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Chairperson: Mrs. Lucas . . . . . (Luxembourg)

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* The summary record of the second part of the meeting is published under the symbol E/2009/SR.13/Add.1.

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The meeting was called to order at 3.17 p.m.

High-level segment (*continued*)

Thematic discussion: "Current global and national trends and their impact on social development, including public health" (item 2 (c) of the agenda) (E/2009/53, E/2009/81, E/2009/NGO/1, E/2009/NGO/2, E/2009/NGO/3, E/2009/NGO/4, E/2009/NGO/5, E/2009/NGO/6, E/2009/NGO/7, E/2009/NGO/8, E/2009/NGO/9, E/2009/NGO/10, E/2009/NGO/11, E/2009/NGO/12, E/2009/NGO/13, E/2009/NGO/14, E/2009/NGO/15, E/2009/NGO/16, E/2009/NGO/17, E/2009/NGO/18, E/2009/NGO/19, E/2009/NGO/20, E/2009/NGO/21, E/2009/NGO/22, E/2009/NGO/23, E/2009/NGO/24, E/2009/NGO/25, E/2009/NGO/26, E/2009/NGO/27, E/2009/NGO/28, E/2009/NGO/29, E/2009/NGO/30, E/2009/NGO/31, E/2009/NGO/32 and E/2009/NGO/33)

The Chairperson invited Mr. Sha Zukang, Under-Secretary-General for Economic and Social Affairs, to present the Report of the Secretary-General on Current Global and National Trends and Their Impact on Social Development, Including Public Health.

Mr. Sha Zukang (Under-Secretary-General for Economic and Social Affairs) presented some of the main points from the Secretary-General's report, noting that global economic activity was bound to slow sharply. Growth would drop below the level required to make appreciable progress towards the Millennium Development Goals, and this was a matter of particular concern.

In light of the threat that climate change posed for the environment and development, it was urgent to take meaningful collective action to reduce greenhouse gas emissions, and to reach full agreement at Copenhagen on measures to be taken.

The global financial and economic crisis had exacerbated the effects of the food and energy crises, which had already pushed between 130 and 155 million people into poverty. This amounted to a major setback in efforts to achieve the MDGs. The food crisis was far from over, and it was essential to respect commitments for addressing it. Surging food prices had also lowered the quality of people's diets, and this was having a serious effect on the health and nutritional status of hundreds of millions.

Economic problems were threatening social cohesion. The lack of cohesion could well undermine efforts to deal with the consequences of the crisis and achieve the millennium goals.

Fiscal revenues of low-income countries were likely to drop, and this could translate into lower social spending, with lasting effects on human development. Efforts would have to be redoubled to maintain or increase funding for public investment in the social sector, if the Millennium Goals were to be achieved.

Job losses were also mounting rapidly, and many of the working poor would be driven below the poverty threshold. Current efforts at economic stimulation should thus be focused on creating productive and decent jobs.

Although it was not yet possible to measure the full impact of the multiple crises of the moment, everything suggested that public health and health services would deteriorate. Declining fiscal revenues would have a heavy impact on the health sector, as public health was closely linked to financial and economic policies. It was essential, then, to preserve health spending in order to maintain access to care.

In the current interdependent world, most of these challenges could not be addressed piecemeal. What was needed was a coordinated effort at the international level to mount large-scale fiscal stimulus plans, as part of a long-term perspective that would take account of sustainable development objectives.

Mr. Ffrench Davis (Chairman of the Committee for Development Policy) recalled that over the past decades health outcomes had improved around the world, but there were still great disparities in health conditions between and within countries. The Committee for Development Policy shared the opinion of the WHO Commission on the Social Determinants of Health, according to which existing social and economic inequalities were the main factors underlying inequalities in access to health care and hence in health outcomes. The Committee considered it necessary to fight more effectively against the effects of the crisis, while improving public health policies.

The poorest countries in particular lacked the fiscal space to respond to the crisis. Fiscal policy was a key component of initiatives for emerging from the current critical situation. The Committee recalled that it had pointed in 2008 to the urgency of reforming

existing mechanisms of compensatory financing and assistance in response to external shocks and global demand downturns. It welcomed the measures agreed at the April G-20 meeting, while noting that delivery on the commitments made had to be expedited and sufficient resources made available to low-income countries. The Committee was also concerned at the persistence of conditionalities attached to emergency financing, which limited countries' policy room. It strongly supported the decision to make significant allocations of Special Drawing Rights (SDRs) and to strengthen the role of SDRs as a global reserve currency.

The Chairperson opened the general exchange of views in the thematic discussion, remarking that the public health issue was particularly pertinent in the context of the recent influenza pandemic.

She noted with satisfaction that the central place of health in the MDGs had been reconfirmed throughout preparations for the current session. She stressed in this regard that only a multisectoral approach, focused on human beings and anchored on results, would allow for an effective and sound health system. It had been said and said again that it was important to integrate health policies into national development strategies and plans. The statements presented by countries at the beginning of the session had shown that these policies were indeed a part of national strategic priorities. It was essential, however, to associate all decision-making levels with the efforts in this field. At a time of crisis, it was vital to support investment in the public health system and in the social protection system. More generally, participation and dialogue needed to be broadened in order to address the challenges and achieve the MDGs deadlines, particularly in the public health area. Partnerships also needed to be established in order to speed the achievement of these objectives.

Mr. Di-Aping (Sudan), speaking on behalf of the Group of 77 and China, recalled that during consultations on the topics for the high-level discussion, the G-77 and China had insisted on the need for complementarity between the thematic discussion and the Annual Ministerial Review.

Developing countries and their poor populations were suffering the consequences of a crisis for which they were in no way responsible. That crisis had already affected the real economy and was compromising the hard-won progress of developing countries towards the Millennium goals. Falling national revenues and growing difficulties in financing their debt were limiting their choices concerning public spending in the social sectors.

There were very sharp inequalities from one country to another, but even within countries themselves. With respect to child and adult mortality, disparities were growing. Diseases such as HIV/AIDS and tuberculosis, which were being treated with great success in rich countries, where too often fatal in poor countries.

The G-77 and China feared that the current crisis would lead donor countries to cut back the already meagre resources they were allocating to ODA, and that many countries would see a decline in the international assistance they were receiving in support of social programmes. For this reason, they were urging developed countries to honour their commitments. The right to health was intimately linked to the accessibility of affordable health care and medications. The international community could not allow patent holders to deny this right by abusing their intellectual property rights.

Mr. Nordstrom (Director General of the Swedish Agency for International Development Cooperation), speaking on behalf of the European Union, candidate countries (Turkey, Croatia and the former Yugoslav Republic of Macedonia), countries in the Stabilization and Association process and potential candidates (Albania, Bosnia-Herzegovina, Montenegro and Serbia) as well as the Ukraine, the Republic of Moldova and Armenia, said that the EU was pleased that the important question of health in the world should be examined by the Economic and Social Council, and it welcomed the Secretary-General's report, the recommendations of which constituted a solid basis for the declaration that would be adopted by the Council.

With respect to the relationships between the overall economy, social development and health, the European Union subscribed to the conclusions of the WHO Commission on the Social Determinants of Health, which stressed that growing inequalities in health were largely due to different living and working conditions in the world, thereby confirming what the International Labour Organization had highlighted in its programme for decent work. The Commission was

calling for a global and multisector approach in the areas of employment, education and gender equality as an essential condition for sustainable physical and mental health. This approach was also essential for reducing the sharp inequalities in life expectancy, within and between countries.

Growth alone would not be enough to achieve better health outcomes. Without investment in health systems and without policies for equitable access to healthcare, government efforts would not be effective. From this viewpoint, it was important to make further efforts in primary health care. It was essential to integrate appropriate social protection mechanisms into national health systems and reinforce them. In the context of efforts to emerge from the current crisis, it was also important to bear in mind other major threats to people's well-being and health, such as climate change, new communicable diseases, and resistance to treatment against infections. The European Union would continue to make a major contribution to joint efforts to address health problems worldwide, and would maintain its commitment to the principle of health for all.

The EU was concerned at the delays in achieving the Millennium goals relating to health, in particular Goal 5. The lack of progress toward this objective reflected persistent discrimination against women. It was time for the international community and decision-makers at all levels to take firm measures in this area. The European Union was energetically supporting full implementation of the Plan of Action from the International Conference on Population and Development and the principal measures for further application of the Beijing Programme of Action, as well as the Copenhagen Declaration and Programme of Action. Moreover, it insisted that there could be no equality between the sexes without respect for women's rights in the area of sexual hygiene and reproductive health.

The European Union was working to achieve the objectives set in 2005 concerning universal access to reproductive health, and it was hoping to reduce maternal mortality by three-quarters by the year 2015. It would also be supporting efforts to supply modern contraception means to 50 million African women by 2010. It considered that the international community must make concerted efforts to resolve the health problems of the most marginalized people and those who suffered the worst forms of discrimination.

The European Union would continue to honour its international commitments, recognizing that governments would remain the principal players in the health field. Governments of some African countries, particularly the sub-Saharan countries, would need outside support to resolve the problems facing them. Their development partners must take new steps to improve coordination of their support to the many national and international initiatives that were underway; these were often focused on a specific disease, something that involved high costs on all sides. Greater resources were required; the supply of comprehensive basic health services in low-income countries would demand a doubling of health investments. Various initiatives, in particular the International Partnership for Health, offered a framework within which development partners could mobilize more effectively to support more suitable and comprehensive national health plans.

The European Union thought it essential to make better use of the resources devoted to health and to improve the effectiveness of the assistance provided. Partner countries must be able to count on a better-designed global mechanism for instituting effective health systems, endowed with sufficient human resources and sustained by viable long-term financing systems. Lastly, it must be recognized that partnerships with civil society were essential for improving the functioning of health systems and ensuring universal access to health

Mr. Rahman (Bangladesh), speaking on behalf of the least-developed countries (LDCs), said that they subscribed fully to the statement of Sudan on behalf of the G-77 and China. Sketching a sombre picture of the health situation in LDCs, Mr. Rahman noted that more than a third of deaths around the world were poverty-related. Every year more than 10 million children were dying of hunger or preventable diseases, representing 30,000 deaths a day; in LDCs one child in 10 would die before the age of five years. Malaria and HIV/AIDS were the most pressing health problems holding back development in the LDCs. According to the United Nations Children's Fund (UNICEF), the risk of dying of complications during pregnancy or childbirth was 300 times higher for a woman living in an LDC than for a woman living in an industrialized country, and the gulf separating industrialized countries from LDCs was clearly wider for maternal mortality than for any other indicator. If there were no

change in the current rate of progress with respect to maternal mortality, the MDGs in this area would be achieved not in 2015 but in 2215, which was unacceptable.

It was regrettable that the disastrous situation in LDCs had not been addressed in the Council documents, particularly the reports published under symbols E./2009/50 and E/2009/53. LDCs were paying the heaviest price for a crisis for which they were not responsible. That crisis, coming in the wake of the food and energy crises, had ruined the economies of the most vulnerable LDCs. The progress achieved over the years had been wiped out and millions of people had sunk into the most abject poverty. Such a grave situation called for immediate, collective and energetic measures at all levels. Those countries needed the international community to deliver urgent assistance to them, commensurate to the scope of the crisis, for they did not have the necessary financial and institutional capacities to counter the effects. Citing the rescue plan drawn up by the London meeting of the G-20, Mr. Rahman hoped that countries of the group would keep the promises they had made at that meeting. He stressed, however, that LDCs must be accorded the manoeuvring room to design their macroeconomic policies in light of their own development imperatives.

In addition, the international community should take a critical look at the causes of the crisis and put in place policies and partnerships to correct the dysfunctional elements of globalization. The world must restore a human face to globalization and integrate into it the development dimension, so that equity and the welfare of the poor would become its cardinal principles.

Mrs. Frick (Liechtenstein) said that progress toward achieving Millennium Development Goals 4, 5 and 6 was essential for making sustainable progress against the other MDGs. While the exemplary action of the international community and the implementation of United Nations programmes have allowed considerable advances in the health field, and especially in combating HIV/AIDS, malaria and tuberculosis, the global economic crisis was undermining these achievements, particularly for women and children in LDCs. The UN Secretary-General and governments must give the necessary impetus for keeping on course.

The progress achieved in maternal health was, at best, very modest. Hopefully, the various initiatives under way, in particular actions under the International Partnership for Health, would stimulate efforts by the international community to achieve Goal 5. Lichtenstein was supporting bilateral projects for maternal health, notably through a project led by Terre des Hommes to reduce infant and maternal mortality in Afghanistan. The crisis had not dampened Lichtenstein's determination to devote more than 0.6 per cent of its gross national product to ODA by the end of 2009, in order to achieve as quickly as possible the agreed goal of 0.7 per cent. Mrs. Frick pointed out that Liechtenstein's ODA did not take the form of debt cancellation, export subsidies or bones.

Mr. Chen Zhu (China) said his delegation supported the statement made by Sudan on behalf of the G-77. China was the most populous country in the world and, as such, its efforts to achieve the MDGs had an impact on global efforts in this area. China considered that basic health services were a public good, available to all. The Chinese government placed the people at the core of its policies and, consistent with its intention to improve its people's living conditions, it had set the objective of guaranteeing universal access to basic health services. These principles, which had guided the reforms of China's health system, were also the principles underlying its efforts to achieve the MDGs. Faced, as were other countries, with the crisis, China considered that improving healthcare would also promote economic development and it had therefore taken steps not only to develop the health system and guarantee well-being for all but also to stimulate domestic demand and to strengthen certain sectors.

The processes of industrialization and urbanization in China had resulted in a growing exodus of people from the countryside to work in the cities. There were some 2 million people in this situation in the country's cities. While these persons were contributing to China's development and its modernization, the social protection accorded them was far from satisfactory. The government attached great importance to improving these people's welfare and had taken steps to assure them the same services as those available to other urban groups. The government had also adopted a law requiring that workers from the countryside who had a contract could benefit from the urban social security system, while those who had no contract could be covered by the rural social security system of the place where they had previously lived.

Credits had also been earmarked to supply medical assistance to these persons, and a law had been adopted guaranteeing their children the right to education.

The Chinese government had taken steps to prevent the spread of influenza A (H1N1). Border controls had been stepped up and programmes put in place. Although the country had 1.3 billion inhabitants and its health system left much to be desired, the figures showed that these measures were effective. Mr. Chen announced that China would be hosting an international seminar in Beijing, on 21 and 22 August 2009, to take stock of knowledge about influenza A and to stimulate research in this area. Health professionals from all countries were invited to participate.

China was in favour of an inventory of non-communicable chronic diseases that posed a threat to achieving MDG 5. Those diseases were currently placing a very heavy burden on China, and it intended to prepare effective prevention-based policies, to reinforce collaboration among the services concerned, and to implement a variety of projects. Achieving the MDGs depended on collective efforts as much as on those of each country, and China would be very happy to enter into collaboration with the WHO and other countries to this end.

Mrs. Kaur (India) said that the financial and economic crisis was compromising efforts to eliminate poverty and to achieve internationally set development objectives. The consequences of that economic crisis on social development, while not perhaps as visible as in other sectors, were nevertheless pernicious. Governments were seeing their fiscal space shrink, and this was having a negative impact on the allocation of resources to key areas such as education and health, at the very time when social safety nets needed to be strengthened to protect the millions of persons at risk of falling back into poverty.

The international community's efforts in the health field tended to focus on certain communicable diseases. It was important not to overlook other diseases, communicable or not, with a high prevalence in developing countries. It must also be remembered that millions of persons still had no access to basic health services or affordable medications. Under these circumstances, developing countries should make full use of the flexibility provisions relating to public health contained in the Agreement on Trade-Related Aspects of International Property Rights (TRIPS).

India's government was paying particular attention to the health sector and intended to boost public spending in this field to 2-3 per cent of GDP by 2012.

In the spirit of South-South cooperation, India was participating in the pan African e-network project to link major hospitals in Africa with specialized Indian hospitals for providing quality tele-medicine.

India also stood out for its capacity to produce cost-effective generic medicines, which were critical to public health strategies in many developing countries by assuring ready availability of affordable vaccines and medicines to vulnerable people.

There had been recently some instances where countries had detained consignments of generic drugs manufactured in developing countries while they were transiting through their ports to other developing countries. Such actions, which disrupted legitimate trade in generic drugs, were contrary to the Doha Declaration on TRIPS and Public Health. India was calling upon all countries to respect the concept of territoriality in the sense of the TRIPS agreement and not to create barriers to legitimate trade, which in turn would hinder achievements in the field of global public health.

Mr. Kamwi (Namibia), associating himself with the statement of Sudan on behalf of the G-77 in China, said that Namibia had made considerable progress towards the MDGs by investing in the social sector. For 19 years, more than 30 of the national budget had been earmarked for health and education. Progress was still slow in reducing infant and maternal mortality rates. Child mortality under five years had risen again since 2000, primarily because of HIV/AIDS and malnutrition. In these circumstances, the goals set for 2012 for infant mortality and child mortality under five years (38 and 45 per thousand live births, respectively) would probably not be achieved.

Maternal mortality had been on the rise since the early 1990s, and the 2012 objective of 337 per 100,000 live births would certainly not be met. On the other hand, the objective of having 95 per cent of births assisted by qualified medical personnel was on the way to being achieved. Significant resources had been invested in combating HIV/AIDS. The seropositivity rate had been in appreciable decline since 2000, reaching 5.1 per cent for persons 15 to 19 years old, and 14 per cent for those 20 to 24 years. The

prevalence of tuberculosis was still high, with 765 cases per 100,000 individuals. As to malaria, the trend in the past 15 years was encouraging, and with a current rate of 48 cases per 100,000 individuals the 2012 goal was close to being achieved. Lastly, access to basic sanitation was still inadequate.

Namibia was a net importer of food products. Because of soaring prices for basic foodstuffs, the authorities had had to mobilize resources for emergency assistance. The country was suffering from the global recession and its growth rate was likely to fall from 4.1 per cent in 2007 to 1 per cent in 2009. Yet an annual growth rate of at least 7 per cent would be needed to achieve the MDGs within the planned time limits. Recent flooding in certain parts of the country had destroyed transportation and sanitation facilities, exposing people to health risks. Additional efforts and resources would be devoted to reconstruction and disaster prevention. The Namibian government was grateful to its development partners, who were continuing to provide ODA and emergency aid to the country despite its classification as a middle-income country, for such aid was still needed to help Namibia build its capacities.

The commitment of the London G-20 Summit in April 2009 to a $1 billion programme for reviving the world economy must be given immediate effect. The regional and subregional development banks should be re-capitalized so as to meet development finance needs. Resources must be mobilized to address the human and social consequences of the crisis and to preserve past accomplishments. While appreciating the aid received from its partners in the health field, Namibia noted that a significant portion of that aid took the form of pre-allocated funds earmarked for projects that did not always fit with national priorities.

Mrs. Skulli (Morocco), associating herself with the statement by Sudan on behalf of the G-77 and China, said that Morocco had enjoyed a decade of exceptionally dynamic growth. Under the impetus of King Mohammed VI, a vast programme of political, economic and social reforms had been instituted. In the economic and social fields, the idea was to integrate the country into free-trade areas, to create new sources of wealth and jobs, and to strengthen social cohesion. Some major projects had been launched to develop infrastructure and provide universal access to drinking water and electricity. Morocco had in this way strengthened the adaptive capacities of its economy and in the current year was enjoying a growth rate in excess of 5.5 per cent. Faced with the crisis, it had taken urgent measures to preserve employment, sustain purchasing power, stimulate domestic demand, and maintain solidarity mechanisms.

The National Initiative for Human Development was a strategy aimed at reducing disparities and combating poverty, insecurity and exclusion. It was based on an innovative approach that stressed reinforcing the capacities of local stakeholders. The municipal elections of 12 June 2009 had seen an unprecedented number of women elected, bringing the female representation rate in the municipalities to 12.4 per cent, versus the previous 0.56 per cent. Measures to encourage gender equality were an essential lever for combating poverty, illiteracy, and all forms of discrimination. The Family Code had been thoroughly overhauled to reflect gender equality.

Morocco had launched several strategies and programmes to speed social reforms and achieve the Millennium Development Goals, and was currently devoting 53 per cent of public spending to the social sectors. This had yielded notable progress: a sharp decline in the fertility rate, from 7 children per woman in 1962 to 2.5 in 2004; free and generalized access to AIDS tritherapy; eradication of various diseases; generalized vaccination coverage, reaching 95 per cent in 2006; health surveillance, thanks to which the 20 cases of influenza A recorded to date in Morocco had been successfully treated. Moreover, 70 per cent of the medications consumed in Morocco were manufactured locally, and use of generic drugs was encouraged.

The health system had a number of shortcomings, however, linked in particular to the shortage of care in rural areas. The maternal mortality rate (227 per 100,000 live births) was still high, and 2,500 children were dying each year before their first birthday. A sector strategy had been prepared for 2008-2012 in order to overcome disparities in the availability of care and to facilitate access for the poorest, particularly in rural areas. A “risk-free maternity” strategy was designed to bring the maternal mortality rate down to 50 per 100,000 and the infant mortality rate to 15 per 1000, by 2012. The issue of violence against women, long a taboo, was now receiving sustained attention from the authorities and from society in general. When it came to caring for the victims, there were numerous phone-links and shelter

facilities run by the competent ministries, the police, and NGOs.

Mr. Estwick (Barbados) said that the deteriorating world economic climate was bringing with it higher unemployment, lower public revenues, and diminished social services. The worldwide collapse of growth threatened the economic and social achievements of developing countries, including small, high-income countries such as Barbados. In the face of these difficulties, one must ask how developing countries and their partners could use the crisis to expand access to high-quality basic social services, which were indispensable for achieving the Millennium goals.

A priority of the Barbadian government was to develop an equitable, effective and accessible health system that would contribute to national development. The multisectoral response adopted by the government in the face of the crisis took into account all the economic and social determinants of health. To safeguard progress made in public health, the government was maintaining health spending at around 4 per cent of GDP. The 2002-2012 strategic plan for health called for reforming the public health system, expanding investment in the health sector, and improving the health of Barbadians. The most significant epidemiological trend was the increasing prevalence of overweight, obesity, and chronic non-communicable diseases, which were the leading cause of morbidity and mortality in the country. The government had launched a number of programmes and partnerships to reduce the incidence of these diseases. In 2008 it had created a national registry for chronic non-communicable diseases, the first of its kind in the Caribbean. A law prohibiting smoking in public places had been adopted, and a bill prohibiting the sale of tobacco products to minors was being drafted.

Although Barbados had already achieved some of the Millennium goals, it remained convinced that the problem of chronic non-communicable diseases must be addressed as part of the global discussions on development. It supported the call for a special session of the General Assembly on this issue, which the Council should also address during its discussion of coordination questions in 2010. Barbados hoped that non-communicable disease indicators would be included in the core monitoring and evaluation system for the MDGs. The WHO had issued similar appeals.

Beyond its domestic efforts to maintain high investment levels in health, Barbados was seeking to strengthen cooperation with CARICOM countries to improve prevention and treatment strategies and make them more cost-efficient. It considered that the multilateral process remained the best arrangement for tackling issues such as public health. In this regard, a serious call for reciprocal responsibility between donor and recipient countries was needed. It was only on this basis that all countries could match their responses to the great public-health challenges facing everyone.

Mrs. Jameel (Minister of Health and Family of the Maldives) cited the particular difficulties facing her country: a small island state comprising more than a thousand small islands scattered across the ocean, devastated by the 2004 tsunami, helpless in the face of the world economic crisis, and vulnerable to the effects of climate change. While its GDP per capita made it one of the richest countries of South Asia, the Maldives was included among the LDCs, although it was working toward graduation to middle-income country status. The first democratically elected government, which had taken office in November 2008, was attempting to reconstitute independent institutions and specific laws were being considered to increase tax revenues for development and to meet internationally agreed development goals.

Of the eight MDGs, the Maldives had already met five. The literacy rate, at 98 per cent, was among the highest in the world. Yet problems persisted in terms of urban-rural income gaps, access to essential obstetrical care, and early detection of high-risk cases in the outer islands. On the environment front, the President had unveiled a plan to make the country carbon-neutral within a decade. Over the medium term the Maldives, which had led an international initiative to shift the world's focus to the human and social dimensions of climate change, was itself at risk of seeing its coral reefs disappear, and with them its two main industries, tourism and fisheries. If countries such as the Maldives were to graduate from LDC status, a new, parallel development category should be created for small and vulnerable economies, one that would be better adapted to the needs and vulnerabilities of those states.

The new government was striving to devote its limited resources to protecting the more viable islands, applying the innovative "safe island" concept, while at the same time pursuing ambitious plans for decentralization. Convinced that exploring alternative

sources of development financing together with the international community was key to achieving sustainable development, it hoped to constitute partnerships between the private and public sectors and to mobilize foreign direct investment for the development of essential infrastructure and services. On the health front, the government was committed to provide universal health insurance and social security by 2010; as to health surveillance, the Maldives was fulfilling many of the requirements of the International Health Regulations, and to date it had recorded no case of Influenza A.

Mr. bin Mohammed bin Moosa (Minister of Health of Oman), associating himself with the statement made on behalf of the G-77, said that a number of conclusions could be drawn from the Annual Ministerial Review. Progress had been made on inserting the question of non-communicable diseases into the international debate on development. On the other hand, the attention given these diseases in developing countries was inadequate, and it was very important to address them, as a third of the world's poorest people were dying from non-communicable diseases, according to World Bank estimates. While developing countries had great need for technical assistance to build their capacities, less than 1 per cent of ODA was devoted to meeting those needs. It was essential that donor countries should redouble their efforts, particularly in light of the 2010 summit to review the MDGs.

To save the 14 million people who would die prematurely of non-communicable diseases in developing countries, the international community should take concerted action, hence the need to hold a world summit on these diseases. The World Health Organization had already taken steps through its action plan for the Global Strategy for the Prevention and Control of Non-communicable Diseases, approved by the World Health Assembly in 2008, but it was the United Nations system as a whole that was best placed to catalyze initiatives and coordinate global action.

Mr. Ramsammy (Minister of Health of Guyana) said that the growing problem of non-communicable diseases in developing countries was undermining efforts to combat poverty and to improve people's health and living conditions. He regretted that these diseases were not taken into account in any of the international instruments dealing with development, and he called for this gap to be corrected. Echoing the heads of state of CARICOM, he asked that the United Nations General Assembly should hold a special session on the question and that the Millennium Development Goals should be revised to include a separate objective for non-communicable diseases, recognizing the problems of accessibility and cost of diagnosis and treatment. On this point, he supported the statement by India. Guyana also hoped that the mental health dimension would be taken into account in dealing with non-contagious diseases, that women in developing countries would have access to human papillomavirus vaccines, and that thought would be given to the worrying problem of health workers' migration.

Science had yielded tools to reduce the burden of chronic non-communicable diseases, and they should be put to better use. The Caribbean Public Health Agency had been created to coordinate efforts to combat these diseases in countries of the region, and it was important to apply more vigorously the provisions of the Framework Convention on Tobacco Control and the Global Strategy on Diet, Physical Activity and Health. Lastly, there must be a halt to the assaults of the fast food industry.

Mr. Andreev (Permanent Secretary of the Ministry of Foreign Affairs of Bulgaria) said that global public health was one of the keys to human security and development, and that sustainable health was one of the prerequisites for achieving the Millennium Development Goals. He subscribed fully to the recommendations set forth in the 2008 report on the MDGs. There had been no lack of initiatives by the international community, but they betrayed problems of fragmentation, lack of coordination, and a shortage of appropriate channels for financing health care and making use of new technologies.

In its contribution to the collective effort, Bulgaria was aware that the national and global social and economic setting was a key element for consideration in health policies. Yet the crisis could also be an opportunity to reform, modernize and strengthen all sectors. Since the end of 2008, Bulgaria had been pursuing urgent actions to diminish and counter the effects of the crisis. In March 2009 it had adopted a range of measures for economic and social security, based on preserving a sound fiscal regime, strengthening the national economy, and guaranteeing social protection, with particular attention to the needs of persons with disabilities. Mr. Andreev supported the

conclusions and recommendations put forth by the Secretary-General in his reports, as well as in the draft ministerial declaration.

Mr. Kenneth (Assistant Minister of State for Planning, National Development and Vision 2030 of Kenya) said that the global financial and economic crisis had certainly affected many countries, but that for developing countries in Africa, and particularly in sub-Saharan Africa, the effects were devastating. These countries had difficulties in financing health, education, poverty reduction, infrastructure and nutrition programmes. Moreover, rising food prices, climate change, and the use of cereals for bio-fuel production had contributed to the food crisis, pushing governments to divert funds from development to humanitarian assistance. The international community, and developed countries in particular, must take urgent measures to help developing countries deal with the situation, by expanding economic stimulus programmes. New and sustainable means must also be found to address food and health challenges.

In light of this situation, attainment of the MDGs was seriously threatened in many countries, including Kenya, where results to date had been mixed. With respect to HIV/AIDS, for example, there was an emerging trend to co-infection with HIV/AIDS and tuberculosis, and countries needed to devote more funds to research, treatment and prevention programmes. Maternal and child mortality rates had declined only marginally. In sub-Saharan Africa, tuberculosis and malaria still accounted for a large proportion of outpatient cases, and malaria was still a great killer, particularly of children. The international community, then, must continue to support national efforts.

Mr. Fronczak (Under Secretary Of State for the Ministry of Health of Poland), associating himself with the statement by Sweden on behalf of the European Union, said that in their public health actions the Polish authorities were paying particular attention to the most vulnerable population groups. With respect to maternal and infant health, the declared objective was to reduce the infant mortality rate, and the decline recorded between 1990 and 2008 (from 19.3 per thousand to 5.6) was testimony to the effectiveness of the actions taken. With respect to HIV/AIDS, a standard, integrated antiretroviral treatment had been used for eight years, the National AIDS Centre was pursuing large-scale education and information campaigns, online education programme for physicians had been instituted, and free and anonymous screening tests were being offered in 25 centres. The situation with epidemics was relatively stable, but there was always a risk of re-emergence in the region.

Fresh from its experience with transition, Poland was giving priority to providing development assistance to countries currently going through a political, economic and social transformation phase. Since 2004, ODA, essentially bilateral, had nearly doubled and currently represented around 0.14 per cent of GDP. The country was also contributing funding to several initiatives of the United Nations Children's Fund, the United Nations Population Fund, UNAIDS, and the African Programme for Onchoceriasis Control. It had also financed health projects in 2008 in Afghanistan, Armenia, the Democratic Republic of Congo, India, Malawi, Rwanda, and South Sudan. Given the growing interdependence of countries and continents, public health problems were now a matter for the entire international community, as was evident with the H1N1 influenza epidemic, and success could be achieved only through collective worldwide action.

Mrs. Slowing Umaña (Guatemala) noted that the Guatemalan financial system was closely linked to the world financial system, and fallout from the crisis had been greater in Guatemala than in other countries of the region. Moreover, the economy was highly dependent on remittances by Guatemalans working abroad. In recent years, those remittances had amounted to 10 per cent of GDP and were the main instrument for combating poverty and inequality in rural areas. The disappearance of this flow of funds, as a result of the financial crisis, had had a catastrophic impact on the local economy and its effects on the health sector were already visible. The government had therefore decided to give priority attention to the right to health and to guarantee free access to basic health services.

The centrepiece of the government's social policy was the programme of conditional grants, designed for persons living in extreme poverty. To receive such allowances, families had to commit to regular medical examinations for their children and to send them to school and ensure that they attended classes. An initiative had been launched in rural areas, particularly those with the greatest proportion of extremely poor people, to boost the availability of medical and education services. This initiative, which would

conclude in 2009, should improve the situation of some 500,000 families. Together with these activities, public water supply and sanitation projects as well as projects in support of small farmers were under way.

The global crisis had caused a drastic reduction in national fiscal revenues, which in May 2009 were 9 per cent below their level a year earlier. The crisis was also likely to accentuate inequalities, and families that were no longer receiving remittances from abroad would be particularly affected. According to the most pessimistic forecasts, the percentage of the population living in poverty would reach 54 per cent, compared to 51 per cent in 2006, meaning that the country would have between 500,000 and 700,000 more poor people than before. As well, maternal and infant mortality could well rise alarmingly, with negative repercussions on economic growth.

At the present time, the main tool for cushioning the social impact of the crisis was the conditional allowance programme mentioned earlier, which was benefiting 350,000 households. There were plans to extend that allowance to another 100,000 households, with the ultimate objective of covering the minimum needs of nearly 3,000,000 poor people and in this way saving them from the scourge of hunger and guaranteeing their children's access to health and education services. Yet the Guatemalan government would need $300 million per year for this programme alone. Although it recognized that national policy makers had an important role to play in halting the degradation of the country's situation, the Guatemalan government hoped that, in the current time of global economic crisis, Guatemala could continue to count on external funding sources and to receive loans, repayable or not.

Mr. Padilla (Philippines) said that the multiple crises gripping the world in recent years, together with climate change and pandemics, had had grave repercussions on the health sector, particularly in developing countries. The international community could not stand by without reacting to the current situation: determined efforts must be made to ensure funding for health spending at the national, regional and global levels. Civil society organizations, the private sector and international cooperation would also have an important role to play.

In the Philippines, the government had taken steps to protect people, in particular the poorest, against the fallout from the crisis. It had swiftly adopted a fiscal policy to protect and assist the most vulnerable groups. A global job creation programme for the poor had been launched and, to counterbalance soaring prices for food and fuels, the government had given unconditional allowances to the poorest families, mounted an accelerated anti-hunger programme in the poorest provinces, and put in place other social safety nets.

During the years preceding the global economic and financial crisis, the health budget had been rising steadily, allowing the authorities to undertake a health sector reform guaranteeing access to healthcare for the entire population. Thanks to that reform, public hospitals had been modernized throughout the country, thousands of neighbourhood pharmacies had been opened, and essential health programmes had been improved, constituting a step forward towards the Millennium goals.

Periodic monitoring of progress in achieving those goals had shown that the Philippines was on track in terms of reducing maternal and infant mortality and halting the spread of tuberculosis, malaria and HIV/AIDS. Yet the Philippine government was fully aware that it must step up its efforts to reduce maternal mortality further and to guarantee people's access to safe drinking water, in order to achieve the Millennium goals.

Mr. Alviarez (Bolivarian Republic of Venezuela), summarizing the results of the economic and social policies applied by President Hugo Chavez, said that significant progress had been made in recent years in the health field: the number of seropositive persons receiving free antiretroviral treatment had risen from 1,059 to 25,657 between 1999 and 2008; there were some 40 organizations involved in prevention work for HIV and sexually transmitted diseases throughout the country; nationwide yellow fever vaccination campaigns had been launched, and more than 10 million people had been vaccinated in the past three years. As part of the disease prevention strategy, seven new vaccines had been introduced since 2000; in 2008 more than 32 million doses had been administered and, for the first time in the country's history, nearly 8.7 million doses had been produced. Costly treatments for non-communicable diseases had been distributed to all hospitals in the national health system and were provided free to all patients in need. Between 2005 and 2008, more than 3 million patients had been able to

buy medications at an affordable price, thanks to a network of 269 subsidized pharmacies. Lastly, between 1999 and 2007 the infant mortality rate had dropped from 19 to 13.7 per thousand live births.

In 2003, the proportion of persons living in extreme poverty was 29.8 per cent of Venezuela's population, but at the end of the first quarter of 2007 that percentage had already dropped to 9.4 o. In 2008, under the programme to assist the homeless and street people, nearly 116,000 persons had been accepted in re-education and care centres in the country's main cities. Measures had been taken to meet the medical, educational and nutritional needs of some 65,000 street children, nearly 3,000 of whom were living in shelters or had been placed in foster homes.

The Venezuelan government had adopted the goal of eradicating hunger from the country completely by 2015. To this end, more than 6,000 canteens had been created in 2008 and were distributing balanced meals to the poorest. In addition, under the school lunch programme, 4 million pupils were receiving balanced meals. Finally, the undernourishment index had shown substantial improvement since 1999, and by 2008 Venezuela had almost achieved the first Millennium goal.

With respect to gender equality, statistics showed that women outnumbered men in university education. They currently represented 47.56 per cent of education system personnel. In March 2007, the organic law on women's right to a life free of violence and the organic law for gender equity and equality had been approved.

Between 1990 and 2007, the Venezuelan government had increased the percentage of the population with access to drinking water from 60 per cent to 92 per cent. Lastly, efforts to guarantee education for all had borne fruit: primary education was universal and, in 2005, illiteracy had been completely stamped out. The net enrolment rate in the basic education system had reached 93.6 per cent during the period 2006-2007. In conclusion, Mr. Alviarez said the examples he had cited showed that the policies applied in Venezuela had helped improve people's living standards and welfare and that, thanks to these policies, the Millennium Development Goals were becoming a reality in his country.

Mr. Khalid al-Qahtani (observer of Qatar) said that Qatar associated itself with the statement by Sudan on behalf of the G-77. In developing countries, one person was dying every two minutes from a non-communicable disease such as diabetes or asthma because the primary health services were not able to provide care. Only 5 per cent of the world population lived in countries with programmes to reduce tobacco consumption and combat poor eating habits and physical inactivity, which were the main causes of many fatal non-communicable diseases. In developing countries, the poorest households were spending more than 10 per cent of their income on tobacco, and the health outlays of a poor family with a diabetic member often exceeded 20 per cent of household income. These problems were urgent and real and were undermining government efforts in developing countries to eradicate poverty and create a prosperous society.

The international community must therefore take concerted action to find a solution to these problems. To this end, a world summit on non-communicable diseases could be held to raise public awareness, launch initiatives and mobilize funds. Many developing countries were in urgent need of external assistance to improve the quality of healthcare provided to persons suffering from these diseases. Qatar gave great importance to the Doha Declaration on Non-communicable Diseases and Injuries adopted at the May 2009 preparatory meeting for the ECOSOC Annual Ministerial Review, and hoped that this question would henceforth feature prominently in discussions about development.

Mr. Sprenger (Netherlands) said that, to give effect to the commitments made for improving the world's public health, policies must focus primarily on combating inequalities in access to health care, which was a fundamental right. The establishment of viable health systems and guaranteed access for all to sexual and reproductive health should also be central features of public health strategies.

Recognizing that lives could be saved through high-quality primary healthcare, which was also crucial in treating diseases such as influenza A (H1N1) and non-communicable diseases, efforts should be made to make primary healthcare accessible locally and to equip local facilities with the capacities to conduct prevention activities, to care for the sick, and to combat the spread of diseases. Awareness raising and information were crucial to disease prevention, and reliable information should be made publicly available: well-informed people were more likely to seek medical advice and care at an early stage of illness. Lastly,

persuaded that solidarity and the predictability of aid were vital to achieving the Millennium goals, the Netherlands was determined to continue devoting 0.8 per centof its GDP to development cooperation. It invited other states to fulfil their commitments as well, and to implement the required measures by adopting a very pragmatic attitude.

The summary record of the second part of the meeting is published under the symbol E./2009/SR.13/ Add.1.