WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTE

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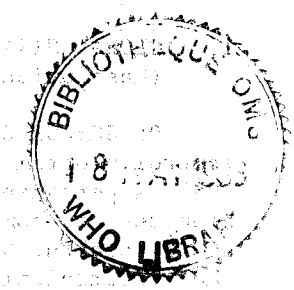
FORTY-FIRST WORLD HEALTH ASSEMBLY

COMMITTEE A

PROVISIONAL SUMMARY RECORD OF THE TENTH MEETING

Palais des Nations, Geneva
Thursday, 12 May 1988, at 14h30

CHAIRMAN: Professor A. R. Y. ABDUL RAZAK (Kuwait)



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TENTH MEETING

Thursday, 12 May 1988, at 14h30

Chairman: Dr A.R.Y. ABDUL RAZAK (Kuwait)

1. GLOBAL STRATEGY FOR THE PREVENTION AND CONTROL OF AIDS: Item 24 of the Agenda (Resolution WHA40.26; Documents A41/5 and A41/Conf.Paper No.2)

Dr GREGORICH-SCHEGA (Austria) said that her country's national prevention and control programme on AIDS was fully in line with WHO's global strategy on AIDS. In April 1983, a permanent AIDS subcommission of the Austrian National Health Advisory Board had been set up, comprising experts in the fields of virology, hygiene, epidemiology, and the social health, blood and plasma donation, immunology and clinical branches. In addition, the "Osterreichische AIDS Hilfe", a private body financed mainly by public funds had been set up in Vienna and several other Austrian States and planned to expand activities nationwide with the aim of providing information to the public, media, physicians and health staff, social and health organizations and persons belonging to risk groups as well as providing permanent counselling services and assistance to HIV-infected persons, their friends and families.

AIDS legislation had entered into force in Austria in July 1986 and focused on preventive measures. Health authorities had to be notified only of manifest cases of AIDS, which remained strictly anonymous. Prostitutes were required to have at least one medical examination every three months and, if found to be HIV-infected, were no longer to engage in prostitution. Physicians were required to inform HIV-infected persons of their condition and counsel them in order to prevent HIV transmission. The law also provided for monitoring of the epidemiological situation and the commissioning of research studies.

Screening was being carried out by means of the ELISA test with results being confirmed by at least two further tests, including the "Western blot" test. Tentative antigenic tests were also being carried out in the context of the screening of blood donors as well as of blood tests made by Osterreichische AIDS Hilfe. A study was being undertaken to show whether unspecific parameters, such as an increase in neopterin, could be used to exclude persons at risk from donating blood already prior to the emergence of antibodies. To ensure the high quality of tests and gain experience for the "Western blot" test, samples were sent to specific laboratories where results were confirmed and recorded.

Comprehensive information to the general public was the most important method of preventing the spread of AIDS. Measures such as mandatory screening and notification of HIV-infected persons were inefficient and counterproductive. Her country was convinced that any discrimination and stigmatization of HIV-infected persons and persons with AIDS should be strictly avoided. Austria therefore supported the draft resolution and was pleased to co-sponsor it.

Dr MAYNARD (Trinidad and Tobago) said that her country was one of those in the Americas with the largest number of AIDS cases in relation to population size. Between 1983 and the end of March 1988, 273 cases had been notified, with 184 deaths, in a population of 1.2 million. AIDS had moved from the homosexual and bisexual to the heterosexual population.

A national AIDS committee coordinated and monitored all AIDS programme activities. The committee comprised four sub-committees: on education and training of health care workers; education of the public, including schools; surveillance and research, and infection control. A medium-term programme had been accepted by the Global Programme on AIDS and initial funding received. In that context she expressed her country's

appreciation for the technical and financial assistance obtained through WHO. She also commended the Director-General on his report and noted with special interest the link between WHO and UNESCO which would allow for the preparation of materials for use both inside and outside the formal school system.

In conclusion, she supported the draft resolution on the avoidance of discrimination in relation to HIV-infected people and people with AIDS.

Dr MANN (Director, Global Programme on AIDS) thanked the many delegates and Member States having expressed support for the Global Programme over the past year.

Replying to questions and comments on the next phase of evolution of the Global Programme on AIDS, he drew attention to the inescapable uncertainties which surrounded the problem of AIDS, the rapid changes in the situation from the epidemiologic, scientific, social, political and cultural points of view. He pointed out that the global environment itself had changed substantially since the Fortieth World Health Assembly. A widely accepted global strategy on AIDS had come into being, the agenda for the fight against AIDS had been established and global mobilization and coordination were under way - all of which meant that management structure and operational activities should remain flexible. The overall objective of the Global Programme on AIDS was to provide support at the national level and encourage the development of strong and comprehensive national AIDS programmes in every country. Over the past year, the Global Programme had oriented and briefed over 200 consultants from more than 50 countries. As the process continued it would become possible to take greater advantage of epidemiologic, virologic and health education resources throughout the world, thus further broadening the pool of consultants and experts. In addition, consideration would be given to how sustained coordination and further support could be provided in the years to come. Increasingly, the support of other WHO programmes would be called upon in full partnership with Regional Offices to ensure that full and coordinated support in action against AIDS was delivered at country level.

Concerning international exchange, he pointed out that AIDS was no longer a subject of finger pointing or questions of origin. The geographical origin of the virus was unknown and the focus of all efforts was on preventing its further spread. It was therefore satisfying to note that discussions were increasingly emphasizing the global nature of the problem. It had been discovered over the past year that existing systems were not adequate for the full, rapid and complete exchange of the scientific information which AIDS called for. Structures were therefore being developed to link research efforts. The reagent project was a mechanism by which researchers in any country could have access to information on standardized viral strains and other reagents in order to facilitate the progress of science. Scientific work on AIDS had become irrevocably international; there could no longer be any purely national AIDS research. It was expected that WHO would play an increasingly important part in the transfer of information, transfer of technology and proactive exchange adequate to meet the needs of AIDS research. It was hoped to be able to link all countries in a network of increasingly intensified exchange of experience in the fight against AIDS. In that context, there had recently been important meetings, such as the WHO/Japan meeting, the international conference in Kuwait, the Pan American Teleconference, and there was to be a meeting on AIDS in Africa to be held in Zaire in October 1988.

On the question of therapies, there was clearly a need to exchange scientific information and experience, including information and experience derived from traditional medicine. He therefore appealed to countries in which research was under way, whether into traditional medicine or other fields, to share it openly through the Global

Programme. WHO was setting up a global data bank that would enable information of HIV seroprevalence to be exchanged widely. It was also becoming possible for the Global Programme to give greater assistance in standardization of methodologies used to collect information. Concerning the relationship between WHO and the industrialized countries, he was pleased that the Federal Republic of Germany, France, the United Kingdom, the Netherlands and Sweden (on behalf of the Nordic countries), among others, had referred to the fact that in addition to contributing to WHO and to the Global Programme, they might also directly benefit from the link with WHO which was an integral part of the global strategy. In that context the nongovernmental organizations had a vital role to play and, where appropriate, the activities of private organizations might also be integrated.

He had noted the considerable number of comments made on the relationship between AIDS and health and between AIDS and health systems. In that context, he referred to resolution WHA40.26 and its insistence that control should be integrated into existing health systems. Indeed that was the cornerstone of the work of the Global Programme. Action against AIDS was hampered by the problems and limitations of existing health and social services. If health systems throughout the world already had integrated blood transfusion systems, if sterilization practices had been the rule everywhere, if community-based education programmes had been widely successful and used everywhere, if laboratory and surveillance infrastructure had been as strong as was wished, the fight against AIDS would have been simplified. However, since there were problems in health and social systems throughout the world, AIDS could provide an opportunity to identify and remedy weaknesses. In fighting AIDS it was possible to fight for health and the strengthening of the health system in the broadest sense. An example of that was the Global Blood Safety Initiative, where efforts were being made not only to prevent the spread of AIDS through blood but to do so in a way which strengthened existing health systems; making blood safe against AIDS, blood could be made safe against other transmissible diseases. Similar examples could be found in relation to strengthening of laboratories, emphasis on training and educational programmes for the public.

AIDS had also been mentioned as a stimulus to research. Thus, it was proposed to rely on a process of institution-strengthening, using existing collaborating centres and developing and supporting centres for prevention-related research in an effort to help countries, particularly in the developing world, to strengthen institutions in a targeted manner so that the research needed in the country to bring AIDS under control could be conducted and completed within the broader research context.

It had been repeatedly mentioned that AIDS was a development problem which seemed to have generated particular political and social commitment. Research into the social and economic impact of AIDS was essential. While the ways in which AIDS was transmitted were the same throughout the world, it was significant that there were very varied epidemiological situations within and between countries. Such differences must be documented to show how epidemiological differences were also social and behavioural differences which called for appropriate research at local or country level in order to continue to adapt the details of programme design, implementation and evaluation within the global strategy. In that context, a technical consultation would shortly be held on AIDS control in Asia to look specifically at the type of problems faced in an area of the world where the virus had so far been relatively rare; the discussion would be epidemiologically based and would consider how programme design could take account of epidemiology while remaining faithful to the principles and basic structure of the global strategy. It was essential to avoid complacency in areas where the virus was not common, because it was clear that wherever the behavioural factors were sufficiently intense and the virus existed, transmission could occur rapidly. He illustrated that point by giving figures for Thailand; in 1985-1986, intravenous drug users presenting for treatment in Bangkok had a 0% HIV infection rate, whereas in 1987 the rate was 1% and in the first three months of 1988 it had risen to 16%. Similar patterns had earlier been seen in New York, Edinburgh and Milan. Recent scientific data confirmed that there were no racial, genetic or ethnic barriers to the spread of the virus and that the only known immunity was behavioural immunity.

Concerning the evolution of test kits, he confirmed that kits were being developed which were quicker and simpler and could be read with the naked eye, which would allow testing in areas where ELISA-readers might not be appropriate. The most promising kits were based on the principle of particle agglutination - there were both gelatin and latex agglutination tests - and were being evaluated in different parts of the world. They offered the promise of bringing to all areas the capacity to test for HIV infection quickly and reliably.

Concerning the risk to health workers, the most recent information pointed to a 0.5% probability of a health worker being infected through an injury when using a needle contaminated with the blood of an HIV-infected patient. That risk was to be compared with the 10%-30% risk of transmission of hepatitis B under similar circumstances. The risk would be further minimized through adoption of the usual preventive strategies.

On the question of drug and vaccine availability, he said that it was essential for the Global Programme on AIDS to help ensure that, when drugs and vaccines became available, safe and effective, and usable, they would be made available throughout the world and there would be no difference between the rich and the poor nations in their capacity to prevent HIV infection.

Concerning World AIDS Day, announced at the London Summit, to be celebrated on 1 December 1988, he said that its purpose was to convey the message that AIDS could be stopped, convince people that their responsible behaviour could protect them and stop the spread of AIDS, encourage compassion and understanding towards those who had AIDS or were otherwise infected with the virus, highlight the extraordinary range and scope of the fight against AIDS all over the world and give additional support to AIDS prevention and control programmes at country level. It was therefore hoped that ministers of health would proclaim the day World AIDS Day in their countries and use it as an opportunity to focus attention on understanding and learning about AIDS. WHO would help by providing materials for adaptation and use in national activities and serving as a focal point to exchange information activities in different countries.

In conclusion, he said that the personnel of the Global Programme on AIDS had drawn additional confidence from the support expressed, and believed that with the steadfast support and guidance of the Health Assembly, the Global Programme on AIDS would go from strength to strength. It would continue to focus on the challenges in a changing environment and to deliver in the best manner possible technical and other forms of support to countries throughout the world.

The CHAIRMAN drew attention to the following draft resolution proposed by the delegations of Argentina, Australia, Austria, Barbados, Belgium, Botswana, Brazil, Burkina Faso, Burundi, Canada, Chad, Congo, Cyprus, Denmark, Egypt, Finland, France, Gabon, Gambia, German Democratic Republic, Germany, Federal Republic of, Ghana, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, Kenya, Kiribati, Lesotho, Liberia, Luxembourg, Malawi, Malaysia, Malta, Netherlands, New Zealand, Nigeria, Norway, Papua New Guinea, Philippines, Poland, Portugal, Qatar, Rwanda, Samoa, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Solomon Islands, Spain, Swaziland, Sweden, Switzerland, Thailand, Tonga, Tunisia, Uganda, Union of Soviet Socialist Republics, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, United States of America, Venezuela, Zambia and Zimbabwe:

The Forty-first World Health Assembly,

Recalling resolution WHA40.26 on the global strategy for the prevention and control of AIDS, Economic and Social Council resolution 1987/75, and United Nations General Assembly resolution 42/8 on the prevention and control of AIDS;

Endorsing the London Declaration on AIDS Prevention unanimously adopted on 28 January 1988 by the World Summit of Ministers of Health on Programmes for AIDS Prevention;

Recognizing that AIDS is a global problem which poses a serious threat to humanity, and that urgent and worldwide action is required to implement WHO's global strategy to combat it;

Acknowledging with deep appreciation the work of WHO, through the Global Programme on AIDS, in directing and coordinating the global strategy;

Noting the medical, ethical, legal, socioeconomic, cultural and psychological implications of AIDS prevention and control programmes;

Recognizing the responsibility of Member States to safeguard the health of everyone and to control the spread of HIV infection through their national policies and programmes in conformity with the global strategy;

Bearing in mind the responsibility of individuals not to put themselves or others at risk of infection with HIV;

Strongly convinced that respect for human rights and dignity of HIV-infected people and people with AIDS, and of members of population groups is vital to the success of national AIDS prevention and control programmes and of the global strategy;

1. URGES Member States, particularly in devising and carrying out national programmes for the prevention and control of HIV infection and AIDS:

(1) to foster a spirit of understanding and compassion for HIV-infected people and people with AIDS through information, education and social support programmes;

(2) to protect the human rights and dignity of HIV-infected people and people with AIDS and of members of population groups, and to avoid discriminatory action against and stigmatization of them in the provision of services, employment and travel;

(3) to ensure the confidentiality of HIV testing and to promote the availability of confidential counselling and other support services to HIV-infected people and people with AIDS;

(4) to include in any reports to WHO on national AIDS strategies information on measures being taken to protect the human rights and dignity of HIV-infected people and people with AIDS;

2. CALLS ON all governmental, nongovernmental and international organizations and voluntary bodies engaged in AIDS control programmes to ensure that their programmes take fully into account the health needs of all people as well as the health needs and dignity of HIV-infected people and people with AIDS;

3. REQUESTS the Director-General:

(1) to take all measures necessary to advocate the need to protect the human rights and dignity of HIV-infected people and people with AIDS, and of members of population groups;

(2) to collaborate with all relevant governmental, nongovernmental and international organizations and voluntary bodies in emphasizing the importance to the global strategy for the prevention and control of AIDS of avoiding discrimination against HIV-infected people and people with AIDS;

(3) to stress to Member States and to all others concerned the dangers to the health of everyone of discriminatory action against and stigmatization of HIV-infected people and people with AIDS and members of population groups, by continuing to provide accurate information on AIDS and guidance on its prevention and control;

(4) to report annually to the Health Assembly through the Executive Board on the implementation of this resolution.

Dr RAY (Secretary) announced that the delegation of Cuba had proposed that the words "taking into account the epidemiological situation" be added after the words "national policies and programmes" in the sixth preambular paragraph.

The delegation of Saudi Arabia had proposed that the words "nationals and residents" be inserted after the words "members of population groups" in operative paragraph 1, subparagraph (2).

The delegation of France had proposed certain changes that affected only the French text.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) thanked all delegations for their overwhelming support of the draft resolution. He fully understood the reasoning of the Saudi Arabian delegate but appealed to him not to pursue his objections, on the clear understanding that his concern would be fully reflected in the record.

Mr AL-HEGELAN (Saudi Arabia) explained that the aim of his proposal had been to draw attention to a problem that could hamper the implementation of the draft resolution. He could accept the draft resolution in so far as it did not affect the interests of Member States and pointed out that 15% of his country's population was at risk. If his amendment could not be accepted, he hoped that the reasons for his opposition to the paragraph in question would be noted. In any case, he would always bear in mind the initial concern of preventing AIDS and protecting all population groups in his country.

The CHAIRMAN thanked the delegate of Saudi Arabia and assured him that his remarks would be noted.

Mr NEWMAN (United States of America) said that it was clearly the sovereign responsibility of each Member State to address its health needs; he associated himself with the remarks of the United Kingdom delegate and thanked the delegate of Saudi Arabia for his considerate attitude.

Dr OKWARE (Uganda) said that the draft resolution represented the minimum that was required. He had no difficulty in accepting the Cuban amendment but thought that the Saudi Arabian amendment would reopen fundamental issues. On humanitarian grounds, he called on the Committee to approve the draft resolution by consensus.

The CHAIRMAN reminded the delegate of Uganda that the Saudi Arabian delegate had graciously withdrawn his amendment.

The draft resolution, as amended, was approved.

Draft resolution on Action programme on tobacco or health

The CHAIRMAN drew attention to the following draft resolution submitted by the delegations of Australia, Bahrain, Belgium, Canada, Finland, Iceland, Iraq, Luxembourg, Mexico, Mozambique, New Zealand, Poland, Sweden, Thailand, Tonga and United Kingdom of Great Britain and Northern Ireland:

The Forty-first World Health Assembly,

Recalling resolutions WHA31.56, WHA33.35 and WHA39.14 and emphasizing the importance of ensuring that these resolutions are fully implemented;

Having considered the Director-General's report on Tobacco or Health, the comments on it by the Executive Board and the report of the Advisory Group on a WHO Global Action Plan on Tobacco or Health;

Encouraged by the response to the first world no-smoking day on 7 April 1988;

REQUESTS the Director-General to draw up a plan of action, bearing in mind the recommendations of the Advisory Group and covering in particular:

(i) the special problems of developing countries which at present depend upon tobacco production as a major source of income;

(ii) targets and intervention plan including consideration of future no-smoking days, for example, on annual World Health Day;

(iii) the administrative and management structure including relations of this programme with other programmes of the Organization;

(iv) resource needs;

(v) sources of finance and other support

for submission, through the Programme Committee, to the eighty-third session of the Executive Board.

The draft resolution was approved.

2. SECOND REPORT OF COMMITTEE A (Document A41/33) (continued)

Dr RAY (Secretary) read out a number of textual amendments to the annexes to the resolutions that had inadvertently been omitted from the versions included in the draft report, which had been adopted at the Committee's ninth meeting. He announced that the corrected version would be distributed on the following day.

The amendments were approved

3. FORTIETH ANNIVERSARY OF THE WORLD HEALTH ORGANIZATION AND TENTH ANNIVERSARY OF THE DECLARATION OF ALMA-ATA: Item 12 of the Agenda (continued)

Draft resolution on leadership development for health for all (Document A41/Conf.Paper No. 7)

The CHAIRMAN drew attention to the following draft resolution submitted by the delegations of Barbados, Colombia, Cuba, Hungary, India, Malaysia, Nigeria, Sweden, Thailand, United Republic of Tanzania, United States of America and Yugoslavia:

The Forty-first World Health Assembly,

Recalling resolution WHA30.43 and WHA34.36 by which the Member States of WHO have unanimously adopted a policy and Strategy for achieving the goal of health for all by the year 2000;

Noting the progress made at this midpoint between the adoption in 1978 of the Alma-Ata Declaration on Primary Health Care, which set a new course for action for health, and the year 2000, but also being aware of the need for accelerated progress to achieve the collectively agreed goal of health for all;

Stressing that accelerated progress will require an even greater involvement of people from all walks of life and mobilization of all potential resources in society in support of primary health care;

Recognizing that informed and committed leadership at all levels of society is crucial for harnessing this potential;

Recalling resolution WHA37.31 on the role of universities in the strategies for health for all; resolution WHA38.31 on collaboration with nongovernmental organizations in implementing the Strategy; resolution WHA39.7 on the evaluation of the Strategy; and resolution WHA39.22 on intersectoral action for health;

1. ENDORSES the Declaration of Personal Commitment and the report on "Leadership development for Health for All" of the Technical Discussions held during the Forty-first World Health Assembly;

2. AFFIRMS that enlightened and effective leadership is vital to intensify and sustain social and political action for health for all;

3. CALLS on Member States:

(1) to develop leadership for health for all actively by using all educational entry points, and by sensitizing current leadership to the issues involved and generating continually new leadership, in order to accelerate progress towards health for all through primary health care;

(2) to launch renewed efforts to increase understanding of health for all and primary health care, utilizing effective communication strategies, including sensitizing the leadership of the media to their social responsibility in promoting communication for health;

(3) to accelerate decentralization and socioeconomic and structural reforms which favour active involvement of people and encourage the emergence of leadership potential and provide opportunities for setting examples of effective leadership at all levels;

(4) to make renewed and innovative efforts to involve people and communities creatively so as to empower them, develop self-reliance and leadership at local level;

(5) to expand supportive partnerships with communities, nongovernmental organizations, educational institutions and other community-based organizations to bring their creativity and commitment to bear on the challenge of health for all;

4. CALLS on the leadership of educational institutions and universities to demonstrate their commitment to achieve health for all through primary health care, by;

(1) accelerating changes in the curricula for the training of health and other professionals, including teachers, involved in health action to promote the value system of health for all and enhance the potential of leadership for health for all;

(2) shifting academic reward systems and providing career opportunities so as to acknowledge and encourage career academic commitments to primary health care;

(3) including in the curricula of institutions throughout the educational system from primary schools on, education for health, social values, attitude change and leadership development;

5. URGES the leadership of national and international nongovernmental organizations to expand their partnership with governments and educational institutions to accelerate progress towards health for all, and to use their flexibility and creativity in developing leadership potential and capacities at community level, involving particularly women and youth groups;

6. REQUESTS the Director-General:

(1) to publish the Declaration of Personal Commitment and the report on "Leadership development for health for all" of the Technical Discussions, and disseminate it widely to all governments, educational institutions and universities, nongovernmental and voluntary organizations, and other interested groups;

(2) to ensure the continuity and sustainability of the Leadership Development Initiative within WHO, building upon the strong beginnings already realized, and establishing other appropriate mechanisms so that it becomes an integral part of WHO's support for the Health for All Strategy, at all levels;

(3) to support the efforts of Member States, educational institutions and nongovernmental organizations in their endeavours to develop leadership to accelerate social and political action towards health for all through primary health care and encourage the use of WHO resources, particularly fellowships, for leadership development;

(4) to establish and foster a technical resource network drawn from educational institutions, and health leaders, to provide support to health for all and leadership development;

(5) to promote and encourage leadership potential through documenting and disseminating information on successful and innovative initiatives in primary health care, through creating incentives such as awards and recognition for such endeavours, and provide simplified and relevant documentation for lay people and community leadership;

(6) to evaluate the impact of the leadership development initiative in implementing the Global Strategy for Health for All in conjunction with the second evaluation of the Strategy in 1991, and to report thereon to the eighty-ninth session of the Executive Board and the Forty-fifth World Health Assembly in 1992.

Dr KHALID BIN SAHAN (Malaysia), introducing the draft resolution, said that the sponsors considered it extremely important and relevant to the health for all goal which, through primary health care, envisaged a number of important changes in many health care systems, including changes in values and perceptions, in the roles of health care providers and the community, in priorities, distribution of resources, more efficient and effective management of programmes and resources, greater intersectoral coordination, use of more appropriate technology and, above all, in the development of a health care system which countries could afford. In order to bring about all those changes there must also be changes in structures and functions, in the basis of decisions and ways of reaching them, and in relationships and working arrangements. Health for all through primary health care could be summarized as an exercise in change, both qualitative and quantitative. It was a challenge to organization and management alike to initiate and manage such change in appropriate directions.

A review of the health-for-all goal had clearly indicated that some progress had been made but there were also instances in which the desired changes or improvements had been too slow or had not taken place. There had even been some actual reversal of health status.

Enlightened and effective leadership had been identified as a crucial factor in the health-for-all goal. The subject had been discussed extensively in various forums, including the Director-General's "round table" in Brioni, Yugoslavia, and at a recent meeting of experts in Riga which had examined the mid-point achievements after Alma-Ata.

Interesting and useful Technical Discussions had taken place during the current World Health Assembly on the subject of leadership development for health for all and there had been agreement on the nature of such leadership and its functions, on what constituted effective leadership and how it could be developed. Effective leadership was a basic requirement for the health-for-all goal. The Health Assembly in plenary had taken note of the report on the Technical Discussions and of the Declaration of Personal Commitment.

The draft resolution before the Committee was appropriate and timely in calling on Member States, institutions, nongovernmental organizations and the Director-General to intensify or initiate efforts towards the development or strengthening of leadership for change, without which the health-for-all goal might remain a dream or merely a partially executed objective.

While the draft resolution rightly focused on leadership development, he emphasized the importance of managerial skill and effective management in health for all. It could, in fact, be argued that leadership and effective management were inseparable. Leaders must also be competent in management because the values and visions, as well as the critical issues which leadership projected or took into consideration, must be translated into practical action programmes. The strengthening and development of management and managerial skill would be an appropriate accompaniment to the action being taken on health-for-all leadership development. That aspect might be taken up at another time and in another forum.

Mr BOBAREVIC (Yugoslavia) reminded the Committee that the activity covered by the draft resolution had originated among non-aligned and other developing countries in the context of the medium-term programme for Technical Cooperation for Health for All. That Programme had been endorsed by the World Health Assembly and had led to the launching of the Leadership Programme by the Director-General. In the past three years, the World Health Assembly had adopted resolutions congratulating the non-aligned and other developing countries on their continuing political commitment and vigorous efforts to attain the goal of health for all through technical cooperation. The developing countries greatly appreciated the support they had received. Some countries that had attended the Brioni "round table" were among the sponsors of the draft resolution. That meeting had been followed by the first international dialogue in India, which had been attended by representatives of developed countries. National and later international colloquia had been arranged. The activity had become a part of the WHO programme. The draft resolution marked the beginning of the second phase of the work, in which Yugoslavia would cooperate with other developing countries and with developed countries to achieve the goal of health for all by the year 2000.

Dr AMONOO-LARTSON (Christian Medical Commission), speaking at the invitation of the CHAIRMAN, said that on behalf of the Commission and of the Geneva-based group of nongovernmental organizations on primary health care he wished to express appreciation for the collaboration nongovernmental organizations had enjoyed with WHO and especially its Director-General, Dr Mahler. The nongovernmental organizations which had participated in the Alma-Ata Conference and in the recent Riga meeting were deeply committed to the Alma-Ata Declaration and would do everything within their means to develop leaders for health for all by the year 2000. Leadership for primary health care

was often more easily said than done, but with dedication for leadership development at country and district levels it was believed it would be possible to select nationals, and especially young nationals, for leadership roles in the health services. At a time when the fortieth anniversary of WHO and the tenth anniversary of the Alma-Ata Declaration were being celebrated, the nongovernmental organizations rededicated themselves to increasing collaboration with WHO, national governments and communities in their efforts to develop equitable systems of health care.

Dr WESTERHOLM (Sweden) said that one reason why all the progress hoped for had not been made towards the goal of health for all through primary health care was lack of leadership at all levels. Her delegation, which was a sponsor of the draft resolution, hoped it would be approved by consensus.

Dr RAKCEEV (Union of Soviet Socialist Republics) asked for clarification of the functions of the technical resource network described in operative paragraph 6(4) and how they differed from the measures envisaged in operative paragraphs 6(2) and 6(3).

Dr KHANNA (Director, Health-for-all Strategy Coordination; Health-for-all Leadership) recalled that the Technical Discussions had recognized that networking had important partnership-fostering functions at community, national, regional and international levels in view of the fact that leadership development was a new initiative and called for new types of learning materials and educational approaches. It had therefore recommended that such networks should be set up to bring together leaders from governments, nongovernmental organizations and educational institutions that had achieved success in implementing primary health care, in order that appropriate learning materials and approaches could be developed and experience shared.

The draft resolution was approved.

Draft resolution on strengthening of primary health care. (Document WHA41/Conf.Paper No.8 Rev.1)

The CHAIRMAN invited attention to the revised draft resolution proposed by the delegations of Botswana, Bulgaria, Cuba, Czechoslovakia, Ethiopia, German Democratic Republic, Ghana, Hungary, Iceland, Kenya, Malaysia, Mongolia, Mozambique, Nigeria, Norway, Pakistan, Poland, Sweden, Switzerland, Thailand, Union of Soviet Socialist Republics, United Republic of Tanzania, United States of America, Zambia and Zimbabwe. The draft resolution read as follows:

The Forty-first World Health Assembly,

Recalling resolution WHA30.43 in which it was decided that the main social target of governments and WHO should be the attainment by all the people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life;

Further recalling resolution WHA32.30 which endorsed the Declaration of Alma-Ata with its emphasis on primary health care and its integrated approach as the key to attaining health for all, and resolution WHA34.36 by which the Assembly adopted the Global Strategy for Health for All by the Year 2000;

Mindful of United Nations General Assembly resolution 36/43 which endorsed the Global Strategy for Health for All, urged all Member States to ensure its implementation as part of their multisectoral development efforts and requested all appropriate organizations and bodies of the United Nations system to collaborate with WHO in carrying it out;

Having considered the statement issued by a meeting in Riga, USSR in March 1988 to mark the tenth anniversary of the Declaration of Alma-Ata, known as "Alma-Ata: Reaffirmed at Riga";[1]

Recognizing that at this mid-point between the launching and the attainment of the goal of health for all by the year 2000, much progress has been made by many countries in parallel with the evolution of their social and economic situation, but that there remain a considerable number of countries in which the health situation and the means for improving it remain highly unsatisfactory 10 years after Alma-Ata;

Convinced of the importance of district health systems for the optimal organization and provision of primary health care as an integral part of national health systems and of the global health system constructed primarily by countries themselves with appropriate support by WHO, and of the need for research and development as a vital step in fostering the development of such care;

Recognizing further that the active participation of the people and the communities and their contribution is essential to the attainment of the goal of health for all;

1. ENDORSES the statement "Alma-Ata: Reaffirmed at Riga", which emphasizes that the Declaration of Alma-Ata remains valid for all countries at all stages of social and economic development and that the application of its principles should therefore be maintained after the year 2000;

2. URGES all Member States:

(i) to accelerate their efforts to attain the goal of health for all by the year 2000 through health systems based on primary health care in line with the global, regional and national strategies to that end;

(ii) to prepare for the continuation of these efforts beyond the year 2000 to ensure the maintenance and progressive improvements of the health of all their people;

3. THANKS all those multilateral and bilateral developmental agencies, nongovernmental organizations and voluntary and philanthropic bodies that have supported the struggle to attain health for all and appeals to them to continue and intensify this support;

4. CALLS ON the international community:

(i) to continue their support to the efforts of Member States in the development of health systems based on primary health care;

(ii) to take unprecedented measures to support the least-developed countries committed to improving the health of their people in line with the policy of health for all;

(iii) to unite such efforts under the international coordination of the World Health Organization;

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[1] Document A41/19.

5. REQUESTS the regional committees:

(i) to pay particular attention to the monitoring and evaluation of strategies for health for all with a view to identifying areas in which particular efforts are required and to taking appropriate action;

(ii) to report thereon to the Executive Board in conformity with the revised plan of action for implementing the Global Strategy for Health for All;

6. REQUESTS the Executive Board:

(i) to intensify its monitoring and evaluation of the Global Strategy for Health for All, paying particular attention to supporting the countries in the strengthening of integrated approaches and to international support to the least-developed countries;

(ii) to report thereon to the World Health Assembly in conformity with the revised plan of action for implementing the Global Strategy for Health for All;

7. REQUESTS the Director-General:

(i) to ensure the widest dissemination of this resolution and the statement "Alma-Ata: Reaffirmed at Riga";

(ii) to intensify programme activities of research and development on primary health care, within the existing organizational framework, with particular emphasis on strengthening integrated health approaches and district health systems within the national context, ensuring resources from within the regular budget of the Organization and the continued mobilization of extrabudgetary resources as additional means for programme implementation;

(iii) to ensure that the activities of the programme and those of all other related programmes give particular emphasis to supporting the least-developed countries;

(iv) to direct all programmes of the Organization to increase their support to countries in strengthening the integrated approach and in research and development in primary health care with emphasis on strengthening district health systems;

(v) to present to the Executive Board at its eighty-third session the proposed intensification of programme activities of research and development in primary health care, and to report to the World Health Assembly from time to time on the implementation of this resolution and, in particular, on the nature and scope of international support to the least-developed countries.

Dr WESTERHOLM (Sweden), introducing the draft resolution, of which her delegation was a sponsor, said it took its origins in resolution WHA30.43, which had set health for all as the social target for governments and WHO, resolution WHA32.30 endorsing the Declaration of Alma-Ata, which had recognized primary health care as the key to health for all, and the meeting in Riga in March 1988 to review progress since Alma-Ata, whose conclusions were set out in document A41/19.

The aim of the draft resolution was to ensure continued commitment to efforts to attain the health-for-all goal through primary health care. It stressed the need to develop district health systems as the best means of organizing and delivering primary health care as an integral part of national health systems and the importance of research and development as a vital step in promoting the development of such care. The draft resolution endorsed the statement: "Alma-Ata: Reaffirmed at Riga" and emphasized that the application of its efforts went beyond the year 2000. It urged Member States to

redouble their efforts. Monitoring and evaluation would be a responsibility of the regional committees and the Executive Board and the Director-General was asked to undertake a number of tasks.

Professor RANSOME-KUTI (Nigeria) said that events in Alma-Ata 10 years earlier had reverberated throughout the world. The Declaration had become a charter for the world community to work for health for all by the year 2000 through primary health care and the fuller and better use of the world's resources, a considerable part of which was being spent on armaments and military conflicts. During the past week, the Organization had celebrated its fortieth anniversary and the tenth anniversary of the Alma-Ata Declaration, both of which were a global response to the health situation of the time. He had been keenly aware of the great significance of Alma-Ata and had been present at Riga from 22 to 25 March, when the mid-point between the Alma-Ata Conference and the year 2000 had been celebrated and when participants had reflected on the achievements of primary health care for health for all and on the obstacles that remained to be overcome. The report of the experts participating in the Riga meeting, which had been summarized at the recent "round table" in Brioni and in document A41/9, clearly indicated the challenge facing countries if health for all was to become a global reality. It had been recognized, however, that there had been many achievements since the Alma-Ata Declaration such as decreased infant mortality rates, improved immunization coverage and safe drinking-water.

The report had indicated that mortality rates among children under five years of age were likely to remain above 100 per thousand births in some African and Asian countries after the year 2000 despite a general worldwide improvement in health status. Even when full immunization coverage had been attained, it might not be sustained unless steps were taken to ensure that the programme activities formed an integral part of primary health care, supported by a strong common infrastructure, particularly in the districts. The collective commitment to the health-for-all target laid a moral obligation on the Health Assembly to ensure that such predictions were averted and that the glaring inequities between countries were removed.

Expressing his support for the draft resolution, he said that specific action was required to respond adequately to the existing situation, particularly in the least developed countries. Individual countries were responsible for their own social and economic development and must all ensure that the limited resources available for health were used so as to have the greatest impact. It was, however, the collective duty of countries within the Organization to support the efforts being made in the poorest countries. That could best be done by strengthening the organization of health systems in those countries, particularly in the districts. Their health personnel must acquire better organizational and managerial skills and find solutions to many operational difficulties, such as weak financial management and poor supervision. Above all, they must be more effective in establishing district health systems genuinely based on the principles of primary health care.

Action research, based in districts in the field but closely linked to national development efforts, would help to provide practical solutions to operational primary health care problems. Such research was therefore essential in developing strategies and plans and monitoring and evaluating the cost and effectiveness of various activities. Although research by academics and external consultants had important supporting roles to play, it must not be allowed to have a monopoly over practical research and systematic learning-by-doing, in which local health personnel were fully involved. Although WHO had acquired some experience in supporting action research in selected districts in a number of countries as a means of strengthening district health systems based on primary health care, much more needed to be done urgently to ensure that country experience was studied and shared for the benefit of all countries, particularly the least developed countries.

The existing world health situation called for substantial support for many countries, which could best be assured by intensifying research and development

activities in primary health care, with particular emphasis on strengthening district health systems in the least developed countries. Such intensification was essential to ensure that every possible effort was concentrated on support to countries. The broad nature of primary health care required, however, that considerable emphasis should be placed on the interaction between that programme and other programmes within the Organization. His delegation believed that the proposal could attract substantial extrabudgetary funds.

He commended the draft resolution for the Committee's approval.

Dr RAKCEEV (Union of Soviet Socialist Republics) said his delegation endorsed the draft resolution, adoption of which would represent a major step by the present Health Assembly for the future development of health care. It confirmed the importance of primary health care as a key element in health-for-all strategies both at present and after the year 2000 for all countries regardless of their level of social and economic development.

Dr KHALID BIN SAHAN (Malaysia) said that Malaysia strongly endorsed the draft resolution, of which it was a sponsor. Although Malaysia had made progress towards its health-for-all goals progress in some areas was slow. Primary health care had been recognized as the most appropriate strategy to achieve such goals and that had been confirmed by the Riga meeting. A reaffirmation by Member States of their commitment to the health-for-all goal and to primary health care was crucial to further progress.

Dr BORGOÑO (Chile) said that the draft resolution would be of major importance in strengthening primary health care. He proposed that the words "and health services" should be added in operative paragraph 7(ii) after the words "primary health care" to emphasize the continuing importance of such services. He proposed further that the Director-General's suggestion in his statement on his report be taken up and that a further sub-paragraph be inserted in operative paragraph 7 to read:

> "to study the possibility and feasibility of setting up a special research programme for health services and report to the eighty-third session of the Executive Board in January 1988".

He realized that it would be difficult to find funds for such work in a dwindling regular budget and that extrabudgetary funds would be needed to launch a special programme. That was why the proposal was merely to look into the feasibility of a special programme, not to suggest its establishment.

Mrs KADANDARA (Zimbabwe) said that her delegation had sponsored the draft resolution under discussion because it considered that primary health care was the only way of achieving health for all. Ten years before, there had been some difficulties in implementing the innovative new primary health care strategy, but staff of most health systems were now fully conversant with primary health care techniques and were implementing them efficiently. Her delegation hoped that support for primary health care would continue at all levels and that the political commitment of Member States would be maintained.

Mrs MANYENENG (Botswana) said that her country had been greatly encouraged in its primary health care policy by the Declaration of Alma-Ata and the statement "Alma-Ata: Reaffirmed at Riga", issued at the recent meeting in Riga, USSR, to commemorate the tenth anniversary of the Declaration (see document A41/9).

Her country was committed to the monitoring and evaluation of the health-for-all strategy in order to identify and act in areas which required particular effort. The Government encouraged research at a local level, not only by research professionals, but also by members of the community and local health workers. Local authorities had complete responsibility for health in their own districts. In June 1988 the country's health services were to be decentralized. In the same month a district health management

training exercise was to be held with the assistance of WHO and USAID, as well as a national health systems research workshop.

Her delegation hoped that the draft resolution would be adopted unanimously.

Mr DIETERICH (Federal Republic of Germany) expressed his gratitude to the delegate of Sweden for explaining the importance of the reasons behind the draft resolution and the USSR for hosting the Riga meeting. He had several observations to make about the draft resolution. The resolution endorsed the conclusions of the Riga meeting, but it did not urge Member States to take them into account in their policies. Such a minor amendment could surely be incorporated into the draft resolution without difficulty.

Operative paragraph 7 did not make it clear that the Director-General should be working with Member States to implement the recommendations of the Riga meeting. He wished, therefore, to suggest a new subparagraph, to follow the current paragraph 7(i), along the following lines:

> "to cooperate with Member States in the implementation of the recommendations made at Riga for accelerating progress towards health for all by the year 2000, giving particular emphasis to maintaining and strengthening political commitment and strategies in the sector of collaboration and the identification of problems that continue to resist solution".

There was no need to refer to the recommendation on leadership training, since that was the subject of a separate resolution. If the proposed subparagraph were approved, it would be logical to continue with the current subparagraphs (iii) and (iv) and then the subparagraph currently numbered (ii).

The current subparagraph 7(ii) did not reflect another of the Riga recommendations, namely the rational use of science and appropriate technology, which was essential for health services research, especially at the district level. He suggested that the subparagraph should be amended to read "..... with particular emphasis on strengthening integrated health approaches and district health systems within the national context, and the development and rational use of science and appropriate technology and its transfer between countries ....". It would then be possible to delete the reference to primary health care at the beginning of the subparagraph, to read "to intensify programme activities of research and development within the existing organizational framework....". It would also be possible to simplify operative paragraph 7(iv) by deleting the reference to research and development and amending the paragraph to read "...strengthening the integrated approach to health for all based on primary health care".

Sir John REID (United Kingdom of Great Britain and Northern Ireland) expressed his delegation's support for the draft resolution. In respect of the special research programmme on health services suggested by the delegate from Chile, he agreed that the feasibility of the project should be investigated, and it was for the Committee to decide whether the matter should be dealt with in a resolution or left to the Executive Board. His delegation provisionally supported the amendments suggested by the delegate from the Federal Republic of Germany, but wished to see the amendments in writing before committing itself.

He wished to pay a special tribute to Dr Joshua Cohen, the Director-General's Adviser on Health Policy, who had done a great deal to develop the philosophy and practice of health for all through primary health care by his ability to communicate complex ideas in lucid writing.

Professor M.T. SY (Senegal) said that after several years of implementation of primary health care, a number of constraints had become evident, including the fact that the political and administrative systems in some countries impeded the proper execution

of programmes through intersectoral cooperation. A further constraint was the way in which the concept of primary health care was understood. In that connection, the Director-General and the Organization might make increased efforts to further such understanding among those responsible for health promotion, and to dispel the idea that the word "primary" had a perjorative meaning. The term used in his country was "priority" or "fundamental" health care.

Senegal was also hampered by lack of resources for the implementation of its health policy. He proposed that the words "accelerate their efforts" in operative paragraph 2, subparagraph (i) of the draft resolution should be amended to read "increase their efforts". Despite the shortage of financial resources, there were human and other resources that could help in adjusting development, in which health services, through primary health care, formed an integral part. Subject to that amendment, his delegation wished to co-sponsor the draft resolution.

Dr RAKCEEV (Union of Soviet Socialist Republics) said that the amendments suggested by the delegate of the Federal Republic of Germany seemed justified, but he would like to see them in writing. He also wished to endorse the tribute to Dr Cohen paid by the United Kingdom delegate.

Dr BART (United States of America) said that as his delegation understood matters extrabudgetary resources were already being mobilized for programme implementation; indeed, paragraph 7(ii) of the draft resolution referred to the "continued mobilization of extrabudgetary resources". The special programme on health services research proposed by the delegate of Chile would surely come under the proposal for intensification of programme activities for research and development in primary health care, referred to in paragraph 7(v) of the draft resolution. He would welcome a clarification from the Secretariat.

Professor A.J. KHAN (Pakistan) said that primary health care had been an important part of the health delivery system in Pakistan, where there were 4100 union councils in the rural areas. Efforts were being made to have a basic health unit for every union council, to cover a population of some 10 000 to 15 000 people. A rural health centre was established for every five to ten union counsels, depending on the population.

The paramedical staff for the basic health units and rural health centres was being trained at 13 training schools established in all the provinces with assistance from the United States Government. Each basic health unit, which had one doctor and three paramedical staff, would be the main centre for primary health care in the rural areas. The rural health centres had some 22 to 25 beds, an X-ray unit, a laboratory, a dental unit, and a labour room manned by three doctors and 14 paramedical staff. Some 3500 basic health units and 498 rural health centres had so far been established and others were under construction, and the target of 4100 basic health units and 700 rural health centres was expected to be reached by 1990. Similar public health centres were also under consideration for urban areas.

Pakistan had made great progress in that area with the help of WHO. As a sponsor of the draft resolution, his delegation hoped that it would be adopted unanimously.

Mr GHACHEM (Tunisia) said that his delegation wished to become a sponsor of the draft resolution.

The CHAIRMAN said that, since the Committee clearly wished to see the proposed amendments to the draft resolution in writing, a drafting group should be established to draw up an agreed text. He suggested that the following delegations should make up the drafting group: Federal Republic of Germany, Sweden, Nigeria, United States of America, Union of Soviet Socialist Republics and United Kingdom of Great Britain and Northern Ireland.

It was so agreed.

The meeting rose at 16h25.

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