. В это решающее время Всемирная организация здравоохранения может сделать еще многое, чтобы не допустить превращения нашей прекрасной планеты в пустыню. 1985 год - год молодежи. Этот год должен стать годом надежды, ведь молодежь - это наше завтрашнее утро.

Победа, которую мы сегодня празднуем, это выстраданный урок, который будет источником сил для еще более энергичной совместной борьбы за сохранение мира на планете, потому что мир - это жизнь, социальный прогресс и здоровье для всех.

Dr MORK (Norway):

Mr President, Mr Director-General, may I first congratulate you, Mr President, and the Vice-Presidents, on your election. I would also like to congratulate and thank the Chairman of the Executive Board and the Director-General for their excellent reports.

This World Health Assembly will address a number of important issues, including the programme budget for the next biennium. We are meeting at a point in history when great problems and challenges are facing humanity. Drought, starvation, economic exploitation, political repression and armed conflicts are afflicting large numbers of people. Unemployment and economic recession hamper further improvements in living conditions and quality of life both in developing and developed countries. Thanks to scientific progress and technological development and to international cooperation, it is also a period of unequalled opportunity. Against this background it is of the utmost importance that our Organization - as stressed by the Director-General in his address to this Assembly - should not lose sight of the need for fundamental long-term solutions to basic problems facing particularily developing countries. We appreciate the Director-General's efforts to raise by not more than 4% in real terms the allocations to countries despite a budgetary standstill for the next few years. Increased WHO allocations in real terms at country level should spur governments to develop a dynamic health policy, strengthen their health management and improve cost-efficiency of national health programmes. These are necessary conditions for sustaining the momentum towards health for all. My Government appreciates the Director-General's will to make optimal use of available resources and supports his proposals to this effect. We are all in need of innovative solutions to pressing health problems. Health is an integral part of the welfare society which has been developed in Norway for the last thirty years. This social policy is being supported by an overwhelming majority of the people.

However, to ensure continuous support, health and social policy must be adapted to the new challenges facing modern society. These challenges include in particular: changes in environment and life-style, increased expectations as to health services, the need for redistribution on the basis of social equity, and optimal use of available resources. Despite the fact that about 45% of all public expenditures in Norway are devoted to health and social services, it is still easy to identify inadeqaute delivery of health services and unmet health needs. Some of the reasons for this situation are to be found in demographic changes. There will in my country over the next 15 years be a substantial increase in the number of elderly aged 80 years or more. The number of single and childless persons will increase. Both trends will lead to increased need for care. At the same time the tendency among women to seek education, training and employment on equal terms with men will reduce the traditional care load hitherto carried by women in the family. These facts will not fail to affect health services.

A Government commission concluded last year a report on the long-term demographic trends and its consequences. There is no doubt that changing age structure and family patterns in the population are great challenges for health policy in Norway and many other countries.

Another challenge is to master the cost and consequences of new health technology. In this field there is an increasing conflict between what is feasible in technical terms, what is appropriate to meet real health needs, what is ethically acceptable, and the economic resources available for the health sector. In Norway steps have been recently taken to assess and monitor medical technology. A comprehensive study of the consequences that recent and foreseeable future development in health technology will have for health services has been initiated. This study is carried out in collaboration with the Norwegian Research Council on Science and Humanities. We are ready to share our experiences in this field with WHO. My Government is also giving active support to WHO and other international research programmes to develop appropriate health technology. In this context I would also mention an emerging problem in some highly developed countries like my own - the surplus of

physicians, dentists and some other categories of health workers. Unemployed or underemployed qualified health personnel create special problems in health planning, service organization and management. Their presence may also lead to an unwanted and potentially harmful medicalization of minor complaints.

Before concluding I would briefly comment on two programmes of particular interest to my Government. My Government is very much concerned with problems related to alcohol and drug abuse. Earlier this year a WHO workshop on assessment of alcohol problem prevention, held with the participation of a number of countries, also from outside the European Region, took place in Oslo. Based on recommendations from this and other meetings, WHO should expand its capacity to meet increasing problems, in developing as well as developed countries, related to alcohol consumption and abuse of traditional narcotic substances and dependence-producing psychotropic pharmaceutical preparations.

I would also like to state my Government's support to the Action Programme on Essential Drugs and to international efforts to promote rational use of drugs. My delegation has with great satisfaction, noted the progress achieved and the momentum with which the Action Programme is now developing. It is also very encouraging that the preparations of the forthcoming conference to take place in Nairobi later this year are in good progress. We are looking forward to the results of this conference, which we hope will provide a basis for further action from future World Health Assemblies.

Finally, I pledge before this Assembly that the Government of Norway will pursue and even increase its contribution to international health development through bilateral collaboration with developing countries and through international health programmes, including the Special Programme for Research and Training in Tropical Diseases, the Human Reproduction Programme as well as other WHO special programmes.

Mr. AL-HEGELAN (Saudi Arabia):

السيد فيصل الحجيلان (المملكة العربية السعودية) :

بسم الله الرحمن الرحيم ، سيدى الرئيس ، السيد المدير العام ، السادة نواب الرئيس ، أصحاب المعالى والسعادة رؤساء وأعضاء الوفود ، أنتهز فرصة حضورى اجتماعات الجمعية العامة ومخاطبتكم لأول مرة فأقدم لكم السيد الرئيس وللسادة نوابكم باسم وفد المملكة العربية السعودية واسمى أخلص التهانى بالثقة التى أوليتموها لرئاسة الجمعية العامة الثامنة والثلاثين للصحة العالمية • وأرجو أن تكلل أعمال هذه الدورة ومداولاتها بالنجاح وتحقيق المزيد من الايجابيات نحو تثبيت الارادة الجماعية للمسؤولين عن الصحة فى العالم أجمع والتقدم نحو تحقيق ما تتطلع اليه كافة الشعوب من رقىّ صحى حده الأدنى توفير الصحة للجميع بحلول عام ٢٠٠٠ •

السيد الرئيس ، لقد أوجز المدير العام فى تقريره بالوثيقة رقم ج٣٨/٣ فأوضح ما قامت به منظمة الصحة العالمية ممثلة فى شخص الدكتور هافدان ماهلر من نشاطات وما بذلته من جهود موفقة وما نفذته من مهام توجيهية وتنسيقية وأخرى تنفيذية ، اقتضتها الضرورة ، خلال عام ١٩٨٤ ، وذلك عبر مكاتبها الاقليمية ومديريها ولجانها المتخصصة ، سواء كان ذلك بالاتصالات المباشرة والمكثفة بالدول الأعضاء أو بالمنظمات والهيئات الدولية والمنظمات الحكومية وغير الحكومية فى سبيل دعم وتعزيز الاستراتيجيات الصحية الوطنية التى اتخذت الرعاية الصحية الأولية مرتكزا أساسيا لها • كما تضمن تقرير المجلس التنفيذى بالوثيقة رقم ج٣٨/٢ نقاطا هامة ألقت الضوء على أهم الانجازات وأشارت بكل وضوح الى التطلعات وما يجب اتخاذه لتحقيق هدف توفير الصحة للجميع بحلول عام ٢٠٠٠ •

هذا ومن المفيد ، لا بل ومن قبيل العرفان بالجهد المثمر والايجابى أن أشير الى أن نشاطات المنظمة خلال العام المنصرم ، التى اتخذت أشكالا عدة وتناولت مجالات مختلفة ، استهدفت عناصر الرعاية الصحية الأولية المقررة فى اعلان ألما آتا والصادر بشأنها قرار الجمعية العامة رقم جصع٣٢/٣٠ ، وأن نتائج هذه الجهود كانت ايجابية وبناءة ، ويسرنى بهذه المناسبة أن أشيد بعلاقات التعاون القائمة بين المملكة العربية السعودية ومنظمة الصحة العالمية ممثلة بالمدير الاقليمى لمنطقة شرق البحر الأبيض المتوسط ، الدكتور حسين الجزائرى ومساعديه • كما يسعدنى التنويه هنا بأن وزارة الصحة السعودية تقوم بتنفيذ العديد من المشروعات بتعاون فنى من منظمة الصحة العالمية ومنظمة اليونيسيف والمركز الدولى لمكافحة وأبحاث أمراض الاسهال فى دكا ومركز مكافحة الأمراض المعدية فى أطلنطا وغيرها •

وأود أن أشيد بالتعاون الصحى القائم مع مجلس وزراء الصحة لدول الخليج العربية ومجلس وزراء صحة العرب اللذين أقاما بدورهما علاقات عمل وتعاون مع منظمة الصحة العالمية •

السيد الرئيس ، لقد استهدفت الخطط التنموية المختلفة فى المملكة العربية السعودية اتاحة الفرصة لكل مواطن للافادة من الرفاة الاقتصادى واعطاء الحق لكل أسرة فى الحصول على ضرورات الحياة الأساسية وتوفير الرعاية الاجتماعية

والخدمات الصحية التى ينعم بها سكان المدن لسكان الريف والبادية ، وتزويد السكان فى كل منطقة بنظام شامل ومتكامل لتقديم خدمات الرعاية الصحية المجانية ، مع اضفاء المزيد من الاهتمام بصحة البيئة والطب الوقائى والرعاية الأولية ، بما يتمشى والاحتياجات المتغيرة والأولويات الخاصة والخدمات الطبية والتى يتم تنفيذها عن طريق مراكز الرعاية الصحية الأولية ، الأمر الذى يتفق تماما ومبادىء الرعاية الصحية الأولية التى اعتمدتها المنظمة أساسا لتحقيق هدف توفير الصحة للجميع بحلول عام ٢٠٠٠ • أما عن أهمية اشراك المجتمع فى النشاطات الصحية عموما ، وتعزيز الرعاية الصحية الذاتية على وجه الخصوص ، فللمملكة العربية السعودية تجارب عديدة من أحدثها الاسهامات الطوعية الواسعة النطاق لمختلف فئات المجتمع فى نشاطات الأسبوع الصحى الذى أقيم هذا العام مع حلول ذكرى يوم الصحة العالمية فى السابع من أبريل الماضى • ونحن حريصون على تعزيز مثل هذه المشاركة واستمراريتها •

كما أنه لا يغرب عن البال الاشارة الى ما يقوم به المواطنون السعوديون ، أفرادا أو مؤسسات بالاشتراك مع حكومة جلالة الملك من مد يد العون الى ضحايا المجاعة بسبب الجفاف فى بعض الدول الأفريقية من خلال مراكز خاصة للاغاثة أقامتها فى المناطق المنكوبة ، بالاضافة الى تبنى البرامج الطويلة الأمد التى تتعامل مع أسباب الجفاف وجذوره مثل حفر الآبار وغيرها •

السيد الرئيس ، من الجميل حقا أن نرى ونلمس وجود مؤشرات كثيرة تعكس التقدم الذى تم احرازه فى مجال الرعاية الصحية الأولية حتى الآن • ومع ذلك ، فانه لا يسعنى الا أن أشير الى العوائق والعقبات التى أدت الى تباطؤ التنمية الاقتصادية والاجتماعية فى كثير من دول العالم ، وأدت بوجه أخص الى عرقلة عملية وضع الاستراتيجية الصحية فى أفريقيا وأخص بالذكر هنا ظروف القحط والمجاعة التى هددت ولاتزال تهدد الأمن الصحى لأعداد كبيرة من البشر •

وانني أناشد كل الدول المقتدرة والمنظمات الدولية والاقليمية ذات العلاقة ألا تتوانى عن تقديم يد العون ليس فقط للتخفيف من النتائج المأساوية لهذه الكارثة بل وفى التوجه الى المساعدة فى ايجاد الحلول الايجابية التى تحول دون استمرارها أو تكرارها •

السيد الرئيس ، أنه مما يدعو الى القلق ويلفت الانتباه ويشكل وضعا بالغ الخطورة على سلام العالم وأمنه استمرار الجو السياسى الذى يسود منطقة الشرق الأوسط حيث لايزال هناك شعب فلسطين الذى شرّد معظمه وبقى من بقى يتعرض لمختلف الممارسات اللاانسانية فى الأراضى العربية المحتلة من عمليات ارهاب وتعذيب وقتل وتدمير لمنازل السكان العزّل ، كما يتعرض أشقاؤه فى جنوب لبنان الى هجمات بربرية مستمرة وأعمال ابادة متصلة ، اضافة الى ما ترتكبه سلطات الاحتلال من مخالفات فى الأراضى العربية المحتلة فى فلسطين والجولان ، وهى مخالفات أقل ما توصف بأنها مخالفات فاضحة لاتفاقية جنيف الموقعة فى ١٢ أغسطس ١٩٤٩ لحماية ضحايا الحرب عموما ، وللمواد ٤٩ و ٧٦ و ١٤٣ المتعلقة بالأراضى المحتلة أرضا وسكانا على وجه الخصوص • فكيف سيكون الحال ازاء هذا الوضع يا سيادة الرئيس ، هل سيتم تحقيق توفير الصحة للجميع بحلول نهاية القرن ؟ انني أتساءل وأرجو أن تتمكن جمعية الصحة من ايجاد الاجابة العملية لدى دراسة البند ٣٢ والبنود الأخرى المشابهة المدرجة على جدول الأعمال ، راجيا للجميع التوفيق والسداد وشكرا سيادة الرئيس •

Dr TSEHAI (Ethiopia):

Mr President, on behalf of the Ethiopian delegation to the Thirty-eighth World Health Assembly and on my own behalf I sincerely congratulate you, the Vice-Presidents and other officers on your election to the high offices of the Assembly.

We also congratulate the Director-General on his most comprehensive and informative report on the work of WHO in 1984. Although the work accomplished during this period appears to be a positive sign of progress, on the other hand it very well indicates how much each country should increase its efforts in implementing its strategy for health for all in the years to come. The two important areas, community involvement and intersectoral coordination and cooperation, stressed in the Director-General's report, must be given close consideration if the social goal of health for all by the year 2000 is to be achieved. Countries which have positive experience in this line must share it with others.

Mr President, I will now briefly share my country's experience in the implementation of primary health care.

The current health policy, which places great importance on the provision of essential health care to the people of Ethiopia, originated in the declaration of the National Democratic Revolutionary Programme in 1976. This policy was re-emphasized by the Commission for Organizing the Workers Party in Ethiopia and at present by the Workers Party of Ethiopia; the policy emphasized the expansion of rural health services, disease prevention and control and promotion of self-reliance and community involvement in health activities.

The considerable increase in the wide spread of health services, infrastructure and programmes that is evident at present in rural Ethiopia bears witness to the implementation of the above policy of equity in health care during the past ten years, which reflect the basic principles and strategy underlying the Ethiopian policy of socialism. These are consistent with the primary health care approach to achieve health for all by the year 2000. Obviously, this is the reason why the Ethiopian Government endorsed the Alma-Ata Declaration in 1978 and considered it as an impetus to its on-going efforts.

The health services delivery system has been strengthened on a six tier structure, with more of the health institutions at the grass-root level given priorities for expansion and equitable distribution. The very essential programmes such as the expanded programme of immunization, maternal and child health, health education, provision of essential drugs, water and sanitation, nutrition, communicable disease control, etc. have been given great importance, and provision of these services initiated in all health institutions, specially since the adoption of primary health care as an approach. Furthermore, the Government has started the implementation of the Ten-Year Perspective Development Plan since the second half of 1984. The health sector is one of the important components of this plan. In the formulation of the ten-year plan, emphasis is given to the eight component programmes of primary health care with an objective of achieving 80% coverage at the end of the plan period compared to the present 43%.

What I have done so far is to show my country's experience in response to the commitment made to the goal of full implementation of primary health care. But the above commitment will only be complete if there is similar commitment to evaluate progress toward that objective. Realizing the need for such evaluation the Ministry of Health of Socialist Ethiopia undertook a comprehensive assessment of primary health care activities. Considering that primary health care has been implemented for the last few years, and implementation of the Ten-Year Plan began in the second half of 1984, the Ministry of Health, with the support of WHO and other international agencies, undertook a major and elaborate joint exercise aimed at reviewing the progress of implementation of primary health care. The review covered rural areas of six regions and Addis Ababa with a total population of over three million. The components reviewed included: immunization, diarrhoeal diseases control, food and nutrition, maternal and child health, essential drugs, manpower development, health education, water and sanitation, health establishments and community health services.

The review is considered unique because it was multisectoral, including staff other than the Ministry of Health staff, participants from mass organizations, other ministries and agencies and international staff.

The findings of the survey have definitely showed us our achievements and weaknesses. The following are some illustrations:

(1) It is not sufficient to clearly define national health policies, unless the policies, strategies, plans and targets for the specific elements of primary health care are clearly defined at national level and disseminated to regions and health facilities.

(2) There has been a significant and commendable expansion of services in recent years, particularly of health stations and health centres. Most of these units are providing some maternal and child health care, health education and environmental hygiene as well as treatment services. Immunization is being provided at 69% of health centres and about 27% of health stations, but at present is only available for 16% of the total population. Within that 16% target group the present coverage of fully immunized children surveyed is between 24% and 77%. In the urban and selected rural population surveyed, use of antenatal services ranged from 50% to 81%, and deliveries by trained health workers ranged from 32% to 64%.

(3) Regarding strengthening of community health services, it is identified that communities need a longer period of discussion before selection of traditional birth attendants and community health agents. This has often been unsatisfactory. Health services have not provided adequate on-going support and supervision.

(4) Communities and mass organizations have a great potential for the support of health development. Revolutionary Ethiopian Womens Association, Revolutionary Ethiopian Youth Association, All-Ethiopian Peasant Association, Urban Dwellers Association, All-Ethiopian Trade Union have been used for health education, mobilization for the expanded programme of immunization, building health stations and maternity waiting houses, water protection and drug supply. However these mass organizations have not been utilized enough, at either central or peripheral levels.

(5) Agriculture (especially home agents) water and education sectors are already undertaking activities with health, reflecting collaboration with other sectors. But, these could be more firmly linked with health by joint planning, which is not taking place at present.

(6) Training activities have also been expanding rapidly in recent years, and have been accompanied by review and revision of numerous curricula. However, recent primary health care programme developments and priorities are not fully reflected in basic training programmes.

These are a few examples of the findings of the review. Detailed findings of each programme reviewed are analysed and specific recommendations made for action. We are encouraged by some of the findings of the review that showed progress in certain activities. On the other hand, we fully realize that we need to aggressively work and accelerate the implementation of primary health care to meet the social goal of health for all by the year 2000.

When I make the above statement, I do not mean to forget factors that have strong bearing on such programmes. The recurrent drought and famine has cost the country human lives, livestock and other resources. This unfortunate episode has already a negative impact on the first year of the Ten-Year Perspective Plan. Its long-term effect will also be reflected during the subsequent years of the plan period.

However, the Party, the Government and the people of Ethiopia, who are aware of the repercussions of the current situation, are taking concrete measures to alleviate the situation. These are the principal objectives:

(1) Immediate objective - Relief, for which the following actions are undertaken: establishment of shelters, feeding centres and dry food distribution centres in drought-stricken areas; activities among the victims for voluntary resettlement; fitness; appropriate selection and mobilization for resettlement. The latest information is that there are still 7.7 million affected and about 1.5 million metric tons of food are required.

(2) Short-term objectives: country-wide campaign to grow vegetables; proper guidance and motivation of the rural population by the Ministry of Agriculture; expansion of state farms and increased agricultural production; and resettlement.

At present there are 30 shelters, about 150 feeding centres for undernourished children, and 250 dry food distribution centres. Over 400 000 people have been resettled.

I do not have to tell you the tremendous challenge this massive, nation-wide mobilization entails for the health services. The drought, with the consequent results of malnutrition, exposes the victims to various diseases, especially the communicable diseases. Therefore the health service requirements are increased in drought-stricken areas and rehabilitation areas.

That is why we insistently appeal to international agencies and communities for their unreserved humanitarian assistance.

At this juncture, I would like to express our gratitude and appreciation to countries, international agencies, nongovernment organizations, and to the world communities at large, who have assisted us in our struggle against the devastating drought and famine problems in Ethiopia. We would like to appeal to all countries to continue their humanitarian assistance for the emergency relief as well as for the rehabilitation programme which we believe is a lasting solution for this recurring natural calamity of drought.

Lastly, I would like to conclude my intervention by expressing my Party's and Government's gratitude and appreciation for the continuous support and encouragement given by WHO and other international agencies and Member States to the health services delivery system of our country.

Le Professeur LYACOUBI-OUACHI (Tunisie) :

Monsieur le Président, Monsieur le Directeur général, honorables délégués, chers confrères, Mesdames, Messieurs, il m'est une grande joie de saisir encore une fois l'excellente occasion qui nous est offerte chaque année par l'Assemblée mondiale de l'Organisation mondiale de la Santé pour saluer en chacun de vous l'amicale présence et les efforts consentis pour assumer la lourde, mais combien édifiante, responsabilité qu'implique la santé dans le monde. Confronter nos expériences, exprimer notre solidarité, chercher et définir ensemble les grandes options de l'avenir, contribuer en somme à maîtriser et dépasser les disparités sur le plan sociopolitique et économique entre le Nord et le Sud, parfois entre le "Nord du Sud" et le "Sud-Sud", constituent à mon avis l'axe principal à suivre pour une dynamisation réelle de nos activités et une concrétisation du droit de tous à la santé.

Monsieur le Directeur général, il est de tradition de commenter votre rapport et de vous féliciter pour la somme incommensurable d'efforts et d'activités que notre Organisation réalise année après année, jour après jour, pour atteindre un des objectifs les plus nobles de l'humanité, à savoir l'état de bien-être moral et physique de chacun des membres de nos sociétés. Ces

félicitations, les remerciements mérités qui vous sont dus, à vous tous et à vos collaborateurs, qu'ils agissent au niveau central ou régional et local, qu'ils soient des professionnels de la santé ou des scientifiques, des administratifs ou des experts; ces félicitations, ces remerciements donc, s'ils expriment le très vif hommage que nous vous rendons, ne peuvent rien avoir de comparable avec l'indéniable et très légitime satisfaction que vous êtes en droit de ressentir et de tirer de la richesse de votre action et de la profondeur de son impact. Je ne m'étendrai donc pas sur cet aspect, convaincue que je suis que le plus bel hommage à vous rendre consiste à participer avec vous et dans l'intérêt de tous à la permanente recherche d'une amélioration de cette action, à la réalisation des stratégies et des plans d'action arrêtés par notre Organisation. L'Organisation mondiale de la Santé constitue, nous le savons, le miroir de notre action et le reflet de nos comportements. Vos succès sont donc les nôtres, vos difficultés le résultat de nos insuffisances, de nos défaillances. Si donc les objectifs généreux et ambitieux que vous nous avez fixés, et auxquels nous avons adhéré, nous paraissent à la fois réalistes et réalisables, il n'en demeure pas moins nécessaire pour nous tous d'éviter qu'ils ne se sclérosent dans l'état de "slogan", ce qui atténuerait considérablement nos responsabilités et affaiblirait notre vigilance. Autant donc nous adhérons à ces objectifs, autant nous nous devons tous individuellement et collectivement d'apprécier avec le discernement nécessaire et l'humilité adéquate le chemin parcouru et celui qui nous reste à faire. Il est vrai que les problèmes de la santé sont universels et universellement complexes, mais ils sont surtout et d'abord spécifiques à chacun de nos pays, de nos populations et de nos systèmes socio-économiques. Comme il est vrai aussi que la solidarité internationale qui s'est manifestée par des actions d'envergure pour réduire la maladie dans le monde a engendré un grand succès, pour ne pas dire le plus grand succès de ces dernières décennies, grâce auquel il a été possible d'améliorer de façon notoire la durée et la qualité de la vie de millions de citoyens. Il n'en demeure pas moins incontestable de conclure que cela reste parfaitement insuffisant, eu égard à nos espérances, qu'elles se situent à l'échelle mondiale ou nationale.

Sur le plan mondial, l'injustice reste encore flagrante entre ce Nord où les grandes épidémies ont été largement vaincues et éradiquées, où le droit à la santé et le droit aux soins sont devenus des droits légitimes et implicites, et tout ce Sud encore ravagé par la malnutrition, les maladies endémiques ou même les foudroyantes épidémies. Il n'est pas de mon propos de mettre encore plus en évidence ces injustices ni leurs causes, mais en tant que responsable de la santé dans mon pays et en tant que membre de cette honorable Assemblée, il est de mon devoir de me demander si les stratégies que nous avons adoptées jusqu'ici sont suffisantes ou suffisamment opportunes. Il est aussi de notre devoir à tous de nous demander si le rôle de notre Organisation, en dépit de son énorme impact actuel, ne doit pas être revu et amélioré. Car, s'il y a déjà sept ans, à Alma-Ata, l'adoption de la stratégie des soins de santé primaires comme méthode universelle est à marquer d'une pierre blanche dans l'histoire de l'humanité, aujourd'hui s'impose la nécessité de réfléchir sur les véritables moyens à lui fournir pour mieux atteindre son objectif, et pour l'adapter aux réalités de chacun de nos pays compte tenu de nos contraintes et de nos possibilités. Si la politique actuelle de l'Organisation mondiale de la Santé a consisté non seulement à proposer des modèles, mais aussi à favoriser leur succès par une redistribution solidaire des moyens financiers et humains, il est peut-être temps aujourd'hui, par le constat des résultats obtenus, d'aller plus loin dans l'analyse de nos insuffisances et de nos déceptions. D'abord, il est nécessaire de constater que quelle que soit la valeur du modèle proposé, il est indispensable de l'adapter à chaque pays, à son environnement socio-culturel, économique et géographique. Ensuite, il est également nécessaire que chaque pays, chaque décideur en matière de politique de santé soit suffisamment, objectivement et scientifiquement armé pour choisir les objectifs qu'il peut atteindre, compte tenu des moyens dont il dispose. Sur ce dernier point, il serait souhaitable que l'Organisation mondiale de la Santé puisse, par des actions diverses, promouvoir le développement des ressources financières en faveur de la santé dans chaque pays. Car, si les pays riches se plaignent effectivement de l'énorme croissance du coût de la santé et cherchent à maîtriser cette croissance, les pays pauvres doivent dans leur stratégie économique développer la notion de rentabilité de la dépense de santé, compte tenu de son effet favorable sur l'amélioration du niveau de vie et donc de la production et de la productivité économique.

L'idée de développer des systèmes de santé nationaux à des coûts tolérables, mais impliquant tout de même une couverture globale et de qualité, n'est pas une idée qui doit rester tabou et irréalisable même pour les pays peu nantis. Tenant compte de cette constatation, nous sommes en droit de nous demander si les entraves au développement sanitaire de ces pays, outre qu'ils peuvent être d'origine conceptuelle, ne sont pas également liés à des causes extrinsèques et très particulièrement à la dépendance technologique. En effet, en ce qui concerne les

médicaments par exemple, notre dépendance reste double : d'abord par leur coût et leur influence sur les budgets déjà fragiles de la santé, ensuite par leur inadaptation réelle aux traitements des pathologies dans les pays pauvres. En outre, si la liste de 200 médicaments peut théoriquement suffire pour faire face à la majorité des situations de façon objective, il n'en est pas moins certain qu'elle reste insuffisante par rapport aux besoins de santé d'une population de plus en plus éveillée, de plus en plus consciente, et de plus en plus exigeante. Par ailleurs, le fait d'avoir réduit la liste des médicaments n'a engendré, à notre connaissance, qu'un faible impact sur le coût global des soins, et encore moins sur le couple coût/efficacité de ces soins. Dans ce domaine, l'Organisation mondiale de la Santé a un devoir très important à assumer, en agissant sur les marchés internationaux du médicament et encourageant de façon plus substantielle la fabrication de médicaments adaptés aux besoins réels de santé de nos populations.

Dans le domaine des équipements notre dépendance, pour ne pas dire notre aliénation, est encore plus angoissante. A mesure que les technologies biomédicales se développent et se sophistiquent, agissant de façon sensible et positive sur le coût de la santé et sur l'efficacité des soins, les pays à faibles moyens restent désespérément des consommateurs passifs et spoliés payant au prix fort des appareillages obsolètes ou en voie de l'être. C'est pourquoi je vous proposerai, Monsieur le Président, de constituer parmi nous une commission internationale de réflexion sur ces véritables entraves au développement sanitaire, et d'y apporter les solutions rapides, qu'elles se situent à l'échelle nationale ou internationale.

A la veille de la Conférence mondiale sur la Décennie pour la femme, des femmes continuent en grand nombre et dans grand nombre de pays à subir le fardeau du sous-développement. Le rapport de M. le Directeur général faisant état de la mortalité maternelle sous-enregistrée, de la malnutrition, de l'insuffisance des soins à prodiguer pendant la grossesse, des problèmes de santé mentale et de bien d'autres entraves à la santé de la mère et de l'enfant, est assez éloquent à cet égard. C'est ce même rapport qui nous indique également que les femmes "ressource clé pour la santé de façon formelle et informelle" ne présentent pourtant qu'un très faible pourcentage par rapport aux hommes dans le pouvoir de décision en matière de santé, que les acquis du développement leur profitent peu, bien que la santé des enfants et de la famille dépendent du degré d'instruction et de culture de la mère

Monsieur le Président, si nous adhérons à la volonté mondiale d'atteindre la santé pour tous en l'an 2000, il est nécessaire de constater que pour beaucoup de peuples ce rêve semble si peu proche dans la mesure où ils sont encore privés des droits les plus élémentaires, soit par l'apartheid en Afrique du Sud, soit par une occupation et une usurpation inconcevable de leur territoire comme le peuple de Palestine. Encore une fois, nous devons du haut de cette tribune, déclarer que le droit à la vie, à la santé et au bien-être de ces peuples passe avant toute considération. Comment pouvons-nous encore rester solidaires si cette Assemblée ne déclare pas haut et fort qu'elle ne pourra continuer à admettre cette injustice.

Pour terminer, je voudrais remercier personnellement et très sincèrement le Dr Mahler, pour l'excellence des relations entre mon pays et l'Organisation mondiale de la Santé, et l'assurer de notre disposition à continuer à améliorer les rapports d'amitié et de collaboration, entre nous et le Bureau régional de la Méditerranée orientale.

Le Professeur DEMBELE (Mali) :

Monsieur le Président, Monsieur le Directeur général, honorables délégués, Mesdames, Messieurs, la délégation du Mali est heureuse de saisir cette occasion pour vous présenter, Monsieur le Président, ses vives félicitations pour votre brillante élection à la présidence de la Trente-Huitième Assemblée mondiale de la Santé. Nous vous assurons de notre entière coopération dans l'accomplissement de votre délicate mission. Il nous particulièrement agréable de renouveler au Dr Mahler, Directeur général de notre Organisation, la profonde gratitude du peuple malien, de son Parti et de son Gouvernement pour tous les efforts qu'il ne cesse de déployer à nos côtés en vue d'atteindre les objectifs de la santé pour tous d'ici l'an 2000. Il nous est également agréable de renouveler nos félicitations au Dr Monekosso pour sa brillante élection comme Directeur régional de l'OMS pour l'Afrique et l'assurer de l'appui total du Mali dans l'accomplissement de sa noble mission.

Honorables délégués, Mesdames, Messieurs, les assises de la Trente-Huitième Assemblée mondiale de la Santé se tiennent à un moment où les pays du Sahel subissent des contraintes majeures qui ont trait à la récession économique, à une sécheresse persistante et implacable depuis près de seize ans et à l'apparition de diverses épidémies qui sont autant de facteurs

négatifs remettant en cause l'ordre de nos priorités dans la mise en oeuvre de notre stratégie de développement sanitaire fondée sur les soins de santé primaires.

L'étude des deux rapports soumis à notre examen appelle de notre part les observations suivantes. Dans le paragraphe 63 du chapitre IV de l'excellent rapport d'activité que le Directeur général nous a présenté, le Mali se réjouit de relever que l'objectif que se sont fixé des pays de la Région européenne en matière de programme élargi de vaccination est que "d'ici l'an 2000, il ne devrait plus y avoir de cas indigènes de rougeole, de poliomyélite, de tétanos du nouveau-né, de rubéole congénitale et de diphtérie". Une telle perspective est des plus réconfortantes et l'on est même en droit de se dire qu'elle constitue un pas important en direction sinon de l'éradication, du moins du contrôle mondial de certaines de ces affections. Toutefois, l'éventualité de cas importés venant d'autres Régions n'étant pas à exclure, les pays européens se retrouveront dans la même situation que celle qu'ils ont connue des décennies durant avant l'éradication de la variole. Il s'avère donc indispensable que les pays où ces affections continueront à sévir à l'état endémo-épidémique parviennent eux aussi à les contrôler pour qu'elles cessent de constituer une menace pour l'Europe. Or, si dans toutes les grandes agglomérations des pays en développement les conditions d'administration de n'importe quel vaccin actuellement disponible se trouvent réunies, il n'en est pas de même dans les zones sahéliennes où l'utilisation correcte d'un vaccin vivant pose des problèmes non encore résolus quant aux conditions de conservation et de transport, transport qui doit s'effectuer sur des centaines et même des milliers de kilomètres à une température ambiante de 40 à 44°C à l'ombre. L'on comprend donc que pour n'importe quelle maladie cible du programme élargi de vaccination, la mise au point d'un vaccin suffisamment stable sous les climats tropicaux est une donnée qui mettra tous les pays en état de s'acquitter de leur responsabilité en matière d'immunisation des enfants. Certes, comme il est précisé au paragraphe 65 du rapport d'activité, d'appréciables efforts ont été accomplis en 1984 en matière de développement et de logistique de la chaîne du froid, mais il faut savoir que le bénéfice à tirer de tels progrès est au prix de va-et-vient fréquents et coûteux entre les collectivités des zones rurales à protéger et les points de conservation des vaccins dans les grands centres.

Pour ce qui est du programme d'approvisionnement en eau saine et d'assainissement de base, c'est malheureusement l'épidémie de choléra qui a frappé le Mali en 1984 qui a contribué à convaincre tous les agents de la vie socio-économique de la pertinence de ce programme, non seulement dans les zones sèches, mais partout ailleurs dans le pays. En effet, la zone des lacs du delta intérieur du fleuve Niger a non seulement été la plus touchée, mais elle demeure aussi celle où nos services luttent contre la maladie jusque dans ses derniers retranchements pour l'empêcher de s'installer à l'état endémo-épidémique. Partout où existe un point d'eau potable, à savoir forage, puits aménagé, système d'adduction d'eau, on est rapidement venu à bout de l'épidémie. C'est seulement dans les zones desservies uniquement par les eaux de surface ou les eaux boueuses des mares que des problèmes continuent à se poser.

Notre Assemblée coïncide avec le dixième anniversaire du programme de lutte contre l'onchocerchose dans la région du bassin de la Volta. Depuis dix ans la lutte contre la cécité des rivières s'est fixé comme objectifs principaux de combattre une maladie particulièrement grave et répandue dans notre Région et de supprimer un obstacle majeur au développement socio-économique. Nous pouvons d'ores et déjà affirmer le succès de ces dix premières années du programme (OCP), succès dû à la compréhension et à la sollicitude des pays et organismes d'aide et aussi à la compétence et au dévouement de fonctionnaires, d'experts et de techniciens. Il me plaît ici de les saluer et de leur rendre un hommage mérité. Comme vous le savez, ce sont les succès spectaculaires obtenus dans la mise en oeuvre actuelle du programme qui expliquent et justifient l'extension à l'ouest et au sud décidée par le comité conjoint du programme. Mon pays est intéressé au plus haut chef par cette extension qui nous permettra de prendre en compte dans une mesure encore plus large la lutte contre l'onchocercose dans nos programmes de développement sanitaire. Le Mali abritera prochainement l'atelier interpays sur l'étude de l'impact socio-économique de la lutte contre l'onchocercose qui sera organisé sous l'égide de l'unité de développement socio-économique du programme.

Notre Organisation a entrepris des actions pertinentes dans douze pays de la Région africaine afin de pouvoir mettre à la disposition de nos Etats des instruments performants de gestion dans le cadre d'un système de santé révisé. Le Mali est désireux de bénéficier d'un appui du Comité mixte FISE/OMS des Directives sanitaires pour mener des études sur la participation des hôpitaux à la mise en oeuvre des soins de santé primaires en milieu urbain et sur les modalités de prise en charge des frais récurrents du système de soins de santé primaires en milieu rural.

Le Mali, bien que pays enclavé ressentant encore plus durement une conjoncture économique internationale difficile aggravée par une nature implacable, ingrate et de plus en plus hostile, poursuit avec plus d'opiniâtreté l'objectif social que nous nous sommes fixé. Notre peuple saura se souvenir du vaste élan de solidarité humaine dont il a bénéficié durant les dures épreuves qu'il connaît depuis plus d'une décennie, épreuves qui sont autant de défis pour l'humanité entière, défis qu'elle saura relever avec tous les hommes de bonne volonté.

Nous souhaitons plein succès aux travaux de la Trente-Huitième Assemblée mondiale de la Santé.

Mr TANOH (Ghana):

Mr President, Director-General, Honourable Ministers, distinguished delegates, ladies and gentlemen,

I have the greatest honour, on behalf of my delegation and the people of Ghana, to congratulate you on your appointment to this high office at this Assembly and to wish you every success in your endeavours.

May I also, at this point, express my Government's congratulations to Dr Monekosso, our new Regional Director for the African Region, on his assumption of office in Brazzaville.

The Government of Ghana has adopted primary health care as a means of achieving equitable distribution of health services to all the people of Ghana. It is also committed to the idea of involving the people in the management of health services, and to this end has developed guidelines which should direct and ensure the implementation of these policies.

Over the past five years, my Ministry has endeavoured to develop a health care delivery system with primary health care as the core. To facilitate the development of primary health care, the health care delivery system has been decentralized to the district level, where primary health care programmes are developed and implemented. Health centres and health posts form the base from which health programmes at the community level are developed. Community health workers have been trained, and are functioning in many communities, and these are supported by their own communities.

The core programmes of our primary health care effort include immunization against childhood communicable diseases, maternal and child health services, nutrition education and rehabilitation, health education, treatment of endemic diseases at the community level, and sanitation programmes. Mass immunization programmes against measles and yellow fever have been initiated and are achieving increases in coverage all over the country. Health education programmes have been intensified on the mass media to educate the general population on both the primary health care programme and specific programmes like immunization, nutrition and oral rehydration. Community-level health education activities in which health educators are assisted by community health workers or health Brigades have been going on.

In all these programmes there is close collaboration with nongovernmental agencies like the Christian Churches, Red Cross Society and Women's organizations like Zonta International and the Council for Women and Development. The Christian missions are the oldest and best organized nongovernmental agencies, and in some cases mission hospitals are used as district hospitals. These nongovernmental organizations also carry out the programmes outlines above in selected areas. There are also mechanisms for cooperation at the national, regional and district levels. In recent years there has been an influx of private and religious organizations who have plans to carry out health activities of various kinds. These new groups need to be organized to become part of the general health care delivery system, although the motives and activities of some of these groups leave room for some concern. It is also heartening to mention that our two medical schools, the Ghana Medical and Pharmaceutical Students' Associations, and the Health Division of the Ghana Army are actively involved in these primary health care activities.

In the area of traditional medicine, the Ministry of Health is collaborating with herbalists and Associations of Traditional Healers in carrying out research into the claims of efficacy of certain herbs. The Centre for Research into Plant Medicine, which has been in existence for 20 years and is working in collaboration with the University of Ghana, is the focal point of such research activity.

Traditional healers' associations are forming their own national council which will regulate their practices. It is planned that cooperation with the traditional healers in providing health care to the people of Ghana will form part of the health development activities in the near future.

Perhaps one of the most significant success stories is the onchocerciasis control programme. In this programme large areas have been freed of the vector and resettlement programmes have been initiated. Ghana is host to two WHO collaborating centres, one of which

is the Chemotherapeutic Research Centre at Tamale where clinical trials of new drugs for the treatment of onchocerciasis are carried out. At the present time, Ghana is in the process of building onchocerciasis control activities into the primary health care system as part of the devolution process of the Onchocerciasis Control Programme.

A Drugs and Equipment Committee, embracing not only officials of the Ministry of Health but also representatives of the universities and the Army Medical Unit, has been established which has produced a list of essential drugs and a priority drug list, which form the basis of our Drug Procurement Scheme. In spite of massive assistance from the Gpovernment of Japan, and such United Nations agencies and bodies as UNICEF and UNFPA, there is still the great need to further develop the logistics for the distribution of drugs, and other medical supplies. This and the management of health care programmes have been identified as areas where WHO could be of great assistance. Recently, a team of WHO consultants visited Ghana to assess our managerial processes, and as a result our managerial weaknesses have been identified. Ghana shall depend on further WHO assistance to develop and strengthen her health management structures. Further, a team of USAID management consultants visited Ghana to develop health management processes and training programmes at the district and health centre levels to help strengthen the delivery of our primary health care programmes on short-term basis.

The Government of Ghana has initiated a hospital and health centre rehabilitation programme to improve the referral systems within the primary health care programme. A number of bilateral agreements have been instituted to assist in the rehabilitation programme. In the past few months, in spite of severe economic constraints, my Government has been able to improve service conditions for health staff to contain the alarming and disastrous exodus of health personnel from the country. Already, the impact of this is being felt and our health professionals who are outside the country have begun to arrive back home.

The area of greatest concern has been the lack of intersectoral cooperation in the development of the primary health care system. This is due to the lack of awareness and understanding among key people and other sectors of the economy of the intrinsic value of health in the socioeconomic development of our country. In this regard the idea proposed by the Director-General, Dr Mahler, of the training of health-for-all leaders is probably the most significant development since the Alma-Ata Declaration. In Ghana such leadership training has been taking place in workshops organized for political groups and other social groupings at the District level, but the impact is yet to be felt. I hope that what WHO plans to do will enable people of all sectors of the economy to gain a better understanding and awareness of the potentialities of the primary health care programme as a community development tool.

It is the intention of my Government to continue to make the maximum use of WHO resources in the effort to develop our health care delivery system. It is my delegation's conviction that with the leadership being provided by our Government and the decentralization and restructuring of the administrative structure of Ghana, coupled with the goodwill of Member States of WHO, we shall achieve our goal of health for all by the year 2000. May I end by expressing the gratitude of my people to WHO and the people and governments of all those countries, and the various organizations, both private and governmental, which have over the years tried to supplement our efforts in this great and exciting socioeconomic programme and endeavour.

M. YANGONGO (République centrafricaine) :

Monsieur le Président, Monsieur le Directeur général, honorables délégués, Mesdames, Messieurs, je voudrais tout d'abord, Monsieur le Président, m'acquitter d'un agréable devoir : celui de transmettre à cette auguste Assemblée les meilleurs voeux, formulés par le Général d'armée André Kolingba, Président du Comité militaire de Redressement national, Chef de l'Etat, pour que les travaux de notre Trente-Huitième Assemblée mondiale de la Santé soient couronnés de succès. Au nom de ma délégation, je voudrais ensuite joindre ma voix à celle de ceux qui m'ont déjà précédé pour vous adresser, Monsieur le Président, mes chaleureuses félicitations pour votre élection à la présidence de notre Assemblée.

Ma délégation et moi-même avons lu avec beaucoup d'attention les rapports du Conseil exécutif sur ses soixante-quatorzième et soixante-quinzième sessions ainsi que l'excellent rapport du Directeur général, le Dr Mahler, rapport qui, cette année, nous fait le point non seulement des activités de l'OMS durant l'année 1984, mais aussi des progrès réalisés et des difficultés rencontrées dans la mise en oeuvre de la stratégie mondiale de la santé pour tous d'ici l'an 2000.

Avant de faire quelques commentaires sur ces rapports, je voudrais m'associer ainsi que ma délégation, au nom de mon pays, à l'hommage mérité que le Conseil exécutif, lors de sa soixante-quinzième session, a rendu à la mémoire du Dr Quenum, qui n'a ménagé ni ses efforts, ni surtout sa santé pour promouvoir celle des collectivités africaines.

Nous voudrions également, ma délégation et moi-même, profiter de l'occasion pour adresser au Dr Monekosso nos vives et chaleureuses félicitations pour sa brillante élection au poste de Directeur régional de l'OMS pour l'Afrique. Nous connaissons déjà la ligne maîtresse de la nouvelle orientation structurelle qu'il propose pour le Bureau régional, et tenons à lui en exprimer notre appui sans réserve. Cette nouvelle structure, qui vise essentiellement une plus grande décentralisation des activités, permettra d'améliorer l'appui technique, financier et administratif aux Etats Membres, et donc l'impact de notre Organisation au niveau des pays.

Pour en revenir aux rapports du Conseil exécutif et du Directeur général, je voudrais tout de suite exprimer ma satisfaction quant au choix par le Conseil exécutif, lors de sa soixante-quatorzième session, du sujet des discussions techniques qui auront lieu à la Trente-Neuvième Assemblée mondiale de la Santé l'année prochaine et qui porteront sur la promotion de la coopération intersectorielle et de la participation communautaire, y compris l'alphabétisation, dans les stratégies nationales de la santé pour tous. Nous pensons que ce sujet est d'une grande pertinence. En effet, s'il est aujourd'hui évident que ces mécanismes sont indispensables à mettre en place dans le cadre des systèmes de santé qui permettent de réaliser des progrès sur la voie de la santé pour tous, mon pays, malgré les efforts honorables qu'il déploie, rencontre de grandes difficultés dans la création de mécanismes intersectoriels, mais aussi dans le fonctionnement de ceux que nous avons réussi à mettre en place. Nous sommes donc très intéressés à l'idée de partager nos expériences avec celles des autres pays à l'occasion de ces discussions.

Nous rencontrons également de sérieuses difficultés à promouvoir l'engagement communautaire et nous sommes d'accord avec le Directeur général lorsqu'il dit dans son rapport que l'absence de participation communautaire est liée à l'absence de textes législatifs et administratifs permettant la décentralisation et la délégation des pouvoirs de décision aux échelons intermédiaires et locaux de l'administration sanitaire et aux communautés.

Comme d'habitude, c'est-à-dire avec clarté, sincérité et objectivité, le Directeur général a parfaitement souligné et analysé les carences rencontrées au niveau de la plupart des Etats, et surtout dans notre Région, qui compromettent sérieusement les progrès réalisés dans la mise en oeuvre de la stratégie mondiale de la santé pour tous. Il serait fastidieux de les énumérer, car cela reviendrait à passer en revue tout le septième programme général de travail. Ce qui est important, c'est que le Directeur général a chaque fois essayé de nous éclairer sur les raisons de ces carences et de proposer des solutions, et c'est là que notre Organisation a un grand rôle à jouer.

Le Directeur général a également souligné les difficultés particulières que rencontrent certains des pays de notre Région, qui ressentent plus durement que d'autres la récession économique mondiale du fait de calamités comme la sécheresse et bien d'autres encore. C'est le cas de la République centrafricaine qui fait partie des 24 pays les plus gravement atteints par la crise, comme le mentionne le Directeur général, citant en cela le rapport du Secrétaire général de l'Organisation des Nations Unies sur la situation sociale et économique en Afrique, rapport préparé avec la participation du Bureau régional de l'Afrique, et présenté à Genève en 1984.

En effet, quoique la sécheresse ait moins durement touché la République centrafricaine que certains pays, elle a néanmoins frappé le nord de mon pays, le privant d'eau potable et faisant apparaître des carences nutritionnelles graves et des gastro-entérites souvent mortelles chez les enfants. Mais elle a surtout considérablement aggravé l'enclavement de mon pays, le privant une grande partie de l'année de la voie d'eau qui le relie à l'océan et qui constitue sa source principale de ravitaillement.

La République centrafricaine doit faire face cette année encore au problème ardu de l'accueil sur son territoire de dizaines de milliers de réfugiés en provenance des pays frontaliers en conflit, et dont les besoins en matière d'alimentation et d'habitat, les conditions nutritionnelles et sanitaires appellent des opérations de secours d'urgence. La situation difficile de nos Etats, celle de mon pays requièrent la solidarité et l'intervention de toute la communauté internationale sous toutes ses formes. Notre Organisation doit étudier les moyens d'une action plus rapide dans les opérations d'urgence. Elle doit surtout intensifier ses efforts en direction des pays les plus déshérités, pour les aider dans l'élaboration, la mise en oeuvre, la surveillance continue et l'évaluation de leurs stratégies et dans la réorientation de leurs systèmes de santé, afin de leur éviter de manquer le rendez-vous de la santé pour tous. Le renforcement de notre capacité gestionnaire et de recherche, l'appui informationnel efficace, la formation de personnels appropriés et de hauts cadres de la santé capables de concevoir et

planifier les programmes de santé prioritaires exigent que le Directeur général puisse trouver et mobiliser de nouvelles ressources financières et techniques.

La République centrafricaine éprouve tous les ans d'énormes difficultés pour éponger ses arriérés de contributions à notre Organisation. C'est pourquoi je ne voudrais pas manquer l'occasion de remercier le Directeur général pour sa proposition tendant à ouvrir un crédit au titre des recettes occasionnelles disponibles au 31 décembre 1984, pour aider à financer le budget ordinaire pour 1986-1987 afin de réduire l'accroissement des contributions des Etats Membres.

Pour terminer, je prends acte du rapport du Directeur général sur le recrutement du personnel international et de la satisfaction du Conseil exécutif de voir que l'objectif fixé par les Assemblées de la Santé antérieures sur ce sujet a été atteint. Je note cependant qu'en octobre 1984, il restait encore 40 pays non représentés à l'Organisation, dont la République centrafricaine, et 13 pays sous-représentés. Je souhaite que le Directeur général poursuive et intensifie ses efforts dans le même sens afin de réduire davantage encore le nombre des pays non représentés.

Le Professeur THIOUNN THOEUN (Kampuchea démocratique) :

Monsieur le Président, au nom de la délégation du Gouvernement de coalition du Kampuchea démocratique, permettez-moi de vous présenter mes chaleureuses félicitations pour votre élection à la présidence de la Trente-Huitième Assemblée mondiale de la Santé. Je forme mes meilleurs souhaits pour que, sous votre sage conduite, notre réunion se déroule dans un esprit de compréhension réciproque et se termine par un succès complet. Je saisis également cette occasion pour remercier M. le Directeur général, le Dr H. Mahler, du dynamisme et de la fermeté dont il fait preuve à l'égard de son programme de la santé pour tous.

Monsieur le Président, Monsieur le Directeur général, Mesdames, Messieurs, le Ministère de la Santé du Gouvernement de coalition du Kampuchea démocratique a régulièrement reçu les différentes publications de l'OMS, comme les Modes actuels de l'allaitement maternel, la Prévention chez l'enfant des problèmes de santé du futur adulte, la Stratégie mondiale de la santé pour tous d'ici l'an 2000, et les numéros de la Chronique OMS et du Relevé épidémiologique hebdomadaire. Toutes ces publications - ainsi que d'autres comme les Carnets de l'Enfance (Revue sur l'enfance, la jeunesse et les femmes dans le développement), et l'Education préscolaire - nous intéressent au plus haut point parce qu'elles nous permettent de suivre les progrès de la science médicale sur le plan international et les activités de l'Organisation mondiale de la Santé.

L'idée de la santé pour tous est très intéressante et fort utile pour les peuples de toutes les nations, mais elle ne peut être réalisée qu'en temps de paix. La paix et la santé sont deux choses intimement liées.

Depuis 1979, une guerre atroce s'est abattue sur le Kampuchea, imposée par le voisin de l'est, atteint d'expansionnisme et qui, pour se guérir, ne rêve que de conquêtes, de menaces, de destructions systématiques (hôpitaux, écoles, lieux sacrés : pagodes, complexe d'Angkor), et ne songe qu'à tuer, massacrer les innocentes populations civiles, fond du décor de ce drame historique qu'est cette guerre de génocide. Le territoire du Kampuchea est quadrillé, ratissé par un corps expéditionnaire de 250 000 hommes. Durant les six années de guerre, grâce à l'effort de notre Gouvernement, une partie de la population venue de l'intérieur du pays a réussi à organiser une communauté presque normale, indispensable à la santé : chaque famille avait sa maison, son lopin de terre, sa volaille et une pagode commune avec les bonzes sur son propre territoire, ce qui a permis une légère amélioration de la vie chaque jour en temps de guerre. Malheureusement, le désir de l'ennemi est d'annexer le riche territoire du Kampuchea sans le peuple khmer. C'est pourquoi il poursuit les réfugiés vivant dans des camps situés loin des bases militaires stratégiques à la frontière khmero-thaï. Durant la récente saison sèche 1984-85, notre ennemi a aligné les armes les plus perfectionnées, l'artillerie lourde, les tanks, les armes chimiques toxiques pour lancer une offensive le long de notre frontière ouest, offensive qui vient rappeler au monde que le conflit au Kampuchea demeure une des principales vedettes de l'actualité, offensive dont le but est de balayer, une fois pour toutes, toutes les bases de la résistance khmère. Il en résulte que chaque fois que les troupes ennemies, après avoir perdu beaucoup d'hommes, arrivent sur les lieux cibles, il est déjà trop tard. Elles ne rencontrent ni installations militaires, ni magasins d'armes et de munitions, ni population. Tout le monde s'est retiré en ordre dans une autre région. Les seules pertes que l'ennemi ait réussi à infliger sont les faibles revenus agricoles et les pagodes, les écoles et les hôpitaux indispensables à la vie quotidienne de chaque famille khmère. En conclusion, cette offensive

n'est qu'un écran pour cacher la faiblesse et l'incapacité de l'ennemi de maintenir sa domination sur un pays dont le peuple tout entier lutte courageusement pour sa survie nationale. Cette lutte est soutenue par toutes les nations éprises de paix et de justice dans le monde entier. Je saisis cette occasion pour les remercier sincèrement de leur constant soutien qui a permis à notre lutte de poursuivre sa route.

Ce que nous désirons, c'est la paix, l'indépendance et la survie de notre peuple. Ce n'est que dans ces conditions que le programme de la santé pour tous pourra s'appliquer. L'ennemi n'a cependant donné aucun signe pour montrer son désir de résoudre le problème du Kampuchea par la voie politique. Aussi sommes-nous obligés de continuer la lutte. Nos forces armées vives, restées pratiquement intactes, au lieu d'affronter directement l'ennemi sur la frontière, pénètrent à l'intérieur du pays. Nous nous battons sur les rivages de la mer, nous nous battons autour du grand lac, le Tonlé Sap, nous nous battons sur les rives du Mékong, à l'est comme à l'ouest. Nous nous battons autour de la capitale Phnom Penh. Voici quelques noms des places fortes ennemies attaquées non loin de Phnom Penh : Mok Kompoul (à l'est de la capitale) sur le rivage du Mékong, Rohka Kong (au nord de la capitale), et récemment la ville d'Oudong, ancienne capitale du Kampuchea à 30 km de Phnom Penh. Si nous nous battons autours de la capitale, c'est uniquement pour forcer l'ennemi à venir à la table de négociation. Mais il continue pour le moment à faire la sourde oreille quant à l'acceptation d'une solution politique, c'est-à-dire retirer sans conditions toutes les troupes d'occupation. Les soi-disant retraits partiels ne sont qu'une farce que l'ennemi utilise déjà depuis quatre ans.

A l'heure actuelle, il n'est plus question de continuer les manoeuvres politiques. Il faut montrer la bonne volonté de mettre fin au conflit du Kampuchea en respectant tout simplement les obligations et les droits légitimes de toutes les nations de vivre libres et indépendantes. L'ennemi est membre de l'ONU mais ne respecte ni la Charte, ni les six résolutions justes et pertinentes des Nations Unies sur le problème du Kampuchea. Il est grand temps que les dirigeants de Hanoï reconsidèrent leur position d'une façon plus adéquate sur le conflit au Kampuchea, et exécutent les résolutions des Nations Unies. Le Gouvernement de coalition du Kampuchea démocratique n'a d'autre but que de libérer son pays et de vivre en paix avec son voisin de l'est. La guerre n'a que trop duré. Notre peuple a déjà tant souffert. Cependant, nous sommes obligés de continuer la lutte, uniquement pour la survie et la santé de tout le peuple du Kampuchea. Il est grand temps que le combat cesse; le plus tôt sera le mieux.

Ne sommes-nous pas près de la fin du vingtième siècle ? N'est-il pas temps pour nous, khmers, d'appliquer le programme de la santé pour tous dans tout le Kampuchea ? Durant les six années de guerre, nous nous sommes efforcés par tous les moyens de le réaliser, avec l'aide des pays amis et des différentes organisations humanitaires dans le monde. Voici quelques exemples de nos actions : la lutte contre les maladies diarrhéiques fondée principalement sur la promotion de la thérapie par réhydratation orale, associée à une campagne intensive d'éducation du public et de communication; les vaccinations contre la diphtérie, le tétanos, la poliomyélite, la rougeole, la tuberculose; la lutte contre le paludisme. Tout cela a été réalisé dans les camps de réfugiés et dans les régions de Nong Chan, Nong Samet, Tatoum, Malai, Chamkar Chek, notamment.

Nous saisissons cette occasion pour remercier tous les gouvernements et toutes les organisations humanitaires qui sont venus nous aider et alléger notre fardeau de guerre. Ces aides nous sont indispensables et soutiennent grandement la poursuite de notre lutte. Le Gouvernement de coalition du Kampuchea démocratique lance un appel pressant aux nations et aux peuples des pays amis pour qu'ils accordent des aides plus importantes au peuple victime du Kampuchea, qui poursuit sa lutte pour sa survie et pour la paix dans le Sud-Est asiatique. Ces aides nous sont nécessaires dans le présent comme dans l'avenir, après la libération de notre pays, pour rebatir un Kampuchea démocratique nouveau, libre, indépendant, pacifique et neutre.

La paix revenue, nous pourrons appliquer et réaliser dans de meilleures conditions le programme de la santé pour tous sur tout le territoire du Kampuchea, car nous sommes persuadés plus que jamais que ce programme est utile pour le bien-être de tous les peuples dans le monde.

Je souhaite sincèrement que l'humanité entière soit épargnée de toute nouvelle guerre aussi bien conventionnelle que nucléaire.

Mr KATOPOLA (Malawi):

Mr President, Director-General, honourable ministers, distinguished delegates, ladies and gentlemen, I join my colleagues in congratulating you, Mr President, and all the Vice-Presidents, upon being elected to the high offices of the Thirty-eighth World Health

Assembly, and pledge our cooperation with your leadership during this session. May I thank all the delegates for electing me a Vice-President.

My congratulations go to Dr Monekosso for his appointment to the regional directorship of the African Region. May I also at this stage take this opportunity to congratulate the Director-General, Dr H. Mahler, on his comprehensive report on the work of the World Health Organization during the period under review?

My delegation notes with satisfaction the work that has been undertaken by the World Health Oganization during 1984 in the field of health development. It is encouraging to recall that many managerial courses were organized in order to equip health personnel with managerial skills for planning and translation of health policies into programmes. In order to translate technical policies to meet social needs, competent health administrators with managerial skills are urgently needed. The task for us now, is to speed up these developments, since time is running out for us to meet our set social goals. We welcome the efforts the Director-General is making in establishing regional health development centres in our Region for this purpose.

Mr President, at the Thirty-seventh World Health Assembly I reported that the primary health care process in Malawi had focused its activities on the orientation of political and traditional leaders at local or village level in understanding their health problems, and in proposing ways and means of addressing them within the available local and government resources. These primary health care activities are being implemented in a phased manner. I have the honour to report now to this august assembly, that full coverage of primary health care activities has now reached 10 of our 24 districts in the country. In the remaining districts, orientation of the government and nongovernmental personnel is going on. It is expected that full coverage will be attained by the turn of the century.

In the field of health promotion and protection, the expanded programme on immunization has now covered the entire country, and much progress has been achieved. Although the 1984 MCH/EPI/PHC review showed success, it revealed that there was still much to be done, especially on the cold-chain management and service provision at the "under-five" clinics, before coverage and full protection of the vaccinated children can be attained.

In the field of nutrition, the situation continues to cause concern. More information is required on the causes of malnutrition, and on the impact of food supplementation on children during the lean period. Malawi is one of the countries that have formulated programmes for the control of vitamin A deficiency and goitre.

In the field of communicable disease control, the leprosy control project, in collaboration with the British Leprosy Association, is carrying out a most exhaustive and systemic major epidemiological survey of leprosy in the country, which will have significant implications for the future control of leprosy, not only for Malawi but also for the region. Similarly, the bilharzia control project, which is supported by the German Government, has developed realistic strategies in the control of the disease at national level.

I regret, however, to report that resistance of malaria to chloroquine is high and is spreading throughout the country. Efforts are under way to establish the most appropriate intervention for the control of malaria in Malawi, including a surveillance system for drug resistance. Operation research activities to investigate the resistance of malaria to chloroquine are currently under way with assistance from the USAID through the communicable disease control project executed by the Centers for Diseases Control, Atlanta, Georgia.

Other communicable diseases receiving attention are tuberculosis, in which the short-course chemotherapy approach to improve compliance is being tried. Programmes for the control of blindness, bilharzia, onchocerciasis and sleeping sickness have also been formulated. On diarrhoeal disease control we have formulated programmes whose objective is to reduce morbidity through the promotion of breast-feeding, the improvement of water supply and sanitation, and the reduction of mortality through the early management of diarrhoea with oral rehydration salts. We intend to focus our diarrhoeal disease control within the primary health care activities to break the chain in the cycle of ill-health. Sporadic cases of cholera are still occurring in Malawi, but they are controlled through health surveillance assistants, the chlorination of shallow wells, and the early management of diarrhoeal cases.

My country is currently preparing a national health plan which takes into account the social goal of health for all by the turn of the century, with particular emphasis on improving the health status of the rural community through the primary health care approach.

May I take this opportunity to express my appreciation to WHO for the support enjoyed by my country in the provision of health manpower personnel to strengthen maternal and child health and child spacing, health manpower development, short-term consultancy, sponsoring of country and inter-country seminars, and the various health development programmes.

Lastly, Mr President, I wish you success in your task of guiding the deliberations of the Thirty-eighth World Health Assembly.

Mr GIRI (Nepal):

Mr President, Mr Director-General, Dr Mahler, excellencies, distinguished delegates, ladies and gentlemen, please allow me at the outset to express my delegation's warm felicitations to you, Mr President, and to the Vice-Presidents on your election to the important positions. I am confident that under your able guidance the Assembly will achieve what we all hope for. My delegation would also like to put on record our sincere appreciation of the excellent report which the distinguished Director-General presented to the Assembly in so many moving words. I also wish to take this opportunity to thank the Regional Director for South-East Asia for his continual efforts in strengthening regional cooperation among the South-East Asian countries.

The Director-General's report provides a good review of the progress achieved and the range of problems encountered in the implementation of the Global Strategy for Health for All by the Year 2000. This brings to our attention the major health problems faced by my own country such as the high population growth rate, waterborne diseases, malnutrition, tuberculosis, acute respiratory diseases, leprosy and malaria. Nepal's determination to overcome these maladies finds its best expression in the solemn resolve of my august Sovereign, His Majesty King Birendra, and I quote him: "We wish to see the hungry fed, the naked clothed, the sick tended". This basic philosophy has provided an important guideline for the overall development plans and programmes of my country and Their Majesties' regular visits to the remotest parts of the mountain kingdom have been a great source of inspiration to the common masses for their participation in development. His Majesty's Government, for its part, is trying to reach the grass-root level through a new Decentralization Act which provides, among other things, for a Health and Family Planning Committee for each and every district. This Committee is made responsible for planning, implementation and evaluation of all activities related to health development. We consider this to be a vital instrument for the realization of the goals set forth in the strategy for health for all by the year 2000.

In our effort to strengthen our health delivery system and to improve the quality of health services, we are engaging ourselves in a process of restructuring the existing health system itself giving due priority to the development of health infrastructure where such facilities do not exist. We are however encountered on our way by a number of obstacles, such as the paucity of financial resources, lack of qualified manpower in rural health institutions, and inadequate logistic support.

The present high rate of population growth in Nepal is a major concern for us. In order to stabilize this growth, we have taken a number of steps in substantially improving the operational efficiency of the family planning programmes. Our action also makes provision for measures to reduce the rate of infant mortality and to improve maternal and child health care through activities such as health education on nutrition, rehydration and immunization. Involvement of nongovernmental organizations has been very instrumental in the progress made in the field of nutrition. We are very much grateful in this connection to the friendly Government of Italy, to WHO and UNICEF for assigning Nepal to carry out activities under the Joint Nutrition Support Programme.

As part of our policy to meet the basic needs of the populace, we are carrying out the supply of essential drugs through the establishment of medical stores at both regional and district levels. We have also started a revolving drug scheme in some districts. The scheme has demonstrated a promising future. We hope that WHO will be able to provide some needed fund for this innovative but effective scheme.

The growing international trade and traffic in substandard and dangerous drugs is a matter of serious concern for a least developed country like ours where many life-saving drugs have to be imported. We hope that WHO will carefully look at this serious problem for the protection of health and safety of innocent consumers.

We have made a substantial progress in the expansion of our immunization activities by covering nearly two-thirds of the country. We have as well launched an internationally supported programme to control endemic goitre. A leprosy control project which includes an expanded programme of multidrug therapy is expected to cover the entire country by the year 1990. Malaria is still a serious public health problem in Nepal; case importation, development of resistance and shortage of insecticides have been a cause of concern for us. Similarly, tuberculosis remains a major public health hazard in Nepal; control projects which now cover several districts are expected to expand all over the country by 1995. Diarrhoea, which is the most common cause of infant mortality in Nepal, still remains a problem; however, with increased community involvement and with the assistance of UNICEF and other donor agencies, we are making a good progress in our effort to combat this problem. We have recently launched a national diarrhoeal disease control programme under the integrated community health project.

Nepal is also taking active steps for the involvement and development of the Ayurveda system of medicine and its integration in the total health care system of the country.

A safe environment is a matter of paramount interest to Nepal. Provision of potable water and proper sanitation facilities still continues to hold a priority in the government programme.

Nepal very well recognizes the great potential role of nongovernmental organizations in national development, in the social service sector in particular. In recognition of this fact, a National Coordination Council for Social Services was established in Nepal in 1977 under the chairmanship of Her Majesty the Queen. One of the important objectives of this Coordination Council is to provide leadership at the national level and to ensure that all social welfare programmes are carried out in an organized and coordinated manner with available resources and facilities properly utilized. Under this Council, a Health Services Coordination Committee has also been established to coordinate health-related activities in Nepal.

It is satisfying to note that the countries of the Region are encouraging and promoting mutual help and support through the programme of technical cooperation among developing countries towards which WHO is entrusted with playing a vital role. We attach a high value to the collaboration in health and population activities through South-Asia regional cooperation, in which Nepal is responsible as a clearing-house on health and population.

With a view to evaluating progress in the implementation of the strategy for health for all in the years ahead, a monitoring exercise was successfully undertaken in Nepal last year with the cooperation of the "Health for All" Steering Committee, His Majesty's Government and the WHO management group. Now a plan of action, on the basis of this evaluation and the shortcomings identified, is being prepared for necessary corrective measures and effective future implementation of the strategy.

In conclusion, I would like to put specific stress on the fact that although some progress has been noticed in the implementation of the Global Strategy for Health for All by the Year 2000, much remains to be done in the years ahead. The enormity of the challenge which that poses for us calls for renewed efforts in the strengthening of national capacities. In view of the slow progress noted especially in the least developed countries, due mainly to their deteriorating health and economic situation, the Executive Board has recommended in its resolution EB75.R14, carried by its seventy-fifth session, that the Health Assembly consider the mobilization of additional financial and technical resources to support these countries in their health development efforts. As one of the least developed among developing countries, Nepal therefore also appeals for all available resources to be mobilized to the fullest possible extent and a special fund to be created and made available to the Director-General for timely support to the least developed countries.

Le Dr GERMAIN (Haïti) :

Monsieur le Président de la Trente-Huitième Assemblée mondiale de la Santé, Monsieur le Directeur général, honorables délégués, Mesdames, Messieurs, permettez-nous, d'abord, de prendre le temps et d'avoir le plaisir de présenter, tant au nom du peuple et du Gouvernement haïtiens qu'en notre nom personnel, nos plus vives félicitations aux Président et Vice-Présidents et à tous les autres élus de cette Assemblée. Nous leur souhaitons, à tous, le succès le plus complet dans leurs efforts et dans leur nouvelle contribution à l'oeuvre la plus grandiose et la plus bénéfique qu'une Organisation ait jamais proposée à ses membres, à savoir la santé pour tous d'ici l'an 2000.

En effet, parmi les nombreuses tentatives d'amélioration des conditions de vie sur cette terre des hommes, aucune ne peut, vraiment, rivaliser de noblesse et de saine ambition avec celle que, depuis l'année 1977, l'OMS nous invite à réaliser. Il ne fait aucun doute que l'histoire de la solidarité humaine sera désormais marquée par deux périodes, dont l'une se situe avant et l'autre après Alma-Ata. A cet égard, nous n'insisterons jamais assez sur le rôle prépondérant joué par le Dr Mahler et ses collaborateurs, ainsi que sur leurs efforts pour susciter, à l'échelle planétaire, cette volonté globale et concertée indispensable à la poursuite des différentes étapes de cet objectif humanitaire.

C'est dans une vision partagée des efforts à entreprendre pour offrir à toute la population une couverture sanitaire efficace et adéquate qu'en 1976, à la suite de la réunion à Washington des ministres de la santé de l'hémisphère américain, le Gouvernement haïtien s'est définitivement engagé dans cette politique de santé dynamique et révolutionnaire. Cet engagement s'est traduit par l'élaboration d'un plan national de santé, prévoyant un ensemble de programmes et de projets bien articulés et convergents. Cet engagement s'est manifesté encore

par la mise au point de nouvelles mesures législatives et juridiques, appuyées par des déclarations présidentielles et ministérielles dépourvues d'équivoque. Cet engagement s'est également concrétisé par la révision de la Nouvelle orientation (programme et stratégie), document dans lequel six problèmes majeurs de santé publique ont été particulièrement retenus pour être affrontés et combattus de façon intensive et spéciale.

Nous ne voulons pas entreprendre, ici, de tracer la trajectoire du chemin déjà parcouru à la poursuite incessante de cet objectif que constitue la santé pour tous. Nous voulons simplement faire remarquer qu'Haïti, malgré ses handicaps financiers, s'est maintenu dans la course à côté des autres nations soeurs. Cependant, nous avons bien compris et nous sommes conscients que, vu nos difficultés économiques, l'assistance externe nous sera encore nécessaire pendant un certain temps. Voilà pourquoi, depuis plus d'une année, des efforts considérables sont faits en matière de politiques et de stratégies en vue d'associer de plus en plus les organisations non gouvernementales à l'exécution des programmes prioritaires entrepris par le Gouvernement.

Dans le document intitulé : "Nouvelle orientation de la santé en Haïti" on lit : "Il existe dans le pays une multitude d'organisations étrangères intéressées à la santé, et une dispersion des ressources étrangères allouées à ce secteur. Le Service d'Assistance externe du Ministère de la Santé publique et de la Population a été organisé de façon à ce qu'il arrive, en accord avec les directeurs des régions et de districts à tenir à jour l'inventaire des organisations non gouvernementales (ONG) qui ont obtenu l'autorisation de fonctionnement, à orienter les ressources des organisations vers la satisfaction des besoins de la population selon les priorités sanitaires, enfin à déterminer leurs zones d'influence, leur programme et à assurer qu'elles suivent les normes du Ministère de la Santé publique et de la Population." Cette démarche d'intégration des ONG était, évidemment, fondamentale et nécessaire, car environ la moitié des institutions de santé en milieu rural sont dirigées par des organisations non gouvernementales. A présent, 40 % d'entre elles reçoivent une assistance du Ministère de la Santé publique sous la forme de salaires accordés à leurs employés, d'où leur appellation d'Etablissements mixtes de Santé par rapport aux Etablissements publics. Cependant l'étape la plus importante a été franchie en avril 1982, lors du colloque organisé à l'intention des ONG. En effet, ces dernières ont pris la décision d'adopter les programmes prioritaires et les normes prescrites par le Ministère de la Santé publique et de la Population. De là est née l'Association des Oeuvres privées de Santé (AOPS) dont le rôle, entre autres, est d'assurer la coordination entre les institutions privées de santé. Rappelons que l'AOPS, actuellement, fournit une assistance technique et financière à seize institutions de santé disséminées à travers le pays, chacune de ces institutions desservant pendant la première année une population de 10 000 résidents pour passer ensuite à 25 000 puis à 50 000 les années suivantes.

A côté de ces efforts d'ordre structurel, nous voulons encore en souligner d'autres touchant des domaines plus spécifiques.

En matière d'immunisations, la croisade antituberculeuse reste, dans ce domaine, le partenaire le plus important du Ministère de la Santé publique, et grâce à ses efforts 10 398 nouveau-nés ont reçu le BCG en 1983. Mais jusqu'à présent les populations infantiles haïtiennes ne sont protégées qu'à 10 % contre les autres maladies transmissibles. A cet égard le Ministère de la Santé publique et de la Population s'apprête déjà à lancer une campagne nationale d'immunisation, en vue d'offrir une couverture vaccinale au moins à 80 % des populations cibles.

Pour ce qui est de la nutrition, 73 % des enfants du pays sont mal nourris, et 27 % de ce nombre tombent dans les catégories modérées et sévères de Gomez. Des déficiences en fer, en vitamine A et acide folique sont notées, dans un fort pourcentage. En réponse à cette situation particulièrement défavorable au développement psychomoteur des jeunes enfants haïtiens, le Ministère de la Santé publique et de la Population entreprend de généraliser un programme de récupération rapide de ceux qui sont déjà atteints de malnutrition. Cette action est soutenue et renforcée par la SAWS, la CARE, le Service chrétien et par les ONG qui, à travers les centres de surveillance nutritionnelle, fournissent les suppléments alimentaires aux enfants des milieux défavorisés.

On estime à 2 à 3 % le nombre de porteurs de lésions tuberculeuses, avec 58 % de cas contagieux. Dans ce domaine également l'International Child Care entreprend des activités de détection et de traitement de la tuberculose; en 1983, 8359 patients ont été mis sous traitement.

Par ailleurs, pour mettre en pratique les programmes et stratégies définis dans la Nouvelle orientation du Ministère de la Santé, l'accent a été porté de façon essentielle sur d'autres problèmes jugés également prioritaires tels que :

- la lutte contre les maladies diarrhéiques et la promotion de l'allaitement maternel; ce programme, qui se généralise dans tout le pays, a enregistré cette année des résultats encourageants, marqués par une baisse spectaculaire de la mortalité infantile par diarrhée tombée de 50 % à près de 1 % dans certaines localités;
- l'hygiène de la mère et de l'enfant, prise en charge depuis plus d'une décennie; les progrès enregistrés dans les villes sont appréciables; actuellement le Ministère de la Santé publique encourage son intégration progressive à l'infrastructure sanitaire nationale et sa pénétration plus profonde dans les campagnes où vit 79 % de la population;
- le paludisme : commencée en 1961, la campagne d'éradication a frôlé le succès en 1968, quand l'incidence de la maladie avait été ramenée à 0,2 %; mais à partir de 1970, la courbe de morbidité du paludisme a connu une remonté préoccupante; à l'heure actuelle la lutte antipaludique s'intègre dans le contexte des soins de santé primaires avec la participation de près de 16 000 collaborateurs volontaires appelés à prolonger l'action des agents de santé.

A côté de ces six priorités déjà énoncées, le Ministère de la Santé publique s'est lancé dans un certain nombre d'activités complémentaires non moins importantes. C'est tout d'abord la formation des cadres et une nouvelle orientation pour toutes les catégories de personnel médical et paramédical, de l'agent de santé au médecin, étant donné que les ressources humaines constituent le facteur primordial pour la réussite de toute politique de santé. Dans cette optique, chaque région sanitaire est actuellement dotée d'une nouvelle école d'auxiliaires s'ajoutant aux écoles d'infirmières déjà existantes. D'autre part, la nécessité impérieuse de disposer de nouvelles catégories de travailleurs de santé se traduit par l'ouverture progressive d'écoles techniques dans toutes les disciplines paramédicales au niveau des différentes régions sanitaires à desservir.

C'est ensuite la réhabilitation des centres intégrés de santé, marquée par une constante progression des dispensaires, avec un éventail de soins renforcés en vue d'offrir tous les services de base à tous les échelons de la pyramide sanitaire.

C'est encore l'établissement des postes communautaires d'hygiène et d'eau potable. En effet, dans le cadre de la Décennie de l'eau potable, le Ministère de la Santé a pris en charge conjointement avec les organismes internationaux concernés un projet de construction de réseaux d'adduction d'eau potable au bénéfice des communautés rurales éloignées. La première phase de ce projet caractérisée par la mise en fonction de 70 réseaux, est en voie d'achèvement; elle s'est traduite par une baisse marquée des maladies cutanées et diarrhéiques au niveau des points d'implantation de ces réseaux, autant de facteurs qui portent les agences de coopération concernées à poursuivre leur collaboration pour la mise en place de la deuxième phase de ce projet, qui vise l'installation de 150 nouveaux réseaux.

C'est enfin l'éducation sanitaire : ce facteur indispensable à la réussite des soins de santé primaires se développe par une campagne qui objective la prise de conscience et la motivation collectives vis-à-vis des problèmes de santé.

Monsieur le Président et Messieurs les Vice-Présidents de la Trente-Huitième Assemblée mondiale de la Santé, Monsieur le Directeur général, sur la terre d'Haïti, sous le leadership avisé du Président à vie de la République, M. Jean-Claude Duvalier, dont les conquêtes sociales ne se comptent plus, nos perspectives d'avenir portent les couleurs de l'espérance et de l'optimisme que nous imposent notre nette conscience des buts à atteindre, des efforts à poursuivre et des actions à amplifier, ainsi que le choix judicieux de nos stratégies dans la trame diverse et le tissu sans cesse renouvelé de nos ressources humaines, économiques, socioculturelles et technologiques.

Dr SEKERAMAYI (Zimbabwe):

Mr President, Director-General, distinguished delegates, ladies and gentlemen, I would like to start, Mr President, by congratulating you on your election to the presidency of the Thirty-eighth World Health Assembly. My congratulations also go to your Vice-Presidents on their election to serve this august Assembly, which has as one of its major tasks this year to consider the proposed WHO budget for the biennium 1986-1987.

In considering the WHO budget this year, it is hoped that the Member States assembled here will take stock of the way we have been utilizing WHO resources in our countries, and assess whether we are indeed utilizing those resources optimally. To this end I have decided in my address today to concentrate on reporting how my country is collaborating with WHO in the health-for-all strategy, and the efforts we are making to ensure that WHO resources are utilized optimally in our strategy for health for all.

Zimbabwe, like many other Member States here, is actively engaged in transforming its health care delivery system from a previously curative-heavy service to a health system that

is based on primary health care. This process of transforming the health system has not been an easy one. The health sector initially had to contend with a lot of resistance to change, both from the health workers - who thought only in terms of medical care as opposed to health promotion - and from the community, which equated progress in the health sector with a proliferation of curative facilities. However, I am glad to say that to a very large extent these problems have now been overcome. Most of our health workers now fully understand the rationale for adopting the primary health care approach and its importance as a strategy that should assure the attainment of health for all by the year 2000. Because our health workers now fully appreciate the importance of primary health care, they are able to reorientate the community to think of health in terms of preventive and health promotive activities, rather than simply in terms of curative services, as was the case in the past.

To attain the necessary attitudinal changes on the part of the health workers however, a great deal of work was required. And here I am glad to say that WHO and my Ministry collaborated very effectively in mounting national workshops that served to orientate, firstly top-level managers, then middle-level and others, in the principles and practice of primary health care and its programme components such as the Expanded Programme on Immunization, and maternal and child health. These workshops, which were first held at national level, were replicated at provincial and district levels. In this way, information on new policies and programmes endorsed at national level has been disseminated effectively to the most peripheral level. It is important to state here that WHO also provided resource persons and facilitators at many of these workshops.

In addition to the national workshops, Zimbabwe's participation at many WHO-sponsored regional and interregional workshops has tremendously strengthened our health manpower's understanding and commitment to primary health care and health for all. It is our earnest hope that collaboration in this area will continue to be strengthened.

Another important area where WHO and my Ministry have collaborated very effectively, assuring the optimal utilization of WHO resources, has been in the field of health manpower training. After our independence, we identified a specific deficiency in the health-sector manpower trained in community health and public health. The WHO fellowships that have been awarded to Zimbabwe have been utilized primarily to remedy this deficiency and also to develop manpower in related fields such as maternal and child health, epidemiology, statistics, and so forth. I am glad to say that collaboration in this field is proving extremely rewarding, as we are now beginning to get a pool of our local people who are appropriately trained to grapple with our health problems. It is also our hope that collaboration in this field will continue to expand and will include the training of those specialist health workers whom we require in order to ensure that our primary health care service has a sound back-up and referral service. I am talking here about the training of such specialists as anaesthetists, pathologists, obstetricians and gynaecologists, paediatricians, and others who are required at our secondary, tertiary and quaternary levels in order to give an effective referral and supervisory service to all primary health care activities.

In the field of technical cooperation, WHO has worked closely with my Ministry in strengthening various units in the Ministry of Health at central level. We have had the very able support of WHO consultants on a medium-term basis, in our epidemiology, health education, nutrition, and health information system units. On a short-term basis we have requested from WHO, and received, short-term consultants in numerous areas such as health financing and health planning, and their contributions to my Ministry have been remarkable. This support is indeed invaluable, particularly at this stage of my country's development when we still have very little manpower trained in the areas mentioned. We have taken the opportunity of seconding to all WHO technical staff deployed in my country a local counterpart, who we hope will gain experience and expertise from the respective consultant. I must say here that we are seriously engaged in training our own people, so that we shall ultimately be self-reliant in the health sector. However, during the interim period while our manpower is undergoing training, we shall continue to require the technical cooperation that has already been established with WHO.

Mr President, I could go on to mention the many areas of collaboration in which my country and WHO are engaged. However, I believe that what I have touched on suffices to indicate that Zimbabwe and WHO are working closely together in the health-for-all strategy, and that Zimbabwe is indeed seeing to it that the WHO resources at its disposal are utilized optimally, for the maximum benefit of the health sector and indeed the country as a whole. We hve benefited tremendously from collaboration with WHO, since our independence. It is our earnest hope that this collaboration will continue to strengthen and expand, so that we can realize our common goal of health for all by the year 2000.

Dr VAN WEST-CHARLES (Guyana):

Mr President, Mr Director-General, distinguished delegates, comrades, it gives me great pleasure to be in Geneva once gain and to be afforded the opportunity of addressing this august Assembly. Permit me, Mr President, to felicitate you, the Vice-Presidents and other offices on your election to office. May I also congratulate the Chairman of the Executive Board and Dr Mahler for their excellent reports. May I also take this opportunity to express my Government's sincere thanks to Dr Mahler and his team for the interest and support given to us.

A few years ago the slogan for World Health Day was: "The countdown has begun" towards health for all by the year 2000. For some of us that countdown has accelerated, while for others it has surely slowed down.

The Ministry of Health in Guyana has accepted that the key to this attainment is the primary health care approach and has therefore developed a strategy utilizing this approach to achieve its goals. The implementation of the approach called for a reorganization of both the technical and the administrative services, which were restructured in accordance with the following principles:

(1) that services be brought as close as possible to the people, where they can be delivered with effectiveness and efficiency, with due regard to cost;

(2) that problems should be solved as close as possible to the point where services are delivered; and

(3) that services be delivered on a regionalized basis, allowing for the appropriate level of care to be provided, with access to higher levels when necessary, through a well-developed referral system.

In the reorganization process, five levels of care have been defined. It is necessary to understand these in order to appreciate the administrative structure which has been developed.

Level I is found mainly in hinterland areas, and is appropriate for any remote or isolated area with a population of 100 or less. Care is provided by a community health worker, who teaches good health practices and preventive care but also takes care of minor ailments and gives first aid. This worker is a member of the community which he or she serves and is chosen by the community for training. Some community health workers work from their homes, but where a facility is provided it is referred to as a health post. This worker is supervised by the health worker(s) of level II.

Level II is typified by services provided by a health centre and manned by professional, paramedical, specially trained personnel such as medics, a public health nurse and midwife, a public health inspector and a dental nurse. It provides for communicable disease control, solution of common medical problems, maternal and child health care, dental care, emergency treatment, and control of the environment through the monitoring of environmental health practices. This level benefits from periodic visits by a district medical officer, or has accces to such service at the next level (III).

At level III the district hospital provides all the services as at level II, but also has the services of a medical officer and a pharmacist/dispenser, basic laboratory and X-ray services and a dental unit. It provides inpatient services for maternity and general medical and surgical care. And it is responsible for the supervision and support of levels I and II, and makes referrals to level IV.

At level IV care is given by medical personnel with postgraduate training or greater experience in specific fields than the medical officers at level III. These specialties include obstetrics and gynaecology, medicine, surgery, paediatrics and anaesthesia. This level also provides for physiotherapy services. A wider range of laboratory, pathology and X-ray services are available. This level provides technical support to the other levels of care, and refers to level V. In each region where four levels of care are provided, there exists the political structure which seeks to involve the community at all levels.

Level V is provided only at the main hospital in the Capital. Here, level IV care is provided and, in addition, there are specialties of orthopaedics: ophthalmology; ear, nose and throat; neonatology; and radiotherapy.

In short, four levels of care are provided in the regions. At these four levels the bulk of health care demanded by consumers of the health services is delivered. Referral to the highly-specialized care at level V accounts for a small percentage of the demand for health care services. This system of stratification of care provides for the integration of the promotive, preventive, curative and rehabilitative aspects of care. However, there are certain services which do not, at this time, fit into this structure and continue to be provided on a vertical basis. These are: analytical services, rehabilitation, vector control, chest services, Hansen's diseases (leprosy), veterinary public health and dental health.

I would like next to direct a few remarks towards a subject which is near to us all during this year. I am referring in particular to the designating of this year as International Youth Year. In the Americas, PAHO has put out two interesting publications, entitled Health of adolescents and young adults in the Americas - a commitment to the future and An annotated bibliography on school-age child and adolescent. Further, WHO has resolved to celebrate World Health Day 1985 under the theme: "Healthy youth, our best resource". I need not emphasize how important our young people are. They are a precious resource which must be protected, nurtured and guided for the future development of any country. We in Guyana cherish our young people and have put into place the mechanisms to ensure their orderly and rounded progression towards adulthood.

We recognize that training and reorientation are the main ingredients for the attainment of health for all and Guyana is embarking on a programme of training of its physicians in order to satisfy a long-felt need - with this new orientation that is more community-oriented.

I should like to turn now to two problematic matters which, in Guyana's considered opinion, should be brought to the attention of the Assembly.

I refer first to the problem of malaria. In the Seventh General Programme of Work, the section dealing with activities aimed at fostering national and international action as regards malaria specifically states that:

"(1) By 1986 most countries where malaria exists or threatens will have developed programmes to prevent and control it;

(2) By 1989 all countries with established countrywide programmes for control and/or eradication will have subsequently reduced the annual malaria morbidity with the aim of attaining less than 1% morbidity. In all countries effective measures will have been taken at least to reduce the mortality from malaria in special groups, such as children under nine years of age and pregnant women;

(3) By 1989 measures to prevent the re-establishment of malaria will be operating as part of the general health system in all areas that have been freed from the disease."

The study further states that in order to attain the targets set there must be collaboration and cooperation with Members States in order to develop and implement realistic plans for malaria control and, where feasible, eradication, including cooperation between neighbouring countries and territories. It gives me pleasure to report to this Assembly that Guyana has sought the cooperation and collaboration of its friendly neighbours to hasten the demise of this disease, since eradication cannot be achieved without the cooperation and collaboration of Guyana, Brazil, Venezuela and Suriname. Our relationship with our eastern neighbour, Suriname, has been more active in that representatives from Guyana and Suriname have met on a formalized basis to work out strategy in this area. We do hope that WHO/PAHO would facilitate this cooperation and collaboration among the countries we have mentioned.

Another area which needs attention is water. Although Guyana has made considerable strides in the provision of potable water, not only in the urban but also in the rural areas, waterborne diseases are still a problem. We wish to thank PAHO, Canada and the Netherlands for their support in this area, but there still remains a great deal to be done.

Mr President, as I have said before, the countdown has begun. But, sad to say, it appears at this point in time that the global commitment of the attainment of health for all may not be met. As we ascend this rostrum to speak, millions of our brothers and sisters die by the minute. I know that, individually, many countries have come to the aid of these unfortunate peoples, our brothers and sisters. The collective efforts of small States, coupled with that of the wealthier nations, could alleviate the present trend of providing what has been described in some quarters as: "Too little too late". Measures have to be devised to prevent the recurrence of a calamity of this magnitude. Prevention underlies the health-for-all solution to this problem, which also epitomizes the development of the New International Economic Order.

Mr President, we may ask ourselves the burning question: How can we seek to achieve the goal of health for all when north/south attempts at dialogue have to date not been successful?

The success of this programme, Mr President, depends not only on the improved utilization of human resources and improved effectiveness within the north and the south, but there is a definite need - may I say an immediate need - for north/south dialogue in order to arrive at a new International Economic Order, accompanied by a change in the attitude of some international institutions which now does not lend itself to the achievement of our global commitment.

Guyana has identified the following important factors for the attainment of health for all by the year 2000, at both national and international levels: (1) a new International Economic Order; (2) a solution to the debt problem; (3) an end to the arms race; and

(4) peace. Unless we address these issues now, in the year 2000, if we fail, we would rationalize the whole situation by saying: "To err is human". I appeal to the conscience of mankind, which no other living organism possesses. Onward to the year 2000 with the spirit and sincerity of Alma-Ata. Humanity's survival rests with us.

3. PRESENTATION OF THE SASAKAWA HEALTH PRIZE
REMISE DU PRIX SASAKAWA POUR LA SANTE
ВРУЧЕНИЕ ПРЕМИИ ФОНДА ЗДРАВООХРАНЕНИЯ САСАКАВЫ
ENTREGA DEL PREMIO SASAKAWA PARA LA SALUD
تقديم جائزة ساساكاوا للصحة

颁发 SASAKAWA 卫生奖

The PRESIDENT:

We shall now suspend the general discussion and proceed to the presentation of the Sasakawa Health Prize. Please remain seated.

Ladies and gentlemen, it is a great pleasure now to introduce the first recipients of a newly created prize - the Sasakawa Health Prize. This prize has been established and funded by Mr Ryoichi Sasakawa, Chairman of the Japan Shipbuilding Industry Foundation and President of the Sasakawa Memorial Health Foundation. The Sasakawa Health Prize rewards innovative work in health development. Its statutes were accepted by the Executive Board of WHO at its seventy-third session.

It is a great pleasure to welcome Mr Sasakawa, who has honoured us today with his presence on this auspicious occasion.

Every Award Committee hopes it will attract applicants of a high calibre - and then when it does, it must contend with some very difficult choices. There were so many applicants of high quality for the first Sasakawa Health Prize that the Award Committee found it impossible to make one single choice. It therefore agreed that this year's Sasakawa Health Prize should be shared by three candidates, namely: Dr Jesus Azurin, Dr David Bersh Escobar, and SEWA-Rural - a voluntary organization, represented by Dr Lata Desai, Associate Director. We are delighted to have all of them with us today.

I am honoured now to introduce Dr Jesus Azurin, Minister of Health of the Philippines. Throughout his distinguished career, and particularly as Minister of Health, Dr Azurin has provided capable and dynamic leadership to the development of health services in his country. His work and achievements have been recognized nationally and internationally, and he is the recipient of several awards and citations.

Dr Azurin's efforts - particularly as Deputy Minister and Minister of Health - illustrate those leadership qualities which are essential to converting political will into political action in favour of health for all. Dr Azurin has personally initiated and promoted a series of innovative measures to make primary health care a reality in the Philippines. Noteworthy among his achievements is the mobilization of resources in favour of primary health care, which has led 99% of all barangays (villages) to initiate primary health care activities as of May 1984. Dr Azurin has reorganized the Ministry of Health in order to decentralize its activities.

A strong believer in low cost and locally available technology in health care, Dr Azurin has vigorously supported the establishment of village pharmacies as community projects to bring essential drugs within the reach of the population at an affordable cost. In the field of communicable diseases control, his dedicated and pioneering efforts have led to the establishment of a research institute for tropical medicine in Manila, as a support to the Ministry's programme to control communicable diseases. Finally, he has actively promoted and fostered linkages with other government and nongovernmental agencies to plan, implement, and evaluate primary health care programmes. For example, almost half a million teachers are now working hand in hand with 58 000 health ministry workers in order to educate the Filipinos in the improvement of their health.

The Sasakawa Health Prize will be used to further this valuable work in favour of health for all in the Philippines.

It is also an honour to introduce Dr David Bersh Escobar of Colombia. Dr Escobar is currently Director of Health of the Committee of Coffee-Growers in the region of Quindio. He is an outstanding public health physician, with exceptional technical and managerial capabilities and a demonstrated sensitivity to community needs. His dedicated efforts since 1978 have played a major role in implementing the principles of primary health care in the region of Quindio, Colombia.

In his early career, Dr Bersh played an important role in the development of rural health services in Colombia. In 1977, he assumed the post of Director of Health of the Committee of Coffee-Growers in the region of Quindio. Here he conceptualized the health plan for the region, and coordinated and directed its implementation. A unique feature of the plan is the integration of the efforts of private industry with the Government's health sector. His vision and initiative have demonstrated how a private industry can promote, stimulate and reinforce government efforts to achieve primary health care. Some achievements of this plan to date are the reorganization of the health care delivery system in accordance with primary health care; the retraining of health workers; creation of a regional health education council and involvement of local community groups in education for health; and health system research studies which have guided the development of health programmes in the region.

Building on these experiences, Dr Bersh has spearheaded the establishment of a National Centre for Health Education. The Sasakawa Prize will be used for the further development of this Centre.

Finally, it is a pleasure to introduce the third recipient of the Sasakawa Health Prize - a recently created voluntary organization - the Rural Society for Education, Welfare and Action in Gujarat Province, India. Receiving the prize is Dr Lata Desai, who is Associate Director of SEWA-Rural's community health project. SEWA-Rural offers an excellent example of a voluntary organization working with government to develop primary health care for disadvantaged rural populations. Its dedicated efforts have already led to the adoption of several innovative yet simple approaches to strengthening community-based health services.

SEWA-Rural was established in 1980 by a group of concerned physicians and other professionals. The group's mission is to work for the removal of the poverty, ignorance and ill-health which affect rural India, through an integrated approach to rural development.

The organization began its activities by taking over the management of a small maternity home and converting it into a fully-fledged community hospital in October 1980. This hospital is now providing a full range of in-patient and out-patient consultation facilities to the surrounding rural populations. SEWA-Rural has also initiated rural community outreach health services, working with village health workers, traditional birth attendants and mobile health teams. Outreach activities include health education, maternal and child health, case detection and treatment of tuberculosis patients, immunization, and supplementary nutrition.

SEWA-Rural's activities have acquired the recognition and support of the Indian Government at the local, state and national levels. In fact, the Government has now transferred to the organization all the health workers, facilities, and corresponding budget for a forty-village area.

The future plans of SEWA-Rural include developing its action in the area of education and economic development, and the Sasakawa Prize Award will be used to further these activities. This year, when the Technical Discussions are on the subject of collaboration with nongovernmental organizations, it is most appropriate that one of the prize-winners should be a national nongovernmental organization.

It is now my privilege and honour to present the 1985 Sasakawa Health Prize to the three laureates.

Amid applause, the President handed the Sasakawa Health Prize to Dr J. C. Azurin, to Dr D. Bersh Escobar, and to Dr L. Desai representing SEWA-Rural.

Le Président remet le Prix Sasakawa pour la Santé au Dr J. C. Azurin, au Dr D. Bersh Escobar, et au Dr L. Desai représentant SEWA-Rural (Applaudissements)

Под аплодисменты Председатель вручает премию Фонда здравоохранения Сасакавы д-ру J.C. Azurin, д-ру D. Bersh Escobar и д-ру L. Desai (SEWA-Rural)

El Presidente hace entrega al Dr. J. C. Azurin, al Dr. D. Bersh Escobar y a la Dra. L. Desai, representante de SEWA-Rural, del Premio Sasakawa para la Salud (Aplausos)

وفي وسط التصفيق ، سلّم الرئيس جائزة ساساكاوا للصحة الى الدكتور خ٠ك٠ أثورين والدكتور د٠ بيرش اسكوبار ، والى الدكتورة ل٠ ديساى ممثلة سيوا-روورال٠

在掌声中，主席将 Sasakawa 卫生奖授予阿祖林博士；伯什博士及农村学会的代表德塞博士。

The PRESIDENT:

It is now my pleasure to give the floor to Dr Jesus Azurin.

Dr AZURIN:

Mr President, and the distinguished officers of this Assembly, Director-General Dr Mahler and his staff, honourable delegates, ladies and gentlemen, it is with great honour that I accept this award, not only for myself but for the entire Philippine Ministry of Health.

The success of primary health care in the Philippines is the result of the unselfish, untiring dedication of the staff of the Ministry and the active participation of the communities in the Philippines. The concept of primary health care is not new in the Philippines. Through the years, programmes have at one time or another been formulated along the basic principle of utilizing every available resource to meet the needs of our communities. People's participation has been encouraged and was actually availed of in the implementation of such programmes. However, it was only recently that President Ferdinand Marcos mandated that primary health care shall be implemented throughout the country. In compliance with this directive, the Minister of Health planned, trained and implemented primary health care.

For this commitment, the Ministry had to reorganize its structure to support primary health care. We realized that it was no longer feasible to use the old structures in the light of the concept of primary health care, and because of this we had to integrate all health services into one structure and also decentralize the various programmes of the Ministry. It called for a complete merging of all aspects of health care. It put them into a common administrative structure, a common budget, with common facilities and manpower resources. Integration of health services assures that our priority programmes will continue to be fully supported. The Ministry of Health can therefore look forward to and achieve a particular degree of accomplishment every year in spite of the differing resources that are allotted to our Ministry. Without integration, limited resources have to be spread out thinly to cover every aspect of health care, thereby aggravating the existing problem of inadequate resources. Therefore, convinced that integration is both necessary and inevitable in order to achieve effectiveness, the Ministry of Health lost no time in implementing a unified approach.

Today, more than ever, as the country goes through these difficult times, it is gratifying to see the precious fruits of our labour: people who have become aware of their responsibilities towards their own health and who have risen up from being mere recipients and become active participants in the maintenance of health, not only of themselves but of their families. The primary health care approach is officially working in all the villages, which we call barangays, in the Philippines, except for probably 1% of these 41 000 villages. These are the inaccessible barangays and those that have some peace and order situations. Our volunteer health workers have now reached a total of 365 941 as of the beginning of this year. We are trying to achieve one health worker for every 20 households. In mid-1984 retraining of these workers was started to prepare them in the implementation of the programme thrusts of the Ministry. The barangay health workers are now utilized not only for IEC activities but in the more expanded role of health providers, as they are the first contact between the people and the health system. They proved to be active partners in community-based disease control programmes. They have also helped a lot in meeting the increasing demand for services by attending to the needs of our sick, using medicinal plants and low-cost essential drugs which are now available in 14 000 village pharmacies distributed throughout the Philippines. Established as a community project, these pharmacies are being managed by volunteer workers chosen by the community and who have trained as pharmacy aids. Also, in keeping with the Ministry's objective of expanding service coverage and providing basic requirements for good health, the herbal medicine projects have been instituted throughout the Philippines.

Primary health care is now beginning to be a way of life for the country. During these uncertain times the Filipinos have looked to their own selves and to their inherent resources for the achievement of an acceptable level of health and well-being. In order to provide a supportive environment for health our Ministry, being the lead agency in the implementation of primary health care, has linked up and reached out to all related sectors. We have forged agreements with various government agencies, among which is the Ministry of Education, in an effort to find solutions to the multifaceted problem of educating the masses towards the achievement of good health. Nongovernmental organizations, considered to be strong and

effective partners in the delivery of health services, have also been identified and steps have already been taken to ensure their support. For example, we have tapped the National Federation of Women's Clubs and drawn up an agreement with them. Also, more than 300 other nongovernmental organizations have been identified. In November 1984, an orientation workship was conducted for the representatives of these organizations, wherein areas of cooperation were identified, obstacles to a harmonious relationship were cleared up, and an agreement was reached for collaboration in primary health care. In the flurry of all these activities the Ministry has always kept one goal in mind: that we be able to achieve health for all Filipinos by the year 2000. This is a direction which the Ministry wants to take. This is a goal that constantly keeps us on our toes.

A review of the current health and socioeconomic situation shows us how much work still has to be done. A look into the future is not entirely encouraging. However, this does not dampen our spirit. On the contrary, it poses a big challenge that we in the Ministry of Health must overcome. With primary health care, we look towards the year 2000 with bright hopes. Filipinos by that time will be enjoying what has actually been their birthright, and there will be a signficant level of health that will permit them to live a socially and economically productive life. Our winning the award will not put a stop to our efforts. Rather, it will be a challenge for us to go on and make our goal a reality.

To Mr Ryoichi Sasakawa, I would like to extend our deep gratitude for his unwavering support to the cause of health, for having graciously and unselfishly contributed to the development of health all over the world and, of course, for making this award feasible.

To WHO's Director-General, Dr Mahler, whose ever-growing concern for health has inspired many countries to work harder, we would like to inform him that during his leadership we have achieved a significant mark in the field of health, and that is the eradication of smallpox, which we consider is the significant contribution of health during this century. And of course to WHO, thank you for acknowledging our contribution to this global pursuit by awarding us this award.

Thank you.

The PRESIDENT:

Thank you, Dr Azurin. Dr Bersh Escobar will now address the Assembly.

Dr. BERSH ESCOBAR:

Señor Presidente de la 38[a] Asamblea Mundial de la Salud, señor Director General, señores Vicepresidentes, señores Directores Regionales, honorable Sasakawa, señores de la Fundación Sasakawa, distinguidos delegados de esta Asamblea: Recibir el Premio Sasakawa para la salud correspondiente a 1985, es motivo de gran complacencia y comprensible orgullo, pues los fundamentos de este Premio, su intención y la calidad de quienes lo administran y adjudican, lo hacen especialmente honroso. Además, el hecho de que sea entregado en presencia de la Asamblea Mundial de la Salud, confiere un singular honor a quienes lo recibimos.

La labor que, según el Comité del Premio, dio mérito a esta distinción, en mi caso ha sido por la ejecutada durante los últimos años en el Quindío, pequeña provincia de Colombia. Dicha labor ha sido patrocinada por la Federación Nacional de Cafeteros de Colombia, entidad gremial de agricultores productores de café, quienes han dado tanta importancia a la salud,dentro de sus políticas sociales, que su política en esta materia puede considerarse un ejemplo que ilustra cómo en los países en desarrollo las organizaciones no gubernamentales pueden llegar a contribuir significativamente a la mejora de la salud de las gentes. Mas si esta participación del sector privado en la salud colectiva ha sido de considerable valor, ella por sí sola no hubiera producido los efectos benéficos que se han registrado, pues éstos han obedecido también,en buena parte, a la capacidad de los servicios de salud del Estado para recibir la colaboración privada, en una integración armónica con sus propios esfuerzos, sin desestimular el entusiasmo ni limitar las iniciativas de su colaborador. De la experiencia del Quindío, en Colombia, se han sacado varias enseñanzas. Entre las cuales destaca el hecho de que la efectividad de las actividades de salud dependa mucho más de la acción integrada de varias disciplinas, que de la sola eficacia intrínseca de las técnicas sanitarias, tal como a continuación explico.

Con el fin de mejorar la administración de la salud en el mundo, se ha hecho un considerable trabajo tendente a aumentar la racionalidad en la organización y en la tecnología, para hacer así más efectivos y eficientes los esfuerzos que se realizan en beneficio de la salud. Esto ha conducido a una mayor precisión en el diagnóstico de las condiciones de salud de las

gentes, de sus problemas y de las prioridades para abordarlos. Igualmente ha generado progreso en el desarrollo y en la aplicación de tecnologías apropiadas para la prevención y el tratamiento de dichos problemas. Como consecuencia de lo anterior, se ha logrado un apreciable acopio de numerosas técnicas y de conocimientos para hacer más eficaces y económicas las acciones de salud. Sin embargo, frecuentemente se verifica que la sola existencia de técnicas y conocimientos no es condición suficiente para que se utilicen. Pues la aplicación y el buen éxito de los programas de salud parecen depender más de otras disciplinas diferentes a las ciencias médicas y a los métodos convencionales de administración sanitaria.

En el caso del Quindío la cooperación de una organización no gubernamental en la mejora de la salud ha permitido explorar un enfoque diferente, partiendo de un claro planteamiento filosófico de lo que es la salud, seguido de investigaciones sencillas y aplicadas, que con la información proveniente de fuentes estadísticas, cimentó la formulación de planes y programas para los problemas de salud. Este enfoque tuvo en consideración los aspectos culturales, sociológicos, económicos y políticos que de alguna forma pueden influir en los hechos y en las decisiones sobre la salud y, sin esperar que las decisiones surgieran como consecuencia de la bondad de las propuestas técnicas, se realizó una gestión activa tanto en las decisiones políticas como en la ejecución, el seguimiento y ajuste de los programas. El componente de la educación para la salud, en la experiencia del Quindío, ilustra cómo la aplicación de tecnologías educativas sencillas ha dependido apreciablemente de que previamente se hayan tenido en cuenta una serie de factores teóricos, sociológicos, económicos, políticos, administrativos y de investigación. En la experiencia mencionada, los programas de educación para la salud tuvieron su origen filosófico en un conjunto de explicaciones teóricas, que muestran cómo es la influencia del comportamiento en la salud. Este planteamiento filosófico sobre la salud dio una gran importancia a la educación sanitaria, ubicándola en un lugar prioritario en el desarrollo de la salud del Quindío. Por lo tanto, tal enfoque sirvió de argumento para motivar la decisión de invertir en educación para la salud y luego guió la planificación y ejecución de las actividades educativas. En un principio, estas actividades se basaron en información estadística, epidemiológica y cultural, pero posteriormente fue necesario completar tal información con investigación aplicada, con el fin de incrementar la efectividad del proceso educativo. Mas el buen éxito no dependió sólamente de la filosofía, las decisiones políticas, la planificación, la programación, la producción y el uso de la información, sino que fue necesario procurar la participación intersectorial y comunitaria en los programas educativos para que alcanzaran mayor fuerza y extensión. Esta tarea dependió de un buen diagnóstico sociológico de las instituciones de otros sectores, de sus fines, sus relaciones, sus intereses y sus estructuras de decisión, seguido dicho diagnóstico de una activa gestión para lograr su participación. Visto así, el proceso parece tan complejo que es lógico preguntarse si no sería más práctico que las organizaciones no gubernamentales que deseen cooperar con la salud lo hicieran donando simplemente una ayuda económica. Empero, los hechos indican que la sola ayuda económica no se traduce necesariamente en desarrollo de la salud, sino que tiende a convertirse en una simple colaboración para el financiamiento de los gastos convencionales de los servicios de salud. El fenómeno no es diferente del que se observa en la cooperación internacional para la salud, en la cual la experiencia ha enseñado que dicha ayuda debe ir acompañada de una adecuada orientación, seguida de la asistencia técnica necesaria para que se logre una satisfactoria planificación, organización y ejecución de los programas.

La solución a la pregunta formulada suscita un interrogante, aparentemente resuelto en la filosofía de la salud, pero aún vigente en la administración de los ministerios de salud. Replanteando el asunto, para darle claridad, nos preguntamos hasta qué punto se debe llegar con las inversiones destinadas a atender los gastos convencionales de operación de los servicios de salud, los cuales no siempre conducen al desarrollo de la salud, sino que atienden, más que a todo, a la demanda tradicional de los servicios usualmente ofrecidos a la población y, en contraste, qué financiamiento debe aplicarse a aquellas cosas que ofrezcan razonables posibilidades de un verdadero cambio en la salud. El examen y solución de este interrogante es importante porque toca uno de los más difíciles problemas de la salud, que es su financiamiento en los países en vías de desarrollo, en los cuales el pronóstico más probable indica un déficit permanente y, tal vez, creciente para cubrir los gastos de atención médica y de programas preventivos. Por lo tanto, a menos que se den argumentos serios y convincentes que indiquen una futura bonanza financiera para la salud, se hace imperativo racionalizar con mayor rigor el gasto en salud, respetando tanto el criterio de humanidad como la legítima aspiración de los seres humanos a tener un desarrollo real de su salud. Esta mayor racionalidad no debe ser sólo un frío perfeccionamiento de las relaciones de causa-efecto, ni debe caer en la superficialidad de separar lo preventivo de lo curativo para considerar lo primero como la única cau-

sa del desarrollo de la salud. A mi entender, ella requiere una reflexión basada en la relación más integrada de las ciencias sociales y administrativas con las técnicas de la salud. La mayor racionalidad como base para una mejor formulación de políticas de salud demanda un mayor esfuerzo, por tener una visión más unitaria del hombre y de su especie.

Agradezco infinitamente a la Fundación Sasakawa su generoso estímulo, tanto moral como material, e igualmente expreso mi reconocimiento a las personas que de alguna forma tuvieron que ver con el estudio y adjudicación del Premio. Ofrezco, como respuesta al mismo, la decisión de utilizar dicho Premio de forma tal que cumpla los fines de la Fundación y de la Organización Mundial de la Salud de lograr salud para todos en el año 2000.

The PRESIDENT:

We shall now hear Dr Lata Desai, representing SEWA-Rural, India.

Dr DESAI:

Mr President, and health workers from all around the world, it is an honour for SEWA-Rural to receive the first Sasakawa Health Award.

We share our concern, interest, and aspirations in providing health for all through the primary health care approach with many people around the world, including all of you. It is heartening to note the resounding voice of concern, not only from developing countries but also from developed ones - but still many more in society do not appreciate its importance. I remember an industrialist who started building a sophisticated hospital to serve the poor. His intention was no doubt good. However, he never thought that the people of the area were more in need of primary health care until he approached the funding agency and discovered that money would be available only if he modified his programme, thanks to the approach of the funding agency and the government. To cite another example: young medical graduates find more glamour in specialties like surgery, and shun community health.

I feel we must be aggressive in emphasizing the importance of primary health care and educating society at large - which includes the common man, the press, politicians, industrialists, universities, and our colleagues in the medical professions. What is most needed is the will at various levels, to make this object a reality.

Speaking of primary health care, and of immunization in particular, it is unfortunate that many developing countries with a high incidence of diseases such as measles and polio, still have to import life-saving vaccines from developed countries. Let us emerge from the primitive idea of competition, at least in the health area, and have a cooperative spirit among all of us in sharing the technology in such matters.

Now let me talk about our organization. SEWA-Rural is a voluntary organization initiated by a group of friends interested in overall community development, though our activities have hitherto been in the health area. We are working in a rural area of Gujarat state, in the western part of India. The population is 100% rural, and 60% tribal; 40% of males and 70% of females are illiterate, and 60% of them are landless labourers. A beginning was made in 1980 with a 40-bed hospital given to us by the local community. After building up the necessary rapport and confidence in the community by providing curative services, we began the community health project in October 1982 with a baseline survey of 10 000 population. Eventually we plan to work in an area of 35 000 population. We spend about 40% of our resources on primary health care and 60% on our referral hospital, to which - in addition to those from our project villages - people now come from more than 400 villages for referral services.

Next, I would like to talk about our innovations, which are (1) to develop a replicable model, with the participation of the Government; and (2) to make programme implementation more effective. Our efforts have been towards evolving a rural health care programme which can be replicated elsewhere. Among the voluntary agencies there is a feeling that cooperation with the Government is not conducive to voluntarism because of system constraints, bureaucracy, and lack of respect for the voluntary agencies. In SEWA-Rural we thought we must find ways and means of working with the Government, as only then could we bring public financial resources to the service of the community. In this way duplication can be eliminated, resources conserved, and confusion in the community avoided. We also thought that, with total commitment and clarity, we should be willing to accept failures if our effort did not yield the desired results. We therefore initiated a dialogue with the district *panchayat* and took on the responsibility of village-level health work for 10 000 population. On the whole, the experiment was found useful by both sides. With this initial success the Gujarat state Government, in an unprecedented gesture, transferred to SEWA-Rural the management of all health activities in an area of 40 villages. Thanks to this

participation and to other innovative approaches we should be able to achieve, for our project area, "health for all by the year 2000" much before the target date. Though there are minor irritants arising from lack of perception at junior functionary level, we find that government organization, by and large, is quite receptive to our methods and approach, provided that we, as a voluntary organization, are ready to accept functional and financial accountability. I must mention that our experiment is at a comparatively early stage; and that the degree of replicability will depend upon political will and the attitude of other voluntary agencies as well as on the community.

Speaking of the second innovation, we know that most government and nongovernmental programmes are well-intentioned, well-thought-out and well-conceived; but many do not achieve the desired results, probably because of difficulties in implementation. We tried to make implementation more effective by mobilization, motivation and participation of the people at various levels, and by attending to the details of the activities. For example, the simple task of providing a delivery pack is done a little differently if it is given to the mother herself (with health education in its use by the supervisor) rather than to the worker, the traditional birth attendant. For activities such as health education and vaccination we go to the fields at a time convenient to the community, that is, early morning or late evening. Technical staff such as nurses, X-ray technicians, laboratory technicians, and so on, are selected from the local community, though with less qualification. But given the practical training, this works out far better than recruiting more qualified outsiders. Through the village health committee, the participation of the community is gradually being increased. The social and status barriers between the different levels of worker are broken down by sitting, eating and having tea together, and also by taking part in local cultural activities such as tribal dances. The training of grass-roots level workers is designed to be carried out in short multiple sessions, and also in the form of a dialogue. A simple technical but practical input is provided by the training posts.

We strongly believe that, to make implementation effective, we need man: man with feeling for the people, man with grit. The backbone of our nation is spirituality and keeping this at the centre, we try to motivate people. This is done at prayer, or at a meeting in the village or at the centre, by sitting together or alone and evaluating ourselves - what we are supposed to do, and what we are doing. Of course, this may be in the form of elevating reading; of listening to or singing inspiring songs; of prayer or meditation.

We try to build all our programmes keeping in mind three basics. The first is social service, in which is included social justice; the second is the scientific approach; and the third is the spiritual outlook. What we have found easiest and more conducive to our culture and society is this spiritual outlook on work and life. I don't mean spirituality in its traditional or popular meaning. Does not the same principle underlie the atheist's humanism, the non-violence of Jainism, the brotherhood of Islam, the compassion of Buddhism, the love of Christianity, and the Vedanta of Hinduism? Probably we may find the answer here whether it is a question of implementing a health programme or even an issue such as a communal riot, nuclear armament, human rights violation, or exploitation of one kind or another.

I would extend my gratitude, respect and thanks to Mr Sasakawa for joining us and becoming a partner in the programme which will take us nearer to our goal. Thank you.

The PRESIDENT:

It is now my privilege to give the floor to the generous founder of the Prize, Mr Ryoichi Sasakawa.

Mr SASAKAWA (interpretation from the Japanese):

Dr Mahler, distinguished delegates to the Assembly, distinguished guests, ladies and gentlemen. At the very outset I would like to extend my most sincere respect and deep gratitude to all the colleagues who are fighting day and night, for the advancement of the health and welfare of peoples on this earth. On behalf of more than 23 million people, whom I represent as Chairman or President of the various organizations I lead, I would like to express my heartfelt gratitude and deep respect to all of you for your dedicated work.

Physically speaking, I became 86 years old on this 4 May. But I am blessed with good health; I do not require glasses to read; I work 365 days a year without a holiday because I believe I can have plenty of holidays when I leave this world. In short, I am trying to realize my lifelong belief and motto - that on this earth the world is one family and all mankind are brothers and sisters. And I try to share my good health with all the people in

the world who still do not have equal access to the outcome of the excellent science and technology that we have developed so as to bring good health, longevity, and happiness to all mankind, and to make "spaceship earth" a clean, comfortable and peaceful place to live.

Many people from all over the world visit my office every day, and most of them ask me: "Why, Mr Sasakawa, are you so healthy? What is the secret of your good health?" To them I always put this question: "If a burglar tries to enter your home do you open the door and give him what he wishes?" And they all answer: "Oh that's absurd; we don't give away anything to burglars!" I believe that aging is like being robbed of your precious life. You may gain age until you reach 60, but beyond that you had better not allow the robber to steal your life.

So when I reached 80 I decided to throw away 60 years from my physical age and became only 20 years old again. Therefore, I am 26 years young. I do not welcome age any more, and I refuse to be dominated by age. Furthermore, I ask everybody to fill their heart with flowers of love and compassion, and I pray day and night for the good health and happiness not only of human beings but also of all living things, animals, birds, and so on. If I happen to see an unfortunate creature being hit by a car on the road, for instance, I stop and pray for them so that they may rest in peace. I also try to extend help and comfort to those who have health problems, and give courage to those who are in distress. There are those who are hungry but without food; there are those who have no house for shelter; and there are those who are sick but cannot afford or reach a doctor. There are many who are not fortunate. Therefore I do not allow myself to indulge in personal pleasures, but I find pleasure in working and serving others. This is the secret of my good health.

On this memorable occasion, allow me to express my gratitude for the opportunity I have had to cooperate with WHO in the historic achievement of the eradication of smallpox, which was realized by the concerted efforts of WHO and health personnel throughout the world, under the able leadership of the Director-General, Dr Mahler. I recall the pleasure of witnessing the declaration of smallpox eradication on this very platform five years ago, as the only private individual outside governments represented here.

My next target is the eradication of Hansen's disease. With the help of many experts on this disease I established the Sasakawa Memorial Health Foundation 12 years ago, in the hope of tackling the problem of Hansen's disease and other dreadful diseases existing in this world. Thanks to help and guidance from the World Health Organization, the Foundation has oriented its efforts towards the development of an anti-leprosy vaccine, and I understand that it will not be long before that vaccine will become available. But, however effective this vaccine may be, it will not be acceptable if it has adverse side effects. So I would like to make sure that the vaccine is safe, and therefore I have volunteered to be the subject of its experimental use.

Today, on this auspicious occasion of the first awarding of the Sasakawa Health Prize, which was created on the initiative of the Director-General, Dr Mahler, in the hope of enhancing the activities of health for all, which promises good health, longevity, and happiness to all mankind, I would like to express my hearty congratulations and appreciation to the winners of the Prize, who have made the utmost effort towards improvement of the health of the peoples in various parts of the world. My deep gratitude goes to you for all the efforts that you have exerted so far.

In closing I pledge to you all that I shall continue to serve mankind to the best of my ability, by joining my efforts with those of WHO and the Director-General, Dr Mahler, and by pursuing my principles: encouragement of goodwill, reward of meritorious services, simplification and rationalization, the highest efficiency with fewer capable people, and the right person in the right place. I pray to God for the prosperity of all the countries of the world and of their people; and also for the good health, happiness and longevity of all of you gathered here today, and of the 4.7 billion people in the world.

The PRESIDENT:

Thank you, Mr Sasakawa.
The meeting is adjourned until 14h30.

The meeting rose at 12h40.
La séance est levée a 12h40.
Заседание заканчивается в 12 ч. 40 м.
Se levanta la sesión a las 12.40 horas.
رفعت الجلسة في الساعة ١٢٫٤٠ .
会议于１２时４０分休会。

= = =