WHO REGIONAL COMMITTEE FOR SOUTH-EAST ASIA
Final Report and Minutes of the Meetings of the
THIRTY-FOURTH SESSION

Denpasar, Bali, Indonesia

15-21 September 1981

WORLD HEALTH ORGANIZATION
Regional Office for South-East Asia

NEW DELHI

December 1981
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SECTION I

*REPORT OF THE REGIONAL COMMITTEE

*Originally issued as "Draft Final Report of the Thirty-third Session of the WHO Regional Committee for South-East Asia", document SEA/RD34/23, on 20 September 1981, with some changes.
INTRODUCTION

The thirty-fourth session of the Regional Committee for South-East Asia was held in Denpasar, Bali, Indonesia, from 15 to 21 September 1981. It was attended by representatives from all Member countries of the Region, the United Nations Development Programme, the United Nations Children's Fund, the International Labour Organisation and sixteen non-governmental organizations having official relations with WHO (see Annex 1 for list of participants).

The session was declared open by the outgoing Chairman, Mr Mohammed Musthafa Hussain, Minister of Health of the Republic of Maldives. This was followed by a colourful opening, with the beating of the ceremonial "gong" by the Health Minister of Indonesia after his inaugural address, and a graceful Balinese dance performed in the traditional style.

The inaugural meeting was also addressed by the Governor of Bali, the Regional Director and representatives of UNDP, UNICEF and ILO.

At the first plenary meeting, a Sub-Committee on Credentials was appointed, consisting of representatives of Burma, DPR Korea and Thailand. Dr Kim Yong Ik (DPRK) was elected Chairman of the Sub-Committee, which held one meeting and presented its report (SEA/RC34/20), based on which the Committee recognized the validity of the credentials presented by all the representatives.

The Regional Committee elected the following office-bearers:

Chairman : Dr Bahrawi Wongsokusumo (Indonesia)
Vice-Chairman : Mr A.M. Hyder Hussain (Bangladesh)

The Committee adopted its agenda (Annex 2), established a Sub-Committee on Programme Budget, consisting of representatives from all countries, and adopted the terms of reference for this sub-committee (document SEA/RC34/4). Under the chairmanship of Dr L. Poudayl (Nepal) the Sub-Committee held three meetings and submitted a report (Annex 3) which was endorsed by the Committee (resolution SEA/RC34/R11).

The Regional Committee elected Mr N.N. Vohra (India) as Chairman of the technical discussions, on the subject of "The Role of Ministries of Health as Directing and Coordinating Authorities on National Health Work", and adopted the agenda for these discussions (SEA/RC34/5 and Add.1). The conclusions and recommendations arising out of these discussions (Annex 4), which were held on 17 September, were later presented to the Regional Committee.

A sub-committee to draft resolutions was established, consisting of representatives from India, Indonesia, Mongolia, Sri Lanka and Thailand.

The Regional Committee decided to hold technical discussions during its thirty-fifth session on the subject of "Control and prevention of leprosy in the context of primary health care".
The Committee reconfirmed its decision to hold its thirty-fifth session in Dacca in September 1982 in response to the invitation of the People's Republic of Bangladesh, and noted the invitation of His Majesty's Government of Nepal to hold its thirty-sixth session in Nepal in 1983 (resolution SEA/RC34/R9).

The closing session was impressive, as it was attended by the Ministers of Health from seven Member countries. The Director-General of WHO was also present and gave an address.

In the course of seven plenary meetings, the Regional Committee adopted twelve resolutions.

Parts II, III and IV of this report are devoted to summaries of the Committee's discussions on important matters. A complete list of documents is given in Annex 5.
PART I

RESOLUTIONS

The following twelve resolutions were adopted by the Regional Committee (The references to the "Handbook" are to the Handbook of Resolutions and Decisions of the WHO Regional Committee for South-East Asia, Vol. 2.).

SEA/RC34/R1 GOITRE CONTROL PROGRAMME IN THE CONTEXT OF HEALTH FOR ALL BY THE YEAR 2000

The Regional Committee,

Recalling World Health Assembly resolutions WHA30.43, WHA32.24 and WHA32.30, which reflect the determination of Member States as well as of the Organization to attain the cherished goal of health for all by the year 2000,

Reaffirming the Regional Committee's resolutions SEA/RC32/R1 and SEA/RC33/R4, which urged Member States to develop a plan of action in consonance with the national and regional strategies for health for all,

Noting with concern that goitre remains one of the most important health problems in most of the countries of the Region, and that efforts in organizing control programmes and resources for the application of goitre control measures are still inadequate,

Being concerned about the grave consequences of goitre, such as varying degrees of physical and mental retardation, especially in the younger age-groups, endemic cretinism and deaf-mutism,

Emphasizing that the technology in goitre control is feasible, simple and economically viable, and

Recognizing the priority accorded to goitre control in the programme of primary health care,

1. URGES Member States:

   (a) to give priority attention to strengthening their goitre control programmes as an integral component of primary health care, and

   (b) to develop a plan of action in respect of goitre control in the context of formulated national and regional strategies for health for all, with the objective of reducing the prevalence of endemic goitre to below 10% by the year 2000;

2. REQUESTS the Regional Director:

   (a) to strengthen the goitre control programme as a component of primary health care in the overall strategies for the attainment of the goal of health for all for the Region,
(b) to cooperate with and assist Member States in formulating national plans and strategies for goitre control and in promoting the development of manpower, resources for research and other resources for the programmes;

(c) to support research in the field of goitre control;

(d) to promote technical cooperation among Member States in respect of national goitre control programmes;

(e) to develop strategies and a plan of operation for a regional programme, in collaboration with other United Nations agencies such as UNICEF, as well as with the assistance of extra-budgetary resources, and

(f) to report to the thirty-fifth session of the Regional Committee on the implementation and progress of the programme.

Handbook 5.2 Sixth Meeting, 18 September 1981 SEA/RC34/Min.6

SEA/RC34/R2 EXPANDED PROGRAMME ON IMMUNIZATION

The Regional Committee,

Having reviewed the progress achieved in the Expanded Programme on Immunization in Member countries;

Agreeing with the recommendations made by the WHO Study Group on BCG Vaccination Policies (WHO Technical Report Series 652) that, on the basis of an extended review of BCG vaccination, the use of BCG as an anti-tuberculosis measure should be continued;

Noting the benefits obtained through training the programme personnel in the various management and technical skills needed for the sound development of immunization services;

Recognizing the importance of generating appropriate information to improve service delivery and to assess the progress and impact of immunization programmes on the target diseases;

Reaffirming the observations and recommendations of the Thirty-first World Health Assembly in its resolution WHA31.53, and

Recalling the conclusions and recommendations of the Consultative Meeting on Planning and Regional Self-sufficiency in Vaccine Production for the Expanded Programme on Immunization, held in New Delhi in April 1978, and its own resolution SEA/RC31/R1,

1. URGES Member States to:

   (a) continue with BCG vaccination as an important component of the Expanded Programme on Immunization;
(b) establish training programmes on a continuing basis, for both new and existing personnel, on the technical and management aspects of the Programme as a routine component of the curricula of health training institutions;

(c) extend the use of sampling techniques (cluster surveys) to gather data on the complete coverage of target populations, particularly those in the 0-12 month age-group, and for the identification of problems and constraints in order to take remedial action for improving the immunization programmes;

(d) strengthen routine surveillance systems for the collection of data on EPI target diseases for establishing baselines against which the impact of immunization can be measured in terms of reduction of morbidity, mortality and disability, and

(e) cooperate with the Organization in identifying and developing appropriate methodologies for the monitoring and evaluation of national programmes of immunization, and

2. REQUESTS the Regional Director to continue to extend the necessary technical and material support to the Expanded Programme on Immunization in Member States, with particular emphasis on:

(a) providing training materials and assistance in developing appropriate training activities, when requested;

(b) giving technical support, when requested, in order to develop techniques for generating appropriate information to measure the progress and achievements of the Programme;

(c) providing training and technical support for the development of the cold chain, and

(d) promoting technical cooperation among countries of the Region, particularly in regard to the exchange of technical information and expertise as well as the attainment of regional self-reliance in vaccines.
2. CONGRATULATES the Regional Director and his staff on this comprehensive review of the work done and sound projections made for the future.

Handbook 9       Sixth Meeting, 18 September 1981
SEA/RC34/R4     SEA/RC34/Min.6

SEA/RC34/R4 STRATEGIES FOR HEALTH FOR ALL BY THE YEAR 2000

The Regional Committee,

Recalling World Health Assembly resolution WHA34.36 on the adoption of the Global Strategy for Health for All by the Year 2000 and its own resolutions SEA/RC32/R1 and SEA/RC33/R4, giving expression to its unswerving commitment to the attainment of this goal through pursuit of the principles enshrined in the Alma-Ata Declaration on Primary Health Care;

Having carefully considered both the Global Strategy as well as the Executive Board's draft Plan of Action for implementation thereof;

Being aware of the efforts that have gone into the formulation of the regional and national strategies for health for all in this region, and the initiative and actions that have been taken by Member States in implementing them, and

Recognizing the necessity for revising and updating the existing regional and national strategies in the light of the Global Strategy recently approved by the World Health Assembly,

1. ENDORSES both the Global Strategy and the Executive Board's Plan of Action,

2. URGES Member States:

(a) to take steps to adopt and update the national strategies and formulate plans of action in the light of the Global Strategy for HFA/2000;

(b) to make organizational plans for the development of national health systems based on primary health care, at the same time ensuring adequate political and financial support to implement these plans, with a view to making the appropriate health services accessible and available to all those in need;

(c) to strengthen, where necessary, the mechanisms of the national administrative systems for monitoring and evaluating the implementation of the Global Strategy, and

3. REQUESTS the Regional Director:

(a) to collaborate and assist in the revision and updating of the national and regional strategies through appropriate actions at national and regional levels;
(b) to follow up on all aspects of the implementation of the strategy and to report to the Regional Committee annually in the initial years and periodically later, and

(c) to strengthen the regional mechanisms for updating, monitoring and evaluating the regional strategies.

Handbook 2.2.1 Sixth Meeting, 18 September 1981 SEA/RC34/Min.6

SEA/RC34/R5 MANAGERIAL PROCESS FOR NATIONAL HEALTH DEVELOPMENT

The Regional Committee,

Recognizing that the countries of the South-East Asia Region are increasingly applying the scientific principles and methods of planning and management in formulating their health development activities and in orienting them to their HFA policies and strategies;

Realizing that there is an urgent need for further strengthening the managerial process for national health development;

Appreciating WHO's efforts to promote the concept and application of an integrated managerial process for national health development, and

Noting the provisions of resolution WHA34.14 on strengthening management and management training in support of national strategies for health for all by the year 2000,

1. URGES Member States of the South-East Asia Region:

(a) to continue to accord high priority to the development of an integrated managerial process for national health development;

(b) to cooperate and collaborate with one another as well as with WHO in further developing this process, with special emphasis on the management training of health personnel in relation to the specific requirements of national management systems, and

(c) to undertake innovative management practices, particularly in respect of the delivery of the primary health care programme, and

2. REQUESTS the Regional Director:

(a) to promote and support the efforts of countries of the Region to develop such a national managerial process, including training of manpower, and to facilitate TCDC in this area as appropriate;

(b) to maintain and strengthen the expertise required for providing technical cooperation to Member States in the development of their managerial systems, in particular the systems of organizational design, supplies and logistics, programme budgeting and financial control, and management information;
(c) to provide technical and material support to new types of management projects, including related studies and publications, and

(d) to support the exchange of valid information amongst countries in respect of managerial developments, particularly in the design and delivery of the primary health care programme.

The Regional Committee,

Appreciating WHO's efforts to conduct a study of its structure in the light of its functions in response to World Health Assembly resolution WHA31.27 and the Regional Committee's resolution SEA/RC32/R7,

Noting with satisfaction the progress made in implementing the Director-General's plan of action in support of resolution WHA33.17 adopted by the World Health Assembly and endorsed by the Regional Committee in its resolution SEA/RC33/R5,

Noting the progress made in the study of its structure in the light of its functions undertaken by the Regional Office for South-East Asia as reported in document SEA/RC34/7,

Realizing the necessity for continuous monitoring of the progress of this study,

1. URGES Member States:

   (a) to strengthen their ministries of health and the national managerial processes for health development in order to provide further stimulus to national efforts as well as to use the Regional Committee as an effective instrument for collective action at regional level for attaining the HFA goal, and

   (b) to review periodically, in collaboration with WHO, the nature of the WHO support required by each country individually and by the Region collectively, in the light of the HFA goals, through establishment of appropriate mechanisms at national and regional levels, and

2. REQUESTS the Regional Director:

   (a) to proceed with the implementation of the recommendations made in the study to meet the changing requirements for WHO collaboration at national and regional levels, and
(b) to make all efforts to achieve maximum utilization of the staff, facilities and resources of the Organization, in support of national and regional plans of action for HFA, involving the Member States closely in the planning, implementation, monitoring and evaluation of the WHO programme activities, through the committee being set up to advise the Regional Director (in accordance with resolution SEA/RC34/R11).

Handbook 1.3
Sixth Meeting, 18 September 1981
SEA/RC34/Min.6

SEA/RC34/R7
SEVENTH GENERAL PROGRAMME OF WORK (1984-1989)

The Regional Committee,

Having reviewed the material for the preparation of the Seventh General Programme of Work for the Specific Period 1984-1989, along with the statements of progress made so far in the formulation of the Programme, 1

Being conscious of the need to ensure that the Seventh General Programme is relevant to the particular needs and priorities of countries in the South-East Asia Region, and

Noting that the main thrusts in this programme as well as its objectives and approaches are essentially oriented towards the implementation of the strategy for health for all by the year 2000,

1. AGREES with the material prepared, and

2. REQUESTS the Regional Director to transmit its comments 2 on this material to the Director-General for consideration by the Programme Committee of the Executive Board.

Handbook 2.2.3
Sixth Meeting, 18 September 1981
SEA/RC34/Min.6

SEA/RC34/R8
INFANT AND YOUNG CHILD FEEDING - DRAFT INTERNATIONAL CODE OF MARKETING OF BREASTMILK SUBSTITUTES

The Regional Committee,

Having considered the paper on the subject of infant and young child feeding (SEA/RC34/13);

Recognizing that maternal and child health care, including nutrition, is an essential element of primary health care;

1Documents SEA/RC34/6 and Corr.1 and SEA/RC34/Inf.2

2As recorded in SEA/RC34/Min.5
Realizing that improvements in the nutrition of infants, young children and pregnant and lactating women are of paramount importance for attaining the goal of health for all by the year 2000;

Emphasizing that the protection and promotion of infant feeding, including the regulation of the marketing of breastmilk substitutes, directly affect the health of infants and young children and constitute a problem of direct concern to both Member countries and WHO, and

Reaffirming World Health Assembly resolutions WHA33.32 and WHA34.22, on "Infant and Young Child Feeding" and "International Code of Marketing of Breastmilk Substitutes" respectively,

1. ENDORSES the draft plan of action outlined in document SEA/RC34/13 as a guideline for programme development in countries;

2. URGES Member States to review and implement resolution WHA33.32 and WHA34.22, and

3. REQUESTS the Regional Director to provide such technical and other support as is necessary to collaborate with governments in implementing the above resolutions.

TIME AND PLACE OF THE THIRTY-FIFTH SESSION AND PLACE OF THE THIRTY-SIXTH SESSION OF THE REGIONAL COMMITTEE

The Regional Committee

1. CONFIRMS its previous decision (SEA/RC33/R12) to hold the thirty-fifth session in Dacca, Bangladesh;

2. DECIDES to hold its thirty-fifth session in September 1982, the exact dates to be decided by the Regional Director in consultation with the Government of Bangladesh, and


SELECTION OF TOPIC FOR THE TECHNICAL DISCUSSIONS

The Regional Committee

1. DECIDES to hold technical discussions during the thirty-fifth session in 1982 on the subject of "Control and Prevention of Leprosy in the Context of Primary Health Care", and
2. REQUESTS the Regional Director to take appropriate steps to arrange for these discussions and to place this item on the agenda of the thirty-fifth session.

Handbook 1.2.2 Sixth Meeting, 18 September 1981

SEA/RC34/R11 REPORT OF THE SUB-COMMITTEE ON PROGRAMME BUDGET

The Regional Committee,

Having considered the report of the Sub-Committee and the detailed programme budget for 1982-1983 (documents SEA/RC34/3 and SEA/RC34/3 Add.1), and

Appreciating the fact that the WHO programme continues to provide support to Member States to enable them to achieve health for all by the year 2000,

1. APPROVES the report of the Sub-Committee on Programme Budget;

2. NOTES the 1982-1983 detailed programme budget with elaboration on the project activities (documents SEA/RC34/3 and Add.1) and the proposals for the UNDP Regional Programme (SEA/RC34/PP/WP1);

3. NOTES the observations made by the External Auditor of WHO in his report to the World Health Assembly (A34/25 and A34/25 Add.1) for the first year of the financial period 1980-81;

4. NOTES the report and the recommendations of the "Small Committee" (SEA/RC34/PP/WP3) appointed by the Regional Director in response to Regional Committee resolution SEA/RC33/R10;

5. REQUESTS the Regional Director:

   (a) to implement the 1982-1983 programme as contained in documents SEA/RC34/3 and Add.1 in accordance with the policies and guidelines laid down by the World Health Assembly and in cooperation with Member Governments;

   (b) to ensure inclusion of the following items in the terms of reference of the Sub-Committee on Programme Budget for the biennium starting from the thirty-fifth session of the Regional Committee:

      (i) to review the implementation of programmes in the current cycle (by country and by projects/programmes) in terms of both financial implementation as well as achievement of envisaged targets;

      (ii) to review financial implementation in respect of the programmes, indicating whether the actual spending has been as planned and the extent of savings in each programme, if any, along with the broad reasons therefor;
(iii) to consider programme proposals for an ensuing cycle reflecting such activities as are not in support of the primary health care package in terms of the proposed outlays, comparing the outlays with the investments in such activities, if any, in the preceding and current cycles, also indicating the broad basis therefor;

(iv) to review the pattern of utilization of assistance in respect of each component, viz., long-term staff, short-term consultants, supplies and equipment, subsidies/grants, group educational activities, etc., during the preceding and current cycles. Similarly, while considering the detailed programme proposals for an ensuing cycle, to compare the envisaged pattern of investments under the aforesaid components with the actual expenditure patterns during the preceding and current cycles, based on available information. (If there have been wide variations in the actual expenditures in respect of any component, the reasons should be identified, so as to enable suitable modification of the programme budgeting, if necessary, to make it more realistic.);

(v) while reviewing programme proposals for an ensuing cycle, to examine whether the "programming approach"/"detailed programme budget" conforms to the parameters of the basic policy and global strategy of WHO and the General Programmes of Work/medium-term programmes approved by the Regional Committee/World Health Assembly, as well as the specific recommendations, if any, made by the Regional Committee at its preceding sessions;

(vi) to consider any other issue in regard to which the Programme Budget Sub-Committee may wish to make a reference or recommendation to the Regional Committee, and

(vii) to apply recommendations made in paras (i) to (vi) above, with such modifications as necessary, also to inter-country projects in the ensuing cycle;

(c) to consider the following programme categories in addition to guidelines and criteria provided by the Director-General in his programme budget guidelines, for establishing inter-country projects: health manpower development; country health planning, programming, monitoring, review and evaluation; control measures regarding urgent problems of communicable and non-communicable diseases; effective preventive and promotive strategies for reducing disease incidence within the framework of primary health care; appropriate technology for improving the primary health care system; health services organizational and operational research; effective surveillance mechanisms, and institutional support, including the manufacture and development of inputs in support of the primary health care package;
(d) to establish a committee, replacing the Small Committee set up in accordance with resolution SEA/RC33/R10, to review the functioning of ongoing inter-country projects as well as recommended fresh project proposals, in accordance with para 5(c) above, to evolve a long-term perspective plan of inter-country projects; to review and redefine guidelines and criteria for inter-country projects every two or three years, and to assess the relevance of inter-regional projects in terms of regional needs and priorities as well as inter-regional interests;

(e) to request the Director-General to review existing criteria for resource allocation among regions, with a view to giving a higher priority to the South-East Asia Region, comprising about one-fourth of the world's population, and

(f) to evolve a suitable mechanism for the mobilization of extra-budgetary resources in support of HFA/2000.

Handbook 3.3 Sixth Meeting, 18 September 1981
SEA/RC34/Min.6

SEA/RC34/R12 RESOLUTION OF THANKS

The Regional Committee

1. WISHES to convey its sincere thanks and gratitude to the people and the Government of the Republic of Indonesia, to the Governor of Bali, and especially to the Ministry of Health, for their warm welcome and the generous hospitality extended to all participants in the thirty-fourth session of the Regional Committee, as well as for the excellent arrangements made for the meeting, contributing to its success;

2. EXPRESSES its sincere thanks to the Regional Director, Dr U Ko Ko, for his effective contribution, and to all the members of his staff for their painstaking efforts towards the success of the session, and

3. PLACES on record its deep appreciation of the presence of the Director-General, Dr Halfdan Mahler, and for his valedictory address highlighting WHO's policy and approach to maximizing the scope of collaboration between WHO and Member States.

Handbook 1.2.3 Seventh Meeting, 21 September 1981
SEA/RC34/Min.7
PART II
DISCUSSION ON THE THIRTY-THIRD ANNUAL REPORT
OF THE REGIONAL DIRECTOR

In presenting his Annual Report, the Regional Director drew attention to the problems complicating the action against malaria, the difficulties posed by leprosy and the diarrhoeal diseases and the importance of maternal and child health programmes, including breast-feeding, weaning and feeding practices, nutrition and immunization. The need for re-orienting the health system infrastructure, the importance of directing research towards solving human, rather than technological, problems and the streamlining of managerial processes for national health development were also stressed. Among the other important items covered were the draft Seventh General Programme of Work, based on regional and global strategies for health for all by the year 2000, and the reorganization of the WHO organizational structure to improve its efficiency and effectiveness in support of that goal. He referred to the SEARO publication, "Perspectives for Health Development in the South-East Asia Region", and called upon all present to urge their governments to launch concerted efforts to ensure the right of every individual to healthful living.

In the discussion on strengthening the health services, it was suggested that, while increasing efforts were being made to provide primary health care at the rural level, inadequate attention had been paid to the urban slums. The Committee was informed that, in collaboration with WHO Headquarters and the Regional Office for the Western Pacific, the South-East Asia Regional Office was organizing a consultative meeting this year to look into this question.

Since health development resources were limited, WHO's role in collaborating with countries to achieve their maximum utilization was appreciated. The Organization's efforts in promoting management information systems, community participation and appropriate technology were also noted.

On the subject of family health, the importance of family planning was stressed. The Committee recognized, however, that population policies varied from country to country, depending on the specific national situation, and that WHO's policy on family planning was based on maternal and child health activities, as an integral part of health services. The Committee called for a more comprehensive approach to the provision of education and information on health matters to the people, irrespective of social and economic status. The shortage of specialists in health education technology was recognized, and further use of technical cooperation amongst countries for training such specialists was recommended. In this regard, active collaboration between the ministries of health and education was recommended.

The Committee stressed the need for improving health laboratory services at the peripheral level. It also emphasized that efforts must be made to promote and support activities for developing self-reliance, at least at regional level, in respect of essential reagents for diagnostic work. This was another area for technical cooperation among developing countries.
The question of essential drugs and of drug policy and management was discussed in detail, and there was a consensus that efforts must be made to initiate action for attaining self-reliance. The Committee also emphasized the necessity of developing a more effective mechanism in the countries for quality control, to test not only the indigenously produced drugs but also those which were imported. It was suggested that WHO should collaborate further to ensure the maintenance of essential equipment in health institutions.

The role of traditional medicine in primary health care and, in this connexion, the use of homoeopathy were discussed.

In regard to the prevention and control of communicable diseases, a major concern about the malaria situation was expressed. To tackle the problem of vector and parasite resistance, it was suggested that, although research must continue to find newer and more effective anti-malarial drugs and potent insecticides, the importance of the effective application of known knowledge and the search for operational and bio-environmental techniques should be stressed. Also, efforts to reduce the incidence should be further strengthened through improved surveillance and the involvement of primary health care workers in case-detection and the distribution of drugs.

Leprosy was also cited as being a serious problem. The urgent need for vigorous efforts to educate the public in order to remove the social stigma, and to institute research for techniques in early case-detection, mass operation and case-holding, while finding more effective drugs, should also be looked into, in addition to strengthening the existing measures.

In discussing the role of BCG in the control of tuberculosis, in the light of the findings of the recently published WHO/Indian Council of Medical Research Study on BCG, the Committee noted that, although it was essential to conduct a further study to fill in the gaps in information in this regard, BCG vaccination should continue as an integral component of EPI. This was reflected in the resolution which was adopted (SEA/RC34/R2).

Regarding viral diseases, it was observed that rabies had become a major problem in most countries and that there was an acute shortage of the vaccine. Mutual cooperation among the countries of the Region was essential to increase the production and improve the situation regarding timely availability of this vaccine. The Committee noted with satisfaction the effort to develop human diploid cell vaccine under a regional project supported by UNDP.

The main aspects of the EPI, viz., training of health workers and the strengthening of the cold chain system for maintaining the potency of vaccines, were stressed. It was considered that the existing knowledge in preventing EPI target diseases should be vigorously applied in order to achieve effective control and reduction of incidence. The importance of improving the operational aspects and of proper supervision, monitoring and evaluation was underlined, and a resolution was adopted in this regard (SEA/RC34/R2). In the discussion on smallpox, the Committee emphasized the need for prompt investigation of all reports on suspected cases as a part of the routine disease surveillance system, which should be strengthened.
Although the major causes of blindness - cataract, trachoma and vitamin A deficiency - were known to vary from country to country, the blindness control programme should be further strengthened by ensuring surgical services for the treatment of cataract, early detection and treatment of trachoma and prevention of Vitamin A deficiency through the adequate administration of Vitamin A capsules. The programme, generally a vertical one in countries, should be reoriented and further developed as a comprehensive eye health programme within the general health services.

In the prevention and control of cardiovascular diseases and cancer, the importance of the role of health education of the public and of early detection and treatment was stressed, as was the need for an epidemiological study based on the socio-cultural situations in the national context of each country in order to plan effective prevention and control.

In considering the environmental health programme, the Committee reiterated the importance of the International Drinking Water Supply and Sanitation Decade and emphasized that as much attention should be given to the sanitation component of the Decade programme as to water supply.

On the subject of health manpower, the Committee cautioned against unbalanced and inappropriate development of medical manpower, which resulted in maldistribution and migration. Incompatibility between the actual needs of the health services and the nature of the education and training being given was recognized as the root cause of the problem of manpower management, with a particularly adverse effect on primary health care. Remedial measures were suggested. In some countries the training of large numbers of alternative categories of health workers had been started. The Committee stressed the need for a comprehensive approach to the solution of the problems.

The Chairman of the South-East Asia Advisory Committee on Medical Research, at the invitation of the Chairman, reviewed the progress made by the SEA/ACMR during the past year, also describing important changes in priorities that had taken place since the SEA/ACMR's inception for a number of reasons: first, the entire concept, structure and orientation of health development had to be changed due to the recent focus on the HFA/2000 goal; second, despite an increase in research activities, there was very little research towards the application of existing knowledge in support of health development, research being dissociated from the application of the results of the research; third, it had now been realized that health problems and medical problems were not synonymous. While solutions to medical problems were easily transferable, research findings on health problems could not, for the most part, be transferred from situation to situation.

The SEA/ACMR had undertaken an analysis of the priorities in the light of these developments, and the concepts and criteria on the basis of which further research activities should be developed in the Region had been delineated in document SEA/ACMR/7 Add.1. The SEA/ACMR was now involved in developing administrative policies and procedures to facilitate implementation of these concepts and criteria.
REPORT OF THE REGIONAL COMMITTEE

It had also taken action to promote health services research, and a sub-committee of the SEA/ACMR had already drawn up the conceptual framework, completed the "quick assessment" of the status of health services research in the Region and produced a work-plan for a medium-term period.

The Regional Committee noted these developments with satisfaction.

In discussing organizational and administrative matters, the Committee expressed its unhappiness that only 55 countries had so far ratified the amendment to the Constitution increasing the membership of the Executive Board so that an additional seat could be provided for the South-East Asia Region. The Committee suggested further efforts by the Regional Director and Member governments of the Region to ensure that the required number of countries supported this amendment.

Finally, the Committee noted that, while there was a definite and continuous shift in fellowships towards study within the Region, the percentage of supplies purchased within the Region remained static, and it expressed the hope that this percentage would be increased.

The Report was adopted (resolution SEA/RC34/R3).
A Sub-Committee on Programme Budget was established, in accordance with the usual practice, to review how the detailed programme budget for 1982-1983 had taken shape after the elaboration of the project details. The Sub-Committee met on 15 and 17 September 1981 and submitted its report to the Regional Committee (see Annex 3).

The Sub-Committee noted that the 1982-1983 budget reflected an increase of 17 1/2% over the 1980-1981 budget and expressed satisfaction that the detailed programme budget for 1982-1983 conformed to the Sixth General Programme of Work and the policies of the Organization.

The Sub-Committee reviewed the report submitted to the Regional Director by the "Small Committee" (established in accordance with resolution SEA/RC33/R10, see Appendix to Annex 3) and agreed with the fresh guidelines and criteria suggested in it for the establishment of inter-country projects, which formed the basis for collaboration among Member States. An analysis of the regular and extrabudgetary programme proposals had revealed the importance of increased support to the primary health care elements. In this regard, it was agreed that any rescheduling of resources should be encouraged normally in favour of the primary health care package, and assistance to low-priority activities discouraged. The Sub-Committee also stressed the need for a review by the Director-General of the present resource allocation criteria in order to make a higher share of the regular budget available for the South-East Asia Region proportionate to the population and their needs. Establishment of a suitable mechanism for the mobilization of extrabudgetary resources in support of HFA/2000 was also recommended.

The revised terms of reference of the Sub-Committee covering the biennium, as proposed by the Small Committee, were examined and approved for application starting with the thirty-fifth session of the Regional Committee. The revised terms met the requirements of the changing situation arising out of the shift of emphasis in the programme of the Organization.

The Sub-Committee noted the inter-country programme proposals approved by UNDP for the period 1982-1986 and urged Member States to strive for a higher allocation of UNDP resources for programmes relating to health sectors.

Observations made by the External Auditor of WHO in his report to the World Health Assembly (A34/25 and Add.1) were noted. It was suggested that a provision for suitable incentives to national staff be made in the project documents of UNDP.

In resolution SEA/RC34/R11, the Regional Committee approved the report of the Sub-Committee on Programme Budget and requested the Regional Director, inter alia, to establish a "committee", replacing the Small Committee, to carry out the functions mentioned by the Sub-Committee on Programme Budget in its report.
PART IV
DISCUSSION ON OTHER MATTERS

1 Consideration of Resolutions of Regional Interest Adopted by the World Health Assembly and the Executive Board

Fifteen resolutions of regional interest adopted by the Thirty-fourth World Health Assembly, and one by the sixty-seventh session of the Executive Board, were brought to the attention of the Regional Committee.

The following resolutions were considered along with the relevant sections of the Regional Director's Annual Report for 1980-81:

(1) Amendment of the International Health Regulations (1969) (WHA34.13).

(2) Organizational Study on the Role of WHO in Training in Public Health and Health Programme Management, including the Use of Country Health Programming (WHA34.14).

(3) Recruitment of International Staff in WHO (WHA34.15).


The following resolutions were considered while discussing appropriate items of the agenda:

(1) International Code of Marketing of Breastmilk Substitutes (WHA34.22).

(2) Nutritional Value and Safety of Products Specially Intended for Infant and Young Child Feeding (WHA34.23).

(3) Periodicity and Duration of Health Assemblies: Periodicity of Health Assemblies (WHA34.28).

(4) Method of Work and Duration of Health Assemblies (WHA34.29).

(5) Global Strategy for Health for All by the Year 2000 (WHA34.37).

(6) Resources for Strategies for Health for All by the Year 2000 (WHA34.36).

(7) Health for All by the Year 2000 - the Contribution of Health to Socio-Economic Development and Peace - Implementation of Resolution 34/58 of the United Nations General Assembly and of Resolutions WHA32.24 and WHA33.24 (WHA34.38).

(8) International Drinking Water Supply and Sanitation (IDWSS) Decade (WHA34.25).
The Committee's observations on three others, which were taken up separately for consideration, were as follows:

(1) Reimbursement of Travel Costs of Representatives to Regional Committees (WHA34.4).

The Committee felt that, after an appropriate lapse of time, the matter of reimbursement of travel costs of representatives to sessions of the Regional Committee should be taken up at a future session.

(2) The Meaning of WHO's International Health Work through Coordination and Technical Cooperation (WHA34.24).

The Committee noted that WHO's coordination with other United Nations, bilateral and multilateral agencies was being strengthened in the Region.


The Committee noted that suitable study groups would be set up by the Regional Director to deal with special matters, including that of WHO collaborating centres in the Region.

2 Technical Discussions

During the thirty-fourth session of the Regional Committee, technical discussions were held on the subject of "Role of Ministries of Health as Directing and Coordinating Authority on National Health Work" (document SEA/RC34/16). Major problems and some of the more significant issues were discussed in detail, and a report was prepared (Annex 4) outlining some recommendations along with related actions which could be taken in countries and by WHO. The Regional Committee noted the report of the technical discussions, some of the recommendations in which were the following:

(1) The planning divisions of ministries of health should be reorganized to include multidisciplinary technical capabilities to deal with health and health-related sector planning.

(2) Effective linkages should be established between planning at the central level and the successive levels to secure meaningful involvement of the plan implementors and coordinated planning.

(3) Mechanisms and methods for continuous monitoring and evaluation of on-going plans and programmes need to be improved so that reliable and timely information is used for their efficient implementation and for measuring their relevance and effectiveness.

(4) Existing administrative and financial procedures should be reviewed with an eye to decentralization and closer involvement of health managers, the communities and private organizations in the management of health development.
(5) Ministries of health should identify, estimate and make reliable projections of supportive actions required from the health-related sectors, e.g., water and sanitation, with the help of technical working groups set up for the health-related sectors either within the ministries or, better still, in the national planning commissions/organizations.

(6) Subject to the organizational pattern and practice in countries, standing intersectoral coordination committees should also be set up in the planning commissions/organizations.

(7) The work of the existing coordinating bodies, e.g., national health councils, national health development committees or equivalent bodies, should be reviewed from time to time as to their efficacy, particularly to ensure that the policy and directives for coordination are, in fact, implemented at the various operational levels.

(8) Member countries of the Region should increase technical cooperation among themselves and with WHO, in support of national and inter-country efforts. Because of the paucity of technical expertise, it was felt that WHO should formulate suitable inter-country programmes of technical cooperation with the object of eventually attaining national and regional self-reliance.

3 Strategies for Health for All by the Year 2000

Attention was drawn to (a) the draft Plan of Action to implement the Global Strategy prepared by the Executive Board which would be submitted to the Thirty-fifth World Health Assembly in the light of observations by the regional committees, (b) a progress report, and (c) the regional draft plan of action.

The progress reported by Member countries in the implementation of national strategies, with the establishment of high-level national councils and committees for coordinated implementation of strategies, and the specific objectives and targets that had been included in country-wide health programmes were noted with satisfaction.

Although there was increasing evidence of intersectoral coordination within the countries, which were keeping the national strategies under constant review, the national plans of action to implement the strategies with internal and international support required to be vigorously pursued.

The Committee noted the problems being faced with regard to trained and motivated health manpower and to the organization of health systems and other material resources, and it was felt that, while concerted efforts to reduce or resolve the problems were already being made, support from WHO and mutual cooperation among countries would also be necessary.

The Regional Director assured the Committee that the regional strategies and actions would be updated on the basis of feedback from the countries.
and that progress would be reported annually to the Committee. Although he agreed that external resources would be required in some countries to implement the strategy and strengthen the health infrastructure, the main efforts and initiative to mobilize and coordinate such resources remained with the countries themselves, and WHO would cooperate in such efforts, as necessary.

A resolution on this subject was adopted (SEA/RC34/R4).

4 Progress Report on the Seventh General Programme of Work

The Committee noted with satisfaction the shift towards full support of various elements of primary health care but thought that the family planning programme should have been included in this component. A suggestion was also made for the collection and dissemination of information on the progress made so far in the Sixth General Programme to become a benchmark for assessing future progress and efforts to be made through the Seventh General Programme.

It was also observed that, in any future review, a clarification on, and specification of, the linkages and priorities among the programmes on the health system infrastructure and health science and technology would be helpful.

The Committee stressed the need for ensuring that the programme was relevant to the particular needs and priorities of countries in this region. A resolution (SEA/RC34/R7) on the subject of the Seventh General Programme of Work was adopted.

5 WHO's Structures in the Light of Its Functions

The Committee noted with satisfaction the progress of the study as reported by the Regional Director (SEA/RC34/7), particularly the recommendations that the level of country operations should be increased and that more comprehensive information be provided to the Regional Committee for reviewing programme planning and programme performance. Two of the main comments made by the Committee were:

(1) The progress of the study and implementation of its results should be reported to the Regional Committee (to this end, the Committee adopted resolution SEA/RC34/R6).

(2) The importance of country-level operations in WHO needed further emphasis and there was a need to strengthen these country operations, including strengthening of the role of the WHO Programme Coordinators.

In considering the role of the Regional Committee in the organization and overall functioning of WHO, the Regional Committee discussed the means by which the nominees of the Committee to the Joint Coordinating Board/WHO/UNDP/World Bank Special Programme for Research and Training in Tropical Diseases (JCB/TDR) and Health Resources Group (HRG) should report back to the Committee. It was decided, after detailed examination, that those Member States who were nominated by the Committee to send
representatives to these bodies should be responsible for reporting back to the Committee on the meetings through their respective representatives to the Regional Committee.

6 Infant and Young Child Feeding - Draft International Code of Marketing of Breastmilk Substitutes

The Regional Committee considered this subject along with two World Health Assembly resolutions (WHA34.22 and WHA34.23).

It was noted that all countries in the Region were interested in this subject, and the Committee felt that improvements in the nutrition of infants, young children and pregnant and lactating mothers were of paramount importance to the attainment of the goal of health for all by the year 2000.

The Committee endorsed the draft plan of action outlined in the background document (SEA/RC34/13), urged Member States to implement the recommendations made in the Assembly resolutions and requested the Regional Director to provide the necessary support to governments.

It adopted a resolution on this subject (SEA/RC34/R8).

7 Selection of a Subject for the Technical Discussions To Be Held During the Thirty-fifth Session

The Regional Committee decided to hold technical discussions on the "Control and Prevention of Leprosy in the Context of Primary Health Care" during its thirty-fifth session in 1982 (see resolution SEA/RC34/R10).

8 Time and Place of the Thirty-fifth and Thirty-sixth Sessions of the Regional Committee

The Regional Committee confirmed its earlier decision to hold the thirty-fifth session in Dacca, Bangladesh, and requested the Regional Director to decide on the dates, in consultation with the Government of Bangladesh, in September 1982.

The Committee also noted the invitation of the Government of Nepal to hold the thirty-sixth session in Nepal in 1983.

A resolution on this subject was adopted (SEA/RC34/R9).

9 National Health Programmes with Synchronized Foreign Assistance in the Context of WHO Technical Cooperation (Item proposed by the Government of Indonesia)

The Committee noted that, with the increase in the financial requirements of health development programmes, their management and administration had become increasingly complex and required coordination. There was also a need for effective coordination of external assistance and national resources. Hence it was necessary to identify the interface of national policies and objectives with those of foreign assistance in
order to facilitate coordinated resource use for implementing, monitoring and evaluating national health programmes. The systematic management and coordination of all foreign assistance in the backdrop of national priorities and needs would very greatly benefit the countries concerned. The Committee requested the Regional Director to initiate specific collaborative activities to this end, for the programme budget for the biennium 1984-1985.

10 Goitre Control Programme Within the Context of Health for All by the Year 2000 (item proposed by the Government of India)

In the discussion on this subject, attention was drawn to the grave consequences of goitre, including irreversible changes, especially in the younger age-group. Goitre had become a major public health problem in many countries of the Region, calling for a coordinated control programme. The Committee adopted a resolution in this regard (SEA/RC34/R1).
Annex 1

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1Originally issued as document SEA/RC34/19 Rev.1 on 17 September 1981.
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Chief, Expanded Programme on Immunization  
Kathmandu

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Additional Secretary, Ministry of Health  
Colombo

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Director of Health Services  
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Ministry of Public Health  
Bangkok

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Chief Medical Officer  
Office of Under-Secretary of State for Public Health  
Ministry of Public Health  
Bangkok

Dr Samlee Plianbangchang  
Secretary  
National Advisory Board for Disease Prevention and Control  
Ministry of Public Health  
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2. Representatives of the United Nations and Specialized Agencies

United Nations Development Programme : Mr Sukehiro Hasegawa  
Resident Representative, a.i.  
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United Nations
Development Programme

International Labour Organisation

United Nations
Children's Fund

3. Representatives of Non-governmental Organizations

International Association for Accidents and Traffic Medicine

International College of Surgeons

International Committee of Catholic Nurses

International Council of Women

International Dental Federation

International Federation of Gynaecology and Obstetrics
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Annex 2

AGENDA

1. Opening of the session

2. Sub-Committee on Credentials
   2.1 Appointment of the Sub-Committee
   2.2 Approval of the report of the Sub-Committee (SEA/RC34/20)

3. Election of Chairman and Vice-Chairman

4. Adoption of provisional and supplementary agenda (SEA/RC34/1 Rev.1)

5. Appointment of Sub-Committee on Programme Budget and adoption of its terms of reference (SEA/RC34/4 Rev.1)

6. Adoption of agenda and election of Chairman for the technical discussions (SEA/RC34/5 and Add.1)


8. Consideration of resolutions of regional interest adopted by the World Health Assembly and the Executive Board (SEA/RC34/15)

9. Technical discussions: "The role of ministries of health as directing and coordinating authorities on national health work" (SEA/RC34/16)

   10.1 Consideration of the report of the Sub-Committee on Programme Budget

11. Consideration of the recommendations arising out of the technical discussions (SEA/RC34/22)

12. Review of the draft provisional agenda of the sixty-ninth session of the Executive Board and of the Thirty-fifth World Health Assembly (SEA/RC34/11)

13. Strategies for health for all by the year 2000 (SEA/RC34/8 and Add.1, SEA/RC34/9 Rev.1, SEA/RC34/10)

1Originally issued as document SEA/RC34/1 Rev.1 on 15 September 1981.
14. WHO's structures in the light of its functions (SEA/RC34/7)

15. Progress report on the Seventh General Programme of Work (SEA/RC34/6 and Corr.1)

16. Infant and young child feeding - draft international code of marketing of breastmilk substitutes (SEA/RC34/13)

17. Selection of a subject for the technical discussions at the thirty-fifth session of the Regional Committee (SEA/RC34/14)

18. Time and place of forthcoming sessions of the Regional Committee (SEA/RC34/12)

19. Adoption of the Final Report of the Thirty-fourth Session of the Regional Committee (SEA/RC34/23)

20. Adjournment

SUPPLEMENTARY ITEMS

1. National health programmes with synchronized foreign assistance in the context of WHO technical cooperation (item proposed by the Government of Indonesia) (SEA/RC34/18)

2. Goitre control programme within the context of health for all by the year 2000 (item proposed by the Government of India) (SEA/RC34/17)
Annex 3

REPORT OF THE SUB-COMMITTEE ON PROGRAMME BUDGET

1 Introduction

The Sub-Committee on Programme Budget held a preliminary meeting on 15 September 1981. Dr L. Poudayl of Nepal was elected Chairman. At this meeting, the detailed programme budget for 1982-1983 (documents SEA/RC34/3 and Corr.1 & 2 and Add.1) and three working papers (SEA/RC34/PB/WPs 1 to 3) were introduced and explained. The Sub-Committee's attention was also drawn to the terms of reference (document SEA/RC34/6 Rev.1), which formed the basis of its work.

The Sub-Committee met again on 17 September 1981 to carry out its work and to finalize its report. The meeting was attended by:

Dr U Kyaw Sein .. Burma
Mr Kwon Sung Yon .. DPR Korea
Dr I.D. Bajaj .. India
Dr Bahrawi Wongsokusumo .. Indonesia
Dr Sriati da Costa .. Indonesia
Dr Soediono .. Indonesia
Dr Abdul Sattar Yoosuf .. Maldives
Professor G. Jamba .. Mongolia
Dr R. Arslan .. Mongolia
Dr L. Poudayl (Chairman) .. Nepal
Mr D. Wijesinghe .. Sri Lanka
Dr Prakorb Tuchinda .. Thailand
Dr Samlee Plianbangchang .. Thailand


The Sub-Committee was informed that, after the endorsement of the Programme Budget for 1982-1983 by the Regional Committee at its thirty-third session, detailed activities were developed by the governments in collaboration with the Organization.

Referring to the terms of reference, paragraphs 1.1 and 1.2, the Sub-Committee noted that the changes in the detailed programme budget as compared to the broad programme budget were within the approved programme budget and were in accordance with the Sixth General Programme of Work and the policies of the Organization. The Committee noted that the recommendations made by the Regional Committee at its thirty-third session, especially those contained in its resolutions SEA/RC33/R10 and SEA/RC33/R11, had been implemented. The Sub-Committee was satisfied with the detailed programme budget for 1982-1983 and had no further comments to make to the Regional Committee.

The Sub-Committee was informed that the 1982-1983 budget registered an increase of 17\% over the 1980-81 budget, which represented approximately a 4\% real increase and 13\% increase in terms of cost.

1Originally issued as document SEA/RC34/21 on 17 September 1981.
3 Review of the Report and Recommendations of the "Small Committee" (SEA/RC34/PB/WP3)

The Sub-Committee reviewed the report of the Small Committee (see Appendix) established by the Regional Director in accordance with resolution SEA/RC33/R10, adopted at the thirty-third session of the Regional Committee in 1980. The Small Committee was given the following terms of reference:

(i) to recommend revised guidelines and criteria for the establishment of inter-country projects;

(ii) to analyse all programme proposals prior to the sessions of the Regional Committee and present its findings to the Regional Director, and

(iii) to frame revised terms of reference for the Sub-Committee on Programme Budget.

3.1 Guidelines and criteria for the establishment of inter-country projects

The Small Committee recognized the need for evolving fresh guidelines within the overall parameters of the General Programme of Work for the establishment of inter-country projects and emphasized the importance of collaboration among the Member States for solving common problems in health-related sectors. One of the major objectives for establishing inter-country projects was to strive towards the attainment of regional self-sufficiency and self-reliance among Member States.

The recommendations of the Small Committee were discussed by the Sub-Committee and the following course of action was decided:

(1) To review ongoing and new inter-country projects to determine whether they fall within the following categories:

- health manpower development
- country health planning, programming, monitoring, review and evaluation
- control measures regarding urgent problems of communicable and non-communicable diseases
- effective preventive and promotive strategies for reducing disease incidence within the framework of primary health care
- appropriate technology for improving the primary health care system
- health services organizational and operational research
- effective surveillance mechanisms, and
- institutional support, including manufacture and development of inputs in support of the primary health care package.

(2) Projects which were found to be not relevant according to the above parameters would be phased out on a time-bound schedule.

(3) The Sub-Committee discussed at length the need for the establishment of a committee involving representatives of Member States of the Region to review the functioning of ongoing inter-country projects and recommend fresh projects where necessary. It was considered that this committee would prove useful in evolving a long-term perspective plan of inter-country projects covering the needs for the next two decades and would also assist in analysing the percentages of funds to be earmarked for the categories of projects indicated above.

(4) It was also recognized that the guidelines and criteria for the establishment of inter-country projects approved by the Regional Committee should be reviewed and readjusted every two or three years in order to take account of changing circumstances. In this respect, the role of this committee would be to ensure that the orientation of inter-country projects supported the efforts of achieving the goal of HFA/2000 after taking into consideration individual country needs and circumstances.

3.2 Analysis of regular and extra-budgetary programme proposals

The Sub-Committee noted that the Small Committee had gone into the modifications in the detailed programme budget for 1982-1983 as compared to the general programme proposals, and was unanimous in its view that the changes in the country programmes needed to reflect increased support to primary health care elements. At the same time, assistance to low-priority activities should be discontinued.

In order to evaluate better the relevance of budgetary proposals to efforts to achieve these objectives, the Sub-Committee emphasized the importance of the following analyses, which should be reflected in the formulation of proposed programme budgets in the future:

(a) Country-wise utilization of regular and extra-budgetary resources in support of primary health care and related elements compared to the current and immediately preceding budgetary cycles, and

(b) Identification of new elements as well as new components of ongoing activities, with suitable explanations in respect of proposals which are not in support of primary health care and related elements.

Deviations and rescheduling of resources should normally be permitted only in support of the primary health care package.
Budget reviews of current and immediately past budgetary cycles should be conducted on the basis of performance in both physical and financial terms beginning with the 1984-1985 biennium. A similar approach would be applicable to the inter-country programme which would also indicate the role of inter-country projects in efforts to achieve the goal of HFA/2000, including relevant linkages with health programmes at country level.

While discussing the resources available to this region, which contained approximately one-fourth of the world's population, the Sub-Committee agreed with the conclusion of the Small Committee concerning the need for further mobilization of resources in support of the objectives of HFA/2000 in this region. In this direction, the Director-General should be requested to review the existing criteria for resource allocation among regions so as to allocate a proportionately higher share of the regular budget to the South-East Asia Region. In addition, a suitable mechanism should be evolved for collaborating with Member States for the mobilization of extra-budgetary resources in support of HFA/2000.

Further, it was considered necessary to assess the relevance of the inter-regional projects, and in order to do so, to provide the Sub-Committee, in future, with adequate information regarding the basis of formulation and implementation of inter-regional projects.

3.3 Review of the existing terms of reference of the Sub-Committee on Programme Budget

The Sub-Committee discussed the revised terms proposed by the Small Committee and agreed to present these to the Regional Committee for formal approval. The proposed terms of reference would be effective from the thirty-fifth session of the Regional Committee, and are as follows:

(1) To review implementation of programmes in the current cycle (by country and by project/programme) in terms of both financial implementation and achievement of the envisaged targets.

(2) To review financial implementation in respect of programmes indicating whether the actual spending has been as planned and the extent of savings in each programme, if any, along with the broad reasons therefor.

(3) While considering programme proposals for an ensuing cycle, to reflect such activities as are not in support of the primary health care package in terms of the proposed outlays thereon, comparing the same with the investments in such activities, if any, in the preceding and current cycles, also indicating the broad basis thereof.

(4) To review the pattern of utilization of assistance in respect of each component, viz., long-term staff, short-term consultants, supplies and equipment, subsidies/grants, group educational activities, etc., during the preceding and current cycles.
Similarly, while considering the detailed programme proposals for an ensuing cycle, to compare the envisaged pattern of investments under the aforesaid components with the actual expenditure patterns during the preceding and current cycles, based on available information. (If there had been wide variations in the actual expenditure in respect of any component, the reasons therefor should be identified, so as to enable suitable modifications of the programme budgeting, if necessary, to make it more realistic.)

(5) While reviewing programme proposals for an ensuing cycle, to examine whether the "programming approach"/"detailed programme budget" conforms to the parameters of the basic policy and global strategy of WHO and the current General Programme of Work/medium-term programmes approved by the Regional Committee/World Health Assembly, as well as the specific recommendations, if any, made by the Regional Committee at its preceding sessions.

(6) To consider any other issue in regard to which the Programme Budget Sub-Committee may wish to make a reference or recommendation to the Regional Committee.

(7) To apply the recommendations (1) to (6) above, with such modifications as necessary, to inter-country projects in the ensuing cycle.

The Sub-Committee complimented the Small Committee on its accomplishments and recommended the establishment of a committee mentioned in Section 3.1, paragraph (3) above, in order to ensure further involvement of Member States in the work of the Regional Office. This Committee would replace the Small Committee and also take over its continuing functions, as mentioned in resolution SEA/RC33/10.

4 Consideration of the Proposals for the UNDP Programme (SEA/RC34/PB/WP1)

The Sub-Committee noted the UNDP inter-country programme proposals for 1982-1986 approved by the United Nations Development Programme. The original submission which was discussed by the Regional Committee at its thirty-third session amounted to $17,525,000, whereas the funds earmarked by the United Nations Development Programme amounted to $4,090,200. The Sub-Committee was concerned with the low allocation to health activities in the UNDP programmes and urged Member States to promote acceptance of proposals in the health sectors through their national coordinating bodies.

5 Consideration of the Observations Made by the External Auditor of WHO (SEA/RC34/PB/WP2)

The Sub-Committee suggested that, as had been observed by the External Auditor of WHO, there was a need to ensure better coordination of efforts of the various United Nations agencies.

The inability of governments to provide counterpart staff was a serious matter. It was suggested that provision of incentives to national staff be considered for inclusion in the project documents of UNDP.
In conclusion, the Sub-committee recommended to the Regional Committee the adoption of the following resolution:

**Report of the Sub-committee on Programme Budget**

The Regional Committee,

Having considered the report of the Sub-committee and the detailed programme budget for 1982-1983 (documents SEA/RC34/3 and SEA/RC34/3 Add.1), and

Appreciating the fact that the WHO programme continues to provide support to Member States to enable them to achieve health for all by the year 2000,

1. APPROVES the report of the Sub-committee on Programme Budget;

2. NOTES the 1982-1983 detailed programme budget with elaboration on the project activities (documents SEA/RC34/3 and Add.1) and the proposals for the UNDP Regional Programme (SEA/RC34/PB/WP1);

3. NOTES the observations made by the External Auditor of WHO in his report to the World Health Assembly (A34/25 and A34/25 Add.1) for the first year of the financial period 1980-81;

4. NOTES the report and the recommendations of the "Small Committee" (SEA/RC34/PB/WP3) appointed by the Regional Director in response to Regional Committee resolution SEA/RC33/R10;

5. REQUESTS the Regional Director:

   (a) to implement the 1982-1983 programme as contained in documents SEA/RC34/3 and Add.1 in accordance with the policies and guidelines laid down by the World Health Assembly and in cooperation with Member Governments;

   (b) to ensure inclusion of the following items in the terms of reference of the Sub-committee on Programme Budget for the biennium starting from the thirty-fifth session of the Regional Committee:

      (i) to review the implementation of programmes in the current cycle (by country and by projects/programmes) in terms of both financial implementation as well as achievement of envisaged targets;

      (ii) to review financial implementation in respect of the programmes, indicating whether the actual spending has been as planned and the extent of savings in each programme, if any, along with the broad reasons therefor;
(iii) to consider programme proposals for an ensuing cycle reflecting such activities as are not in support of the primary health care package in terms of the proposed outlays, comparing the outlays with the investments in such activities, if any, in the preceding and current cycles, also indicating the broad basis therefor;

(iv) to review the pattern of utilization of assistance in respect of each component, viz., long-term staff, short-term consultants, supplies and equipment, subsidies/grants, group educational activities, etc., during the preceding and current cycles. Similarly, while considering the detailed programme proposals for an ensuing cycle, to compare the envisaged pattern of investments under the aforesaid components with the actual expenditure patterns during the preceding and current cycles, based on available information. (If there have been wide variations in the actual expenditures in respect of any component, the reasons should be identified, so as to enable suitable modification of the programme budgeting, if necessary, to make it more realistic.);

(v) while reviewing programme proposals for an ensuing cycle, to examine whether the "programming approach"/"detailed programme budget" conforms to the parameters of the basic policy and global strategy of WHO and the General Programmes of Work/medium-term programmes approved by the Regional Committee/World Health Assembly, as well as the specific recommendations, if any, made by the Regional Committee at its preceding sessions, and

(vi) to consider any other issue in regard to which the Programme Budget Sub-Committee may wish to make a reference or recommendation to the Regional Committee;

(Note: The recommendations made in paras (i) to (vi) above, with such modifications as necessary, should also apply in regard to inter-country projects in the ensuing cycle.)

(c) to consider the following programme categories in addition to guidelines and criteria provided by the Director-General in his programme budget guidelines, for establishing inter-country projects: health manpower development; country health planning, programming, monitoring, review and evaluation; control measures regarding urgent problems of communicable and non-communicable diseases; effective preventive and promotive strategies for reducing disease incidence within the framework of primary health care; appropriate technology for improving the primary health care system; health services organizational and operational research; effective surveillance mechanisms, and institutional support, including the manufacture and development of inputs in support of the primary health care package;
(d) to establish a committee, replacing the Small Committee set up in accordance with resolution SEA/RC33/R10, to review the functioning of ongoing inter-country projects as well as recommended fresh project proposals, in accordance with para 5(c) above, to evolve a long-term perspective plan of inter-country projects; to review and redefine guidelines and criteria for inter-country projects every two or three years, and to assess the relevance of inter-regional projects in terms of regional needs and priorities as well as inter-regional interests;

(e) to request the Director-General to review existing criteria for resource allocation among regions, with a view to giving a higher priority to the South-East Asia Region, comprising about one-fourth of the world's population, and

(f) to evolve a suitable mechanism for the mobilization of extra-budgetary resources in support of HFA/2000.
Appendix

MEETING OF THE SMALL COMMITTEE TO REVIEW THE ORGANIZATION'S TECHNICAL COLLABORATIVE PROGRAMME

BALI, INDONESIA, 11-14 SEPTEMBER 1981

Report to the Regional Director

1 Introduction

1.1 The Regional Committee, at its thirty-third session, after considering the Report of the Sub-Committee on Programme Budget, requested the Regional Director, through its resolution SEA/RC33/R10, to establish a "Small Committee", to:

- review the existing terms of reference of the Sub-Committee on Programme Budget and frame revised terms which are harmonious and relevant to present and future budgetary concerns;
- review existing guidelines and criteria for the establishment of inter-country projects, and recommend a revised framework;
- analyse all regular and extra-budgetary programme proposals, including the detailed proposals for 1982-1983, prior to each session of the Regional Committee, and present its findings to the Regional Director.

1.2 The Small Committee, consisting of a representative from each of the Member States in the Region, was established, and met in Denpasar, Bali, from 11 to 14 September 1981. A list of the participants is given on page 47.

1.3 The Committee elected Mr D. Wijesinghe as Chairman and Mr N.N. Vohra as Rapporteur.

2 Discussions and Recommendations

Discussions on the terms of reference given in para 1.1 above are set out in the ensuing paragraphs in the order in which these were considered by the Small Committee:

2.1 Review of the existing guidelines and criteria for the establishment of inter-country projects and recommendations in regard to revised framework

2.1.1 Tracing the evolution of inter-country projects, the criteria for their selection and their funding from various sources, the utilization of inter-country projects (ICPs) over the past decade was

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1Originally issued as document SEA/RC34/PB/WP3 on 14 September 1981.
reviewed. It was agreed that there was a need for evolving suitable fresh guidelines within the overall parameters of the General Programmes of Work for establishing these projects in order to ensure that they were directly related to the priority objectives of the Organization within the Region, in the context of the goal of HFA by the year 2000, and that the mechanisms for the involvement of the Member States in the formulation of inter-country projects should be strengthened.

2.1.2 Taking into account the actual experience of the Organization's assistance to the countries during the past three decades and more, and also fully keeping in mind the present varying state of technological advancement of the countries in the Region, it was agreed that there was a strong basis for continuing the inter-country programmes. It was also felt that, in view of the present challenges, in addition to country programmes, organized efforts should be made to foster collaborative inter-country activities by pooling resources to solve common problems of the Member States in the health and related sectors, on a time-bound basis.

2.1.3 After detailed discussion, the following recommendations were made:

(1) All inter-country projects which are found to be outmoded in their objectives should be phased out within a time-bound programme. Such projects as satisfy the criteria of relevance and priority should be reorganized to secure results within well-conceived time frames so that the achievements gained could serve as direct inputs into the strengthening and enlargement of efforts in support of HFA/2000.

(2) One of the major objectives for establishing inter-country projects should be the attainment of regional self-sufficiency and/or self-reliance in respect of basic health needs which are common to the majority of Member States through joint inter-country efforts.

(3) Within the objective of resolving common problems on a time-bound basis, the new inter-country project proposals should be identified, and both the ongoing and new inter-country proposals should be scrutinized applying the following criteria:

(a) projects in support of health manpower development, with special reference to identified training requirements for the delivery of the primary health care packages (medical professionals, para-professionals and technicians, auxiliaries and volunteers);

(b) projects which support, strengthen and enlarge country health planning and programming, monitoring, reviewing and evaluation efforts;

(c) projects which seek to resolve urgent problems of communicable and non-communicable diseases and commonly prevalent, widespread health problems;
(d) projects which seek to evolve effective preventive and promotive strategies, to bring down the incidence of disease and improve the health status of all people through public health measures, education, improved awareness, etc.;

(e) projects which seek to translate existing knowhow and expertise into readily applicable and cost-effective, appropriate technology/procedures which can constitute direct and immediate inputs for improving the primary health care delivery system;

(f) projects for research in the health services organization to bring about suitable structural changes and improve operational efficiencies;

(g) projects relating to the establishment of effective surveillance mechanisms, identification, analysis and timely dissemination of information regarding emerging health problems (a certain number of such projects could also deal specifically with the related research aspects), and

(h) projects which seek to provide institutional support, and strengthen and enlarge the capacities to promote national and regional self-sufficiency, self-reliance, skills and competence, in regard to the manufacture and development of essential inputs in support of the primary health care package.

(4) In order to scrutinize regularly ongoing inter-country projects, to take decisions regarding the phasing out of projects which are no longer relevant to the common, collective needs and priorities of the countries in the Region, to review the functioning of ongoing projects as well as to recommend fresh project proposals, the Regional Director should establish a committee involving the representatives of the Member States. The proposed committee may meet periodically as required and undertake such site visits as may be necessary to enable it to assess and evaluate inter-country projects. To undertake the review, monitoring and evaluation of inter-country projects, the Regional Office should establish suitable mechanisms in supporting the said committee.

(5) The said committee may evolve a long-term, perspective plan of inter-country projects, covering the next two decades. Outlays required to be mobilized for the implementation of identified projects should be related to the perspectives, needs and priorities. For the purpose of effective financial management it would be beneficial, after further analyses, to earmark, in percentage terms, available resources for the implementation of inter-country projects, as priorities, under the broad categories listed under para (3) above.
It was noted that planning and programming for health and related sectors constitute a dynamic situation, involving constant assessments and reappraisals, to introduce timely remedial measures on account of synergistic effects and influences. In this context, it was agreed that guidelines and criteria for the establishment of inter-country projects, finally approved by the Regional Committee, would require review and redefinition every two to three years for introducing such modifications and shifts as may be necessary. Recommendations in this regard may also emanate from the committee proposed in para (4) above.

2.2 Analysis of the regular and extra-budgetary programme proposals

It was observed that insofar as the detailed programme proposals for 1982-1983 are concerned, the broad approach in regard thereto was endorsed by the Regional Committee at its thirty-third session. As such, at this juncture, there is no scope for introducing any modifications. However, in view of the fact that the programme budget for 1982-1983 constitutes one of the significant steps towards the achievement of the goal of HFA/2000, the deviations in the Detailed Programme Budget from the Proposed Programme Budget for 1982-1983 (SEA/RC33/3) were discussed. It was felt that the various country-wise deviations, taken together, should represent a sharper realization of the necessity to support primary health care elements, eliminating assistance to the non-priority activities. With a view to ensuring that the utilization of available technical and financial resources by Member States in the ensuing biennial budgetary cycles becomes more visibly and directly related to the strengthening and enlargement of support to the primary health care package, it was agreed that the following aspects should be given due and timely attention at the stage of preparatory activities in the formulation of the proposed programme budgets:

2.2.1 Programme budget proposals for an ensuing cycle must bring out, by country, how the regular budget and extra-budgetary resources are proposed to be utilized in support of primary health care and related elements. This analysis would require to be compared between the corresponding overview during the current and the immediately preceding budgetary cycles.

2.2.2 The presentation of proposals for an ensuing budgetary cycle should adequately identify the new elements as well as the new components of ongoing activities, suitable explanations being given in respect of proposals which are not in support of primary health care and related elements.

2.2.3 Normally deviations and reschedulings of resources should be discouraged except in support of the primary health care package, as per the needs and priorities identified by each country.

2.2.4 As the basic and foremost objective of all preparatory activities in the future connected with the formulation of budgetary proposals
would require to be directly related to the needs and priorities emanating from the regional strategies for achieving the goal of HFA/2000, it appears essential that, depending upon the existing organizational capacity of Member States, time-bound steps may be organized to introduce the review of the budget on the basis of performance, preferably effective from the 1984-85 budgetary cycle. The adoption of such a procedure, besides enabling the countries to clearly identify and assess the benefits accruing from the assistance of the Organization, would provide the latter with a very effective mechanism to evaluate, in quantifiable terms, whether the country-wise efforts are moving towards the achievement of the targeted HFA goals in specified areas of activity.

2.2.5 An identical approach, as in paras 2.2.1 to 2.2.4 above, would require to be followed in regard to the formulation and presentation of proposals for inter-country programmes.

2.2.6 The presentations and analyses of inter-country projects should specifically indicate the role and share of inter-country projects in the overall effort of achieving the goal of HFA/2000, inter alia, indicating the relevant linkages between the health programmes at country level and the inter-country projects.

2.2.7 In the process of the overall review of regular budget and extra-budgetary resources, it was observed that there was a need for further mobilization of resources in support of HFA objectives in this region, and it was recommended that:

(1) Considering the fact that the South-East Asia Region contains about one-fourth of the global population, the Director-General of WHO may be requested to review the existing allocation criteria, so as to obtain a proportionately higher share of regular budget resources for the Region.

(2) In so far as the extra-budgetary resources are concerned, the Regional Office should establish a suitable mechanism to collaborate with the Member States in mobilizing external resources as well as in formulating appropriate projects based on priority needs which have a high potential of acceptance by the existing and potential funding agencies.

2.2.8 In the future, the Regional Office may obtain and provide adequate information regarding the basis of formulation and implementation of inter-regional projects so that an assessment can be made as to the relevance of such projects to regional needs and priorities as well as inter-regional interests.

2.3 Review of the existing terms of reference of the Sub-Committee on Programme Budget

It was observed that the terms of reference of the Sub-Committee on Programme Budget have been relevant and satisfactory to the requirements of the situation in past years. However, consequent to the commencement of the biennial system of programme budgeting and the
specific need to ensure a conscious shift in the utilization of resources in support of primary health care in order to achieve the goal of HFA/2000, changes are required in the terms of reference.

In this context, the following revised terms of reference are recommended:

2.3.1 Country budget

(1) Review of the implementation of programme in the current cycle (by country and by project/programme) should be in terms of both financial implementation as well as achievement of envisaged targets;

(2) Review of financial implementation in respect of the programmes should indicate whether the actual spending has been as planned and the extent of the programme-wise savings, if any, along with the broad reasons thereof;

(3) While considering programme proposals for an ensuing cycle, such activities as are not in support of the primary health care package should be reflected in terms of the proposed outlays thereon, comparing the same with the investments in such activities, if any, in the preceding and current cycles, also indicating the broad basis thereof;

(4) The programme review should indicate the pattern of component-wise utilization of assistance for long-term staff, short-term consultants, supplies and equipment, subsidies/grants, group educational activities, etc., during the preceding and current cycles. Similarly, while considering the detailed programme proposals for an ensuing cycle, the envisaged pattern of investments under the aforesaid components should be compared with the actual expenditure patterns during the preceding and current cycles, based on available information. If there have been wide variations in the actual expenditures in respect of any component, the reasons thereof should be identified, so as to enable suitable modification of the programme budgeting procedure, if necessary, to make it more realistic;

(5) While reviewing programme proposals for an ensuing cycle, to examine whether the "programming approach"/"detailed programme budget" conforms to the parameters of the basic policy and global strategy of WHO and the General Programmes of Work/Medium-Term Programmes approved by the Regional Committee/World Health Assembly, as well as the specific recommendations, if any, made by the Regional Committee at its preceding sessions, and

(6) Any other issue in regard to which the Programme Budget Subcommittee may wish to make a reference or recommendation to the Regional Committee.
2.3.2 **Inter-country programmes**

Recommendations made in Section 2.3.1, paras (1) to (6) above, with such modifications as necessary, should also apply in regard to inter-country projects in the ensuing cycle.

2.3.3 **Application of proposed terms of reference**

The Committee, however, recommends that the proposed terms of reference as detailed above should be applied with effect from the thirty-fifth session of the Regional Committee, as these cannot be implemented in the forthcoming thirty-fourth session.
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Annex 4

RECOMMENDATIONS ARISING OUT OF THE TECHNICAL DISCUSSIONS ON THE ROLE OF MINISTRIES OF HEALTH AS DIRECTING AND COORDINATING AUTHORITIES ON NATIONAL HEALTH WORK

1 Introduction

The technical discussions were held under the chairmanship Mr N.N. Vohra (India), with Dr M. Fernando (Sri Lanka) acting as Rapporteur.

Referring to documents SEA/RC34/5 - 5 Add.1, SEA/RC34/16 and SEA/RC34/ TD/IP1 to 8, the Chairman focused attention on the principal issues involved in the discussion of "The Role of Ministries of Health as the Directing and Coordinating Authorities on National Health Work". It was observed that consequent to the commitment to the attainment of the goal of HFA/2000, the national ministries of health were becoming increasingly aware of their directing and coordinating roles, especially the planning and implementation of the primary health care package, and supporting services had highlighted, in sharp focus, the need for a well-coordinated and harmonized approach. It was noted that in view of the enormous challenges, the health ministries could no longer afford merely to be equipped for crisis management, undertaking fire-fighting tasks on a day-to-day basis. As the situations in each country had been very adequately reported in the documents referred to, the Chairman asked the participants to consider, and offer their comments and suggestions in regard to the main problems and the significant issues relating to the subject.

2 Discussions

It was observed that the role of the central health ministries in directing and coordinating national health efforts could be viewed as encompassing two main areas of responsibility: (1) problems relating to the effective functioning of the ministries in respect of their existing jurisdiction, i.e., the extent to which they are already in a position to draw up plans, formulate and implement programmes, undertake the review, monitoring and evaluation, etc., of the specific areas of functioning which have been allocated to them under the rules of business of the national governments, and (2) areas of functioning which involve inter-ministerial and inter-sectoral coordination involving the functioning of other departments and organizations outside their own control and jurisdiction.

It was observed that, as the first step, urgent action was required to make the functioning of ministries more effective technically and administratively, within the realm of their present jurisdiction. It was agreed that, while variations in the policy and planning approaches would continue to exist, depending upon the political philosophies, administrative cultures, etc., of Member States, it would be necessary to ensure that the central health ministries received the requisite support to be able to build up essential planning and administrative

1Originally issued as document SEA/RC34/22 on 18 September 1981
mechanisms to make the best possible use of available resources and achieve the requisite cost-effectiveness and efficiencies in the implementation of schemes and programmes in the health and related sectors. It was noted that while every Member State might already have established suitable planning and administrative mechanisms, there could still be gaps at various levels which would need to be filled and the entire planning and implementation set-up made more effective and beneficial.

3 Recommendations

In the context of the extensive discussions, the following recommendations are offered to enable the central health ministries to become more effective:

3.1 Sectoral planning

(1) The existing planning mechanisms for the health and related sectors require to be suitably strengthened. The planning organizations should have the support of professional economists, demographers, social scientists, medical scientists and administrators, researchers, planners and health administrators. The planning divisions of the health ministries should accordingly be reorganized with a view to improving visibly their technical capabilities in the most recent planning techniques and hence increasing their credibility with the other departments and organizations with which they are required to deal in evolving and finalizing national health plans. Inter alia, the planning organization within the health ministries must be effectively equipped to undertake health manpower planning, health manpower development, and identification of training requirements (by categories of workers), to assess the projected costs involved in the securing of identified objectives, to identify the role of the private medical practitioners, mobilize resources, identify management problems, etc.

(2) The planning mechanisms at central level must have effective and meaningful linkages with the planning mechanisms at the successive levels, viz. state/province/district, etc., so that the perspective plans are drawn up in adequate consultation with the state/provincial/district authorities, which are ultimately responsible for implementing the schemes and programmes. As in the case of (1) above, the planning organizations at state/provincial/district level also require to be suitably strengthened so as to be able not only to evolve and submit meaningful proposals to the central planning organization but also, at their own levels, to be able to undertake a coordinated approach to policy planning.

(3) The existing national health information systems, from district to central level, must be strengthened, so as to obtain reliable feedback and information regarding the difficulties encountered during implementation with a view to introducing suitable corrective and remedial measures in the very process of planning. It was observed that the mechanisms available for review,
monitoring and evaluation were not effective enough at all levels of the structural organization to enable an appraisal of on-going plans in regard to the relevance, acceptability and efficacy of schemes and programmes which were launched in various areas of activity. It will therefore be necessary to fill this gap and establish reliable systems, through which the planning organizations at the successive levels of the structure can receive timely feedback, not only to assess the effective benefit of on-going schemes but also to be able to evolve sound, cost-effective approaches for the next succeeding planning cycles.

(4) To ensure the effective implementation of the various schemes and programmes to improve the health status of all people, it has become unavoidably essential progressively to secure the fullest involvement and participation of the individuals, families, communities, voluntary organizations and private bodies in the overall national health efforts. To be able to achieve this objective, it will be necessary to examine the present administrative and financial organizations and decide upon appropriate decentralization of authority, at all levels of the structural organization, with the broad objective of equipping health managers with the necessary authority harmonious with their responsibilities. Unless this is done, bureaucratic delays will continue to dampen and restrict local initiatives, thus also militating against the meaningful involvement of the communities and the voluntary organizations.

3.2 Inter-sectoral plans

On the assumption that the recommendations made in Section 3.1 above will become effective in the foreseeable future, it will be necessary for the central ministries progressively to equip themselves in effecting meaningful, inter-ministerial coordination to achieve joint formulation of plans and programmes in each of the health-related sectors. In this context, it was observed that the central health ministries would not be able to negotiate effectively or secure an entry point in the planning mechanisms of other concerned ministries unless the health ministries were, in the first instance, able to build up reliable planning mechanisms which can clearly identify and project needs and demands relating to the functioning of the other sectors, e.g., higher education, adult and non-formal education, water supply, drugs and pharmaceuticals, rural housing, social welfare, integrated rural development, etc. To secure the above-mentioned objective, the following recommendations are made:

(1) With the ultimate objective of moving towards health and human development as it is an integral part of planned economic development, it will be necessary for the central ministries, in meaningful collaboration with the planning organizations at the state/provincial/district levels, to draw up reliable projections of support and assistance required in each of the various health-related sectors. By way of illustration, if the specified objective is to reduce mortality and morbidity on account of water-borne diseases, then it will be essential for the central health ministries to be able to outline clearly the extent and
nature of the effort required to be mobilized by the department/ministry concerned for the supply of potable water and sanitation, also clearly identifying the priorities of action required in this connexion. The building up of such projections and consequent negotiations, on an effective basis, with the central planning commissions/organizations as well as each of the various concerned ministries will be possible only if the central health ministries equip themselves with the necessary expertise to be able to put together all relevant information, collect such data as are required, etc., and build up a reliable picture of needs and priorities. For this purpose, the central health ministries may require to establish sub-groups for each of the health-related sectors in regard to which the requisite support in the overall national plan is necessary.

Even after the central health ministries have been able to establish the mechanisms suggested in (1) above and to draw up reliable projections of needs and priorities in each of the various health-related sectors, it will be essential to establish effective institutional mechanisms to ensure that the overall demands of the central health ministries are given due and serious consideration at the time of finalizing national development plans. For this purpose, depending upon the organizational arrangements in a country, it will be necessary to establish standing inter-ministerial coordination committees with the central health ministry acting as the focal point, or to persuade the national planning commissions/organizations to establish standing inter-sectoral working groups in support of health and all related sectors.

3.3 Existing mechanisms

It will be observed that in each of the countries of the Region, there already exist certain mechanisms, of an ad hoc or standing nature, e.g., national health councils, national health development committees, etc. Some of the mechanisms are of relatively recent origin, developed to promote intersectoral cooperation and to monitor and evaluate programmes. It is obviously too early in the way to draw conclusions on their effectiveness. However, it needs to be ensured that there are suitable mechanisms established to see to it that the policy and directives for coordination are actually implemented by the various operational levels concerned.

3.4 Implementation

With a view to implementing the recommendations set out in Sections 3.1 to 3.3 above, it was felt that there should be collaborative efforts in respect of technical and managerial aspects between Member countries. WHO should provide collaborative support to these national efforts. It was felt that, in view of the scarce national resources, the optimum use of the Organization's technical and other resources would appear to lie in the formulation and implementation of relevant inter-country programmes, bilateral or under the TCDC efforts, so that, within the foreseeable future, the countries in the Region will effectively assist one another in achieving a larger measure of national and regional self-reliance.
### Annex 5

**LIST OF OFFICIAL DOCUMENTS OF THE THIRTY-FOURTH SESSION**

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1Originally issued as document SEA/RC34/24 on 20 September 1981.
REPORT OF THE REGIONAL COMMITTEE

SEA/RC34/14 Selection of a Subject for the Technical Discussions at the Thirty-fifth Session of the Regional Committee

SEA/RC34/15 Consideration of Resolutions of Regional Interest Adopted by the World Health Assembly and the Executive Board

SEA/RC34/16 The Role of Ministries of Health as Directing and Coordinating Authorities on National Health Work (Paper for the Technical Discussions)

SEA/RC34/TD/IP1 Country Information Paper, Mongolia
SEA/RC34/TD/IP2 Country Information Paper, Nepal
SEA/RC34/TD/IP3 Country Information Paper, Sri Lanka
SEA/RC34/TD/IP4 Country Information Paper, Thailand
SEA/RC34/TD/IP5 Country Information Paper, Indonesia
SEA/RC34/TD/IP6 Country Information Paper, India
SEA/RC34/TD/IP7 Country Information Paper, Bangladesh
SEA/RC34/TD/IP8 Country Information Paper, Maldives

SEA/RC34/17 Background Document for the Proposed Agenda Item on Goitre Control (Paper presented by the Government of India)

SEA/RC34/18 National Health Programmes with Synchronized Foreign Assistance in the Context of WHO Technical Cooperation (Paper presented by the Government of Indonesia)

SEA/RC34/19 Rev.1 Revised List of Participants

SEA/RC34/20 Report of the Sub-Committee on Credentials

SEA/RC34/21 Report of the Sub-Committee on Programme Budget

SEA/RC34/22 Recommendations Arising Out of the Technical Discussions on the Role of Ministries of Health as Directing and Coordinating Authorities on National Health Work

SEA/RC34/23 Draft Final Report of the Thirty-fourth Session of the Regional Committee for South-East Asia

SEA/RC34/24 List of Official Documents of the Thirty-fourth Session

INFORMATION DOCUMENTS

SEA/RC34/Inf.1 Strategies for Health for All by the Year 2000 - Regional and National Strategies
Regional Strategies and Content of the Seventh General Programme of Work, 1984-1989

Guiding Principles for Facilitating Reporting by Member States on Action Taken in the Field of Infant and Young Child Feeding

National Consultation on the Implementation and Monitoring of the International Code of Marketing of Breastmilk Substitutes

Minutes

First Meeting, 15 September 1981, 9.00 a.m.
Second Meeting, 15 September 1981, 2.00 p.m.
Third Meeting, 16 September 1981, 9.00 a.m.
Fourth Meeting, 16 September 1981, 2.00 p.m.
Fifth Meeting, 18 September 1981, 9.00 a.m.
Sixth Meeting, 18 September 1981, 2.00 p.m.
Seventh Meeting, 21 September 1981, 9.00 a.m.

Resolutions

Goitre Control Programme in the Context of Health for All by the Year 2000

Expanded Programme on Immunization

Thirty-third Annual Report of the Regional Director

Strategies for Health for All by the Year 2000

Managerial Process for National Health Development

The Study of WHO's Structures in the Light of Its Functions

Seventh General Programme of Work (1984-1989)

Infant and Young Child Feeding - Draft International Code of Marketing of Breastmilk Substitutes

Time and Place of the Thirty-fifth Session and Place of the Thirty-sixth Session of the Regional Committee

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*Held in conjunction with but not as a part of the regular proceedings of the Regional Committee.
16. Infant and young child feeding – draft international code of marketing of breastmilk substitutes

17. Selection of a subject for the technical discussions at the thirty-fifth session of the Regional Committee

18. Time and place of forthcoming sessions of the Regional Committee

19. Adoption of the Final Report of the Thirty-fourth Session of the Regional Committee

20. Adjournment

SUPPLEMENTARY ITEMS

1. National health programmes with synchronized foreign assistance in the context of WHO technical cooperation (item proposed by the Government of Indonesia)

2. Goitre control programme within the context of health for all by the year 2000 (item proposed by the Government of India)
SUMMARY MINUTES*

First Meeting, 15 September 1981, 9.00 a.m.

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ANNEXES

1 Text of address by H.E. the Governor of Bali, Professor Ida Bagus Mantra  
2 Text of address by the Regional Director, Dr U Ko Ko  
3 Text of inaugural address by H.E. the Minister of Health of the Republic of Indonesia, Dr Suwardjono Surjaningrat  
4 Text of the Regional Director's address introducing his Thirty-third Annual Report  

*Originally issued as document SEA/RC34/Min.1, on 15 September 1981.
1 Opening of the session (item 1)

MR MOHAMMED MUSTHAPA HUSSAIN, the outgoing Chairman, welcomed the Governor of Bali, the Indonesian Minister of Health, the delegates, and representatives of United Nations agencies and non-governmental and inter-governmental organizations. He said that during the previous year the Regional Committee had held its session for the first time in his country, and it was a unique experience. He felt that the goal of health for all by the year 2000, adopted at Alma-Ata, provided a real opportunity for countries in the field of health, and his own country had forged ahead towards the goal with WHO's support. At the present session important subjects would be reviewed, covering the entire spectrum of WHO's activities, as well as resolutions adopted by the Executive Board and the World Health Assembly, and he hoped that the deliberations would be fruitful. He also referred to the forthcoming meeting of ministers of health of countries of the Region, scheduled to be held in Jakarta immediately after the session of the Regional Committee, which would deal with regional cooperation and coordination in the health field.

He was happy that the present session was being held in the beautiful island of Bali, with its cultural traditions, as depicted in numerous paintings, dances, etc.

2 Address by the Governor of Bali

H.E. PROFESSOR IDA BAGUS MANTRA, Governor of Bali, extending a warm welcome to the delegates and participants, stated that the island of Bali had two main sources for development, viz., agriculture and tourism. He believed that a good health programme was a basic requirement for the promotion of these development potentials. With this object in mind, in 1969 the Government had launched the National Health Programme, which had so far covered most of the Province. There were now 65 health centres staffed by doctors and paramedical personnel. It was planned to increase the number of these centres to 80 within the next two years in order to have one health centre each for 30,000 of the population. The people's participation in the health activities was ensured. At the same time, the island was faced with the problem of meeting the health needs of increasing numbers of tourists. He hoped that the national health officers, assisted by the Central Government and WHO, would find alternative approaches to both meeting the health needs of the local people and promoting tourism. He wished the Regional Committee a successful session and the delegates a pleasant stay (for full text, see Annex 1).

3 Address by the Regional Director

The REGIONAL DIRECTOR expressed appreciation to the Health Minister of the Government of Indonesia for being present, despite his many commitments, and for all of his support to WHO. He thanked the Government for hosting the session - for the second time in Bali and the fifth time in Indonesia; he also thanked the Governor of Bali for attending the meeting, and welcomed the representatives of Member States, international agencies and non-governmental agencies, as well as other guests.
He referred to Indonesia's famous natural beauty and to the breathtaking scenery of the island of Bali, which had also been the centre of cross-fertilization of some of the great religions and cultures, enabling its people to maintain an artistic, peaceful and joyous way of life.

Indonesia's determined efforts toward health development were reflected in the formulation of its third National Five-Year Plan, with health occupying its due place, and in its emphasis on such aspects as expansion of the health infrastructure, training of appropriate manpower, improvement of both service and research elements of primary health care, mobilization of resources and evaluation. The Government would undoubtedly continue to make progress in attaining the HFA goals.

As for the health situation in the Region as a whole, the Regional Director listed some commendable achievements which showed that there had undoubtedly been general improvement; nevertheless, the peoples' aspirations toward a higher level of health were yet to be fulfilled, and the adoption of the goal of health for all by the year 2000 thus offered a unique opportunity and challenge to health leaders. The present needs for redefining priorities and the target population, reallocating resources, etc., depended on correct political decisions, based on which national, regional and global commitments would subsequently be made.

He referred to the strategies for attaining the goal of health for all which had been formulated at all levels. The Regional Committee would have the opportunity to review the global strategy, along with the regional strategy and the draft plan of action. Also, a draft of WHO's Seventh General Programme of Work, prepared in consultation with governments, would be presented for review.

With the crystallization of the concept of HFA/2000, it had been found necessary to examine the organizational structure, ways of functioning and the staffing pattern of WHO, so as to ensure that the Organization could play its assigned role as the coordinating and collaborating agency in international health. As it was imperative to have a very close dialogue with countries at all possible levels, a meeting of the Ministers of Health of all the countries in the Region was being convened in Jakarta - again at the kind invitation of the Indonesian Government - immediately following this session of the Regional Committee. It was thought that this meeting would do much to reinforce governments' commitment to HFA goals.

The Regional Director concluded by alluding to the address of India's Prime Minister, Mrs Gandhi, to the Thirty-fourth World Health Assembly, in which she said, "Life is not mere living, but living in health". Although tremendous efforts were required, he felt that at this session the Regional Committee would be able to make a real contribution to the goal of health for all.

4 Address by the Minister of Health

DR SIJWARDJONO SURJANINGRAT extended a warm welcome to those attending the thirty-fourth session of the Regional Committee. He was grateful to
WHO for its trust in Bali's ability to host and organize such a gathering, and said that the people had high expectations of the outcome, including the planning of a joint course of action to achieve the goal of health for all by the year 2000, which would never have been dreamed of ten years earlier.

The Minister said that while it was possible to look back at past achievements with pride, there was no room for complacency, as the avenues to reach the common objectives might not be so smooth in years to come. There was thus the need to proceed with due caution but at an increased tempo. A consensus had been reached on the target of health for all by the year 2000 with primary health care as the key approach, and on the global strategy. The task of the Regional Committee was even greater than usual, as they must transform these ideals into operational plans to benefit the common man. The meeting should deliberate on common approaches and joint action to meet the challenges. In this context, WHO was expected to provide effective coordination in TCDC, and also give the necessary leadership to ensure that the Region as a whole moved forward in one systematic approach. He was confident that, during the course of the meeting, meaningful resolutions covering areas for possible innovative actions would be adopted.

The Minister wished the meeting every success (for full text, see Annex 3).

* * *

With the ceremonial opening of the session by the beating of the gong, and some Balinese dances, there was a recess for tea, hosted by the Government.

5 Statement by the representative of UNDP

On resumption of the meeting, MR HASEGAWA (UNDP), conveying the greetings of the UNDP Administrator, mentioned that UNDP, in close collaboration and coordination with WHO, was assisting health projects in many fields as indicated in the plan of action. Additional inputs in water supply and primary health care amounted to 4.5 million US dollars through 35 country and inter-country projects. Several IPF-financed UNDP projects, aimed at supporting technical cooperation among developing countries, had been instrumental in furthering joint government development programmes in the health sector within the Region. Referring to continued UNDP support to health development endeavours in the Region, he stated that the detailed budget for 1982-83 envisaged assistance to the extent of US$6 million for the country projects and US$2.15 million for inter-country programmes. In addition, UNDP's global and inter-regional programmes would continue with emphasis on health research. Through various other UNDP-administered funds, such as the UNCDF, the Interim Fund for Science and Technology, and the UN Voluntary Fund for Women, UNDP would be supporting a number of health projects aimed at specific target groups. He hoped that UNDP involvement in the International Drinking Water Supply and Sanitation Decade would be expanded.
6 Statement by the representative of UNICEF

DR ASLAM (UNICEF), conveying the greetings of the UNICEF Executive Director and the Regional Directors of EAPRO and SCARO, expressed the regret of the EAPRO Director at her inability to be present at this meeting because of another pre-scheduled meeting, and also mentioned the close collaboration between WHO and UNICEF at country, regional and global levels in the field of primary health care. Most of the countries had been implementing this community-based approach to health care for a number of years now. On the basis of her experience in Burma and Indonesia, she said that these two countries, while expanding the programme coverage, were concurrently concentrating their efforts on consolidating on-going activities based on experience gained and information available through both regular monitoring and specific assessment of the programme activities. As an example of the joint support of the two organizations in this particular aspect, she mentioned the decision which had been endorsed by the Joint Committee on Health Policy to undertake in selected countries a study of "implementation of PHC with emphasis on the most effective support that WHO and UNICEF could give jointly to governments". She emphasized that joint collaboration at country level between the two organizations and the governments concerned should be further strengthened to maximize effectiveness and avoid duplication of resources and efforts. This was why UNICEF was deeply interested in the deliberations of this Regional Committee, which would bring to focus the major areas where joint close collaboration between assisting agencies, particularly UNICEF and WHO, and the government concerned was considered vital towards reaching the set target of HFA by the year 2000.

In concluding, Dr Aslam informed the Regional Committee that a meeting of UNICEF Representatives and the Regional Director of the EAPRO Region was currently in session in Bali.

7 Statement by the representative of ILO

MR TANAKA (ILO), conveying the greetings of the Assistant Director-General of the ILO Regional Office, mentioned the close collaboration of ILO, WHO and UNEP in the field of industrial safety and occupational health. Protection of workers' health from occupational hazards had been a principal obligation of ILO. With rapid industrialization and the introduction of newer technologies and industries, occupational health assumed greater importance. Most countries in this region were not yet sufficiently equipped to counteract such occupational risks to the large number of workers. Poor working conditions and environment coupled with malnutrition were adversely affecting the health of the workers. ILO had therefore launched its new international programme - PIAC - for the improvement of their working conditions and environment. He hoped that closer collaboration between ILO and other United Nations agencies would bring about safer and healthier living and working conditions for workers in the Region.

8 Appointment of the Sub-Committee on Credentials (item 2.1)

The Committee agreed to the CHAIRMAN's proposal that the representatives
of Burma, the Democratic People's Republic of Korea and Thailand should constitute the Sub-Committee on Credentials.

The meeting was adjourned for a few minutes to enable the Sub-Committee to consider the credentials of the representatives attending the session.

9 Approval of the report of the Sub-Committee (item 2.2)

When the meeting was resumed, DR KIM YONG IK (DPR Korea), who had been elected Chairman of the Sub-Committee on Credentials, read out the report of the Sub-committee (document SEA/RC34/20) recommending the recognition of the validity of the credentials presented by all the representatives of Bangladesh, Burma, Democratic People's Republic of Korea, India, Indonesia, Maldives, Mongolia, Nepal, Sri Lanka and Thailand.

The report was adopted.

10 Election of Chairman and Vice-Chairman (item 3)

DR I.D. BAJAJ (India), seconded by DR PRAKORB TUCHINDA (Thailand), proposed Dr Bahrawi Wongsokusumo (Indonesia) for the office of Chairman.

The proposal was accepted.

On taking the chair, DR BAHRAWI thanked the delegations for electing him as Chairman, saying that he considered it a privilege personally as well as an honour for his country. The sessions of the Regional Committee provided an excellent forum for the exchange of views and ideas among representatives of the countries of the Region and also served as a link with the sessions of the Executive Board and the World Health Assembly. He requested the cooperation of the representatives in dealing with the items of the agenda.

On the proposal of MR YOOSUF (Maldives), seconded by Col. TUN HLA PRU (Burma), Mr Hyder Hussain, Representative from Bangladesh, was elected Vice-Chairman.

11 Adoption of provisional and supplementary agenda (item 4)

The REGIONAL DIRECTOR stated that since the time of issue of the provisional agenda, two items had been proposed by the Governments of India and Indonesia and had been included in the supplementary agenda. The Committee then adopted the provisional and supplementary agenda (documents SEA/RC34/1 and SEA/RC34/1 Add.1).

12 Review of draft provisional agenda of the Sixty-ninth session of the Executive Board and of the Thirty-fifth World Health Assembly (item 12)

At the same time as it took up item 4, above, the Regional Committee noted the document on this subject (SEA/RC34/11).
13 Appointment of the Sub-committee on Programme Budget and adoption of its terms of reference (item 5)

The REGIONAL DIRECTOR said that, in terms of resolution SEA/RC33/R10, adopted at the thirty-third session of the Regional Committee, he had appointed a small committee with the terms of reference outlined in the resolution. This small committee had met in Denpasar just preceding the present session of the Regional Committee and had submitted a report to him, which would be presented to the Sub-committee on Programme Budget (agenda item 10.1). He suggested that the Sub-committee on Programme Budget be constituted, as in past years, of representatives of all Member countries, and that it would be useful to include those persons who had participated in the work of the small committee. This was agreed, and the terms of reference of the Sub-committee, as suggested in document SEA/RC34/4 Rev.1, were then approved.

14 Adoption of agenda, and selection of Chairman for the technical discussions (item 6)

On the proposal of DR POUDAYL (Nepal), seconded by MR HYDER HUSSAIN (Bangladesh), Mr Vohra (India) was elected Chairman of the technical discussions. The proposed agenda for the technical discussions (documents SEA/RC34/5 and Add.1) was then adopted.

15 Thirty-third Annual Report of the Regional Director (item 7)

The REGIONAL DIRECTOR, in presenting his annual report (documents SEA/RC34/2 and Corr.1 and Add.1) said that, as this was the first time that he was attending a session of the Committee as Regional Director, he would take the opportunity to express some of his thoughts on collaborative efforts toward health development in the Region.

Looking back at the events of the recent past, he mentioned the dangerous situation created by the resurgence of malaria, which, fortunately, owing to concerted action, was now showing a declining trend; however, the technical problem of resistance as well as financial and management problems and shortage of trained manpower still persisted. To solve the technical problems, appropriate research was being pursued, whereas for the financial/management problems, the communities must be involved, resources mobilized and the possibility explored of taking collective action at regional level towards making countries self-reliant in regard to drugs and insecticides.

Leprosy was also causing considerable concern. Insufficient knowledge of the epidemiology, limitations of the known preventive and curative measures, as well as the social stigma still associated with leprosy, were all obstacles; not only the research which was under way, including the development of a vaccine, but also health education of the public should be intensified, and the excellent work which was being done by many voluntary agencies should be expanded.

Diarrhoeal diseases were high on the list of causes of morbidity and mortality, as well as malnutrition, among infants and children. It was
urgent for national authorities to launch programmes for the wide use of the oral rehydration technique - a very effective and inexpensive curative tool, which was simple to use - in order to reduce the rates of infant mortality. As for prevention, the supply of safe drinking water and basic sanitation were essential and must have priority. In this connexion, he mentioned the progress made by countries in activities under the International Drinking Water Supply and Sanitation Decade.

To provide adequate health care services to the most vulnerable groups in developing countries, i.e., infants and young children and pregnant and lactating mothers, and also to develop and apply sound population policies, WHO, with the cooperation of UNICEF and UNFPA, had been collaborating with governments to develop a balanced programme of family welfare. One of the most important parts of this programme was the maintenance of nutrition of the growing child, and, in this context, breast-feeding, child weaning and feeding practices assumed particular significance.

Experience gained so far in the Expanded Programme on Immunization had been most encouraging in indicating that the morbidity and mortality rates due to the EPI target diseases could be reduced to the extent that they would no longer remain public health problems. Nevertheless, some of them that were taking a heavy toll on children's lives had persisted for many years and threatened to continue for many more, not primarily because of lack of knowledge on how to tackle them but because the knowledge and technology available were not being applied effectively. Thus, research should be directed towards solving human rather than technological problems. WHO was trying to stimulate health services research, and he urged members of the Committee to give priority attention to this matter.

The health infrastructure in most of the countries, which was conventional, needed to be reoriented towards balanced promotive, preventive, curative and rehabilitative services, with the full involvement of the community. It was gratifying that most of the countries in the Region had already directed their attention to the development of the appropriate health manpower, including different kinds of primary health workers, and to the necessary referral support.

Since the reiteration by the Thirtieth World Health Assembly that health was a basic human right and that every human being had the right to live a healthy and socially and economically productive life, governments had been taking practical action to formulate, delineate and implement the strategies for attaining the goal of health for all. However, meeting the HFA goal would depend on the wisdom of and determined action by both the professional and the political leadership. Some governments in the Region had already established national health coordination councils or similar bodies at high decision-making levels to promote and strengthen mechanisms for multi-sectoral coordination. It was now important to sustain these efforts.

The Regional Director listed a composite series of activities in respect of the managerial process for national health development, which WHO had
been supporting, and added that the Organization was now developing modules for training health personnel based on the experience so far gained. In programme planning WHO was also trying to relate its own activities closely to HFA goals by providing for more effective programme implementation, with perhaps a revised organizational set-up. The draft Seventh General Programme of Work was based entirely on these strategies.

The Regional Director remarked that, in spite of continuing problems, national health leaders had made remarkable progress. He was distributing a small publication, entitled "Perspectives for Health Development in the South-East Asia Region", brought out by the Regional Office, which gave a brief history of the Organization and reviewed the current health situation, analysing the linkages in the health development process and visualizing a more meaningful use of WHO's potential in the coming years.

Never before, he felt, had the health problems in the Region and the strategies for achieving the goals been so clearly defined; everyone was now aware of the responsibility for ensuring the right of every individual to healthful living, and the time was therefore ripe to launch concerted efforts to meet this challenge.

MR VOHRA (India) thanked the Committee for electing him as Chairman of the technical discussions.

He complimented the Regional Director for bringing out a useful and well-presented report, which dealt with not only the realizations and achievements of the Organization, but also the health problems. The report also contained very useful tabulated information on some aspects of the work, e.g., fellowships; this practice might be adopted for other subjects as well.

He suggested that a regional picture of the progress in the various major programme areas, especially with reference to health development indicators, would be useful.

He was glad to see the initiative taken in the field of research, and expressed full hope that the Regional Advisory Committee on Medical Research would bring forth the desired results.

Speaking of the growing attention that was being paid to primary health care, he felt that not adequate attention was being paid to the health of the millions living in sub-standard urban areas.

Referring to the structure study of the Organization and the changes that were being contemplated in that context, he suggested that it would be useful if the Regional Director could report briefly on the initiatives taken in this direction.

Mr Vohra suggested that the Regional Director should constitute study groups for the various high priority problems in the same manner as was done at WHO Headquarters. The required expertise for such studies, he felt, was available in the Region itself. He said that training in
public health, including continuing education, deserved greater attention. A further suggestion was that the Organization should explore the possibility of progressively increasing the purchase of supplies and equipment from the countries of the Region.

The REGIONAL DIRECTOR, in his reply, stated that as regards a periodic review of the progress towards health for all, he would agree with the suggestion in principle; it could be done, to begin with, every year, and later on, once in two or three years.

He said that it was planned to have, in collaboration with the Western Pacific Region, a consultative meeting in 1981 to look into the question of the health of the urban population. It was also proposed to start an exploratory meeting on this subject in this region in 1982. As regards supplies and equipment, it would be a good idea to encourage local purchases. He agreed with the suggestion that the Annual Report should include more analytical information.

DR SOEHARTO (Indonesia), on behalf of the Indonesian delegation, congratulated the Regional Director on his excellent and extensive report, which was his first since his assumption of office as Regional Director. He asked what criteria were being followed for inclusion of various country activities in the Annual Report. In this context, he referred to the nutrition project undertaken in Indonesia with the assistance of IBRD, and suggested that such important activities should find a place in the report.

The REGIONAL DIRECTOR stated that since the report was a review of the work of the Regional Office, the focus was on the activities of WHO programmes in the various countries. Wherever there was an interface of WHO activities with other activities, they would be mentioned as well, but it would not be possible to include all activities of the countries in this report. He pointed out that the present format of reporting was based on the Sixth General Programme of Work and might need to be changed when the Seventh General Programme of Work came into effect.

DR PRAKORB (Thailand) congratulated the Chairman, the Vice-Chairman and the Chairman of the technical discussions on their election. He commended the Regional Director for his stimulating and inspiring report. He praised WHO's role in collaborating with the countries in achieving maximum utilization of resources, and looked forward to further development on a country-to-country basis. He supported the management information system, particularly for the PHC programme, and in this context, referred to the recent meeting on the development of primary health care, which had been attended by ten countries from the South-East Asia and Western Pacific Regions. He welcomed the emphasis in the report on integration of primary health care with community participation, appropriate technology and the building up of self-reliance.

MR YOOSUF (Maldives) joined the other delegates in congratulating the Regional Director on his report, which had laid stress on the importance of primary health care to reach the goal of HFA. He praised WHO's role in bringing about a consensus among the countries in the
Region in regard to the strategies for health for all. The countries in the Region certainly felt that their health programmes would ultimately benefit the people.

DR POUDAYL (Nepal) congratulated the Chairman and the Vice-Chairman on their election. He commended Dr U Ko Ko on bringing out a very valuable annual report - his first as Regional Director. There were always many reports and big plans, but implementation, especially middle-level management, had remained a problem. He was gratified to note that this had been given due stress in the Annual Report.

DR ARSALAN (Mongolia) congratulated the Chairman and the other office bearers on their election. He complimented the Regional Director on his excellent report, which, he said, fully reflected the work done by the Regional Office in close collaboration with Member countries. Even though successes had been achieved on some fronts, still there were many problems being faced, such as malaria and the supply of drinking water, as enumerated in the report. In order to tackle them effectively, he emphasized the need for more and more support from international agencies, and for finding ways of attracting extra-budgetary resources. He endorsed the suggestion of the Indian delegation that the Regional Director should set up study groups to go into the priority health problems and propose solutions not only at the regional but also at the country level.

The REGIONAL DIRECTOR thanked the delegates for their words of appreciation of the Annual Report and said that their observations and suggestions had been noted. He would try to improve it with the guidance of the Committee. Regarding the proposal for the establishment of study groups, he said that the matter could be discussed under item 13, i.e., "Strategies for Health for All by the Year 2000".

15 Adjournment

The meeting was then adjourned.
Annex 1

TEXT OF ADDRESS BY H.E. THE GOVERNOR OF BALI,
PROFESSOR IDA BAGUS MANTRA

It is my privilege and honour to extend a warm welcome to you who have come together here in Bali, attending the thirty-fourth session of the World Health Organization's Regional Committee for South-East Asia.

Even though I am sure that most of you have much information about Bali, on this important occasion I would like to add some more for you.

Bali is one of 27 provinces in Indonesia. The island is very small, only 5632.86 square kilometres, inhabited by almost 2-1/2 million people. Potentially there are two main sources for its development: those are agriculture and the tourism industry, with a socio-cultural background.

In the field of agriculture, we have been successfully producing our staple food. You will see terraces of paddy fields throughout Bali, beautiful scenery and a mutually helpful way of life (Gotong-royong) of our people, based on the Hindu religion and socio-background, which attract tourists coming to Bali.

To promote both aspects of development potential, I believe that the health programme is one of the basic investments, together with the high health status that everyone needs. Therefore, the national health programme, which has been launched systematically since 1969 in our province, has so far covered most of the area, especially the villages. Among 51 sub-districts in Bali, there are 65 health posts staffed by doctors and paramedical personnel.

The health centres are strengthened by sub-centres, where there are 200 polyclinics and 190 mothers and child health centres. According to our plan, there will be 80 health centres in the next two years altogether, to achieve a ratio of one health centre to 30,000 people.

On the community level, people are participating in health activities. This approach is parallel with the Alma-Ata Declaration of 1978. Health promoters and women's organizations (the P.K.K.) are the backbone of the community's participation. My mentioning this progress and these achievements does not mean that we are not facing any problems. We do have some other problems, to meet the health needs of the growing number of foreign visitors coming to Bali.

There are around 200,000 tourists visiting Bali yearly. I do hope that our health officers, assisted by the Central Government, together with the World Health Organization, can find alternative approaches and basic programmes to be conducted by every health care unit both to meet our people's needs and simultaneously to promote the tourism industry.

I am sure that there are many country members in this region who face similar problems.
I think the facts invite our thinking and research. Hopefully, while you are in Bali, there will be ideas to be discussed in detail later.

Finally, on behalf of the Government and the people of Bali, we offer you opportunities to study Bali in depth and to understand our people, their way of life and their socio-cultural background.

We wish you all a successful session and a pleasant stay in Bali.
Annex 2

TEXT OF ADDRESS BY THE REGIONAL DIRECTOR,
DR U KO KO

On behalf of the World Health Organization and its Regional Office for South-East Asia, and on my own behalf, I should like to convey to Your Excellency Dr Suwardjono Surjaningrat, our deep appreciation of the fact that you are here with us today, in spite of your busy schedule and pressing engagements. Your presence indicates not only great interest in promoting the health of the people but also your support to WHO and what it stands for. I must also take this opportunity to thank the Government of Indonesia for having invited us to hold the thirty-fourth session of our Regional Committee here in Bali. This is the second time that we are meeting in Bali and the fifth time in Indonesia, when the Government has so kindly hosted the Regional Committee, offering its legendary hospitality. We greatly appreciate the presence, also, of Your Excellency, Professor Ida Bagus Mantra, Governor of Bali, on this occasion. Finally, I should like to extend a warm welcome to the distinguished representatives of Member States, international agencies and non-governmental organizations, as well as to other guests.

As is well known to everyone throughout the world, Indonesia is justly famous for the natural beauty of its islands, large and small, dotting the vast ocean and adorning it like a string of precious pearls. But Bali, variously known as the "Isle of Paradise", the "Gem of the Tropics", "Palace Dewata" and the "Isle of Light", has always been considered the most enchanting of all tropical islands, with its breathtaking scenic beauty. One cannot but admire the remarkable serenity of its hills and its mountains, as contrasted with the bright sunny beaches, the colourful countryside, the many temples, terraced rice fields and volcanic peaks, displaying the most magnificent aspects of nature.

Not only is Bali beautiful but it has also been, since ancient times, the centre of cross-fertilization of some of the world's great religions and cultures. Indeed, the heritage of the people of Bali is enriched by their assimilation of the most humane tenets of Hinduism, Buddhism and Islam. This unique synthesis of different religions and cultures has helped the people of Bali to preserve, and to maintain to this day, an elegant, artistic, peaceful and joyous way of life, reflected in their daily chores, religious rituals and social practices, which should be an inspiration to us all.

The ongoing efforts for health development in Indonesia are indeed a shining example of determination to achieve this goal, on the part of the people and the Government. The Third National Five-Year Plan, which reflects a policy for action towards social justice in socio-economic development, has already taken definite shape. Health continues to occupy its due place in the intersectoral setting. The development and expansion of the health infrastructure, and the training of appropriate manpower to provide health care to the under-served and underprivileged, have been given priority. Emphasis has been laid on the horizontal development and further improvement of the various service elements of primary health care as well as on health services research. Medical and health service research has been given due importance; the mobilization of internal and external resources for health development and their appropriate utilization have been rationalized; the monitoring and evaluation of health programmes have been streamlined. These
are encouraging signs, and I am sure that, during the coming years, we shall see further tangible progress in the health sector in Indonesia, as measured by the indicators already identified by the health planning authorities in the country.

When we turn to look at the situation in South-East Asia as a whole, I think we all have mixed feelings. There are areas in which the progress made so far justifies our satisfaction, but there are other areas where we still have a long way to go in order to bring the necessary services to those who need them most. There is no doubt that there has been general improvement in the state of health in the Region. The expectation of life at birth has increased, and the infant mortality rate has fallen; some of the communicable diseases have been eliminated or reduced in incidence; water supply, sanitation and housing facilities have been improved and nutritional levels raised; rural health care services have expanded, and the people in general are now better informed about health and disease. These are commendable achievements. However, the aspiration of the people toward a higher state of health and better health care facilities, especially for those who are still under-served and even unserved, is yet to be fulfilled.

To meet this expectation, the adoption of the goal of health for all by the year 2000 by the world community of nations offers a unique opportunity to health leaders. Certainly it is not just a dream, a vain ideal or a mere slogan. It is now a moral responsibility and a sacred duty - a challenge that the intellectual genius of man can meet by utilizing to the maximum all available talents and energies and by mobilizing all human and material resources.

All of this, however, presupposes political commitments and, more fundamentally, moral options. The time is now ripe for redefining our priorities, reallocating resources, renovating the health infrastructure, redirecting health manpower training and identifying the target population. These imperatives can be met only by taking the right political decisions, inspired by moral concern for all the people. Once these political decisions are clearly made, the next steps will follow on a surer ground of national, regional and global commitment.

I am happy to be able to report that the Member States in our Region have been enthusiastically engaged in developing strategies for health for all, often with the involvement of those at high policy and decision-making levels. Significant progress has been made in framing these strategies and working out mechanisms for improving and translating them into action. Regional strategies have also been developed, and in May of this year, the Thirty-fourth World Health Assembly adopted a Global Strategy for HFA/2000, which at this session you will have a chance to review, along with our regional strategy and a draft plan of action.

For implementing WHO's collaborative activities, one of our main tools in Member countries is its general programme of work. At this point in time, when activities resulting from the health for all strategies are ready to be launched, the Seventh General Programme of Work, covering the period 1984-89, is of great significance. I am happy to say here that, based on regional contributions which were prepared in intimate and close consultation with Member States, a draft of the global Seventh General Programme of Work is now ready for your review.
Along with these developments, a serious study of the style of functioning, organizational structure and staffing pattern of WHO has also been instituted, under the wise guidance of the Director-General, Dr Halfdan Mahler. Such an examination of structure and functioning became imperative, with the crystallization of the concept of HFA/2000, formulation of strategies to achieve it, and the preparation of the Seventh General Programme of Work in support of the strategies.

It will be obvious that WHO, as the collaborating and coordinating agency in international health work, is seriously engaged in preparing itself to play its assigned role in achieving the objective of health for all. However, we can succeed in performing this task effectively only if we work with, and not for, Member States. This is why we must have a very close dialogue with countries at all possible levels, especially at the policy level, not only to carry out our own collaborative work at country, regional and global levels but also to stimulate technical cooperation among the countries themselves. In this context, we are convening a meeting of the ministers of health of countries of the South-East Asia Region - and, again, Your Excellency, we are most grateful to you for offering to be the host. This meeting will be held in Jakarta immediately following this session of the Regional Committee. I am sure that it will reinforce further the commitment of Member States to the HFA goals. It should also inject a new spirit of dynamism by providing an excellent opportunity for the exchange of views and the exploration of new avenues of further cooperation at policy level, not only between WHO and its Member States but also among the countries themselves.

The Prime Minister of India, Mrs Indira Gandhi, in her keynote address to the Thirty-fourth World Health Assembly, stated that "Life is not mere living, but living in health". Needless to say, to achieve an acceptable standard of living in health for all our people, stupendous efforts are required at all levels and in diverse spheres. In spite of this, the sense of involvement and dedication that prevails in our countries gives us the courage collectively to stand up to it.

On this beautiful morning, I wish to conclude on a hopeful note, Excellencies, ladies and gentlemen. The exhilarating environment of beauty, joy and peace that Bali offers should stimulate, through a meeting of minds during this session of the Regional Committee, innovative ideas for contributing meaningfully towards the goal of health for all by the year 2000.

It is my conviction that we will certainly achieve this goal, with the commitment and determination that has now been generated in our countries, which I am sure will grow with each passing day.
TEXT OF INAUGURAL ADDRESS BY H.E. THE MINISTER OF HEALTH OF THE REPUBLIC OF INDONESIA, DR SUWARDJONO SURJANINGRAT

It is indeed a great pleasure for me to be present today in such a distinguished forum, and to be able, on behalf of the Indonesian Government and on my own personal behalf, to extend our warmest welcome to the thirty-fourth session of the Regional Committee.

Today marks the second opportunity for Bali to have hosted sessions of the WHO Regional Committee. This, for us, manifests the trust you have in us in organizing and hosting an important and distinguished gathering of this stature.

It is not with exaggeration that I say that I value highly the importance of your presence at this forum - indeed a rare occasion, where senior officials from health ministries in the Region meet annually. The expectations with which people have entrusted you and the outcome of your deliberations are certainly beyond our anticipation a decade ago. The thought of having a consensus on a common course of action toward health for all by the year 2000 was remote in our minds only ten years ago. Yet, within a few short years we are reaching the stage where it becomes imperative to plot joint cooperative and collaborative action to overcome common problems regionwide, and even the world over.

It is with great pride and pleasure that we look retrospectively at the past achievements we have marked to date. However, let us not be swayed in reminiscence, and let us not be complacent about the few but significant strides we have made. Even if the horizon seems brighter today, the avenue to reach our common objectives may not be too smooth. The rising expectations of the population for our services demand that we proceed with due caution but also at an increased tempo.

We have in the immediate past come to a consensus on the targets for health for all by the year 2000. We have also arrived at an agreement that primary health care is the key approach, and on this we also have laid down the global strategy.

This, indeed, makes the task of the Regional Committee even greater in transforming those ideals into operational plans in such a fashion that the people in our region will reap the greatest benefit.

In this regard, permit me to emphasize that, to this end, coordinated and carefully orchestrated endeavours are necessary to raise the health status of the people.

It is in this light that I value this meeting greatly, where we all gather to deliberate upon common approaches, and to acquaint ourselves with, and become more deeply involved in the various challenges in our region, and proceed jointly from this point onwards.

It is evident that, with no exception, all countries in our region are trying to accelerate their development endeavours. Although each country has its own characteristics with regard to economic growth, development stage, population size and health status, together we all strive towards a common goal.
In this regard the achievements of each country, with determination and coordinated efforts, will to a certain extent contribute to the attainment of this goal.

It is within this context that the World Health Organization plays a significant role. Firstly, WHO is expected to provide effective coordination in the TCDC, such that maximum benefit of the opportunities provided by the interrelation and interdependency among Member countries can be ensured. I am of the conviction that TCDC, if effectively executed, is one of the most important means of shortening the path to our goal. Secondly, WHO is expected to manage all endeavours in the Region as one system in its totality.

I have great faith that this thirty-fourth session of the Regional Committee will devote due consideration to these major issues at hand.

With senior health officials who are familiar with our common cause and problems facing each country in this region, I am confident that, within a few short days, you will arrive at resolutions regarding areas for possible innovative actions.

However, I do hope that the tasks before you will still permit time for you to visit the countryside and acquaint yourselves with the beauty of this idyllic island.

I do sincerely wish this distinguished meeting every success in its deliberations. May the Almighty bestow upon you His divine guidance.

With this brief note, I have the honour of declaring this thirty-fourth session of the Regional Committee as officially opened.
TEXT OF REGIONAL DIRECTOR'S ADDRESS INTRODUCING HIS
THIRTY-THIRD ANNUAL REPORT

It is my pleasure and privilege to present to this important meeting the Thirty-third Annual Report of the Regional Director, as contained in document SEA/RC34/2 (and Corr.1 and Add.1). The right tone for our deliberations has already been set by the distinguished speakers at the inaugural session. In introducing the Annual Report, I should like to take the opportunity to express some of my thoughts and ideas in respect of health development in this region vis-a-vis our collaborative efforts to secure for all our people an acceptable level of health. I feel that this may be an opportune moment to place these thoughts before you, as this is the first time that I am attending a session of this Committee as Regional Director since you so graciously elected me to this office last year. I am certain that the views and reactions expressed during this session will be of immense value to me, as guidance for future action.

If we look back over the events of the recent past, in our attempts to solve some of the urgent health problems in the countries of our Region, the dangerous situation created by the resurgence of malaria comes first to our mind. It is true that, owing to concerted action by Member States, WHO and other agencies, this disease is now showing a declining trend. However, the technical problems of resistance of the parasites and vectors to commonly used drugs and insecticides continue to remain unsolved; also financial and management problems and, above all, a shortage of trained manpower still persist. In order to find solutions to the technical problems, appropriate research is being actively pursued, whereas the financial and management problems must be tackled by innovative approaches, by involving the communities and by mobilizing both internal and external resources. Since, in most countries, the drugs and insecticides essential for malaria control are not always available, either in adequate amounts or at the time when they are needed, it would seem that possibilities of taking collective action at regional level towards making countries self-reliant and even self-sufficient in this respect would be worth exploring.

Other diseases which are causing considerable concern in this region are leprosy and the diarrhoeal diseases.

As you are aware, South-East Asia accounts for almost a third of the cases of leprosy in the world. Our knowledge of the epidemiology, prevention and control of this disease is still meagre. Known curative measures also are not very satisfactory and involve prolonged treatment. Moreover, the social stigma associated with leprosy prevents the application of even those control measures which are known. To solve the technical problems, mission-oriented research, including the development of a vaccine, is being pursued, but at the same time it is extremely urgent for us to generate strong public opinion, through health education, in favour of handling leprosy patients just like patients suffering from other communicable diseases and saving them from the existing social segregation. The excellent work done by many voluntary agencies, such as, for example, the Damien and the Sasakawa Foundations, in identifying, treating and rehabilitating leprosy patients
is a shining example of how this problem can be tackled humanely in the existing situation. I feel that it is now essential to emulate and expand these experiences into nation-wide programmes through community education and involvement, with adequate support from both internal and external sources.

Diarrhoeal diseases have now been recognized as a serious public health problem, as they are high on the list of causes of infant and childhood morbidity and mortality in our Region. In addition, they are responsible for a large part of the malnutrition found in infants and children, playing, in many cases, an even more significant role than inadequate diet. Thus fairly large numbers of children are victims of stunted physical and mental growth, if not of premature death, because of malnutrition brought about by diarrhoeal diseases. Both preventive and curative steps are important in tackling this problem. As the disease is of multi-etiological origin, the appropriate preventive measures may vary according to the epidemiological factors involved, and their application is thus difficult. However, as a result of research in the field, we now have at hand a very effective and inexpensive tool which can cut down on the mortality due to diarrhoea, whatever the etiological factor. I have in mind the oral rehydration technique, which has been standardized by WHO in collaboration with Member States. The technique is so simple that it can easily be used by the family with a minimum of instruction. Unfortunately, the programme has not made as rapid a progress as could have been expected, and I urge the national authorities to generate comprehensive programmes in the wide use of oral rehydration as quickly as possible, to reduce the rate of infant mortality, which is one of the main indicators chosen to measure the progress of efforts towards HFA.

For the prevention of diarrhoeal diseases, however, the supply of pure drinking water and basic sanitation are essential measures, which must have priority. In this regard I am happy to state that appreciable progress has been made by our countries in developing the strategy and plan of action for activities under the International Drinking Water Supply and Sanitation Decade, which was officially launched in January this year. As you are aware, this movement aspires to achieve the target of "safe drinking water for all by the year 1990". Such an achievement will, I fear, remain mere wishful thinking unless national, international and bilateral funds are mobilized quickly and adequately in its support. Success in this effort not only will markedly reduce the existing morbidity and mortality caused by contaminated water and insanitary conditions in our countries but will also raise the quality of life by providing a wholesome environment.

I must remind you that the most vulnerable groups in developing countries such as ours are infants and young children, and pregnant and lactating mothers. In this situation, what is needed is a composite programme of family welfare, with well-coordinated components of maternal and child health care, family planning, nutrition and health education. While we must provide adequate health care services to the existing mothers and children, it is equally urgent to develop and apply sound population policies consistent with the social, economic and cultural factors in each country. Keeping this in view, WHO, with the cooperation of UNICEF and UNFPA, has been collaborating with governments to develop balanced programmes in all four components.
One of the most important aspects of child health care is the maintenance of nutrition of the growing child to ensure satisfactory physical and mental development. In this context, breast feeding, child weaning and feeding practices are extremely important. As you are aware, the serious concern of governments in this aspect of child care has been vividly reflected in recent World Health Assembly resolutions (WHA34.22 and WHA34.23). I am sure you will avail yourselves of the opportunity to deliberate further on this subject under item 16 of our agenda.

Also in relation to child health, another important activity that is gradually gaining momentum and needs continuous support is the Expanded Programme on Immunization. The experience gained so far in this programme clearly indicates that it is quite feasible for us to reduce the morbidity and mortality due to the EPI target diseases to such a level that they will no longer remain a public health problem. In the case of neonatal tetanus, however, although there is also a simple and effective measure for greatly reducing this problem in the adequate immunization of pregnant mothers, yet this condition continues to be a major cause of infant mortality in countries of this region. Poliomyelitis, as is known, is common in developing countries, being prevalent equally in both urban and rural areas, and crippling large numbers of children. Tuberculosis, diphtheria, pertussis and measles are also taking a heavy toll on children's lives in some of our countries. Therefore, the Expanded Programme on Immunization, integrated with the health services, has been supported by WHO in collaboration with UNICEF and other agencies, WHO's effort being directed mainly towards training in technical and management aspects and in developing the cold chain.

I have touched on only a few of the health problems that are plaguing the lives of the people of our region. What is apparent is that they have persisted for many years and threaten to continue for many more, not primarily because of lack of knowledge on how to tackle them but because of inadequate efforts in applying the knowledge and technology which are already available. While not, of course, belittling the value of research undertaken to obtain new information and technology, I must point out that the South-East Asia Advisory Committee on Medical Research, which has analysed various aspects of research needs in support of the HFA goal, has come out with the concept that our research must be directed towards solving human problems and not technological problems per se. Hence, the application of knowledge and technology, side by side with research seeking newer solutions, assumes great importance. The Organization is striving hard to stimulate health services research, keeping this concept in view. Conventional institution-based research may be more prestigious, and it is easier to organize and conduct than is application-oriented health services research involving field activities; hence, very few projects of the latter type have materialized in most countries of our Region. I would urge you to give urgent attention to this limitation in our research efforts, and to stimulate national scientists to undertake application-oriented research, directed towards the solution of human problems related to health in your countries.

I should now like to refer to the critical question of development of the health infrastructure.
The health infrastructure in most of our countries is a legacy of past efforts to imitate the conventional health services in the affluent West. However, with the recent adoption of the HFA goal, with primary health care as the main approach, we must now endeavour to reorient our health set-ups towards balanced promotive, preventive, curative and rehabilitative services, with the involvement of the communities, in order to meet their needs through a health service of and by the people. One of the major efforts needed to develop such community-based primary health care is to prepare the appropriate health manpower. I am happy to state that most of the countries of the Region have already directed their attention to this aspect, and different kinds of primary health workers, according to the cultural pattern of the country concerned, are being trained to support primary health care services. In addition to these efforts, appropriate referral support is also being developed. In this context I must emphasize that good supervision of the health care worker and provision of prompt referral support are indispensable for the success of primary health care.

Several years have passed since the Thirtieth World Health Assembly reiterated that health is a basic human right and that every human being has the right to live a healthy life which is socially and economically productive, and since the time when our governments committed themselves to the goal of health for all by the year 2000. During this time a series of events has taken place. The great interest shown by Member States in initiating practical action to formulate, elaborate and implement the strategies for attaining the health for all goal bears witness to the fact that, to us, in this region, this is not just a slogan but an article of faith. However, you will agree that in spite of this initial enthusiasm, ultimate success will depend on pragmatic wisdom and determined action on the part of both the professional and the political leadership. The traditional technocratic value system of the professional must be tempered by the flexibility and adaptability which are necessary for appropriate action to meet the health needs of the millions, especially in rural areas. At the same time, political sagacity is needed to create a climate conducive to preferential allocation of available resources to the real priority areas. I wish to assure you that WHO, in active collaboration with Member States, will continue to strive to bring about these changes in order to achieve the HFA goal.

In this context, the efforts that have been generated both in the countries and within the Organization are worth reviewing. The upsurge of activities for developing appropriate strategies for HFA at sub-national, national and regional levels has already led to the delineation of broad strategies and approaches for individual countries and for the Region as a whole. You will now be re-examining the strategies, in the context of the global strategy for HFA approved by the World Health Assembly in May of this year. As you are aware, their basic characteristic is the community-based, integrated primary health care approach, taking into account a two-way multisectoral relationship between health and other relevant sectors. For the implementation of such strategies there is therefore a need to reorganize the mechanisms for multisectoral coordination for health development at various echelons of the national administration, including high policy and decision-making levels. I am happy to state that our countries have already taken steps in this direction; some have established national health coordination councils or similar bodies. Thus the much needed intra- and
inter-sectoral coordination for health development is receiving increasing attention. This is highly commendable. However, what is now crucial is action to sustain these efforts and to continue to encourage the trends by providing both political and professional support. In this way these mechanisms will be appropriately institutionalized.

WHO has, in fact, been supporting countries in developing a composite series of activities in respect of the managerial process for national health development. This includes planning, programming, programme budgeting, monitoring of implementation, evaluating and reprogramming, as well as the steps involved in the generation, processing and use of national health information. The Organization is now developing modules for training health personnel based on the experience so far gained in all the regions. The activities supported by WHO in this area at present are an extension of WHO collaboration in country health programming, which encompasses the entire gamut of health management processes. I am happy to state that in our Region, at least five countries have been able to make use of country health programming in developing their planning processes in the health sector. Through a number of country and inter-country projects, the Regional Office is also continuing its efforts to promote further development of the managerial process in countries.

The Organization has also taken steps in its programme planning to make its own activities as relevant as possible to HFA goals, in its programme implementation to make it more efficient, and in its organizational set-up and style of functioning to make it more effective. These new approaches are reflected in its plans for collaborating with governments, in developing and implementing HFA strategies, in the draft Seventh General Programme of Work, which is entirely based on those strategies, in the efforts initiated to align the medium-term programme strictly with the Seventh General Programme and, finally, in the principles now being followed in programme budgeting. During the session you will have opportunities to discuss in detail various elements of this orientation process.

The progress achieved by national health leaders, beset as they are by day-to-day worries and problems, is indeed remarkable. The Regional Office has just brought out a small publication entitled "Perspectives for Health Development in the South-East Asia Region", a copy of which has been provided to you. In this booklet we have tried to give a brief history of the Organization, review the current health situation, analyse the linkages in the health development process and visualize a more meaningful use of WHO potential in the coming years. We sincerely hope that it will be of use and assistance to you.

Never before have we so clearly defined our problems and our goal, as well as the strategies for achieving this goal. Never before have we been so acutely conscious of and actively committed to our responsibility to ensure the right of every individual to healthful living and a socially and economically productive life. The time is therefore ripe for us to launch concerted efforts with determination and, undaunted by difficulties and obstacles, to meet this challenge of ensuring better health for all our peoples. I can assure you that the Organization will continue to collaborate with Member States more earnestly than ever before in accordance with their expressed needs and desires.
SUMMARY MINUTES*
Second Meeting, 15 September 1981, 2.00 p.m.

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*Originally issued as document SEA/RC34/Min.2, on 16 September 1981
Thirty-third Annual Report of the Regional Director (item 7) (continued)

DR BAJAJ (India) congratulated the Chairman on his election and the Regional Director on his excellent report. He made general remarks on a number of communicable diseases and suggested that surveillance of smallpox, although the disease had been declared eradicated, should be maintained. There was a need to improve vaccine stability and ensure the potency of vaccines for the Expanded Programme on Immunization (EPI), particularly polio vaccine. The EPI should be included also in school-health programmes.

To tackle the problems of drug and vector resistance in malaria control, he emphasized the need to find new insecticides and potent drugs. Also, the problem of leprosy was aggravated by the emerging resistance of the leprosy bacillus to the commonly available drug, dapsone. Other drugs being considerably more expensive, the control programmes had become costlier. He suggested that WHO should consider carrying out (a) realistic sample surveys to determine the magnitude of the problem, and (b) assessment of the impact of the control programmes and also of rehabilitation measures undertaken so far.

Sexually-transmitted diseases were on the increase, and drug resistance was not uncommon. In spite of improvements, the quality of the VDRL antigen was not satisfactory.

Tuberculosis was widely prevalent in the countries of the Region, and facilities for diagnosis and treatment needed improvement, particularly at the peripheral level.

He also pleaded for greater attention to curable blindness.

MR HYDER HUSSAIN, Vice-Chairman, speaking as the representative of Bangladesh, congratulated the Chairman on his election and the Regional Director on his report. In his view, the resurgence of malaria and resistance of parasites to drugs and of vectors to insecticides merited careful attention.

Replying to the points raised by the delegates, the REGIONAL DIRECTOR said that, while the surveillance of smallpox was important, this should be a part of the general disease surveillance system, which should itself be further strengthened. The International Control Commission on Smallpox had declared that the disease had been eradicated after the stipulated surveillance period. However, the countries should remain alert and any suspected case reported and thoroughly investigated.

He agreed with the representative of India on the need to ensure the potency of all vaccines at all levels of delivery. Considering the complexity of and prolonged efforts involved in the production of quality polio vaccine in sufficient quantities, it might not be necessary for every country to embark on the manufacture of polio vaccine. He felt that this was a good subject for technical cooperation among developing countries: some of those with the necessary capability could produce the vaccine for others, to the mutual benefit of all.
The situation in regard to malaria was indeed a cause for concern. Since South-East Asia reported the largest number of malaria cases, any improvement in the malaria situation in this region would improve the global malaria situation. Hence there was a need for gearing up the malaria control programme further, while the gains already made should not be lost.

The Regional Advisory Committee on Medical Research had taken note of the problem of leprosy control, including the lack of response to dapsone. Regarding tuberculosis, sexually-transmitted diseases and rehabilitation programmes, these should be tackled through an integrated approach using the available infrastructure for primary health care services.

**Part I - General Review of Activities (pp.1-110) and Resolutions of regional interest adopted by the World Health Assembly and the Executive Board (item 8)**

1. **Strengthening of health services (pp.1-30) and Resolution WHA34.14**

Planning and development of health services; primary health care, and traditional medicine (pp.1-12)

DR SOEHARTO WIRJOWIDAGDO (Indonesia), referring to the last paragraph on page 2 of the Report, under Section 1.1.1, "Health Planning, Programme Formulation and Evaluation", said that he wished to provide the following additional information:

"Indonesia had made significant headway in reformulating its national health system by preparing a long-term health development plan which would lead to HFA/2000, and by formulating the basic structure of the national health system."

Referring to the last paragraph on page 11 in Section 1.3, "Traditional Medicine", he wished to add the following:

"With the establishment of a Directorate of Traditional Drug Control under the Ministry of Health, the regulatory mechanisms in terms of registration of practitioners as well as production and quality control had been geared up. A 'Materia Medica Indonesia', prescribing standards for traditional drugs, had also been published. The basic policy was to encourage the manufacture of traditional drugs, using good manufacturing practices, and at the same time to encourage the community to grow known traditional plants and use them for tackling common diseases. In this regard appropriate leaflets and booklets also had been published for the use of all concerned. Investigations into the efficacy and effectiveness of some of the known preparations would be undertaken, possibly with WHO support, and those which would give satisfactory results might gradually replace the corresponding modern drugs in the list of 'essential drugs', thereby decreasing the dependence on imports."

MR ABDUL SATTAR YOOSUF (Maldives) said that in his country traditional birth attendants were being utilized as paramedical workers. Also, a
national committee on traditional medicine, consisting of leading traditional medical practitioners, had been established.

DR BAJAJ (India) said that, along with traditional medicine, attention should also be paid to homoeopathy, which was very cheap and very popular with the people.

The REGIONAL DIRECTOR, thanking the delegate of Indonesia for the additional information provided, explained that, as he had mentioned earlier, the Annual Report covered mainly activities carried out within the WHO collaborative programmes, as well as those national activities which interfaced with the WHO-assisted activities. However, this supplementary information could be included in the summary minutes.

Regarding traditional birth attendants, particular attention was necessary to follow up and supervise those who completed their training. As for homoeopathy, although it was not a traditional system of medicine, there was a need to look into ways of utilizing this system.

DR POUDAYL (Nepal) said that he agreed with the Regional Director that it was difficult to consider homoeopathy as a traditional system of medicine. It should be treated as a separate system of medicine, and one should avoid giving the impression that it was being thrust on a particular section of the people simply because it was inexpensive.

DR BAJAJ (India), clarifying his earlier statement on homoeopathy, said that he merely wanted this system to be considered along with, but not necessarily as a part of, traditional systems of medicine.

MR WIJESINGHE (Sri Lanka), congratulating the Chairman and Vice-Chairman on their election and the Regional Director on his excellent report, said that there were several systems of medicine in Sri Lanka, of which Ayurveda was one; homoeopathy had come in later, and most recently acupuncture had been introduced. If the people adhered to a particular system of medicine, it was the Government's duty to support and encourage that system. Regulations should, of course, be laid down to enforce registration and other control measures to prevent malpractice. He then mentioned the measures taken by his government in this regard.

DR POUDAYL (Nepal), referring to the observations of the delegate from Sri Lanka, asked whether the registration in Sri Lanka was meant merely to accord government recognition or to find out whether the traditional practitioners were really qualified. This, he said, was an important issue. In his own country, many people who were practising various systems of traditional medicine were demanding government recognition.

MR WIJESINGHE (Sri Lanka) explained that the registration procedure was to regulate the level of competence with which these practitioners worked. In respect of homoeopathy, there was as yet no registration, but a council had been set up to develop suitable procedures. As for Ayurveda, in addition to a University Department of Ayurveda, there were ayurvedic institutions and colleges where ayurvedic medicine was taught, and the Government had established statutes to control and supervise the teaching. To obtain registration, practitioners were required to present
themselves before a panel of qualified ayurvedic practitioners and to pass a test.

The REGIONAL DIRECTOR stated that the interest of Member States in traditional medicine seemed to have developed along with their interest in primary health care. It had been felt that the large number of practitioners of traditional medicine in the countries could be conveniently involved in primary health care if the systems were institutionalized. He assured the Committee that WHO would further collaborate with the governments, if requested, in the institutionalization and integration of traditional or any other systems of medicine to promote primary health care.

DR ARSLAN (Mongolia) stated that in his country, on the basis of the main trends in the development of the national economy for the years 1981-85, a new Five-Year Health Plan had been prepared as an integral part of the overall national development plan. In this new plan, priority had been accorded to primary health care, out-patient services, further improvement of specialists to serve the rural population, and expansion of MCH services. An effort was being made to bring about a balance between the different sectors and to utilize the available resources effectively. In 1980, 21 million tugriks had been spent on the construction and setting up of 29 health establishments throughout the country. The number of hospital beds had been increased by 5.3%.

DR KWON SUNG YON (DPRK), stressing the important role of traditional medicine in the protection and improvement of people’s health, said that Korean traditional medicine (Tonguikak) was being used in his country’s public health services. It was scientifically based and used along with modern medicine for the medical care of the population. At the central level, there was a Tonguikak Institute for developing traditional medical treatment as well as for nation-wide scientific research work. In the provinces and main regions, there were hospitals offering Korean traditional medicine. He requested that the Regional Office arrange for an exchange of experience in traditional medicine among the countries in the Region.

The REGIONAL DIRECTOR, referring to the remarks of the delegates from Mongolia and DPRK, mentioned that both governments had been spending a sizeable portion of their national budgets on a health service infrastructure, which, he felt, facilitated the process of integration of the traditional system with modern medicine and medical care in these countries.

Family health; nursing; health education and nutrition
(pp.12-22)

DR BAJAJ (India), referring to document SEA/RC34/17, submitted by his government, said that goitre control was a major public health problem in the Region; it was preventable by a simple technology, namely, introduction of iodized salt. He drew attention to the grave consequences of goitre, which included irreversible changes, particularly in the younger age-group. Urgent control measures were required, as the presence of cretins, deaf-mutes and mentally defective persons placed a heavy
burden on the community. He requested that the Regional Committee adopt the resolution on the subject which had been circulated as an annex to document SEA/RC34/17.

DR POUDAYL (Nepal) said that he shared the concern of the representative from India and wholeheartedly supported this resolution. Goitre was also a major problem in the high hills of Nepal. He asked WHO to take urgent action to control the disease in this International Year of the Disabled.

Regarding family health, he said that population explosion was a problem in almost all the countries, and governments were concerned about it. He requested closer WHO collaboration in the development of an integrated PHC approach for population control.

As for nurse training, the traditional system, though effective in urban areas, had not been successful in reaching the rural population. The training of nurses needed to be reoriented and strengthened for this purpose.

Emphasizing the importance of health education, he said that it was first necessary to motivate the practising physicians. Much remained to be done in the area of health education of the public, which should be accorded the highest priority.

MR VOHRA (India), referring to the statement on population control made by the representative from Nepal, said that, though he felt that family planning should form part of the delivery of total health services in an integrated manner, he could find no specific reference to family planning in the Annual Report. He wondered whether MCH should not be considered as a section under the general heading of family planning. In his country, family planning had been integrated with the delivery of health services, particularly since it had been realized that most of the problem was in the vast rural areas.

Replying to the various points raised, the REGIONAL DIRECTOR recalled the policy of WHO on the population problem in the early 60s and the change in the latter part of the decade, based on guidance from the Executive Board and the World Health Assembly. WHO had been interested in family planning not so much for the sake of population control as for the part which it played in maternal and child health. The countries in this region, as well as in other parts of the world, had different policies on the population question. For example, Mongolia was interested in increasing its population and not in controlling it. On the other hand, in countries such as India and Indonesia, population control was the objective of family planning, which was a very large programme.

He said that while family planning might remain a major concern to some countries, family health could still be understood to cover the broad spectrum of maternal and child health, nutrition, family planning, etc. WHO, as an international organization, considered this grouping appropriate (in catering to the different needs of its Member States).
In the WHO programme of activities, particular attention was being paid to the improvement of nursing services and continuing education for nurses.

Regarding health education, one of the problems was lack of trained specialists who could develop the most effective technology for delivering the health message through appropriate channels.

He agreed that a coordinated goitre control programme should be evolved, since it was a problem in a number of countries. The draft resolution of the Government of India on goitre control might be examined by the Drafting Sub-Committee which, he suggested, could be established during the session.

DR ASLAM (UNICEF) said that, as part of the nutrition programme, UNICEF was assisting the Government of Indonesia in its goitre control programme, including the supply of equipment for the production of iodized salt. UNICEF would also be prepared, as in the past, to assist in conducting surveys of this problem. Regarding family planning, she said that, like WHO, UNICEF viewed family planning as part of the overall family welfare programme, with emphasis more on spacing than on family limitation.

DR BAJAJ (India) said that he agreed that family welfare needed to be considered as part of an integrated programme, including child health and the nutrition of mothers. The problem should be tackled from two points of view - namely, the control of fertility and the increase of fertility, depending on the situation obtaining in each country.

DR POUWAYL (Nepal) said that population explosion seemed to be a serious problem in the Region except in one country. Family planning was a priority programme in Nepal. WHO should not hesitate to assist in family planning programmes per se, as socio-economic development was not possible without family planning.

The REGIONAL DIRECTOR said that, depending on the needs of countries, WHO would be quite prepared to assist them in their family planning programmes.

DR SOEHARTO (Indonesia) wished to provide the following additional information in respect of Section 1.7, "Nutrition", in the Annual Report: "The National Research and Development Centre at Bogor, in collaboration with several universities, had already completed a situational analysis of the nutrition component of primary health care. The Centre, assisted by US AID, was now continuing a study on the national nutrition surveillance system. In this connexion WHO's assistance had been utilized in developing and implementing a health centre-integrated recording and reporting system, including health-related indicators."

MR VOHRA (India) said that health education had come to mean focusing attention on the illiterate masses. On the other hand, health education should provide an effective basis for reaching not only the rural masses
but also the ill-informed urban population living in large cities and semi-urban areas. Hospital-based personnel, including specialists, needed to be properly equipped to deliver health education as a programme, to tell people about the general principles of good health, irrespective of their level of education or socio-economic status.

The REGIONAL DIRECTOR, agreeing with the approach suggested by the delegate from India, said that the problem should be tackled through a coordinated effort. The medical curriculum in some countries, such as Sri Lanka, India and Burma, was being reoriented so as to cover health educational technology, as was already the case in DPRK and Mongolia. The problem of shortage of health education specialists would in this way be adequately dealt with in the course of time.

DR BAJAJ (India) said that, to promote health education and self-education, the Ministry of Health in India had been collaborating with the Ministry of Education to include chapters on health in school and college text-books.

DR POUDAYL (Nepal) said that there was an urgent need to motivate the doctors to serve in rural areas and to provide leadership in PHC. WHO should make a special effort in this area.

The REGIONAL DIRECTOR stated that the Organization would, if requested, wholeheartedly offer appropriate collaborative support in this regard.

**Medical care (pp.22-23)**

DR POUDAYL (Nepal) said that the availability of drugs at health posts at all times, the possibility of referring difficult cases to hospitals, and the provision of minimum equipment, especially surgical equipment for minor surgery, to hospitals, were all necessary conditions for enhancing the credibility of primary health care.

He suggested that steps should be taken for the wide dissemination of information on drug policy and management so that countries could benefit from the experience of others. He recalled that one country had cut down its expenditure on drugs by 50% by importing the basic material and manufacturing the drug in the country itself; another had reduced its expenditure by 20% by avoiding over-prescription; yet others had reduced the cost by not using the brand names for drugs.

**Care of the Aged, disability prevention and medical rehabilitation; oral health; mental health, and drug policies and management (pp.23-30)**

DR BAJAJ (India), stressing the importance of medical stores management and maintenance of biomedical equipment, stated that these were areas in which WHO could usefully arrange training programmes. In the absence of trained personnel, expensive equipment often lay idle. Regarding the care of the aged, in his opinion, the best way to ensure proper care was through the maintenance of the joint family system, which was perhaps not so much in vogue as it had been earlier in countries of the Region.
In the field of oral health, he emphasized the importance of prosthetics and reconstructive surgery and stated that, here again, training programmes would be very beneficial.

DR SOEHARTO (Indonesia) said that in his country, with the assistance of UNDP and the WHO Regional Office, a preparatory study for the establishment of a comprehensive national drug policy had been completed, with the help of a team of multidisciplinary consultants. The report was in the final stages of publication. In the meantime, a comprehensive drug policy and programme in regard to the selection, production, distribution, quality control, evaluation/testing/licensing, procurement and supply of drugs, research and development (including manpower), as well as self-treatment and use of traditional medicine, had been formulated.

MR VOHRA (India) stated that, in the context of primary health care, it was necessary to ensure the easy availability of essential drugs, particularly life-saving drugs. The basic prices had been increasing, and governments were finding it difficult to meet the demands. It was important to have meaningful proposals for technical collaboration among the countries of the Region to increase the local production of these drugs, biomedicals, vaccines and sera. This could perhaps be a subject of discussion at the forthcoming meeting of ministers of health.

The REGIONAL DIRECTOR, replying to Dr Bajaj, stated that WHO had assisted several countries of the Region in the field of medical stores management. He had noted the suggestion about training personnel.

Regarding the care of the disabled, all countries in the Region had expressed an interest in this field, and several activities were at present going on. WHO was also participating in the International Year of the Disabled, which might be a good starting point for a later programme.

He referred to the subject of the technical discussions to be held at the next World Health Assembly, which would be "Alcohol and the prevention of alcohol-related problems." A preliminary outline for a background document, prepared by Headquarters for these discussions, had been circulated.

The subject of drug policies and management, which almost all the countries of the Region considered important, was a particularly good area for TCDC. It might also attract considerable amounts of extra-budgetary resources, if suitable regional programmes were started. Many agencies were interested in this field, and he thought it might be possible to work toward self-sufficiency in essential drugs for the Region. WHO Headquarters was developing a new unit for instituting a "Drug Action Programme", which might address all the elements of drug policy and management mentioned by the Indonesian delegate. This unit was still in the formative stage, but in a year or two might develop a comprehensive programme.

Essential surgery as part of primary health care was also being carefully examined, and, before long, some definite indication and outline of a possible programme for surgical procedures integral to primary health care could be expected to emerge.
2. Disease Prevention and Control - Communicable Diseases (pp.31-63)

Epidemiological surveillance, diseases subject to the International Health Regulations and resolution WHA34.13 (SEA/RC34/15)

There were no comments.

Malaria and other parasitic diseases (pp.38-48)

DR PRAKORB (Thailand) said that, in 1979-1980, concurrently with the mass migration of Kampuchean refugees into Thailand and increasing agricultural activities along the Thai-Kampuchean border, failures of the successful therapeutic regimen of pyrimethamine-sulfadoxine for *P.falciparum* had begun to be commonplace. In November 1980, a project for dealing with the extremely serious health problem of malaria occurring on this border had been taken up at a national malaria conference and sent to the Regional Office. It was expected that through this project it would be possible to achieve a significant reduction of mortality and of incidence of the disease. Vigorous action in the project area would, it was hoped, delay the spread of drug-resistant malaria to other parts of the country and to other neighbouring countries.

DR POUDAYL (Nepal) said that, in his country, the problem of insecticide resistance had become acute. Another problem caused by the mosquito vector was the occurrence of outbreaks of encephalitis. Stronger insecticides, or a combination of insecticides, did not solve the problem of malaria control and also created environmental pollution. Perhaps biological control of mosquitoes might provide an answer to the problem.

DR ARWATI (Indonesia) said that, although the Regional Director's Annual Report had mentioned a reduction in malaria cases, it was clear that certain parts of each country had a serious problem of malaria and of insecticide resistance. Along with the use of insecticides, efforts should be made to find alternatives in the form of drugs and other supplementary measures.

MR WIJESINGHE (Sri Lanka) endorsed the views of the delegates from Nepal and Indonesia as to the need for finding alternatives, as the use of insecticides had certain inherent problems. In the meantime, the present surveillance and control measures should not be relaxed.

The REGIONAL DIRECTOR, replying to the points raised by the speakers, pointed out that there was an error in his report on p.31 (repeated on p.38); the reduction in the projected malaria positive cases should read 7% and not 17%. All the senior administrators of health concerned with the malaria programmes agreed that never in the history of malaria eradication had there been such a delicate situation as at present. Though there had been a decline in positive cases, all the countries were faced with the problem of increasing resistance of parasites and vectors to drugs and insecticides respectively.
The programme currently being implemented in Thailand seemed to be worth noting; it was attempting to streamline and make more effective the different components of control programmes, especially the use of primary health care workers in malaria surveillance, the use of malaria clinics for early treatment, and a trial of new insecticides. Indonesia also was conducting trials with a new insecticide.

It was due more to the heavy and indiscriminate use of pesticides in agriculture that the use of insecticides for vector control had acquired a bad name. However, he considered that DDT could still be used in most cases with good effect. In any case, the limited and controlled use of insecticides for malaria control did not seem to constitute a significant environmental hazard.

Other methods of malaria control, including the development of a vaccine, were being explored, but would probably not be available very soon for wide use. Newer drugs were also being considered: in October, a WHO-sponsored scientific working group would be meeting in China to assess the efficacy of a traditional medicine for treating malaria.

He also drew attention to bio-engineering and bio-environmental methods which were being tried out. Some of these trials had been going on for some time but had not been found to have solved the problem in the natural environment. Also, they required large inputs of manpower. Studies on mefloquine were also under way. He stressed that there was a necessity to gear up activities to control malaria, as there was certainly no room for complacency in spite of some decrease in incidence.

MR YOOSUF (Maldives) said that the programme in Maldives was at a delicate stage, due to imported cases. During 1980, only 52 cases had been detected, in contrast to 329 in the previous year, and in the current year the number of cases would again probably be cut by half. Of these cases, more than half were imported. His country had established 1985 as the target date for malaria eradication. National efforts in this direction had been showing promise, and this goal was likely to be achieved.

2 Adjournment

It was announced that the discussion of the Annual Report would be continued at the next meeting, and the meeting was adjourned.
SUMMARY MINUTES*

Third Meeting, 16 September 1981, 9.00 a.m.

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*Originally issued as document SEA/RC34/Min.3, on 17 September 1981
The CHAIRMAN introduced Dr S.D.M. Fernando, Director of Health Services, Sri Lanka, and welcomed him to the meeting.

1 Annual Report of the Regional Director (item 7) (continued)

Bacterial diseases (pp.48-53)

Tuberculosis (pp.48-50)

DR SOEHARTO (Indonesia) referred to the study by the Indian Council of Medical Research on the effect of BCG, including its efficacy in the control of tuberculosis. The findings had given rise to some doubts in the tuberculosis control programme in Indonesia. Tuberculosis, being a chronic disease, required treatment over a prolonged period. Also, rifampicin, being a costly drug, was not easily affordable by the poor. He requested further information on the work carried out in India regarding BCG and its efficacy. It was also suggested that the WHO Regional Office should promote research on various aspects, including control methods, therapy, the regimen, and health education for tuberculosis control.

DR BAJAJ (India) informed the meeting that the pilot study that had been undertaken in India had conclusively shown that BCG had no adverse effects and was effective in the control of tuberculosis. The BCG vaccination programme was being continued. In order to reduce the treatment period, domiciliary treatment using a multiple regimen schedule was being tried. He agreed that rifampicin, being so costly, was not likely to be affordable by the masses and requested that WHO undertake research to find some effective alternative drugs.

DR FERNANDO (Sri Lanka) said that, following the controversy as regards BCG, Sri Lanka had decided to postpone compulsory legislation for BCG vaccination. He suggested that WHO undertake further study on the effect and usefulness of BCG vaccination in the control of tuberculosis.

DR POUDAYL (Nepal) observed that the tuberculosis control programme had not seemed to have had a significant impact as yet. BCG vaccine was unstable and photosensitive. Tuberculosis was an economic disaster for society and had a definite bearing on the socio-economic conditions of the affected families. WHO should review its tuberculosis control strategy, since countries like Nepal did not have adequate technical and financial resources to undertake the necessary research.

DR BAJAJ (India) said that BCG vaccination was included in the Expanded Programme on Immunization. Although streptomycin injections did reach the primary health centres, experience showed that oral drugs were easier to administer. Hence, in the rural areas, the strategy had been to give oral drugs, and this method had proved equally effective.

DR SOEHARTO (Indonesia) suggested that, in view of the discussions on BCG, WHO should make a clear statement on its use and that a resolution on this subject should be adopted by the Regional Committee.
Leprosy and sexually-transmitted diseases (pp.50-53)

DR POUĐAYL (Nepal) said that leprosy was a serious problem in Nepal. The social stigma attached to it led people to hide the disease, and this was one of the reasons why the programme has not met with much success. He suggested that, as in the case of tuberculosis control, the strategy needed to be changed by being addressed either to health education or other social actions.

Sexually-transmitted diseases were more of an economic than a social problem. Tourism had been partly responsible for an increase in incidence.

DR BAJAJ (India) said that the treatment of leprosy was a problem in India because of resistance to dapsone. The country was experimenting with short-term treatment with drugs like lamperine, but they were very costly. He therefore suggested that something be done to obtain drugs at cheap rates.

DR FERNANDO (Sri Lanka) said that leprosy was not a serious problem in Sri Lanka, with only 691 cases reported in 1980.

As regards sexually-transmitted diseases, he agreed with Dr Poudayl that tourism was a contributing factor. In Sri Lanka eight cases had been reported which were drug-resistant, and since even a single case could spread the disease, the health authorities had to be on guard.

DR ARWATI (Indonesia) said that leprosy was a problem in Indonesia, with the social stigma attached to the disease causing difficulties in making the programme effective. Considering that 1981 was the International Year of the Disabled, she suggested that more attention be paid to the control and rehabilitation aspects.

DR SOEHARATO (Indonesia) observed that, in addition to what had been said by Dr Arwati, many non-governmental organizations, like the Sasakawa Foundation and ILEP, were assisting with the programme. He suggested that WHO should collaborate and cooperate further with non-governmental organizations in this effort.

As for sexually-transmitted diseases, he suggested that since they were predominantly found among the younger generation, approximate sex education should be imparted to the young. He inquired as to what WHO was doing in sex education, and suggested that if no study on this subject had been undertaken, WHO should conduct one.

The REGIONAL DIRECTOR, replying to the points raised, stated that these diseases were partly of a socio-economic origin and tended to abate as the economic and social situation improved. In Europe, the incidence of tuberculosis had decreased along with the improvement of the socio-economic conditions.
He also remarked that since the completion of the WHO/ICMR study on BCG, two meetings had been held. One was a meeting of the WHO/ICMR Scientific Working Group, which had concluded that the study had been the best ever conducted in this part of the world and that its findings were correct. The Group had further reviewed various aspects of tuberculosis control but not drawn any firm conclusions. Therefore, another meeting of experts had been held, and it was concluded that even though the study had been scientifically sound and the results indisputable, further work on the efficacy of BCG was essential; vaccinations with BCG should, however, not be discontinued. Therefore, WHO policy was (a) to continue to study various aspects to fill the gaps in knowledge, and (b) pending the findings of the study, to advise that BCG vaccination be continued, particularly in the EPI. Meanwhile, WHO was also looking into the problem of drug availability, as it was necessary to stop transmission of the disease.

With regard to the efficacy of drug treatment of leprosy, it was observed that dapsone had not been very effective in some areas. Studies had been carried out in Chingleput, India, and in Mandalay, Burma. There were no conclusive findings on the effectiveness of these high-potency drugs, but this was no reason to discontinue the treatment with dapsone. As for the control of leprosy, apart from medical rehabilitation, social rehabilitation was necessary. India had taken up reconstructive surgery. However, the emphasis in countries continued to be on early case-finding and treatment, before investments in reconstructive surgery were considered.

Regarding sex education, the Regional Director said that this was a country-specific and culture-specific matter. Sex education could be linked with the general education of adolescent groups, as well as being a part of health education. The actual content would have to take into account the social and cultural values of individual countries.

Early this year, WHO had organized a consultative meeting, and it was possible to develop a suitable programme to meet the situation. The Regional Director also referred to the global programme on acute respiratory diseases which was being formulated, and also to Confucius' saying that the essence of knowledge is, once having had it, to apply it.

Viral, chlamydial, rickettsial and related diseases (pp.53-55)

DR POUDAYL (Nepal) said that Japanese encephalitis was a serious problem, and there were two divergent views on how to control this disease, viz., (a) through control of the mosquitoes, and (b) through vaccination. He sought WHO's guidance on a common approach to the problem.

DR SRIATI (Indonesia) said that trachoma control was linked with the programme for the prevention of blindness in Indonesia. She emphasized the necessity of mobilizing resources for the prevention of blindness and appealed to WHO to collaborate in studies on trachoma control.

Poliomyelitis was not yet a major problem in Indonesia, but there was no room for complacency. The disease was being controlled by introducing
vaccination and by the establishment of a cold chain, for which effective coordination was required. She asked for WHO support of training in cold chain management.

DR BAJAJ (India) said that the merger of the trachoma programme with the prevention of blindness programme had proved successful in India. Poliomyelitis was also an important problem in the country, and, to tackle it effectively, the cold chain system had to be strengthened. The problem of logistics and supplies, including shortage of refrigerators, electricity and kerosene, was acute. A solution was urgently needed to preserve the potency of the vaccine to cover the rural population.

There had been sporadic epidemics of Japanese encephalitis in the country, generally after the floods, when there was large-scale breeding of mosquitoes. The main problem was of administering three doses of the vaccine, which was not thermostable. A Japanese team had recently visited Kasauli to advise the Indian Government on the development of a suitable vaccine.

DR ARSLAN (Mongolia) said that viral hepatitis continued to be a major public health problem in his country. The disease was common in other countries of this region and was now spreading to some developed countries as well. A special control programme had been implemented with good results. With WHO assistance, better diagnostic methods had been introduced. The morbidity had been reduced. He endorsed WHO's and other Member countries' efforts to improve the situation and to provide reagents for appropriate laboratory tests.

DR FERNANDO (Sri Lanka) said that the six-year cycle of poliomyelitis had been broken in Sri Lanka but that effective control of the disease had not yet been achieved. Eighty per cent immunization had been attained for the first dose, but the difficulty was in administering the other doses. This was an area which needed strengthening, and he hoped that, with the introduction of primary health care, effective immunization coverage would improve.

Dengue haemorrhagic fever was not a problem in Sri Lanka, though the vector existed, and the health authorities would need to be vigilant.

The incidence of viral hepatitis was on the increase, but measures to improve sanitation were being taken in order to control it.

The REGIONAL DIRECTOR said that the trachoma control programme was being integrated into the programme for prevention of blindness. The focus of WHO assistance would depend on the particular epidemiological situation in the country. For instance, cataract was a major problem in India; Vitamin A deficiency was of concern in Bangladesh and Indonesia, and Burma had the problem of trachoma. The overall programme of prevention of blindness was receiving continuing support from bilateral and voluntary agencies.

Poliomyelitis was another important health problem, and even though questions were being raised with regard to the effectiveness of the two
vaccines, it was possible, given good management, logistics, and training, to achieve very good results. In this context, he referred to Mongolia and DPRK, where poliomyelitis had been controlled successfully with the use of the available vaccines.

Viral hepatitis was a major health problem not only in Mongolia but also in other countries of the Region, and WHO was collaborating with Burma, India and Mongolia and providing assistance in the conduct of studies concerning transmission of the disease.

As regards Japanese encephalitis, it was important to bear in mind that the vaccine was not like those for polio or DPT; it did not provide protection for a long time. Spraying with insecticides would remain a major tool for controlling the mosquitoes, and it was in this area that WHO was hoping to collaborate with Member countries.

**Expanded programme on immunization (pp.55-60)**

DR Poudayl (Nepal) felt that the Expanded Programme on Immunization had been conceived rather hastily. The cold chain was a luxury that few developing countries could afford. His country was entirely dependent on imports for all the equipment required for the cold chain. In the absence of more stable and potent vaccines, a false sense of security was created with vaccinations of uncertain potency. He would therefore plead for self-reliance - or at least regional reliance - with regard to vaccine production.

DR Bajaj (India) mentioned the need for ensuring adequate and appropriate training of all staff - from the medical officers to the vaccinators. In India, the training programme had begun, with WHO collaboration, and he felt that the EPI would not be effective until the training of all levels of workers was completed. His experience had been that some medical officers involved in the programme were not even aware of the dosage schedules. He also advocated the inclusion of school-going children in the EPI.

DR Fernando (Sri Lanka) stated that the EPI was being carried out by the Ministry of Colombo Hospitals and Family Planning. He mentioned that one of the main causes of ineffectiveness was the high drop-out rate in the case of second and third doses of polio vaccinations. Regarding the cold chain, he agreed with other speakers that the cost of transporting vaccines from the central point to the periphery was high, as were the costs of the operation and maintenance of the cold chain. He stated that the development of a more stable vaccine was of great importance.

DR Aslam (UNICEF) agreed that the initial outlay required for the cold chain equipment was considerable; similarly, as brought out by various representatives, the operational costs were high. It was necessary to take particular account of the suitability of the equipment in countries in different situations. Both UNICEF and WHO were collaborating in the management aspects of EPI. She agreed that there were several aspects of the programme which needed to be examined and to which there were no immediate answers.
DR SINGH (Nepal) said that he had attended a training course on EPI in Mongolia recently, and mentioned that the problems encountered in other countries of the Region were not relevant to Mongolia, as the cold climate helped the cold-chain operation. A new type of refrigerator was being field-tested in Nepal; these refrigerators would maintain appropriate temperatures if they worked even six hours per day. Regarding utilization of solar energy for refrigerators, he felt that this would be very expensive. He suggested that this was a good field for TCDC and for WHO and UNICEF to provide the necessary impetus.

MR YOUSUFF (Maldives) said that the transport of vaccines was a problem in his country, especially since the mode of transport which had to be used, i.e., by sea, was slow. He pleaded for more stable vaccines and speedy development of solar energy refrigerators.

The REGIONAL DIRECTOR pointed out that the approach in the EPI was quite different from that adopted for smallpox eradication, as the latter was a short-term and time-bound programme. The EPI covered six diseases, whereas the smallpox eradication programme was concentrated on one. The global success of the smallpox eradication programme, however, had provided the necessary stimulus and inspiration to launch the EPI. He agreed that there were numerous problems regarding the cold chain and that there was a need for a simpler, more stable and potent vaccine. Two countries in the Region had reported that some of the diseases covered by the EPI no longer existed. It would be worthwhile for other countries to explore how it was possible to achieve this status by using the existing vaccines. On the subject of the cold chain and solar energy refrigerators, he said that field testing of such refrigerators, each costing about $1000, was being carried out in India and Maldives. He would report to the Committee on the results of these studies.

There were no differing opinions on the need for training workers at all levels, and this fact had been stressed by the representative from India. WHO had been organizing training courses for different levels of health workers, and it was for the governments now to take over the training within their countries. The Organization would be ready to provide any technical expertise that might still be necessary. He also mentioned that proper management of the programme would lead to the success of the EPI.

Veterinary public health, vector biology and control (pp.60-63)

DR POUDAYL (Nepal) said that for several years his country had been facing the problem of rabies, which was now becoming more acute. Unfortunately it had not been possible to manufacture anti-rabies vaccine within the country, and it was difficult to import. Mutual cooperation in the Region was essential in order to increase the production and availability of the vaccine. He sought WHO’s assistance in making it available from within the Region.

MR WIJESINGHE (Sri Lanka) said that in Sri Lanka rabies had been a continuing public health problem over the years. The main difficulties faced were lack of cooperation from the community and the divided responsibility between the central and local government, with the resultant difficulty in synchronizing areas of priorities and action.
DR BAJAJ (India) observed that the Pasteur Institute in Coonoor was in a position to produce human diploid cell rabies vaccine. There was the problem of lack of public cooperation in eliminating the susceptible dog population in India also; a possible solution could be the use of some quick-acting poison for killing dogs. Some research work in this area was worthwhile.

The REGIONAL DIRECTOR said that rabies was a problem throughout the Region. A post of Public Health Veterinarian had been established in the Regional Office, to provide countries with the necessary technical advice. In collaboration with UNDP, the possibility of establishing a demonstration centre in India was being explored. Anti-rabies vaccine was being produced in some countries, and the Regional Office was continuing to strengthen the rabies control programme.

He added that a unit had been set up in the Regional Office for dealing with veterinary public health. WHO would be willing to provide appropriate assistance in this area within its limited resources.

3. Disease Prevention and Control - Non-Communicable Diseases

Cancer; cardiovascular diseases; prevention of blindness, and immunology (pp.64-71)

DR FERNANDO (Sri Lanka) said that in Sri Lanka cardiovascular diseases constituted killer number one. Cancer occupied the seventh place among causes of mortality. Though cancer therapy had improved, the cost involved was prohibitive. In Sri Lanka, cancer had also been included in the primary health care package. He feared, however, that the integration of all kinds of services beyond the eight elements of primary health care might overburden the primary health care worker and produce negative results. He asked for WHO's views on the inclusion of the control of a number of diseases in the primary health care package.

Regarding prevention of blindness, he said that cataract was the main problem in Sri Lanka. Eye camps for providing surgical services to cataract patients had shown good results.

MR HYDER HUSSAIN (Bangladesh) requested that WHO ensure future supplies of vitamin A capsules used in the blindness prevention programme in his country.

DR BAJAJ (India) said that in the cancer control programme, health education of the public played a vital role, and the supply of suitable audio-visual material might be considered. Regarding cardiovascular diseases, WHO should consider the possibilities of assisting in the development of some cardiac-disease centres in a few countries of the Region, in order to bring treatment for these diseases within the reach of the poorer people of the Region. He also asked that WHO ensure the regular supply of vitamin A capsules to prevent blindness.

DR POUDAYL (Nepal) observed that the exact types of cardiovascular diseases that were occurring in any country should be ascertained in
order that appropriate steps be taken for preventing and controlling the diseases which were a national problem under specific situations. For example, in one area near Kathmandu, bronchitis caused by smoke from cooking ovens led to cor pulmonale, and, by providing adequate ventilation, this problem could be reduced.

As regards prevention of blindness, in Nepal, in spite of sufficient funds being made available by donor agencies, the blindness programme tended to be a vertical one. He felt that any vertical programme like the blindness programme should also provide a small packet of primary health care.

DR V.A. LOVRIC (Secretary-General, International Society of Hematology, Australia) took the floor at this stage and said that this Society would be able to offer a comprehensive package which would enable the people to carry out scientific investigations into the extent and severity of nutritional anaemia and which could be used at the primary health care level with minimum training. This package would be made available to governments, directly or through WHO, without cost. A pilot project was in operation in Central Java and was proving successful.

The REGIONAL DIRECTOR, replying to some of the points raised, said that each country should decide on its own priority problems for inclusion in the primary health care package. Priorities would also change with time. He promised to look into the question of the continued supply of vitamin A capsules, which had been raised by the representatives from Bangladesh and India.

As for assistance in developing treatment centres for cardiovascular diseases, while, in principle, WHO would be interested in such a project, there was the question of priorities, which the countries would need to decide.

As for Dr Lovric's statement, he said that he would take up the matter with Headquarters to see whether there was a possibility of taking action on a global level. Countries could also seek assistance directly from the Society, as had been done by Indonesia.

4. Health Laboratory Services

Organization of laboratory services; quality assurance; quality control of pharmaceuticals and biologicals, and vaccine production (pp.71-74)

DR BAJAJ (India) enquired as to whether WHO could set up a reagent bank. Laboratory work often suffered for want of reagents.

DR SOEHARTO (Indonesia) said that Indonesia had taken quite a few measures to ensure food quality and safety. On the subject of producing vaccines in Indonesia, he said that, up to now, Biofarma in Bandung had been able to produce an adequate quantity of DPT, tetanus toxoid, BCG and polio vaccines for the national EPI programme. He sought WHO's technical support in improving the capability of Biofarma and stated that UNDP also played a role in this regard.
DR FERNANDO (Sri Lanka) said that in Sri Lanka a change had been made in ordering pharmaceuticals, from brand names to generic names, and that their importation had been rationalized to 400 items, with about 800 dosage forms. At that stage the State was the sole importer of drugs. However, import of pharmaceuticals by the private sector had been liberalized, but it could import only from manufacturers who had been approved by the National Formulary Committee. The existing quality control laboratory did not have sufficient capacity for quality control work on pharmaceuticals imported by the private sector, and WHO assistance would be needed in this regard. He suggested that WHO should make available to Member countries information on the availability of pharmaceuticals which would be effective and economical, in which case quality control would not be a serious problem.

DR U KYAW SEIN (Burma) said that, in the context of the Expanded Programme on Immunization in his country, it was essential to have a cold chain for the vaccine, for which he requested WHO's assistance.

DR ARSLAN (Mongolia) stressed the importance of self-reliance in vaccine production and stated that Mongolia was importing most of the vaccines required for the health services. He hoped that WHO and other agencies would be able in future to provide some support to his country in achieving self-reliance in the production of vaccines and biologicals.

DR POUDAYL (Nepal) said that the development of laboratory services in rural areas for carrying out fundamental and simple tests was essential in the context of HFA/2000.

DR ASLAM (UNICEF) observed that, in accordance with an earlier policy, UNICEF used to supply all the requirements of UNICEF-assisted programmes. With the change in approach to self-reliance, UNICEF had shifted its emphasis to assisting countries to increase their capacity to produce drugs locally. In this context, she referred to UNICEF's assistance to the Burma Pharmaceutical Industry and to Biofarma in Bandung. In addition to the assistance provided through supplies, UNICEF also made available to countries a system of reimbursable procurement of drugs, which would help to ensure economical prices. She said that there was a need to ascertain the real requirements before undertaking any local production.

DR SOEHARTO (Indonesia) stated that Indonesia was effectively implementing quality control procedures for pharmaceuticals and biologicals and that the third edition of the Indonesian Pharmacopoeia would shortly be published.

The REGIONAL DIRECTOR said that he had noted the suggestions and comments made by the delegates. An inter-country workshop had recently been held for the training of trainers in the methodology of reagent production. A drug action programme at global level had been launched by WHO and would cover monitoring, production and quality control. This would also be an appropriate area for future exploration for TCDC activities.
5. Environmental Health (pp.74-82) and resolution WHA34.25 "International Drinking Water Supply and Sanitation Decade"

Environmental health; occupational health; radiation medicine and food safety programme (pp.75-82)

The REGIONAL DIRECTOR informed the Committee that the programme on International Water Supply and Sanitation Decade had started from January 1981 and was in various stages of implementation in different countries. He urged the representatives to ensure that it was implemented successfully.

DR FERNANDO (Sri Lanka) stressed the need for paying due attention to sanitation aspects along with drinking water supply.

DR BAJAJ (India) said that there was a need for training in food laboratory work.

MR YOOSUF (Maldives) said that food safety was an important problem in Maldives. Since his country imported its foodstuffs from outside, the health authorities concerned should ensure strict observance of food safety regulations in regard to the raw food.

The REGIONAL DIRECTOR stated that the food safety programme so far was comparatively weak both in the Organization and in the countries. The multisectoral nature of the programme often created problems of coordination. The Regional Office was initiating action to improve the situation.

6. Health Information and Statistics (pp.83-87)

DR SOEHARTO (Indonesia) said that an exchange of health information among countries, between the Regional Office and Member countries, and also between the South-East Asia and the Western Pacific Regions should be promoted. There was already active cooperation among the countries of the two regions through the South-East Asian Medical Information Center (SEAMIC), which should be promoted. He also asked WHO for assistance in establishing a school for medical administration along the lines of what was being done in India.

DR U KYAW SEIN (Burma) said that the two-way feedback system should be an important component of national health information systems.

MR YOOSUF (Maldives) observed that the health information system was a very important aspect of primary health care. In Maldives, this area needed to be developed appropriately. A health information evaluation exercise had been carried out in 1980 - the first time that a systematic evaluation of the health situation in the country had been attempted. Assistance by WHO and UNICEF in this field would be useful.

Referring to the last paragraph on page 85, DR SOEHARTO (Indonesia) said that the perinatal mortality study in Indonesia had now been completed and a final report was being prepared.
The REGIONAL DIRECTOR said that, with respect to establishing a school for public health administrators in Indonesia, although this proposal was acceptable to WHO in principle, it would be essential to define clearly the actual need.

7. Development of Health Manpower (pp.87-105)

Medical education (pp.90-93)

DR BAJAJ (India) said that so far the expansion of medical education in his country had been haphazard. There were very few specialists in some disciplines, while there were too many in others, leading to an imbalance. A similar situation obtained in the case of paramedical workers. The training of health manpower should be geared to the needs of the country, and in this context reorientation of medical education was indicated. He therefore pleaded for a closer look into each country's programme for the development of health manpower in the light of recent developments, including the brain drain. In India, each of the medical colleges was linked with three health centres and the undergraduates provided the link between the periphery and the medical institution. It was felt that in this way the medical students would obtain appropriate experience in a rural setting.

DR SAMLEE (Thailand) stated that a national seminar had been held in Thailand early in 1981 jointly by the Ministry of Public Health and the Bureau of State Universities, which had made recommendations on the subject of cooperation among professionals and institutions and the development of research proposals. These had been sent to WHO for further support. As regards continuing education, a national "focus" had been started for its promotion, with the main objective of orienting/reorienting all health workers to the development of the primary health care programme. With the close cooperation of the National Medical Council, continuing education for physicians was in an advanced stage of development. Such programmes for other health personnel were being formulated. He hoped that WHO would be increasing its support to such programmes.

DR FERNANDO (Sri Lanka) stated that the brain drain was an important problem in his country. One of the major reasons for this was inappropriate training of health manpower. There was no coordination between the producer and the consumer of health manpower. However, gradually a rural bias was being introduced into the training programmes. There was a shortage of specialists in a number of disciplines, e.g., radiotherapy and pathology, and WHO could provide assistance in this regard.

DR SOEHARTO (Indonesia) said that a Presidential Decree had been helpful in assigning doctors to rural areas. Moreover, care had been taken to orient the curriculum to the new global strategy, to HFA/2000 and to the primary health care approach.

MR WIJESINCHE (Sri Lanka) said that, in supplementing the comments made by Dr Fernando, he would like to point out that since it was not possible
to rely on medical doctors alone for manning the health services, the training of the assistant medical practitioners in his country had been revived.

It was also planned to train about 2600 family health workers, which would provide one such worker for every 3000 of the population by 1983. The erstwhile Institute of Health at Kalutara had been redesignated as the National Institute of Health Services and, with assistance from WHO, UNDP and US AID, would provide in-service training for different categories of health workers.

The REGIONAL DIRECTOR felt that a comprehensive approach must be taken in reorienting the entire manpower training programme to improve the situation. The Organization would willingly support national efforts in this field wherever possible.

Education and training in maternal and child health, sanitary engineering, epidemiology, auxiliaries and community health workers; group educational activities; fellowships and Regional Office library (pp.94-105)

DR BAJAJ (India) observed that training in epidemiology needed strengthening, particularly in relation to specific diseases.

DR SOEHARTO (Indonesia) said that he wished to report on some activities which had not been mentioned in the Annual Report. Training in maternal and child health was conducted in Indonesia with the assistance of international agencies within the framework of primary health care. Training of traditional birth attendants was being given special attention.

The REGIONAL DIRECTOR stressed the importance of training specialists in epidemiology and in maternal and child health. He stated that action had been taken to initiate appropriate regional training programmes in epidemiology. At the national level, WHO was providing support to the NICD in India and to NIPSOM in Bangladesh for instituting training in epidemiology.

DR KWON SUNG YON (DPR Korea) said that his country had made notable progress in the development of public health activities. As compared to 1979, the Government of DPR Korea had increased its health budget by 1.2 times. The new Pyongyang Maternity Hospital and the general hospitals provided the people with specialized medical services. The Government was confronted with the important task of studying and developing new scientific technologies needed for protecting the health of the people. It was the intention of the Government to send fellows for training in genetic engineering, molecular biology and medical cybernetics in the immediate future. WHO's assistance might be needed for this purpose.

The REGIONAL DIRECTOR, referring to Section 7.8 of the Annual Report, said that the Regional Office was very much interested in developing health literature and library services. A regional network was being established with the cooperation of other agencies.
In reply to the statement made by the delegate from DPRK, he said that appropriate action would be taken in due course.

8. Research Promotion and Development (pp.105-109)

The CHAIRMAN invited Dr Loedin, Chairman of the South-East Asia Advisory Committee on Medical Research, to make a statement on the subject of research.

DR LOEDIN, Chairman of the South-East Asia Advisory Committee on Medical Research, pointed out that the SEA/ACMR was an advisory committee to the Regional Director, mainly on research policy. Since the Regional Director's Annual Report (pp.105-109) contained a concise account of the research conducted during the year under review, he would deal only with some additional details.

At its first session, in 1976, the SEA/ACMR had defined the priorities in six areas of research, which were the basis for allocating resources and for promoting research activities. In 1980, at its sixth session, it had decided to review these priorities. The reasons for this endeavour were that:

(1) It was realized that, in reaching the goal of health for all by the year 2000, science and technology and their development in the form of research played a prominent and even decisive role. Health problems were quite different from medical problems. In medical problems there was practically complete transferability of the research findings, whereas health problems were shaped and coloured by the environment, the way of life and the social and cultural background. For that reason, research findings in the field of health were mostly non-transferable; thus the research had to be conducted in the country and by the country. As one of the shortcomings in developing countries was the shortage of able research workers, the SEA/ACMR felt that a much sharper priority setting was needed in order to use this scarce resource in the most efficient and effective way.

(2) An assessment of the research carried out in the countries of the Region had shown that the number and quality of research activities had increased but that the results had not been applied or, when applied, were not producing the expected impact. Even though most of the programmes in the Region were formulated in meetings where scientists, decision-makers and implementers were present, scientists seemed to be more greatly attracted by scientific challenges and implementers by constraints in carrying out their programmes. For that reason, as had been expressed by the Regional Director, the SEA/ACMR had stressed that research should address itself to human problems. An example was that in leprosy control, meeting dapsone-resistance was one of the top priorities. The SEA/ACMR was of the opinion that the main problem of leprosy was early case-finding, case-holding and community participation: adding a new drug would not solve the problem. Similarly, all the programmes directed towards communicable diseases had in their priority list the development of vaccines, but these vaccines would experience the same fate as the very good vaccines, such as poliomyelitis vaccine and tetanus toxoid, in the absence of the necessary
infrastructure, e.g., cold chains and the ability to use the vaccine in an optimal way.

(3) Even during the short period between 1976 and 1980, many changes had taken place in the countries: problems had been solved or had disappeared, and the ability of the countries to undertake the relevant research had increased rapidly, as better infrastructures and able manpower were now available; during the same time-span, new approaches in health such as primary health care and TCDC had emerged. The strategy for health for all by the year 2000 had strongly influenced the health programmes of Member States.

With this justification and motivation, the 1980 SEA/ACMR session had advised the Regional Director to form a sub-committee to formulate the research needs for health for all by the year 2000. The report of this sub-committee (given in document SEA/ACMR/7 Add.1, distributed to representatives) had been accepted with some modifications by the SEA/ACMR at its 1981 session. Even though the sub-committee had already fulfilled its terms of reference, it had been arranged for it to meet with the WHO secretariat in the Regional Office in July 1981 to formulate administrative policies and procedures.

At the 1981 SEA/ACMR session, it became clear that health service research would play a key role in achieving the goal of health for all by the year 2000. However, as it was found that even the SEA/ACMR members did not all have the same understanding of the meaning of "health services research", it was proposed at this session that the Regional Director form a sub-committee to address this problem. This sub-committee was formed and was asked to: (1) draw up a conceptual framework of health services research to end the semantic confusion about the term; (2) make a quick assessment of the status of health services research in the Member States, and (3) produce a working plan for the Regional Office. It had already met and would hold a second meeting in December in Indonesia.

With this development, the Regional Office had been provided with criteria and new procedures for allocating resources and for promoting research.

In 1979, in Sri Lanka a meeting of persons responsible for research activities in the countries had been held, not only bringing Member States together to promote research but producing some valuable information. The next meeting would be held in Rangoon in November of this year, and it was expected that this meeting, besides providing for the exchange of information, would increase coordination in research fields.

DR PRAKORB (Thailand) said that he was pleased to report that, as a result of his country's participation in the first Regional Meeting of the Directors of Medical Research Councils in December 1979, the Ministry of Public Health in Bangkok had set up a research committee to formulate policies and strategies. With the cooperation of Chulalongkorn University, three training workshops on research methodology had been
organized for about 100 technical personnel. A national workshop on health services research to identify specific subjects for research had also recently been conducted.

DR BAJAJ (India), drawing attention to the last para on page 106 of the report, asked for details of the operational studies to which there was a reference.

The REGIONAL DIRECTOR, replying to the above points, clarified that the SEA/ACMR Sub-Committee did not handle specific programmes, which, instead, were taken up with specialists who were well acquainted with the subjects. In 1980 WHO had convened a meeting on the control of leprosy. This was in the nature of a research-cum-action group and had made recommendations for some future studies.

9. Technical Information and Reference Services (pp.109-110)

DR BAJAJ (India) enquired about the mechanism for sending technical reports to countries.

The REGIONAL DIRECTOR stated that this section of his report dealt with arrangements for the dissemination of technical information by the Regional Office through its distribution and sales programme. There was a standard distribution list. Under this arrangement, government departments such as health ministries were sent almost all the technical papers, while the technical units received only those publications which were relevant to them. However, WHO could always add to or revise this list in consultation with governments.

Replying to Dr Bajaj, the REGIONAL DIRECTOR agreed to send him a copy of the distribution list.

2 Adjournment

The meeting was then adjourned.
SUMMARY MINUTES*

Fourth Meeting, 16 September 1981, 2.00 p.m.

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*Originally issued as document SEA/RC34/Min.4, on 17 September 1981.
Part II - Organizational and Administrative Matters (pp.111-128),
Resolution WHA34.15, "Recruitment of International Staff",
and National health programmes with synchronized foreign assistance in the context of WHO technical cooperation (supplementary item 1)

DR SOEHARTO (Indonesia), referring to item 5.3 on page 136 of the Annual Report, said that the Asian Development Bank had assisted Indonesia in a feasibility study to establish a plant for the manufacture of essential drugs; this study had since been completed. In view of the significantly higher investment expected by the AsDB consultant, as compared to that in the study made by a WHO consultant, the feasibility study report had not been accepted by the Government. In order to accelerate the progress of the project, he requested direct WHO involvement.

Introducing document SEA/RC34/18, the paper presented by his government under supplementary item 1, and giving the historical background for this idea, Dr Soeharto said that, with the increase in the financial requirements of health development programmes, their management and administration had become increasingly complex and required coordination. There was also a need for effective coordination of foreign assistance and national resources in the context of the strategies and objectives of national health programmes. In Indonesia, the interface of national policies and objectives and those of foreign assistance had been identified and thus had opened up prospects of coordinated use of resources for implementing, monitoring and evaluating the national health programmes. The systematic management and coordination of all foreign assistance would go a long way toward benefiting the recipient country, and he requested that WHO initiate specific collaborative activities in at least the 1984-1985 biennium.

DR ARWATI (Indonesia), referring to the statement in the Annual Report regarding continued cooperation with non-governmental organizations, observed that such cooperation should be further promoted and strengthened, particularly in the context of primary health care and NFA. She added that, in connexion with the International Year of Disabled Persons, 1981 (resolution WHA34.30), attention should be given by WHO to collaborating with Member States in developing permanent programmes for the benefit of the disabled, including those persons who were mentally retarded.

The REGIONAL DIRECTOR said that the supplementary agenda item proposed by the Government of Indonesia was relevant; this would certainly be covered during the technical discussions on the "role of ministries of health as directing and coordinating authorities on national health work". He also agreed with Dr Arwati that it was essential to establish further close working relationships with the non-governmental organizations at all levels, particularly at the level of primary health care. At international level, a number of organizations were in official relation with WHO.
DR BAJAJ (India), referring to the section on Public Information, asked what type of public information material was being produced and distributed to the zonal offices of Indian Railways and ministries such as the Ministry of Information and Broadcasting and the Ministry of Agriculture.

The REGIONAL DIRECTOR said that he would enquire and that this information would be provided to Dr Bajaj during the course of the session.

DR PRAKORB (Thailand) expressed his delegation's support and agreement to the proposal of the Government of Indonesia (SEA/RC34/18). Based on the country health planning exercise, carried out, with WHO support, in 1975-1976, Thailand's fourth five-year health plan had been formulated, and later oriented in line with the priority health care needs of the country, which had been clearly identified.

The National Health Development Plan, covering the period 1982-86, had also been formulated with its objectives and strategies aimed at attaining the goal of health for all by the year 2000. A country programme budget exercise was planned to take place in Thailand in October 1981. During this exercise, WHO's collaboration in national health development during the previous years would be reviewed, and a joint WHO Headquarters and Regional Office team would visit Thailand to conduct the exercise with the national health administration in order to draw up programmes for 1984-85 and make the most effective use of WHO collaboration.

DR MOHAMAD KARTONO (Representative of the International Planned Parenthood Federation) said that he wished to draw the attention of the representatives to the Memorandum of Understanding between WHO and IPPF, circulated earlier. IPPF would provide to countries all facilities in their family planning efforts. Following a shift of emphasis in the policy of IPPF, support was now provided on a priority basis to countries with pressing population problems. The policy was based on the countries' economic condition and population growth rate as well as on demonstrated government policies in support of national family planning programmes.

MRS GEMALA CHALIL-HATTA (International Federation of Health Records Organizations) said that the Federation derived its significance from the services it provided to those who actually delivered health care to the people. There was a strong similarity between the relationship of the health records practitioner with health care providers and that of the Federation with WHO. There had been collaboration between the Federation and WHO which, however, needed further strengthening. It would be highly desirable for Member countries of this region to become members of the Federation.

DR IDA BAGUS NARENDRA (International Association for Accident and Traffic Medicine) said that road traffic accidents caused significant morbidity, mortality and disability in developing countries, and that in this region more attention should be paid to this health and economic problem. Traffic safety provided a rationale for the implementation of effective accident prevention measures. There were proposals for establishing centres for the study of road accidents and traffic
medicine in Indonesia, Singapore and Thailand. Activities promoting research and health education in order to tackle these problems would receive support from the Association.

DR SUMA'MUR (Permanent Commission and International Association on Occupational Health), conveying the greetings of the President and Secretary General of the Commission and the Association, said that occupational health was now receiving attention in the countries of the Region. It was of importance for both the welfare and the productivity of the working population. Activities planned in this region included training and education of workers, services, setting up of standards, etc. WHO and the International Labour Organisation had collaborative programmes in these areas, and the Permanent Commission had excellent relationships with both organizations. It was hoped that occupational health activities would further develop in this region since they not only were indispensable but also could make a significant contribution to achieving the goal of health for all by the year 2000.

Part III - Activities undertaken by Governments with the help of WHO (pp.129-184b) and Annexes I-6 (pp.185-213)

In reply to a query from DR BAJAJ (India) as to whether a consolidated list of reports of WHO consultants was available, the REGIONAL DIRECTOR stated that the Regional Office maintained such a list, which was brought up to date from time to time. Normally assignment reports of consultants were sent to the government concerned for clearance and, after this was obtained, were made available on request.

Conclusion of discussion on the Annual Report

The REGIONAL DIRECTOR said that the format of presentation of the Annual Report would probably have to undergo changes from 1984 in the light of the programme classification in the Seventh General Programme of Work. Comments on the arrangement of the Report would be welcome and could be sent to him in writing after governments had a chance to study this matter further.

2 Appointment of Drafting Sub-Committee

The CHAIRMAN said, now that the entire Annual Report of the Regional Director had been gone through, it would be desirable to adopt a suitable resolution. He proposed that representatives from India, Indonesia, Mongolia, Sri Lanka and Thailand should constitute a sub-committee to draft this resolution as well as resolutions on other important subjects. This proposal was accepted by the Regional Committee.

3 Strategies for health for all by the year 2000 (item 13)
(SEA/RC34/8 and Add.1, SEA/RC34/9 Rev.1, SEA/RC34/10
SEA/RC34/Inf.2, WHA34.36, resolution 34.58 of the United Nations General Assembly, WHA33.24, 34.37)

The REGIONAL DIRECTOR, introducing this agenda item, recalled that in 1977 Member States had resolved at the World Health Assembly that their main social target in the next two decades should be the attainment of
HFA. Since then, countries had taken steps to develop their health policies and strategies along with quantitative targets. The national and regional strategies synthesized therefrom for the attainment of HFA/2000 had been formulated and had been considered by the Regional Committee at its last session. Document SEA/RC34/8 reviewed the further refinement and progress of implementation of these strategies, while document SEA/RC34/9 Rev.1 gave an account of further developments in the countries of the Region. The HFA/2000 goal had been incorporated in national plans and policy documents; national councils or committees with intersectoral representation had been constituted at very high levels, and the need for equitable distribution of health resources accepted. However, implementation of the plans had yet to gain the expected momentum.

In May 1981, the World Health Assembly had adopted a Global Strategy for HFA/2000, with its main thrust on the development of the health system infrastructure, starting with primary health care, for the delivery of countrywide health programmes covering the entire population, and using appropriate science and health technology. In addition to national action, the strategy spelled out the international action to be taken to support the national activities. In accordance with the WHA resolution on the subject, the Executive Board had prepared a draft "plan of action" for the implementation, monitoring and evaluation of the strategy which had been sent to governments. The Board would be submitting the plan of action to the Thirty-fifth World Health Assembly after recasting it in the light of the observations of the regional committees. He hoped that the discussions on this agenda item would deal with the progress report and the draft plan of action to implement the global strategy.

DR BAJAJ (India), speaking on the strategies adopted in India, said that his country had laid down population stabilization by reducing the net reproduction rate as a long-term objective and had restructured the health care system, under which the emphasis would be shifted from city-based medical care services to rural health care. The infrastructure for rural health care would consist of primary health care centres and sub-centres serving the rural population. Facilities for treatment in basic specialties were provided at the primary health centres. Water supply and sanitation, control of communicable diseases, family planning and maternal and child health care were coordinated to ensure the optimum health impact. Adequate medical and paramedical manpower would be trained and community participation ensured.

DR SOEHARTO (Indonesia) said that he had participated in the deliberations of the "Small Committees" on programme budget, and he was gratified to note that document SEA/RC34/9 Rev.1 incorporated the latest situation in Indonesia.

DR KWON SUN YON (DPRK) expressed appreciation of the efforts that had gone into the preparation of document SEA/RC34/9 Rev.1. These regional strategies had taken into account the national strategies and were based on the actual situations prevailing in the countries. He hoped that the Regional Office would take measures to implement the regional strategies effectively.
The REGIONAL DIRECTOR clarified that document SEA/RC34/9 Rev.1 reflected the information as received by the Regional Office up to the time of preparation. He requested the delegates (particularly from DPRK) to provide up-to-date information on the latest developments.

DR FERNANDO (Sri Lanka) said that the per capita income in Sri Lanka was 200 dollars; infant mortality was 37.1; the crude death rate was 6.8 per thousand, and the expectancy of life for females was 67.4 and for males 64 years. Relatively higher expenditure was being incurred on curative services than on preventive services. The national strategies for health for all emphasized the preventive aspects. It was proposed to achieve the HFA objectives at grass-roots level with the family health workers, each of whom would be responsible for providing preventive and curative services to a population of 3000 in the fields of nutrition, family planning, safe water, rehabilitation, mental and oral health, and simple forms of treatment. Grade I health centres, under the charge of assistant medical practitioners (medical assistants), would provide preventive and curative services, with one centre for every 20 000 people. The Grade I health centre, with three doctors and auxiliary staff, would cater to 60,000 people. A national health council had been established, with the Prime Minister as chairman, and a national health development committee had also been set up as the technical arm of the Council. The latter committee, with its sub-committees, was charged with the responsibility of drawing up appropriate strategies and plans of action for HFA/2000. Steps would be taken to reorganize the health administration structure, and a seminar which had been organized in this connexion had provided ideas for effecting such a change.

DR PRAKORB (Thailand) expressed satisfaction at the draft plan of action for implementing strategies for health for all in accordance with resolution EB68.R6 Rev.1. Thailand had reviewed its own national strategies and prepared a plan of action for HFA in the light of the global strategies with specific targets and lines of action to implement the strategies. The National Health Development Plan, drawn up on the basis of experience of country health programming, had registered increased resource allocation for primary health care. A primary health care committee in the Ministry of Public Health undertook programme planning, coordination and evaluation. The Ministry of Interior formed inter-sectoral committees at central, provincial, district, sub-district and village levels. The village development committee, which was the medium of community participation, included village health volunteers and village health communicators, supplemented by local healers, traditional birth attendants and traditional medical practitioners. This functioned as an advisory body to the village headman. At the central level, the medical schools and training institutions for medical auxiliaries jointly prepared curricula to suit the primary health care concept. By the end of 1981, the primary health care programme was expected to cover 22 400 villages with a population of 18.5 million - representing 50% of the total population. By 1986, all the villages would be covered; there would be 50 000 village health volunteers and village health communicators covering 50 000 villages; 12 000 health supervisors would also be trained. The health authorities were trying to provide adequate numbers of health centres in every district. Each district would have a 30-bed hospital and each province a 240-260 bed hospital. Fifty per cent of this target had already been reached.
DR POUDAYL (Nepal) said that mention of the goal of health for all by the year 2000 had been made in Nepal's Fifth and Sixth Five-Year Plans. It was planned to provide minimal health care to the maximum number of people, but his country found itself unable to cover the entire population with health posts due to lack of appropriate manpower in adequate numbers. There were not enough auxiliary workers, and a plan to post auxiliary nurse-midwives to health posts also had not worked out because of existing social and cultural traditions. Traditional healers and dais were likely to be used to man the health posts to tide over the situation.

In addition to the problem of manpower, the question of financial resources also posed a constraint. For any improvement in the delivery of health services, these resources would have to be increased. At present, most of the national resources went to urban health services, and it was now difficult to reverse the trend. Additional resources for the rural areas would have to be found, and he requested WHO's intervention in this regard.

In the present approach to an integrated rural development, he felt that WHO must provide leadership. If additional external resources were not forthcoming for his country, attainment of the goal of HFA/2000 might be difficult to achieve, and he hoped that WHO would motivate bilateral and other agencies to provide the necessary funds. He suggested the establishment in the Regional Office of a mechanism for monitoring progress in attaining HFA/2000 and for motivating national governments towards greater efforts to this end.

The REGIONAL DIRECTOR said that he had noted the information given during the discussion on the progress made so far in the countries of the Region, and would try to update the regional strategies on that basis. He agreed that the regional plan of action could be reviewed annually and appropriately modified on the basis of feedback obtained from the countries of the Region and presented to the Regional Committee every year.

He agreed with the representative of Nepal that strategies must be translated into action and that for this purpose external resources were essential. The establishment of the Health Resources Group was a mechanism for this purpose. The governments themselves must, of course, also make efforts to tap all available resources. WHO would be glad to cooperate with the countries in their efforts as far as possible.

WHO's structures in the light of its functions (item 14) and resolutions of regional interest adopted by the World Health Assembly and the Executive Board (item 8)

The REGIONAL DIRECTOR, introducing the document on this subject (SEA/RC34/7), said that this agenda item provided yet another opportunity to the Regional Committee to review the progress of WHO's study of its structure in the light of its functions since the time that the Committee had examined this subject at its thirty-first session in 1978. The Regional Structure Study Group had completed its work, and a detailed report had been submitted to the Director-General for examination, along with similar reports that would come from other regional offices. There
were some important recommendations included in this report, such as the consensus that the level of country operations should be increased, and that better information should be provided to the Regional Committee for the purpose of reviewing programme planning and evaluation, providing policy analyses and formulating, at regional level, plans for stimulating and coordinating extra-budgetary resources for national health development.

While steps were being taken for the progressive implementation of these ideas, particular attention would be paid to the preparation and results of the 1984-1985 programme budget discussions. It would be helpful if clear indications could be given regarding the views of the Regional Committee in this respect. Guidance would also be welcome on how best the Regional Committee could assume more responsibility and authority in the context of the structure study and on the steps which the Regional Director could take to strengthen the functioning of the Organization, particularly WHO's work at country level.

Referring to the Assembly resolutions given in document SEA/RC34/15, on the periodicity of Health Assemblies (WHA34.28) and method of work and duration of Health Assemblies (WHA34.29), the Regional Director pointed out that the Thirty-fourth World Health Assembly had decided that, though the periodicity of the Health Assemblies was not to be changed, the Assembly, in even-numbered years, starting in 1982, would meet for only two weeks.

DR SOEHARTO (Indonesia) said that the progress report on the study of WHO's structures in the light of its functions had been very well documented. However, the important question was whether any improvements had been effected, and this question could be answered by Member States only on the basis of factual information. The time was not yet ripe for such an analysis, since the report had been finalized so recently. To answer this question, however, it would be useful, he thought, to constitute a sub-committee, including a management expert, to look into this matter thoroughly. The main task of such a sub-committee would be to make an external evaluation of the performance of WHO. The Regional Office and the countries of the Region should provide it with all the information and assistance needed, and visits to the countries might be envisaged if these were found necessary. Its report should be submitted to the Regional Committee at its thirty-fifth session.

The establishment of such a sub-committee would be particularly relevant in the light of the World Health Assembly's resolution WHA33.17 - Study of the Organization's structures in the light of its functions - and especially that part of the resolution which had urged regional committees to increase their monitoring, control and evaluation functions.

DR POUDAYL (Nepal) felt that the ritual type of procedures adopted by the Organization in the meetings of its governing bodies were not commensurate with the enormity of the problems and the responsibility it had taken upon itself for the health-for-all goal.
If HFA were to be made really meaningful, countries should be able to exchange ideas in meetings such as those of the Regional Committee, Executive Board, etc., which should be well attended. The role of WHO should be to help the Member countries as a friend, philosopher and guide.

It seemed to him that the Organization functioned under a centralized power system, the WHO Programme Coordinators having the least power. He thought that whereas the counterparts of the WHO Programme Coordinator in other United Nations agencies were able to take decisions on the spot, the WHO Programme Coordinator almost always had to refer matters to the Regional Office for approval. Also, as discussed at the last session of the Regional Committee, there was no need for the title of the "WHO Representative" at country level to have been changed to "WHO Programme Coordinator".

Finally, he observed that a vacancy in the Executive Board membership intended for the South-East Asia Region still could not be filled. He suggested that the Organization should inform the governments of the formalities they needed to complete so that this situation could be remedied.

DR BAJAJ (India) wondered whether the South-East Asia Regional Office could not expedite this matter, since the vacancy was to be filled from this region.

The REGIONAL DIRECTOR said that, although some years ago the Assembly had passed a resolution providing for the Board to have an additional member from this region, as a change in the Constitution was involved, it had to be ratified by two-thirds of the Member States. When the resolution had been approved, the membership of WHO had been only 120 or 130, but it was now 156, and therefore approval by 108 or 109 governments was needed. So far only 55 Member States had ratified the amendment. He assured the Committee that he had requested the governments of this region to persuade other countries to expedite ratification.

DR BAJAJ (India), speaking on the subject of the additional seat in the Executive Board for a member from the South-East Asia Region, asked why the ratification of the amendment was taking so much time and what the mechanism for contacting the countries would be. Could the Regional Director approach the governments directly?

The REGIONAL DIRECTOR replied that countries probably had no real objection to this amendment, but as it affected only those in South-East Asia, others might have no real interest in it and therefore had not bothered to ratify it. He had taken the matter up with the Director-General, who had, in turn, written to the regional directors asking them to try to expedite this matter by approaching the governments in their regions. He had also written to the governments in the Region asking them to ratify it and to use their influence to have it ratified by other governments. They had all agreed to do so. However, there had so far been no encouraging response.
As regards the observation on the nomenclature of the WHO Programme Coordinators, the Regional Director reminded the Committee that this change had resulted from a recommendation made in an organizational study and only after having been agreed to in a resolution by the World Health Assembly; it could not easily be changed. Although the WPCs could be called by any other name, they had, on paper, to remain WPCs. Nevertheless, the countries of the Region could continue their efforts to restore the title of WHO Representatives.

As for meeting the cost of representatives' attendance at the sessions of the Regional Committee, many governments represented in WHO were not inclined to support this idea. It was after a great deal of discussion that the World Health Assembly had adopted a resolution entitling those governments who were assessed the least to send representatives to Regional Committee sessions at WHO expense; even then only the travel costs, not per diem, could be borne by WHO. However, this subject could be taken up again, if desired.

With regard to Dr Soeharto's suggestion for appointing a sub-committee, there would be no difficulty, if the Regional Committee endorsed this suggestion. In this context, however, he recalled the developments leading to the formation of the "small committee" at the Regional Committee's last session, where the idea of having a sub-committee responsible to the Regional Committee was initially mooted, but as this would have meant deciding immediately on the membership and specifying the terms of reference, it was ultimately decided, instead, to ask the Regional Director to appoint a "small committee" to advise him. This small committee had now made its report to the Regional Director; the report would be reviewed by the Sub-Committee on Programme Budget and then submitted to the Regional Committee. Any action emanating from this report would be taken only thereafter.

If the Committee so desired, he could constitute another such small committee and could include a management specialist in the membership.

MR WIJESINGHE (Sri Lanka) stated that he felt that it would be cumbersome to have a multiplicity of committees. It might be a good idea to have only one "small committee", with terms of reference which would be broad enough to enable it to advise the Regional Director on various issues. This committee could be made up of representatives of all the countries. It would be different from a sub-committee of the Regional Committee in not being subject to constitutional procedures, which might otherwise be necessary, and could also be convened as often as necessary without difficulty, whereas the Regional Committee met only once a year. Details about the nomenclature and the shape to be taken could perhaps be worked out later. He repeated that his suggestion was that there should be one committee with broad terms of reference which could be used as an instrument by both the Regional Committee and the Regional Director.

DR SOEHARTO (Indonesia) said that he thought that entrusting the same small committee which had been established at the last session with additional terms of reference would constitute a burden for it and make
its task difficult to accomplish. He said that he had proposed a separate sub-committee to be responsible to the Regional Director; the Regional Committee should lay down the terms of reference for this sub-committee, which should submit its report to the Regional Committee through the Regional Director.

The REGIONAL DIRECTOR suggested that a specific concrete proposal on the type of committee desired be formulated and distributed to all the members of the Regional Committee for consideration on Friday, 18 September.

The CHAIRMAN said that he would like to assign the task of formulating the proposal to a working group consisting of the representatives of India, Indonesia and Sri Lanka; the WHO secretariat (Director, Programme Management) should also be associated with this group.

These suggestions were accepted.

The REGIONAL DIRECTOR mentioned that Indonesia and Thailand had been nominated by the Regional Committee at an earlier session as members of the Special Programme for Research and Training in Tropical Diseases/ Joint Consultative Board (TDR/JCB) for three years, and Bangladesh and India as members of the Health Resources Group. He enquired whether the Regional Committee would like these representatives to report to it and, if so, in what form. If the Committee desired to have such reports, he wondered whether the working group just established by the Chairman might not also be asked to suggest the form of reporting which would be most useful.

DR BAJAJ (India) said that he thought it would be appropriate for the representatives to keep the Regional Committee informed, and that it should thus receive reports from these members.

It was agreed that the representatives should be asked to report to the Regional Committee from 1982 on, and that the working group just appointed would be asked to propose a suitable format.

The discussion on this item was thus postponed until Friday, 18 September 1981, when the working group would submit its proposals.

Adjournment

The meeting was then adjourned.
SUMMARY MINUTES*

Fifth Meeting, 18 September 1981, 9.00 a.m.

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*Originally issued as document SEA/RC34/Min.5, on 19 September 1981.
In the absence of the Chairman, the Vice-Chairman took the chair.

WHO's structures in the light of its functions (item 14) (cont'd)

The REGIONAL DIRECTOR recalled that when the plenary meeting had adjourned on 16 September, two points were being discussed: the establishment of a small committee or sub-committee to look into the follow-up of the WHO structure study, and in what manner the Regional Committee would like to be kept informed on the participation of its representatives at meetings of the Health Resources Group and Joint Coordinating Board on Tropical Diseases Research. He said that the Working Group composed of the representatives of Indonesia, Sri Lanka and Thailand, which the Chairman had appointed to advise on these two matters, was now ready with its report.

DR SOEHARTO (Indonesia), a member of the Working Group, said that the group had recommended that the Regional Director appoint a small committee, as had been recommended by the Sub-Committee on Programme Budget, and that this same committee should have the following additional terms of reference: (a) to assess the progress made in the WHO structure study and in the implementation of its results, (b) to suggest ways and means of pursuing the study and implementing the recommendations, and (c) to report to the Regional Director annually so that he would be able to keep the Regional Committee informed of the latest developments in the implementation of the study.

MR SIDHU (India) mentioned that, as this was the first day on which he had been able to participate in the plenary meeting, he would like to congratulate the Chairman and the Vice-Chairman on their election and the Regional Director on his excellent annual report, and he thanked the Government of Indonesia for the excellent arrangements made for the session. On the structure study, he welcomed the suggestions made by the Working Group, and asked for confirmation that there would be only one "small committee", for the programme budget as well as for the structure study. He felt also that there should be flexibility in the implementation of the recommendations. For example, though it had been mentioned that the offices of the WHO programme coordinators should be strengthened, there should be sufficient flexibility to meet the varying requirements of each country.

DR SOEHARTO (Indonesia) confirmed that the small committee recommended by the Sub-Committee on Programme Budget would also be responsible for the structure study.

MR SIDHU (India), in response to a query from the Representative from Nepal on the question of flexibility, clarified that, on going through the report of the Sub-Committee on Programme Budget, he found that certain norms had been laid down with regard to the functioning and strengthening of the offices of WHO programme coordinators. As the conditions varied from country to country, he felt that, in the case of India, the Government itself might be able to take care of the functions of the WHO Programme Coordinator, though his delegation was in agreement with the duties as set out.
In reply to points raised in the earlier discussions, the REGIONAL DIRECTOR clarified that it was for the Regional Committee to decide on the composition of the small committee it wished to establish and to decide upon the terms of reference. The Regional Committee could, if it so desired, direct him to establish such a committee to look into the progress made in the structure study. Dr Soeharto had suggested that one member from each country be represented on the small committee, and had also suggested its terms of reference. If the Regional Committee agreed with this suggestion, these terms of reference would be added to the existing terms of reference of the small committee proposed by the Subcommittee on Programme Budget.

He agreed that there should be flexibility based on the needs of individual countries. Referring to page 8 of document SEA/RC34/7, he suggested that structure at country level could always be modified to suit the country's needs. He quoted the example of Thailand, where there was an effective national coordinating committee, for which the WHO Programme Coordinator served as both technical expert and secretary. Similar committees existed in Sri Lanka and Nepal.

MR SIDHU (India) said that he thought it would be advisable to leave the formulation of the advisory committee to the Regional Director's discretion. If it consisted of only four or five members, it would not be unwieldy and could perform its various tasks, including the monitoring of programme performance and budgeting, in a business-like manner. However, if other members felt that all countries should be represented, he would have no objection.

MR WIJESINGHE (Sri Lanka) said that he felt it would be advisable for the proposed committee to have a representative from each Member country so as to have the benefit of the views of all.

The REGIONAL DIRECTOR said that with only ten countries in the Region, even though the proposed committee might have one representative from each, it would not be very large; unlike the Regional Committee, the proposed committee would deal only with specific items, and duplication could be avoided. Such exercises had been undertaken in the past by other committees, which had formulated the structure study, health charter, etc.

The CHAIRMAN then invited Dr Samlee Plianbangchang, another member of the small group appointed by the Chairman, for their views on the mechanism for reporting back to the Regional Committee by the Committee's representatives to the Joint Coordinating Board on Tropical Diseases Research and the Health Resources Group during their tenure.

DR SAMLEE (Thailand) said that they had considered three different alternatives: (1) having these representatives send in written reports to the Regional Office, which, in turn, could submit them to the Regional Committee, (2) having them provide briefs to their country delegates to the Regional Committee, who themselves would report to the Committee, or (3) inviting these representatives to attend the sessions of the Regional Committee so that they could report personally.
After consideration of the three alternatives, the Group had felt that, since the Regional Committee appointed the countries to nominate members of these bodies and not particular persons by name, it was the responsibility of the country concerned to report back to the Regional Committee. Hence alternative (2) was recommended for approval.

MR VOHRA (India) observed that by the time the report had been submitted to the country by the person attending the meeting, by the country to the Regional Office and then by the Regional Office to the Regional Committee, the report of the meeting issued by WHO Headquarters also would have reached the countries. He therefore wondered whether it was really necessary to ask the persons attending the meetings to submit special reports. Also, though the Tropical Diseases Programme was, in the main, a programme for this region, he thought that there was not much evidence of a flow of assistance to the Region in this direction, except to one or two countries. Perhaps those attending the meetings could suggest improvements in the situation.

DR SAMLEE (Thailand) said that although it was true that comprehensive reports of these meetings were brought out fairly promptly, he considered that it would still be useful if representatives of this region who attended the meetings brought to the attention of the Regional Committee points of particular relevance to this region.

The REGIONAL DIRECTOR said that he felt that Mr Vohra was only seeking clarification and not objecting to the proposed pattern of reporting, and since the clarification had been provided by Dr Samlee, if the Committee agreed to accept alternative 2, as recommended by the small group, the Regional Office would work out ways of implementing the suggestion.

This was agreed.


DR RAHMAN (Director, Programme Management) introduced this item, saying that it had been discussed at many Regional Committee sessions. A history of the Seventh General Programme of Work had been given in the introductory chapter of document SEA/RC34/6. The Seventh General Programme was still in the process of development. The progress made since the thirty-third session of the Regional Committee had also been outlined in the introductory chapter. He invited suggestions and comments on the Programme for consideration and further development.

He added that the Seventh General Programme of Work had been prepared in consultation with Member countries through the WHO Programme Coordinators and in a consultation meeting. The responsibility for its preparation rested with the Executive Board through a Constitutional mandate, but any suggestions by the Committee to make the programme more relevant to the Region's needs could be considered and communicated to WHO Headquarters for incorporation.
He invited special attention to Chapter 2, which described some of the obstacles which might be encountered by national health systems. Chapter 3 summarized the global strategies for the achievement of health for all by the year 2000, and section 4.3, on the managerial process, described how the medium-term programme would be prepared for implementation within the framework of the Seventh General Programme of Work. Section 5.2 dealt with the criteria for selecting programme areas for WHO involvement, which he considered particularly important, as they would be applied to programme budgeting at country level.

He suggested that the description of the classified list of programmes in the annex to the document be carefully reviewed, with particular attention to the paragraph on health system development infrastructure.

The programme classification structure in the Seventh General Programme differed from that contained in the Sixth General Programme, as the thrust now was on the infrastructure for the development of health systems and of health science and technology. These were the two main areas around which the programme would be elaborated. Chapter 7 gave the main objectives, targets and approaches in each programme area, also containing information which was relevant to this region. Finally, Chapter 8 briefly discussed the implementation, monitoring and evaluation of the Seventh General Programme of Work.

He stated that WHO would like to maintain effective consultations with governments on the instruments for implementing the Seventh General Programme of Work, viz., the medium-term programme and the programme budgets, in order to make this process more effective and purposeful. He would be grateful for suggestions, specifically with regard to the preparation of medium-term programmes and their implementation. Since the Seventh General Programme of Work and medium-term programmes should reflect the needs and priorities of Member countries, the national health programme formulation process should identify the activities in which WHO collaboration was needed. He particularly requested consideration of ways in which the progress and impact of WHO's collaboration with national governments in health development could be better monitored and advice on the most feasible methods of joint evaluation.

MR SIDHU (India) said that he was glad to note the shift of programmes and budget in the Seventh General Programme towards the fullest support to the various elements of primary health care through the establishment of comprehensive guidelines, priorities and approaches. He hoped that the regional budget for 1984-1985 would closely follow this shift, which formed the basis of the Seventh General Programme of Work. He noted that under primary health care there seemed to be no mention of the family planning programme, which was closely linked with health and medical care. This most vital programme had to be included. He elaborated on the steps being taken in his country to provide family planning services at the grass-roots level. To enable a proper appreciation of the efforts under the Seventh General Programme, it would be useful if information on the progress so far achieved in the Sixth General Programme could be collected and compiled early enough to become a benchmark for future progress and assessment of the efforts to be made through the Seventh General Programme. Such information would also help in a more realistic
preparation of the Seventh General Programme. He further suggested that, starting from 1982-1983, the Regional Office might bring out an annual review of the work done under the General Programme of Work.

MR MUSTHAFI HUSSAIN (Maldives), referring to the subject of health legislation, stated that quite often workers trained for primary health care left the programme half way through. This resulted in a setback to the health care delivery programme. He therefore pleaded for legislation to prevent this practice in order to ensure the best results; otherwise, the efforts of the countries to train their workers would be wasted.

He felt that a community might expect from the health worker services normally provided by a fully-trained doctor, and since the health worker might not be fully geared to catering to the needs, the confidence of the community in the institution of the health worker might be shaken. It was therefore important, through health education and information, to inform the community of what to expect from the health workers. He urged serious consideration of these aspects to help tackle actual problems.

DR PRAKORB (Thailand) said that he appreciated the progress made in preparing the Seventh General Programme of Work and thought that the modifications made were relevant. The clear emphasis and programme specifications given to the development of health systems based on primary health care were appropriate. In any future review, a clarification on, and specification of, linkages and priorities among programmes in health system infrastructure development and the development of health science and technology would be helpful. He agreed with the conclusion on page 73 of the publication, "Perspectives for Health Development in the South-East Asia Region", which stated "...the Seventh General Programme of Work will be an instrument which can become a powerful tool if it is attuned to the declared objectives of the Member States and complements the strategies which they develop in order to meet the attainable target of health for all by the year 2000".

MR WIJESINGHE (Sri Lanka) expressed satisfaction with the Seventh General Programme of Work, which had been drawn up taking into account the latest health developments in the countries. Since the criteria laid down in this document were similar to those discussed in the Programme Budget Sub-Committee, he requested that the latter's recommendations be considered by the Regional Director, as they would be of benefit in the implementation of health programmes, in which use should be made of the programme budget as a vehicle for achieving the goals already set. Agreeing with the Indian delegate, he said that he hoped that in the next budget cycle an attempt would be made to ensure the shift towards fuller support of primary health care, and that, in allocating funds, in consultation with governments, due weightage would be given to each of the components.

DR POUDAYL (Nepal) said that the population explosion indeed posed a serious challenge. This had been reflected by the United Nations in forming the UNFPA. The health sector could help with various facets of population control, and WHO should play a leading role in this health-related programme and state clearly that it took a serious view of the problem.
DR ARSLAN (Mongolia) said that he appreciated the efforts that had gone into the preparation of the Seventh General Programme of Work. The proposals made at the last session of the Regional Committee regarding the needs of the countries and the emphasis on close linkages between the Seventh General Programme and the strategies for health for all by the year 2000 were satisfactorily reflected in the revised documents. The Seventh General Programme would be the first such programme to be implemented which was directed to the achievement of this goal. Therefore, a great responsibility would devolve on the Organization as well as on the countries to see that the Programme was started in earnest from 1984.

In this regard, WHO's coordinating role, described in Chapter 7, was extremely important, especially in mobilizing extra-budgetary resources to tackle priority health problems and in the implementation of the International Drinking Water Supply and Sanitation Decade. By 1989, he hoped, most of the targets set out for the Decade would have been achieved as regards improvement in drinking water supply, sanitation and excreta disposal, as they were important components of primary health care and essential for achieving the HFA/2000 goal. A national commission for the International Drinking Water Supply and Sanitation Decade had been recently established and a plan of action drawn up. Because of financial constraints, his country had been facing difficulties in implementing the plan. Perhaps a similar situation prevailed in other countries of the Region, and he hoped that the Regional Director would look into the problems and advise the national authorities on future plans of approach.

DR BAJAJ (India) suggested that, since it would be two years before the Seventh General Programme of Work came into operation, changes which might take place in the intervening period should be kept in mind in formulating the final draft of the Programme. Referring to document SEA/RC34/6 Corr.1, which mentioned technical cooperation among developing countries, he said that he was very happy to offer his country's facilities to others in the Region. For example, his country was collaborating with Sri Lanka in Ayurveda and in radiological services and with Bangladesh in malaria control activities. Training facilities were available in different spheres such as communicable-disease control, pharmaceuticals, research in tropical diseases, traditional medicine, and production of teaching aids.

DR FERNANDO (Sri Lanka) suggested payment of incentives by WHO to encourage the utilization of the locally available talent.

The REGIONAL DIRECTOR clarified that the main purpose of bringing the subject of the Seventh General Programme of Work to the attention of the Regional Committee was to seek the opinion and advice of representatives; the comments which they had made had been noted.

He confirmed that the Seventh General Programme of Work would start only from 1984. The next step was for the Executive Board to review the draft, which would then be examined and approved, with possible modifications, by the World Health Assembly before becoming the official policy.
of the Organization. The present discussions would be useful for the representatives attending the sessions of the Executive Board and the World Health Assembly.

Regarding family planning, he felt that the point made by the Representative of Nepal was well taken. The subject was dealt with on pages 69 and 71, Sections 9.1 and 9.2 of document SEA/RC34/6 and, from the point of view of infrastructure, training, etc., in Chapter 7 (Sections 3, 5, etc.).

He clarified that document SEA/RC34/6 referred to the global programme. In a global document, a country's individual needs or priorities could become diluted. Therefore, a document outlining the regional situation had been prepared by the Regional Office (document SEA/RC34/Inf.2), which was closer to the needs of the countries of this region.

He drew attention to the fact that, at the end of 1981, the 1984-1985 budget would be formulated. He requested representatives to keep in view the discussions that were now taking place and to reflect in their budget proposals these comments on the Seventh General Programme of Work.

Referring to the comments made by the Mongolian representative, he said that the IDWSSD targets indicated for the countries were general in nature and should be taken, for the most part, only as guidance. In the case of large countries such as India, however, targets had been set and individual plans drawn up for each State.

DR RAHMAN (Director, Programme Management) pointed to the shift towards an emphasis on primary health care, which should be reflected in the Programme Budget for 1984-1985. Unless this were done, the proposed Seventh General Programme of Work would be meaningless, and he therefore hoped that the programmes would adequately reflect this emphasis. He welcomed the suggestion for an annual review of progress made under the General Programme of Work.

As regards the benchmark which had been suggested by Mr Sidhu for activities for the period of the Seventh General Programme of Work, he said that such targets had been mentioned in Chapter 2 of document SEA/RC34/6 in a general way. Document SEA/RC34/Inf.2 also gave some idea of the regional benchmarks, against which the progress made in the implementation of the Programme could be assessed.

Referring to Dr Prakorb's observations, he said that the development of essential linkages between technology and infrastructure was very important, and should be kept in view in formulating the 1984-1985 proposals.

As for the question of utilizing national talent, raised by Dr Fernando, there was already a provision for this through the mechanism of contractual technical services agreements, which was in use.

Concerning the point made by Dr Arslan on the International Drinking Water Supply and Sanitation Decade, he said that an analysis of the proposals received from the Member countries in connexion with the programmed activities for the Decade revealed that they were not closely
related to the primary health care package. There was thus a need to reorient the efforts. The efforts should emanate from the community if the proposed programme activities were to be successful. The views of the Regional Committee would be welcome in this regard to enable a proper reorientation of the activities. They would also be useful in the light of the forthcoming meeting in Headquarters on this subject.

Replying to the point raised by Dr Bajaj, he said all plans, including the draft Seventh General Programme of Work, had necessarily to be flexible, if they were to succeed.

3 Infant and young child feeding - Draft International Code of Marketing of Breastmilk Substitutes (item 16) and Resolutions of regional interest adopted by the World Health Assembly and the Executive Board (item 8)

The CHAIRMAN drew attention to the three background documents (SEA/RC34/13, SEA/RC34/Inf.3 and SEA/RC34/Inf.4) which had been prepared for agenda item 16 and proposed the consideration also of two resolutions of the World Health Assembly (in document SEA/RC34/15), which were on the same or related subjects (WHA34.22 and WHA34.23).

The REGIONAL DIRECTOR, introducing the subject, said that several years ago the World Health Assembly had noted with concern the decline in breast-feeding and had urged Member countries to effect a reduction of the sales promotion activities by regulating the advertisements and enacting suitable legislation where necessary. Some measures had been taken by WHO to encourage and support breast-feeding, including assistance in formulating the necessary legislation relating to infant foods and breastmilk substitutes. He drew attention to the fact that Member States had been asked to take effective steps to implement the recommendations made in the Assembly resolution and that the Regional Committee had been requested to follow up and review this implementation.

The Regional Director said that WHO had meanwhile developed guiding principles which would help Member countries in carrying out their responsibilities for implementing and monitoring the Code and in their reporting. These principles dealt with areas such as the legislative framework, current health care practices, orientation of the health curriculum towards promoting breast-feeding practices, and marketing practices where breastmilk substitutes were concerned. These guiding principles had been prepared not only in relation to the Code of Marketing but in a comprehensive manner to cover other aspects of infant and young child feeding. A draft set of these guiding principles had been submitted to delegates as document SEA/RC34/Inf.3, which would help governments to:

(a) assess their relevance to their own national situations;

(b) identify suitable national institutional mechanisms for implementing, monitoring and reporting on the Code;

(c) consider steps to be taken in order to translate the information gathered into action programmes, and
(d) decide on the kinds of support and cooperation required from WHO to meet their needs.

In the case of India, a WHO-sponsored consultation meeting had been held in the Regional Office from 2 to 4 September 1981 to review these guiding principles and to test them in the Indian context. Most of the principles were found to be relevant to India, and it would be necessary to undertake a further review to identify those areas which were of the highest priority in the context of the Indian plans and strategies. These principles would also help orient national discussions on the type of information that was relevant to the planning, implementation and monitoring of activities designed to improve infant and young child feeding practices.

The discussions on this item would help to indicate the steps to be taken by Member States to review and adapt these guiding principles based on the special characteristics, needs, local conditions and resources of each country. WHO was ready to assist national authorities in developing programmes on infant and young child feeding, and in preparing detailed guides for data collection based on these guiding principles.

MR SIDHU (India) said that this subject was of very great importance to India, and hoped that it was equally so to other countries of the Region. He reaffirmed his government's very strong support of this programme.

In India, a working group had been formed to evolve the lines on which a legislation could be brought about. In the meantime, under existing legislation relating to the adulteration of food, baby-food manufacturers had been asked to print prominently on every packet or tin the fact that breastmilk was the best food for the child.

He stated that most of the information required was available in one form or the other. What was needed was an effective mechanism for its timely collection, compilation, analysis and dissemination. To achieve this, he favoured the participation of private and voluntary organizations active in the field. In some cases, it would also be necessary to provide them with suitable administrative and even financial support.

DR POUDAYL (Nepal) said that in Nepal breast-feeding was part of the people's culture, but slowly, with the infiltration of other cultures, educated women tended to resort to artificial feeding. The problem had been accentuated by forceful publicity by baby-food manufacturers. Also, poverty, resulting in the poor health of mothers, and an increase in the number of mothers working outside the home, were causes of the early discontinuation of breast-feeding. He suggested that the causes of the problem should also be studied.

DR ARWATI (Indonesia) stated that the Government of Indonesia recognized the need to protect society against foods which did not meet the required standards. Steps had been taken to implement the recommendations contained in the World Health Assembly resolution by regulations on
quality control, marketing (including advertisements) and distribution of infant foods and also preventing their improper use, distribution and promotion. In Indonesia, breast-feeding was still the predominant way of feeding infants and was practised by 95% of women until the infant was about a year old. The Indonesian Food Codex Committee was at present elaborating the standard for infant foods, and the Indonesian Committee for Food Hygiene had prepared a draft for good manufacturing practices in their production.

DR FERNANDO (Sri Lanka) said that the subject was of great importance to his government, which had started its campaign with the main stress on health education. It was hoped that, with more than half the primary health workers in position by next year, this knowledge could be imparted widely. The problem of a large number of working mothers was engaging the attention of the Government. Since his country imported all its requirements of infant foods, it should be possible to know about the impact of the campaign by studying the import figures.

DR PRAKORB (Thailand) stated that his country had supported the World Health Assembly's resolution adopting the International Code of Marketing of Breastmilk Substitutes. In accordance with the country's Food Control Act, infant foods had been classified as a specially controlled food, and standards laid down for the quality control and manufacturing processes. With the cooperation of the Paediatric Association of Thailand, a national code of marketing of breastmilk substitutes, using the International Code as a guide, was under preparation. The importance of breast-feeding had been stressed for all strata of society.

DR SOEHARTO (Indonesia) thanked WHO for sending a team of short-term consultants, consisting of a legal expert and a paediatrician, early in the year to assist his government in drafting legislation on this subject.

DR BAJAJ (India) stated that, whereas much emphasis was being placed on breast-feeding, there was no reference in the document to the observation of hygienic practices by lactating mothers. This was essential to protect the infants from infections.

The REGIONAL DIRECTOR stated that he was encouraged by the positive response of the Member countries which had been indicated. Since the subject was of global interest, he would report in detail to WHO Headquarters on the proceedings of the Committee, for appropriate action at global level. He pointed out that there were two aspects to be considered: (1) infant and young child feeding, which had to be dealt with along with maternal and child health, nutrition and health education programmes, and (2) the International Code of Marketing of Breastmilk Substitutes. The Regional Office had been in consultation with the Member countries, and all ten of those in the Region had expressed their interest in this subject, though the situations and requirements of each country differed. The Regional Office would continue to provide whatever support Member countries might need in this area.

4 Adjournment

The meeting was then adjourned.
SUMMARY MINUTES*
Sixth Meeting, 18 September 1981, 2.00 p.m.

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*Issued as document SEA/RC34/Min.6, on 20 September 1981.
1 Consideration of the Report of the Sub-Committee on Programme Budget (item 10.1)

DR POUĐAYL (Nepal), Chairman of the Sub-Committee on Programme Budget, presented the report of the Sub-Committee (document SEA/RC34/21) for consideration by the Regional Committee.

MR VOHRA (India), referring to the previous discussions on changes in style and on the restructuring of the Organization to bring it into line with its changed functions, said that the terms of reference proposed for the Programme Budget Sub-Committee were a concrete example of the change being brought about by consensus on the style of WHO's functioning in order to make it more responsive to the current needs and feelings of Member States, and to ensure their greater participation in the functioning of the Organization. He suggested that whatever changes the Regional Office was able to bring about in one year should be reflected appropriately in the next year's Annual Report.

The REGIONAL DIRECTOR thanked the group which had prepared the report and agreed that it was a very good example of trying to effect changes. He assured the delegates that he would take action in this regard in accordance with the wishes of the Regional Committee. He drew attention to the draft resolution which was contained in the report.

The resolution was adopted (SEA/RC34/R11).

2 Consideration of the recommendations arising out of the technical discussions on the role of ministries of health as directing and coordinating authorities on national health work (item 11)

MR VOHRA (India), Chairman of the technical discussions, presenting the recommendations contained in document SEA/RC34/22, offered to provide any clarifications that might be sought. He thanked his fellow delegates, especially the Vice-Chairman and the delegates from Nepal (Dr Poudayl) and Sri Lanka (Dr Fernando) for their help in drafting the recommendations.

The report was noted by the Committee.

3 Selection of a subject for the technical discussions at the thirty-fifth session of the Regional Committee (item 17)

The CHAIRMAN said that document SEA/RC34/14, containing the topics of the technical discussions held in the past ten years, had already been circulated. The document also listed five subjects for possible consideration as the topic for discussion at the thirty-fifth session. The delegates might like to choose one of these, or a combination of two or more, subjects.

MR VOHRA (India) stated that there had recently seemed to be a convention of considering a non-technical and a technical subject in alternate years. Since a non-technical subject had been taken up this year, next year one of a more technical nature might be selected. Leprosy was a high priority health problem in the total primary health care approach, and he therefore suggested the topic, "Control and prevention of leprosy
in the context of primary health care", as the subject for the technical discussions to be held at the thirty-fifth session of the Regional Committee. This suggestion was accepted by the Committee, which adopted a resolution to that effect (SEA/RC34/R7).

4 Time and place of forthcoming sessions of the Regional Committee (item 18)

The REGIONAL DIRECTOR mentioned that it was customary to hold alternate sessions of the Regional Committee at the Regional Office unless there was an invitation from a government to hold the session in one of the countries. The invitation of the Government of Bangladesh to hold the 1982 session in Dacca was before the Regional Committee.

The VICE-CHAIRMAN, speaking as the representative of Bangladesh, renewed his Government's invitation to hold the thirty-fifth session in 1982 in Dacca, the exact timing to be decided in consultation with the Regional Office.

The Regional Committee accepted his invitation with appreciation.

DR POUDAYL (Nepal) extended an invitation from His Majesty's Government of Nepal to hold the Regional Committee's thirty-sixth session in Nepal in 1983.

The Regional Committee took note of this invitation, also with appreciation.

A resolution on this subject was adopted (SEA/RC34/R8).

5 Resolutions of regional interest adopted by the World Health Assembly and the Executive Board (item 8)

The REGIONAL DIRECTOR pointed out that all the resolutions of the World Health Assembly and the Executive Board listed in document SEA/RC34/15, except for three, viz., WHA34.4, WHA34.24 and EB67.R15, had been considered by the Regional Committee during the discussions on the appropriate items of the agenda. It was now necessary for the Committee to review, comment on or note these three remaining resolutions.

(i) Reimbursement of travel costs of representatives to Regional Committee (WHA34.4)

DR POUDAYL (Nepal) expressed his thanks to the Regional Director for his efforts towards facilitating an agreement on meeting the costs of travel of representatives of certain countries to sessions of the regional committees. He hoped that the Regional Committee would pursue its earlier decision requesting the Organization to meet the per diem and travel costs of more representatives, since he felt that the work of regional committees was very important for small countries which wished to participate in its sessions more fully and actively.

The REGIONAL DIRECTOR pointed out that, as a first step and as a result of considerable discussion and debate - and in the face of opposition
from several countries - the Assembly had agreed to meet the travel costs of one representative from certain countries. He had noted Dr Poudayl's view, and suggested that the subject of reimbursing per diem costs as well could be taken up after some time.

This was agreed.

(ii) The meaning of WHO's international health work through coordination and technical cooperation (WHA34.24)

The REGIONAL DIRECTOR, explaining the significance of the resolution, said that while, in the past, WHO's assistance had been termed as "technical assistance", the Organization was now moving towards "technical collaboration", particularly using coordinated efforts as the basic principle for future WHO work.

MR VOHRA (India) said that the key words used in this resolution were "transfer of resources for health...". The resolution was related to the one on the "new international economic order". It would be of interest to know what mechanism would be used to achieve transfer of resources for health, including coordinated action, and he asked what role WHO was proposing to play as the directing and coordinating authority in the field of health. Information on any recent examples of real transfer of resources for health without involving multinational agencies would be welcome. Unless the countries of the Region took concrete collective action, resolutions would remain mere pieces of paper.

DR POUDAYL (Nepal) said that this resolution covered technical cooperation among developing countries and also the role of WHO in transferring the resources from developed nations to the developing ones. Nepal had been receiving considerable aid from other countries in the Region, but further efforts were needed to tap resources outside the Region. WHO had so far organized only one donors' meeting, and he thought that it would be desirable to organize such meetings more often so that countries in the Region could use them as a forum for dialogue with donor agencies.

The REGIONAL DIRECTOR said that the question of transfer of resources for health was one of the main problems in international activities and the major stumbling block at international meetings. WHO had made a start in this field, but much still remained to be done. The donors' meeting held two years ago had resulted in some projects being financed by donor agencies. The meetings of the Health Resources Group provided yet another forum, especially for getting resources for research in areas such as human reproduction and tropical diseases. Efforts were also being made to mobilize resources for primary health care, and the Regional Office was in the process of strengthening its coordination group. If the goal of health for all was to be realized, no effort should be spared in this regard. One of the possible topics for the forthcoming meeting of health ministers could usefully be the mobilization of resources, including technical cooperation among developing countries. It should be emphasized that efforts in this field called for the necessary political guidance and technical back-up in order to succeed.
Explaining the background to this resolution, the REGIONAL DIRECTOR said that five years ago the Executive Board had established a committee to undertake a study of the functioning of WHO collaborating centres as well as expert advisory panels. After an exhaustive review, including visits to collaborating centres, this committee had recommended certain steps for improving the centres technically and for the functioning of the expert panels.

MR VOHRA (India), recalling the observations contained in the report of the study, said that some of them were very disquieting. The cost of maintaining a collaborating centre in a developed country worked out to ten times that of such a centre in the developing countries.

A situation had arisen under which, by and large, the same persons continued to figure in these expert panels. The resolution under discussion sought to give a greater role to regional directors in the matter of convening study groups at regional level. Adequate expertise was available in the Region itself, and should be involved in finding solutions to problems facing the countries. He therefore requested the Regional Director to convene appropriate study groups to deal with high priority problems of common interest to most countries of the Region.

The REGIONAL DIRECTOR pointed out that the study team had indeed made some disturbing observations about the management of the collaborating centres. Decisions on the establishment of collaborating centres had, in the past, been taken by Headquarters without involving the regional offices at any stage, but now the regional offices were in the picture. Nevertheless, some problems such as the overall management of collaborating centres, starting from identification, establishment, recognition and derecognition, had emerged from this study.

He said that if the Regional Committee so wished, he would constitute a study group to take up this problem; otherwise he would ask the South-East Asia Advisory Committee on Medical Research to study the matter intensively in accordance with any terms of reference which the Regional Committee might wish to suggest. Such a study would, of course, be limited to this region.

MR VOHRA (India), speaking on the suggestion to refer the matter to the SEA/ACMR, said that most of the problems were outside the area of medical research and covered aspects such as management, delivery of services, etc. They could not all be viewed purely from the medical research or technical angle alone. He suggested a separate forum to take an overall view of the problems.

DR POUDAYL (Nepal) said that this study could be included in the terms of reference of the "Small Committee on Programme Budget". He appreciated
the efforts to recognize certain well-established institutions in the
countries of this region as collaborating centres, but suggested that
whenever such recognition was envisaged, the small countries should not
be forgotten; they also should be encouraged in their research efforts.

The REGIONAL DIRECTOR pointed out that the SEA/ACMR did not deal only
with medical research but also with health services research. However,
he said that if the Regional Committee agreed, he would form a small
group using the available expertise from the SEA/ACMR and would include
a few economists, administrators, etc. This group could go into the
overall management of the collaborating centres, and report back to the
Regional Committee.

This was agreed.

DR SOEHARTO (Indonesia) said that he wondered whether the name of the
SEA/ACMR could not be changed to "Regional Advisory Committee on Medical
and Health Research" in order to reflect its work more clearly.

The REGIONAL DIRECTOR said that, since WHO Headquarters and other
regional offices also had "ACMRs", he would not like to change the name,
but, in spirit, the SEA/ACMR was already functioning under these broader
terms of reference.

6 Consideration of Draft resolutions

The following resolutions, which had been drafted by the Drafting
Sub-Committee, were considered by the Regional Committee:

(1) Goitre Control Programme in the Context of Health for All
    by the Year 2000 (draft resolution 1)

DR SOEHARTO (Indonesia) suggested that in the paper presented by the
Government of India, the following objective should be added: "The
prevalence of endemic goitre would be reduced to below 10% by the year
2000". He also suggested that mention should be made in the resolution
about the use of iodized salt and iodized oil.

The REGIONAL DIRECTOR explained that, since the paper had been presented
by the Government of India, Dr Soeharto's suggested additions might be
reflected in the minutes of the meeting. As for the mention of iodized
salt and oil, as there were also other methods of control, this would,
in his view, restrict the scope of the resolution.

DR BAJAJ (India) said that the subject had been discussed in detail by
the Drafting Sub-Committee, and he suggested that the resolution be
adopted without any change. As far as his government's paper was
concerned, he agreed that it could be revised by adding the targets
suggested by Dr Soeharto.

DR SAMLEE (Thailand) suggested that the last sentences of the preamble
of the resolution should be incorporated in the operative paragraph, to
underline the priority being given to this subject.
DR POUDAYL (Nepal) said that he agreed with Dr Samlee's suggestion.

The REGIONAL DIRECTOR suggested that the operative paragraphs in this resolution were addressed to the Member Governments and to the Regional Director, perhaps changing the word "endorsing" to "recognizing" would take care of Dr Samlee's suggestion.

DR SOEHARTO (Indonesia) suggested that the resolution be suitably amended to reflect the objective of reducing the prevalence of endemic goitre to below 10% by the year 2000. Regarding the use of iodization, he agreed that this was just one method and could be reflected in the record of the meeting if it were not possible to incorporate it in the text of the resolution.

MR SIDHU (India) agreed that the target should form part of the text of the resolution. This could perhaps be done by amending operative para 1(b) to read "to develop health for all with the objective of reducing the prevalence of endemic goitre to below 10% by the year 2000". As for the use of iodized oil, he agreed that this was only one of the methods of goitre control, and that it might be sufficient to refer to this in the minutes of the meeting.

DR POUDAYL (Nepal) said that injection of iodized oil as a treatment for goitre was widely prevalent in his country, as it was inexpensive and suited to the country's difficult terrain. Therefore, even though this was only one method of goitre control, it was very important.

After further discussion, it was agreed that the draft resolution would be adopted with the change of "endorsing" to "recognizing" in the last paragraph of the preamble and with the re-wording of the last line of section 1(b) to read "strategies for health for all, with the objective of reducing the prevalence of endemic goitre to below 10% by the year 2000".

(2) Expanded Programme on Immunization (draft resolution 2)

DR FERNANDO (Sri Lanka) said that, while there was 80% coverage by the first dose of vaccination in Sri Lanka, the coverage was much less in respect of the second and third doses. He suggested that in item 1(c) on page 2, the second line should read "gather data on the complete coverage of the target population", and that the target population should be defined. There was no point in giving the immunizations involved in this programme to children over one year of age.

The REGIONAL DIRECTOR said that immunization procedures and the targets differed from one disease to another. However, if delegates considered that "target population" should be defined, this could be done.

DR SINGH (Nepal) said that primary health care in Nepal was not well developed and that the epidemiological situation in his country required that the focus be on children in the age group of 0-12 months.

The REGIONAL DIRECTOR felt that the words "target population" would include the age group of 0-12 months. However, the wording could be made more specific if the delegates so desired.
DR BAJAJ (India) said that "target population" in general meant target population for each country as appropriate.

DR SINGH (Nepal) observed that at a recent meeting on EPI held in Ulan Bator, the EPI managers from the countries had decided that the target group should be 0-12 months. He suggested that the resolution of the Regional Committee should reflect that recommendation.

DR Poudayl (Nepal) stated that for certain diseases, immunization with a single injection or two injections would suffice, since certain types of antigens, particularly the toxoid group, worked well in immunological response, but there was a problem with BCG and at times also with polio vaccine. Since the efficacy of BCG was doubtful, he wondered why BCG vaccination was being stressed.

The CHAIRMAN, speaking as the representative of Indonesia, said that it was clear from reports on the Madras study that the efficacy of BCG was in doubt. Therefore, if BCG were not to be a part of the present resolution, his delegation would like to propose that a separate resolution on tuberculosis control be drafted to cover the aspects of BCG vaccination, case-finding and treatment, drugs, costs, the vaccine problem, etc. He also hoped that the Regional Director would take steps to try to bring down the cost of the drug.

DR Poudayl (Nepal) said that, after hearing the views of the representative of Indonesia, he agreed with mentioning BCG in the present resolution.

The REGIONAL DIRECTOR suggested that the words, "particularly infants" might be inserted after "target population" in item 1(c) of the draft resolution.

DR SINGH (Nepal) said that he still considered that words "children 0-12 months" should be mentioned.

DR BAJAJ (India) said that he thought it was important to cover not only infants of 0-12 months but school-going children, as they were most vulnerable to infection at that age.

DR SINGH (Nepal) said that the priority age-group for purposes of immunization differed from one country to another. The emphasis should be on the 0-12 month age-group. He quoted the example of Czechoslovakia, where tetanus toxoid was being administered compulsorily every tenth year.

DR Fernando (Sri Lanka) said that he had no objection to the resolution as it stood, but that certain doubts had arisen in the minds of people about the results of the BCG trial, and he suggested that another trial be carried out to set these doubts at rest. Legislation which was proposed to be enacted in his country had been postponed until this could be done.

It was decided to resume the discussion on this draft resolution later in the meeting.
(3) Thirty-third Annual Report of the Regional Director (draft resolution 3)

The draft resolution proposed was adopted (SEA/RC34/R3).

(4) Strategies for Health for All by the Year 2000 (draft resolution 4)

The draft resolution was adopted with minor modifications (i.e., the insertion of the words "where necessary" and the deletion of "at all levels" in item 2(c)) suggested by the representative of India (see SEA/RC34/R4 for final text).

(5) Managerial Process in National Health Development (draft resolution 5)

DR SAMLEE (Thailand) proposed adding the following three sub-paragraphs to make the resolution more effective:

Under operative para 1:

"(c) to undertake innovative management practices, particularly in respect of the delivery of the primary health care programme, and"

Under operative para 2:

"(c) to provide technical and material support to new types of management projects, including related studies and publications, and

(d) to support the exchange of valid information amongst countries in respect of managerial developments, particularly in the design and delivery of the primary health care programme."

DR FERNANDO (Sri Lanka) wondered whether it was necessary to mention in detail, in the operative paragraph, the sub-systems to be strengthened.

The REGIONAL DIRECTOR agreed that it might not be necessary, but perhaps the Drafting Sub-Committee felt that these details should be given. If the Regional Committee so desired, the specific mention of sub-systems could be omitted.

The resolution was adopted with the changes suggested by the representative from Thailand (for final text, see SEA/RC34/R5).

(6) Study of WHO's Structures in the Light of its Functions (draft resolution 6)

MR SIDHU (India) said that sub-paragraphs (1) and (2) in operative paragraph 1 should be reversed, so that the ministries were first strengthened and the periodic reviews followed.

This was agreed.

The CHAIRMAN asked for clarification as to how the question of strengthening the ministries came up in a resolution which actually dealt with the study of WHO's structures in the light of its functions.
The REGIONAL DIRECTOR said that the Director-General of WHO had always viewed the national ministries and WHO as a complete integrated entity, which included the World Health Assembly, Executive Board, Regional Committee, Director-General and the Regional Director. If the governments were not there, there could be no WHO. The governments were the determinant partners.

The CHAIRMAN said that in the light of this explanation, he agreed that the operative paragraphs relating to "Member States" should be reversed.

This was agreed, and a suggestion by MR SIDHU (India) that the words "in detail" in operative paragraph I(1) of the draft, and "as far as possible" in line 1 of operative paragraph II(1) should be deleted, was also accepted. The resolution was then adopted (for final text, see SEA/RC34/R6).

(7) Seventh General Programme of Work (1984-1989) (draft resolution 7)

This resolution was adopted with a minor editorial change (deletion of the word "fully" from line 1 of paragraph 2 of the preamble) and the rewording of operative paragraph 2 to:

"REQUESTS the Regional Director to transmit its comments on this material to the Director-General for consideration by the Programme Committee of the Executive Board" (for final text, see SEA/RC34/R7).

(8) Infant and Young Child Feeding - Draft International Code of Marketing of Breastmilk Substitutes (draft resolution 8)

The REGIONAL DIRECTOR suggested that the word "assist" in operative para 3, be replaced by "collaborate with" or some other suitable wording. This was agreed (for final text, see SEA/RC34/R8).

(9) Time and Place of the Thirty-fifth Session and Place of the Thirty-sixth Session of the Regional Committee (draft resolution 9)

This draft resolution was approved with the addition of the following as operative paragraph 3:

"NOTES with appreciation the invitation of the Government of Nepal to hold its thirty-sixth session, in 1983, in Nepal" (see SEA/RC34/R9).

(10) Selection of Topic for the Technical Discussions (draft resolution 10)

It was agreed that the title of the subject which was selected, "Control and prevention of leprosy in the context of primary health care", should be inserted in operative para 1.

At the suggestion of MR SIDHU (India), the Committee decided to omit operative para 3.

The resolution was then adopted (see SEA/RC34/R10).
(11) Report of the Sub-Committee on Programme Budget
(draft resolution 11)

This resolution had already been adopted at the time when the Report of the Sub-Committee on Programme Budget had been reviewed (see Section 1 above).

Expanded Programme on Immunization
(draft resolution 2) (continued)

Resuming its discussion on this resolution, the Committee decided that operative para 1, item (c) should read:

"Extend the use of sampling techniques (cluster surveys) to gather data on the complete coverage of target populations, particularly those in the 0-12 month age-group, and for the identification of problems and constraints in order to take remedial action for improving the immunization programmes;"

The resolution was adopted (for final text, see SEA/RC34/R2).

7 Adjournment

The meeting was then adjourned.
**SUMMARY MINUTES**

Seventh Meeting, 21 September 1981, 9.00 a.m.

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*Originally issued as document SEA/RC34/Min.7, on 5 October 1981*
148 MINUTES OF THE SEVENTH MEETING

The CHAIRMAN, at the outset, informed the meeting that the Director-General of WHO and the Health Ministers of India, Indonesia, Sri Lanka and Thailand would all be honouring the session by attending this meeting, besides the Health Ministers of DPRK, Maldives and Mongolia, who were already participating.

1 Adoption of resolutions (SEA/RC34/R1 to R11)

Resolutions 1 to 11, which had been issued in a resolution series, were considered individually and formally adopted.

2 Adoption of the Final Report of the Thirty-fourth Session of the Regional Committee (item 19)

The draft final report (SEA/RC34/23) was considered page by page and was adopted with the following minor changes:

1. On page 1 of the Introduction, paragraph 7, the last sentence should be a separate paragraph.

2. On page 12, last paragraph, line 3, "Joint Consultative Board" should read "Joint Coordinating Board" and in line 4, "World Bank" should be inserted between "UNDP" and "Special Programme".

3 Arrival of Health Ministers and the Director-General of WHO

The CHAIRMAN welcomed the Ministers of Health and the Director-General.

4 Address by the Director-General

The CHAIRMAN then requested the Director-General to address the meeting.

The DIRECTOR-GENERAL, in his address, stated that the unanimous adoption of a global strategy for health for all had been a major triumph for international cooperation in health. The strategy would be useful, however, only to the extent that it was used.

The Assembly had called the strategy a solemn agreement between three partners, viz., governments, the people and WHO. WHO was more than ready to cooperate with governments in implementing their plans of action. In suggesting the health ministries' role, he referred to the need to adopt the strategy at the highest possible level, review the health systems to strengthen the infrastructure, with primary health care as its central function, reconsider the health technology being used, mobilize resources, reinforce the managerial capacity and cooperate with one another to ensure success. Ministers would need to think in terms of giving their people the right to assume growing responsibility for their own health, and helping them to understand the national strategy so that individuals, families, communities, associations and non-governmental organizations might all take an active part in developing the health system and in carrying out its functions.

He said that, with WHO and the governments ready to fulfil the terms of their agreement, there was nothing to hold them back. There would
certainly be some obstacles, but, the solidarity which they had displayed in defining international health policy and adapting it to national situations would enable them to overcome them. The holding of a meeting of ministers of health was in itself clear evidence of the solidarity that prevailed in the Region and of the fruitful relationships that existed between governments and WHO. But if the health ministries were dedicated to the implementation of the strategy, what of the governments as a whole? The agreement for attaining health, reached collectively in WHO, and the South-East Asian Charter for Health should be used for getting the message across and ensuring governments’ full political commitment to the strategy for health for all.

Referring to the tasks of ministries of health in implementing the strategy, Dr Mahler said that the first task was that of reshaping the ministries themselves to make them capable of taking over their expanded role, and then of reorganizing the health systems, basing them genuinely on primary health care. He wondered what had happened to the concept of a well-defined pattern of health centres, of which this region had been the birthplace many years ago. The health centres which had been established, in not dealing sufficiently with community health as such, were not inspiring the necessary confidence on the part of the people.

Referring to the publication "Perspectives for Health Development in South-East Asia", just issued by the Regional Office, and its description of the IDWSSD targets (for supplying safe drinking water and sanitation by the year 1990), he wondered why sanitary waste disposal had been separated from safe drinking water in these targets. He had been surprised to see that the target set for population coverage for the former was only half of that of the latter. Communities should be deeply involved and made to understand what was involved so as to work enthusiastically in this giant endeavour.

Noting that the ratio of population to doctors was quite reasonable in the Region, and that nevertheless the rural health services were understaffed with medical personnel, he emphasized the need for the social motivation and proper technical training of doctors, and asked that WHO be informed on how it could help in carrying out the policy of linking health manpower development to health care. He suggested that governments should look for bright candidates to become health generalists, doctors and nurses - young people with a sense of dedication and adventure, a flair for simple epidemiological analysis and an ability to plan, execute and enlist the support of community leaders and politicians. Then WHO and governments together could find ways of encouraging them to enter and stay in the field by providing them with suitable incentives and the right kind of training and ensuring that they would have an exciting experience. The development of such people was, he considered, a top priority for the use of WHO’s resources.

As regards the complaint of shortage of international resources for the Region, he suggested that the unusually flexible and pragmatic mechanism for the programme budgeting of WHO’s resources should be used to ensure the utilization of these resources for the progressive improvement of primary health care where it was most needed and for the specific elements that were most needed. With the help of WHO, health ministries
should be ruthless in ensuring that external support was channelled into meeting the urgent primary health care needs. The aim of the Global Health Resources Group for Primary Health Care was to match needs with the resources that would be available. However, as there would be a tremendous competition for funds, it was essential for regional committees to make objective reviews of the countries' needs and requests for external resources. The regional committees, the Executive Board and Health Assembly could then correlate their work so as to ensure effective and efficient allocation and use of all available resources in support of well-defined strategies for health for all.

Finally, he mentioned with much regret the apparent breakdown of the so-called "North-South" dialogue, but said that efforts in this direction should by all means be continued - and that, inspired by success in the health field, which would certainly be attained, others might renew the dialogue in other specific fields until a wide spectrum had been covered.

He was confident that the meeting of health ministers which was to take place in Jakarta during the next two days would result in some concrete ideas that would make the Organization even more dynamic (see Annex for full text of the address).

The CHAIRMAN thanked Dr Mahler for his address, which he described as very thought-provoking.

DR POUDAYL (Nepal) said that his government had always felt that the deliberations in Regional Committee sessions had a positive effect on arousing health consciousness among the Member States. It was probably the first time that so many health ministers had been present at a session of the Committee. He conveyed the regrets of Mr Nabaraj Subedi, the Minister of Health of Nepal, who had planned to attend the meeting but could not do so, owing to sudden illness.

The presence of Dr Mahler and his inspiring address had done much to raise morale. His dynamic leadership had, he thought, been at least partly responsible for the universal acceptance of the great challenge of health for all by the year 2000.

It was the desire of His Majesty King Birendra to provide at least minimum health care to all the people of his country. However, the economic forecast indicated that by the year 2000, 850 million people in the world would be below the poverty line - 100 million more than at present - and unless serious thinking were given to the developmental approach by international organizations, poor countries such as Nepal would have very little chance of raising the quality of life of their peoples. Now that the peoples' expectations of attaining health for all by the year 2000 had been raised, the implementation aspect needed to be considered even more seriously.

He reaffirmed his country's confidence in the new Regional Director, whom he described as "action-oriented". The multi-sectoral approach to HFA needed, he felt, continuous back-up at country level. This meant a
strong WHO structure at this level, besides the need to strengthen the regional set-up.

5 Adjournment (item 20)

5.1 Vote of Thanks

MR SIDHU (India), speaking on behalf of all the delegations, complimented the Chairman on the admirable way in which he had conducted the business of the Committee, the Vice-Chairman for handling the work so efficiently in the absence of the Chairman, and the Chairman and Rapporteur of the Sub-Committee on Programme Budget, and those of the technical discussions, for having so competently carried out their tasks. He also congratulated the Regional Director and the members of his staff for their work, which he described as excellent.

It was gratifying that the meeting had dealt with all of the 18 substantive items on the agenda, which had included so many important subjects. Emanating from the discussions, eleven resolutions had been adopted. He had no doubt that, under Dr Mahler's able direction, and with the great leadership of India's Prime Minister and Health Minister, his country would succeed in its endeavour to achieve better health for all of its people.

Finally, he thanked the Government of Indonesia and the Indonesian Minister of Health for their sincere and generous hospitality. He was sure that everyone would carry away pleasant memories of their stay at Denpasar and in Bali.

Mr Sidhu then proposed a resolution of thanks (see resolution SEA/RC34/R12), which was unanimously adopted, the Secretariat being asked to add it to the final report.

5.2 Closing speeches on behalf of individual delegations

DR PRAKORB (Thailand) remarked on the impressive nature of the closing meeting, attended by the Ministers of Health from seven Member countries and the WHO Director-General.

He also thanked the Chairman and the Vice-Chairman for the dignity and able leadership with which they had conducted the proceedings, the Chairman of the technical discussions and the Chairman of the Sub-Committee on Programme Budget for their efficient work, the Director-General for his inspiring address and for his frankness and courage, and the Regional Director for his enthusiasm in tackling the various problems facing the Region.

He thanked the host Government, the Indonesian Minister of Health and the Governor of Bali for their generous hospitality and arrangements, and he expressed appreciation of the work of the secretariat and those "behind the scenes". Finally, he wished WHO success in its endeavours to attain the goal of health for all by the year 2000, and the delegates a pleasant journey back home.
DR YOOSUF (Maldives), thanking the Chairman and others for their contribution to a successful meeting, said that the deliberations, which had included consideration of the most pressing health problems, had taken countries closer to the actual concept of primary health care in attaining the universal goal of HFA/2000. His country was proud to be a Member of WHO's South-East Asia Region, as all the countries represented shared a common heritage and common cultural background essential for reaching a consensus on solutions to common problems. The history of the science of healing in most of the countries of the Region revealed that primary health care, though not known as such, had existed all along in their traditional medical systems.

He also welcomed the presence of the Director-General to witness the successful completion of the session. Dr Mahler's address had again elevated their hopes.

Finally, he expressed his government's gratitude to the Government and people of Indonesia and, in particular, of Bali, for the wonderful hospitality extended during the delegates' stay, and wished the people of the island health, happiness and harmony. Pleasant memories of their visit here would remain with the delegates for a long time to come.

DR YON (DPRK) said that he thought that the meeting had made an important contribution to the strengthening and further development of the collaborative relations of countries within the Region.

He expressed appreciation to the Chairman, Vice-Chairman and the Chairmen of the technical discussions and the Sub-Committee on Programme Budget for their important contributions to the highly satisfactory deliberations, to the Regional Director and his staff for devoting themselves to developing the public health services in the Region and for the good preparations for the session, and to the Government and people of Indonesia for their warm hospitality and the facilities provided. His delegation would remember their stay in Bali for a long time. He wished Member countries further progress in their endeavours to carry out their health programmes.

DR POUDAYL (Nepal) said that, in associating himself with the sentiments expressed by the previous speakers, he also wished to convey the greetings and good wishes of the people of Nepal to those of Indonesia.

DR ARSLAN (Mongolia) thanked the Indonesian Government and the Minister of Health and his staff for their warm welcome and generous hospitality, the Chairman and Vice-Chairman for having conducted the session so successfully, and the Regional Director and his staff for their contributions. He wished to convey to the people of Indonesia his government's best wishes for their prosperity and for achieving the highest possible level of health by the year 2000.

MR WIJESINGHE (Sri Lanka) said that he would like to associate himself with the sentiments expressed by previous speakers. During the session,
subjects of common interest to WHO and the people of the Region had been discussed, and free and frank opinions expressed. The presence of the Director-General and his thought-provoking address had been very inspiring. He expressed appreciation of the smooth and able manner in which the Chairman had conducted the meeting and gratitude to the Indonesian authorities for their efforts in making the surroundings pleasant and congenial. He said that he also wished to convey the warm regards of the Sri Lankan people to the people of Indonesia, and thanked the Regional Director and his staff for their efforts in making the session a success.

DR SOEHARTO (Indonesia) also expressed appreciation of the spirit of cooperation and frankness among the representatives which had characterized the meeting, and his gratitude to the Chairman, Vice-Chairman, Chairman of the Sub-Committee on Programme Budget and the Chairman of the technical discussions for their excellent leadership. His country had much appreciated the assignment and contributions of Dr El Zawahry as WHO Programme Coordinator to Indonesia. He hoped that WHO would promote collaboration amongst countries not only within the Region but also between regions. This was the first session of the Regional Committee to be held since Dr U Ko Ko had become Regional Director, and the first to have so many health ministers present during the concluding session, along with the Director-General of WHO.

5.3 Concluding remarks of the Regional Director

The REGIONAL DIRECTOR said that this was indeed a historic session for the Regional Committee, to be holding one of its meetings in the presence of the Ministers of Health from seven countries. It was also gratifying to have the Director-General in their midst. The representation on the delegations had also been of a very high order.

The Committee had discussed many significant issues which would have a bearing on the countries' health development activities in years to come. The decisions taken would undoubtedly hasten the process of achieving the universal goal of health for all. He felt that the deliberations had once again brought out the commonality of approach in the Member countries' desire to build for their peoples a better, healthier and more peaceful world. However, mere desires were no substitute for action, and he hoped, back in their own countries, the delegates would give shape to and act, individually and collectively, upon what had been decided upon in this session.

As the Director-General had so often said, never before had we faced such a challenge to ensure that health did not remain the exclusive preserve of any one group or stratum of society. It was therefore everyone's duty to make health the right of every individual. He assured the Regional Committee that the Organization would not fail to stand up to the occasion and to justify the trust reposed in it by the countries' voiceless millions who deserved better health.

He thanked the Government and Minister of Health of Indonesia and the Governor of Bali for their warm and generous hospitality and for the
cultural programmes and field visits arranged for the delegates. Concluding, he said that one lived today in a world of contradictions. While, on the one hand, the frontiers of science had opened up exciting vistas, on the other, the vast majority of the people in the Region were still living in want, squalor, hunger and disease. In this context the goal of health for all by the year 2000 acquired added significance.

5.4 Closure of the session

The CHAIRMAN thanked the Regional Director for his presentation and expressed his gratitude to fellow delegates for their wholehearted cooperation and active participation in making the session a success. He hoped that these deliberations would help all, on return to their countries, to embark upon innovative projects and to mobilize the resources required for achieving the universal goal of health for all by the year 2000. He wished delegates a safe journey home and a happy reunion with their families and friends.

He then declared the thirty-fourth session of the Regional Committee closed.
1. The unanimous adoption by the recent World Health Assembly of a Global Strategy for Health for All by the Year 2000 is a major triumph for international cooperation in health, because it crystallized the efforts set in motion by the Declaration of Alma-Ata and the call of previous Health Assemblies. In response to these, a large number of countries in all regions have formulated national strategies and all regions have formulated regional strategies. The Global Strategy reflects these and gives them a new strength, and a very important dimension, through its expression of international coherence, not found in any other international organization.

2. But we must not become euphoric nor lulled into a sense of complacency just because we have an agreed Strategy. The Strategy will only be useful to the extent that it is used. We have spent enough time on conceiving it. We must now devote all our energies to delivering it.

3. It was in this spirit that the Health Assembly asked the Executive Board to prepare a plan of action for the immediate implementation of the Strategy. You have had that draft plan of action before you. As you can see, it is only a skeleton. It is for you and your people to bring that skeleton to life and give it flesh and blood, and it is also WHO's duty to help you do so. For, when the Health Assembly adopted the Global Strategy, it called it a solemn agreement for health, a social contract, between three partners - governments, people and WHO.

4. I shall start with WHO's duties as one of the partners, because I am in a position to assure you that the Organization is more than ready to support you in deciding how to convert your plans into realities, to cooperate with you in doing so, and to help mobilize the resources you require.

5. But what of you? What are you ready to do? I ask you as representatives realizing full well that the answers do not depend on you alone.

- Are you ready to adopt the Strategy at the highest possible level, to ensure the means for implementing it in your country and to fight the resistance you will encounter during its introduction?

- Are you ready to continue the agonizing review of your health systems, and to strengthen your health infrastructures with primary health care as its central function, as its main focus whatever the obstacles you will have to face?

- Are you ready to reconsider the health technology you are using so that it would become really appropriate in your health and socio-economic circumstances?

- Are you ready to mobilize all human, financial and material resources that will ensure the implementation of your national strategy?
- Are you ready to reinforce your managerial capacity to give effect to your Strategy, to monitor progress and to report on it openly and unashamedly to your colleagues in the Regional Committee so that all of us can learn from your success and failures?

- Are you ready to cooperate with one another in many other ways to ensure the success of your Strategy?

6. As for your people, are you ready to give them the right to assume growing responsibility for their own health and to help them in doing it?

- Are you ready to help them understand what your national strategy is all about, so that individuals, families, communities, associations and non-governmental organizations can all increasingly take an active part in developing your health system, in carrying out part of its functions, and above all in assuming social control over it and the technology used in it, and so that your people will know where to seek appropriate help when they feel that they need it?

7. If you are ready, and if your people are ready, as WHO is certainly ready, what can possibly hold us back from fulfilling the terms of our solemn agreement? Yes, certainly it would be foolish to ignore the obstacles, whether these stem from political, social, economic, managerial or technical issues in your countries, or whether they stem from the international political and economic climate of today. It would be even more foolish to allow these obstacles to deflect us from our path. The solidarity you already have displayed in defining international health policy in WHO as in no other organization and promoting its adaptation to national health policy has enabled you as Member States of WHO to overcome no less formidable obstacles in the past. Nevertheless, we must be realists, and must work hard together to solve those problems that we know will plague us as they do now.

8. That you are realists in this Region, and that you are ready to work hard together with your WHO, are abundantly clear from the initiative of holding a meeting of Ministers of Health immediately following this Regional Committee. This in itself is clear evidence of the health solidarity that prevails in the Region and of the fruitful relationships that exist between you and your WHO. But, if the Hon'ble Ministers of Health of the Region are dedicated to the implementation of the Strategy for Health for All, what about the governments as a whole? This is where you can use the solemn agreement for health for all that you have reached collectively in WHO. You also have a South-East Asian Health Charter signed by many heads of state. Use it to the full! Use the mass media to get your messages across. Invite these people in the mass media to visit the villages! Who cares if this is dubbed propaganda? Propaganda has been used in so many areas of doubtful value to mankind; so I see no reason why it should not be used for something so evidently beneficial as health. You can also refer to a number of WHO documents to give widespread publicity to the Health for All Movement - the green book containing the Alma-Ata Report on primary health care, the blue one containing the Executive Board's guiding principles for formulating strategies for health for all, the red one containing the Global Strategy for Health for All, and the regional strategy for health for all which you adopted last year.
9. When, distinguished delegates and ministers, I invite you to take such action, please do not think that I am in any way underestimating the difficulties you will face. Please be sure that in overcoming these difficulties, you have an ally in WHO, but I am convinced that you could strengthen your own ministries of health so that they become no less an ally. Unfortunately, in too many countries ministries of health have become relics of a past in which health goals and ways of attaining them were far less defined than they are. I am not at all sure that even in those days the predominantly bureaucratic nature of most ministries of health was permissible. Today, if national strategies for health for all are to have any chance of success, the way ministries of health are functioning will have to change radically. I am happy that you have been discussing this issue at your technical discussions, and I am taking the liberty of making a few remarks on the matter because I unfortunately could not participate in your discussions.

10. One way that has proved itself over and over again, in human history, of succeeding in any endeavour is to entrust the endeavour to a highly dedicated individual or group. That is what a ministry of health should be in relation to the national strategy for health for all. No other group can be expected to be as dedicated as it is. In recognition of this, and in spite of all the sneering remarks from some sceptics, the Global Strategy for Health for All describes in detail how a ministry of health could discharge the role assigned to it, namely, that of the directing and coordinating authority on national health work. This consists in essence of acting on behalf of the government as a whole in order to channel activities into the national strategy for health for all and to spearhead action for implementing the Strategy through appropriate mechanisms in the health as well as other sectors. Once more I would beg of you, in taking action in your own countries following your technical discussions, please use the wealth of ideas you have been spelling out in the Global Strategy to decide how best to reshape your ministries of health in order to make them more capable than ever for fulfilling the vastly wider and more decisive roles in the life of the country that historical events have now bestowed on them. We have dared to take great strides in arriving together at the desired profile of ministries of health: we must now take much greater strides in working together to make the reality conform to that profile.

11. One of the first tasks of any ministry of health that wants to implement a national strategy for health for all would be to reorganize the health system as necessary so that it is genuinely based on primary health care. Many years ago this region was the birthplace of a well-defined pattern of health centre that at that time was a source of great expectation. What happened to that idea? Why is there now a crisis of faith in it? And what lessons can we learn from what took place in reality?

12. These health centres, in spite of their ambitious name, concentrated on the local provision of medical care as well as family planning efforts. Only to a limited extent did they deal with community health as such. And what kind of medical care did they provide? Just listen to some extracts from the Report of an Institute of Management in one large country in your region:

"the health centres, which have no diagnostic facilities, are expected to provide treatment for common ailments. Cases requiring diagnosis
are supposed to be referred to the district hospitals. The budgets for
drugs and other supplies for individual field units are very meagre.
Dispensing of medicine is done by fairly qualified doctors."

Yes, that is what it says: "fairly qualified doctors"! I continue:

"Since most pharmaceutical companies follow aggressive marketing
practices, these doctors develop strong brand preferences and like to
prescribe only branded speciality drugs".

Incidentally, the report goes on to state that out of the 126 drugs that
were supposed to reach field units, only 70 in fact reached them, and after
a careful review only 30 drugs were found necessary.

13. How do you expect people to trust the health system under these
circumstances? - and I would like to add that this report presents a
deliberately 'rosy' picture of the average health centre in that particular
country. How do you expect the people to listen to advice about their
health, no matter how well-meaning, which totally misses the point from
their perspective, for it does not deal adequately with their infants'
diarrhoea, the water they drink, the food they eat, the houses they live in
or the absence of houses, and the unsanitary environment in which they are
condemned to exist. And it cannot even provide them with the drugs they
need when they are ill. So they bypass the health centres, go to the
hospitals as outpatients, receive a very perfunctory medical examination
because the large numbers of patients to be seen leave little room for more
than that, and are given a prescription for drugs, often in inadequate
amounts, and whose use is often not explained to them. So the vicious
circle continues without their main health problems being dealt with.

14. I mentioned drinking water as a health problem. I have just been
reading in your book "Perspectives for health development in South-East
Asia" what lies ahead for this region to reach the target of safe drinking
water and adequate sanitation by 1990. Eight hundred million people still
have to be supplied with safe water and 400 million with adequate sanitation
at an estimated cost of 62 billion US dollars. And less than nine years to
go! It is clear to me that, even if you make superhuman efforts, using
conventional pipeline approaches you will be very far off your target in
1990. In the book I have just referred to it is pointed out that the main
constraints are shortage of financial resources, insufficient institutional
arrangements, lack of supplies and equipment, lack of trained manpower, and
lack of community involvement and participation. I would start with the
last constraint. We must turn it into an opportunity so as to generate the
social energy required to get this gigantic undertaking enthusiastically
started! I was startled to read that safe drinking water has somehow been
separated from sanitary waste disposal and that the population coverage
target for waste disposal is only half of that for water. I am sure people
would not separate the two if they understood what that implies, and after
all water and sanitation concern people, not pipes.

15. If the health centre would deal with people as people rather than as
patients, and if they would involve themselves in all the interrelated
factors that affect people's health, I am sure that faith in them could be
restored, and this is badly needed. There is no getting away from the
experience, good and bad, that led to the policy of primary health care as outlined in the Report of Alma-Ata. It was not for nothing that the enlightenment and involvement of people and communities was placed at the very top of the list of essential components of primary health care so that people could take their health destiny into their own hands.

16. WHO will enlighten people and get them involved? On reading the statistics on health manpower in your regional strategy one can note that the ratio of population to doctor is reasonable in most Member States in the Region, certainly as compared with some other regions, in spite of the heavy brain-drain. So why are your rural health services so underpopulated with proper medical staff? Can it be that your hospitals in the towns are overstuffed with doctors? Can it be that, in spite of the relatively high numbers of medical colleges in the Region, doctors are not at all socially motivated and technically trained to perform the tasks most required of them? You have all subscribed to the concept that was generated some years ago in WHO of linking health manpower development to health care. Please let us know how you want to make use of WHO in carrying out this policy in your own countries because it is sadly neglected.

17. I said some moments ago that you should be realists, and I shall try to be realistic too. Even if we cannot expect all doctors to become involved emotionally and practically in primary health care and in supporting primary health care, surely it must be possible to find some. Where are they, these health generalists, doctors and nurses with a sense of dedication, a flair for simple epidemiological analysis, an ability to plan and get things going, organize and improvise, and influence people and health workers, community leaders and politicians? Today there are far too few of them. I should like to suggest that you make every effort to spot right candidates to become health generalists. Then, through joint efforts, we could find ways of encouraging them to enter and stay in this new field by providing them proper incentives and the right kind of training, and making sure that they get exciting experience. Surely there must be enough women and men in this region with an adventurous spirit who, if given the right encouragement, would enjoy working in primary health care, organizing it, and providing guidance and training in it, and who would eventually graduate to become the Region's health leaders of tomorrow! I see the development of such people as a top priority for the use of WHO's resources and I am convinced that with a bit of imagination we could work out together concrete proposals to this effect.

18. Even if you are comparatively well off in some categories of health workers, you have consistently maintained that shortage of financial resources is a main obstacle to making progress towards health for all in the Region and you also complain that you receive from international sources far fewer resources for health per capita than any other region in the world. Unfortunately, I do not have enough valid information to agree or disagree with these contentions, but let me deal first with the use of WHO's own resources in your countries. As I told you last year, and I cannot repeat often enough, you have at your disposal an unusually flexible and pragmatic mechanism for programme budgeting WHO's resources in your countries. You can at least use these resources to ensure the progressive improvement of primary health care where it is most needed and for those specific elements that are most needed. I shall not dwell on these. They appear in the Report of Alma-Ata and are amply specified in the WHO docu-
ments I referred to before. I would also beg of you to use WHO to identify those parts of your primary health care strategy that could benefit most from more massive external support and to secure the commitment of the appropriate authorities to ask for such support. You will have to be absolutely ruthless in ensuring that external support is channelled into your urgent primary health care needs. That is one sure way of redressing imbalances in the distribution of your health budget, and it will lead sooner or later to increased national investments in these same areas.

19. WHO has set up on a trial basis a Global Health Resources Group for Primary Health Care whose aim is to match needs with resources to the extent that these can become available. Your Regional Committee can be of great value in identifying needs, but you must realize that there will be tremendous competition for funds, so you will have the very difficult and delicate task of screening and guaranteeing the authenticity of your requests. These requests, and the ways they are dealt with by the Global Health Resources Group or any other mechanism, will continuously be reviewed by the Executive Board and Health Assembly, so this is another example of WHO's coordinating role being used to help you in a way that goes far beyond the possibilities of WHO's own limited funds. But here again I have to ask you another question:

- Are you ready to use your regional committee as a peer group for reviewing objectively your needs for external resources in support of your strategies, so that the regional committees, the Executive Board and the Health Assembly can correlate their work in such a way as to ensure that all available resources are effectively and efficiently used in support of well-defined strategies for health for all?

If this process for mobilizing resources for your health strategies is to succeed, then there can be no answer to this question but a resoundingly positive one.

20. I cannot end without mentioning in deep sorrow the status of the so-called North/South Dialogue, because unless something very drastic happens soon to change that situation, I am afraid it has to be considered as nothing less than a breakdown. Have we any chance of succeeding in our efforts in this very cold international climate? At the risk of once more being called a starry-eyed romantic, I think we have, because, under the aegis of WHO, dialogue between North and South and East and West with regard to health has never been so intimate. Our collective aims and policies transcend political philosophies and economic dogmas. I even believe that through our success, as succeed we will, others will take heart and will renew the dialogue in specific fields until a wide spectrum of social and economic issues will be covered. This is an additional reason for us to pursue our aims resolutely.

21. It is in this spirit of genuine dialogue and cooperation that I should like to end. I desperately want you to feel that I am talking with you and not at you. I am sure that this same spirit of cooperation will be evident at the Meeting of Ministers and result in concrete ideas that will make the Organization even more dynamic.

Thank you.