

## **FOURTH MEETING**

**Wednesday, 21 January 2009, at 09:10**

**Chairman:** Mr N.S. DE SILVA (Sri Lanka)

### **TECHNICAL AND HEALTH MATTERS:** Item 4 of the Agenda (continued)

**Prevention of avoidable blindness and visual impairment:** Item 4.4 of the Agenda (Documents EB124/7 and EB124/7 Corr.1) (continued)

Professor ALI (alternate to Professor Haque, Bangladesh) said that his country was committed to providing ophthalmic care for its citizens and had created infrastructures in both the public and the private sectors. However, expanding those services to cover the entire population would require more technical assistance.

Although diabetic retinopathy and trachoma were referred to in the report, corneal opacities were not covered. WHO's and global and national initiatives did not adequately address that issue, notably the identification of cases, the promotion of eye donation, the establishment of eye banks or the organization of corneal transplants. Those specialized measures were difficult for developing countries to implement without international technical assistance. He therefore requested that corneal opacities and related measures be included in the draft action plan. He stressed that nutritional blindness caused by diarrhoeal diseases was a problem in many countries, including his own, and the report should not have ignored that issue.

In the South-East Asia Region, the prevalence of visual impairment among people over the age of 40 was as much as 25.1%. Much could be done with relatively little investment if a proper plan of action was developed and implemented. Regrettably, despite the development of VISION 2020: the Right to Sight, no significant step had been taken in the Region since 2001 when countries had held consultations in New Delhi. Moreover, in the Regional Office, the unit dealing with eye care emphasized injury and other areas of disability.

WHO should therefore accord more importance to eye care in order to achieve the objectives of VISION 2020. More information was needed on how best to integrate basic eye care into primary health care. Furthermore, the recommendations of the VISION 2020 regional consultation, concerning the planning of human resources in eye care, should be fully implemented.

Dr JAYANTHA (alternate to Mr de Silva, Sri Lanka) said that under VISION 2020 his country had significantly reduced avoidable blindness. WHO's support in developing human resources and the infrastructure for eye care was welcome. He expressed support for the draft action plan and its earliest implementation.

Dr WRIGHT (United States of America) welcomed WHO's success in combating avoidable blindness and expressed support for the draft action plan as it stood. His country continued to break new ground in its vision research and to develop nascent care and treatment options for the visually impaired around the world. It had been contributing to the global efforts to help people retain their vision since 1979. Cataracts affected the ageing population of both developed and developing countries: in the United States an estimated 20.5 million people over the age of 40 had cataracts in either eye. Furthermore, the growing prevalence of diabetes in the United States and globally, and its visual impairment complications, remained a concern.

Dr ADITAMA (alternate to Dr Supari, Indonesia) said that his country had developed a strategic plan for VISION 2020 and set up a committee for the prevention of blindness. Activities included the establishment of eye clinics throughout the country; collaboration with professional societies; and a prevention and control programme. He called on WHO to prioritize the prevention of avoidable blindness and visual impairment in health programmes, and also drew attention to the importance of research, prevention and treatment.

Dr AL RAJHI (Saudi Arabia)<sup>1</sup> welcomed the report and the evidence relating to the causes of visual impairment, the emphasis on activities to prevent blindness in the alleviation of poverty and improved quality of life, and the prompt response by the Secretariat in its elaboration of the action plan. The draft plan sought to increase the efforts of Member States, the Secretariat and international partners in preventing blindness and visual impairment by means of comprehensive national and local programmes for eye-health; and to support the implementation of WHO's Eleventh General Programme of Work and the Medium-term strategic plan 2008–2013. It was an important step in implementing resolutions WHA56.26 and WHA59.25. He joined other speakers in supporting the draft action plan, which should be submitted to the Sixty-second World Health Assembly for final adoption.

Dr SOPIDA CHAVANICHKUL (Thailand),<sup>1</sup> expressing support for the draft action plan, said that a national survey in 2006 had shown the prevalence of blindness to be 2.18%. The major causes identified were cataracts and glaucoma; macular degeneration had been identified as an emerging eye disease that impeded the independence of affected individuals, and retinopathy of prematurity remained a major eye problem among children. She stressed efforts against eye conditions that were related to age, in particular diabetic retinopathy, through screening, treatment and follow-up programmes. Since in many cases glaucoma was asymptomatic, intensive efforts should be made to detect the condition, to follow-up clinical assessment and ensure adherence to treatment.

The challenge was to translate action plans into reality and to prevent blindness among populations with few resources. The problem of access to expensive medicines for glaucoma needed to be addressed.

Dr ALVIÁREZ (Bolivarian Republic of Venezuela)<sup>1</sup> said that his country sought to meet the objectives outlined in the draft action plan: political, financial and technical commitment was being increased; national policies had been strengthened; research capacities had been increased; and cooperation and international alliances had been improved. Programmes were in place, inter alia for the promotion of visual health in schools, the community and the workplace; the provision of medication for glaucoma and diabetic retinopathy and of corrective lenses; the training of human resources; and the rehabilitation of patients with visual impairment. In order to achieve universal primary education, glasses were provided to patients on literacy programmes. He described the achievements in prevention and treatment.

Venezuela had also forged alliances with international organizations, and had established a VISION 2020 committee. It had increased access to health services and promoted coordination across sectors. Since 2006, considerable investment had been made in training human resources in ophthalmology. Venezuela had, together with Cuba and other Latin American countries, launched Mission Miracle, an anti-blindness programme. Results included the establishment of a modern ophthalmic centre in Venezuela that treated some 150 patients a day; some 200 000 surgical operations had been performed in Venezuela (regional estimates totalled 750 000). He emphasized coordination, cooperation and solidarity with neighbouring countries, particularly in the prevention of

---

<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

blindness; the decrease in the level of blindness in the country over the previous five years had promoted growth and development.

Mr GARMS (International Agency for the Prevention of Blindness), speaking at the invitation of the CHAIRMAN, recalled that his organization was WHO's joint partner in the VISION 2020 global initiative. Implementation of resolutions WHA56.26 and WHA59.25 had led to an unprecedented focus on the strengthening of eye-care services. He emphasized committed international partnership for improved eye health. The draft action plan would lend new momentum to global efforts. Resources must be made available at WHO headquarters and regionally for technical support to Member States. His organization would continue support to WHO in the shared objective that would benefit millions of needlessly blind people. He looked forward to endorsement of the draft action plan by the Sixty-second World Health Assembly.

Dr ALWAN (Assistant Director-General) thanked participants for their contributions, which would guide the Secretariat in strengthening and finalizing the draft action plan to be submitted to the Sixty-second World Health Assembly. With regard to the comments made by the member for the United Kingdom, he said that the language of paragraphs 40 and 41 of the revised draft action plan would take into account the organizational structures and implementation approaches in different Member States. Referring to the remarks made by the member for Bangladesh, he said that corneal opacities were included under trachoma and nutritional causes of blindness. However, the draft action plan, in particular paragraph 58, would be amended to indicate that corneal opacities were also a significant cause of blindness and visual impairment. Turning to the comments on nutritional causes, he said that vitamin A deficiency had been included in paragraph 52 of the draft action plan; nutritional issues tended to be covered under strategies relating to childhood blindness. He fully agreed with the member for Niger about the importance of integrating eye health into national health systems, which had always been the basic approach recommended by WHO; that would be reflected in the revised version of the draft action plan. He appreciated the comments by the representative of Thailand and other speakers on the need to emphasize age-related macular degeneration and noncommunicable disease-related causes of blindness and visual impairment. Age-related macular degeneration had already been included in the action plan for the global strategy for the prevention and control of noncommunicable diseases that had been endorsed at the Sixty-first World Health Assembly.

Additional resources would be needed to implement the action plan for the prevention of avoidable blindness and visual impairment. WHO would mobilize resources to cover its component of the plan and work closely with the partners of VISION 2020 to that end. The recommended interventions of Member States under the five objectives set out in the action plan would have to be prioritized according to local situations and needs.

The CHAIRMAN said that he took it that the Board wished to endorse the action plan.

**It was so agreed.**

**Primary health care, including health system strengthening:** Item 4.5 of the Agenda (Document EB124/8)

The CHAIRMAN drew attention to two draft resolutions on primary health care, including health system strengthening, proposed respectively by Afghanistan, Oman, Tunisia and United Arab Emirates and by Argentina, Australia, Canada, Chile, Japan, Kazakhstan, Monaco, Republic of Korea, Russian Federation, Singapore, Turkey and Venezuela (Bolivarian Republic of), which read as follows:

The Executive Board,  
Having considered the report on Primary health care, including health system strengthening,<sup>1</sup>

RECOMMENDS to the Sixty-second World Health Assembly the adoption of the following resolution:

The Sixty-second World Health Assembly,  
Having considered the report on Primary health care, including health system strengthening;

Recalling the Declaration of Alma-Ata (1978) and subsequent resolutions of WHO regional committees and the Health Assembly;

Recalling the discussions at the series of international, regional and national conferences that have reaffirmed the commitment of Member States to primary health care and strengthening health systems;<sup>2</sup>

Noting the analyses contained in *The world health report 2008*,<sup>3</sup> the report of the Commission on Social Determinants of Health,<sup>4</sup> and the report on monitoring of the achievement of the Millennium Development Goals;<sup>5</sup>

Gravely concerned by the potential effects on health and health systems, of the international financial and food crises and climate change as well as the impact of global economic conditions on national budgets and international funding for health,

1. STRONGLY REAFFIRMS the primary health-care values and principles of equity, solidarity, social justice, universal access to services, community participation and intersectoral action as the basis for strengthening health systems;
2. URGES Member States:
  - (1) to apply the values and principles of primary health care in health policies and the structuring and functioning of health systems at all levels, including the rehabilitation and strengthening of health systems in countries facing complex emergencies;
  - (2) to protect health budgets in response to the current economic crisis and to seize the opportunity of crisis in order to accelerate the rate of change towards strengthening their health systems on the basis of the values and principles of primary health care;
  - (3) to strengthen health ministries, enabling them to provide inclusive, transparent and accountable leadership of the health sector and to work with other sectors in order to address the social, economic, environmental and cultural determinants of health;

---

<sup>1</sup> Document EB124/8.

<sup>2</sup> Buenos Aires 2007, Beijing 2007, Bangkok 2008, Tallinn 2008, Ouagadougou 2008, Jakarta 2008, Almaty 2008, Doha 2008.

<sup>3</sup> *The world health report 2008: Primary health care – now more than ever*. Geneva, World Health Organization, 2008.

<sup>4</sup> Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health*. Geneva, World Health Organization, 2008.

<sup>5</sup> Document EB124/10.

- (4) to put people at the centre of health care, adopting delivery models focused on the local or district level that provide preventive, promotive and curative services, integrated and coordinated according to need;
- (5) to ensure people's participation, including community leaders and young people, in action to improve health and health care, and to engage civil society organizations in policy development for the renewal of primary health care;
- (6) to accelerate action to achieve universal coverage and equitable access to services according to need, ensure social protection, especially for the vulnerable, avoid catastrophic expenditures and impoverishment, and improve health equity through the development of health financing systems, human resource policies and service delivery models;
- (7) to take advantage of opportunities presented by new health-related partnerships and initiatives to improve health outcomes and strengthen health systems based on primary health care;
- (8) to ensure political commitment and leadership at the highest levels of government in order to address major determinants of health through relevant sectoral policies and intersectoral action to improve health outcomes;
- (9) to design and implement information systems for monitoring and measuring the development and impact of health systems based on primary health care, which include use of the Millennium Development Goals indicators and make better use of information and communications technology;

3. REQUESTS the Director-General:

- (1) to provide support to Member States in strengthening capacities to develop and implement health systems based on the values and principles of primary health care;
- (2) to facilitate consolidation and sharing among stakeholders at all levels of lessons learnt and successes in strengthening health systems based on primary health care, including public health programmes such as those for disease control, maternal and child health and essential medicines, in order to support the drive for universal access to health services;
- (3) to promote networks of institutions and provide appropriate skills and experience to Member States in developing and strengthening their health policies and systems based on primary health care;
- (4) to strengthen WHO's methodologies and capacities, enabling the Organization to respond to Member States' requests for technical and policy support in strengthening health systems based on primary health care and to measure and evaluate progress;
- (5) to align the Secretariat's support to Member States and strengthen cooperation with partners in order to be consistent with national policies and plans for strengthening health systems based on primary health care, thereby improving coordination and harmonization of international cooperation with countries, in keeping with the principles of the Paris Declaration on Aid Effectiveness: ownership, harmonization, alignment, results and mutual accountability (2005);
- (6) to propose frameworks and tools that can be used for sectoral policy reviews and for monitoring and evaluating of performance of health systems based on primary health care and to provide support to countries in adapting and implementing them.

The Executive Board,  
Having considered the report on primary health care, including health system strengthening,<sup>1</sup>

RECOMMENDS to the Sixty-second World Health Assembly the adoption of the following resolution:

The Sixty-second World Health Assembly,  
Having considered the report on primary health care, including health system strengthening;

Recalling resolutions WHA54.13, WHA57.19, WHA58.17, WHA58.33, WHA60.22, WHA60.27, and WHA61.17 calling for health system strengthening in various contexts, as well as resolution WHA61.18 on monitoring of the achievement of the health-related Millennium Development Goals, and resolution WHA60.24 on health promotion in a globalized world;

Reaffirming the values and principles of the Declaration of Alma-Ata (1978), the Ottawa Charter for Health Promotion (1956) and the United Nations Millennium Declaration (2000);

Welcoming, in this regard, *The world health report 2008*,<sup>2</sup> published on the 30th anniversary of the international conference at Alma-Ata, which identifies four key policy areas: tackling health inequalities through universal coverage, putting people at the centre of care, integrating health into broader public policy, and providing inclusive leadership for health, and also welcoming the Commission on Social Determinants of Health's final report;<sup>3</sup>

Reaffirming the need to build sustainable national health systems, strengthen national capacities, and fully honour financing commitments made by national governments and their development partners in order to better fill the resource gaps in the health sector; to take concrete, effective and timely action in implementing all agreed commitments on aid effectiveness; and to increase predictability of aid, while respecting recipient countries' control and ownership of their health system strengthening;

Recognizing the structural changes of the current global health architecture which require collaborative, multi-stakeholder approaches to policy-making, including intergovernmental organizations, nongovernmental organizations and private foundations, as seen in the International Health Partnership and related initiatives, including International Health Partnership Plus (IHP+), the Providing for Health Initiative (P4H), and Health Eight (H8);

Recognizing the critical role of research on health systems in generating evidence for policy-making to achieve national and international health-related goals, especially the Millennium Development Goals as reported by the High-Level Task Force for the Global Ministerial Forum on Research for Health (Bamako, 17–19 November 2008);

Welcoming the substantive contributions from global, regional and national conferences on health system strengthening, including the G8 Summit (Hokkaido, Japan, 7–9 July 2008), the International Conference on Global Action for Health System

---

<sup>1</sup> Document EB124/8.

<sup>2</sup> *The world health report 2008: Primary health care – now more than ever*. Geneva, World Health Organization, 2008.

<sup>3</sup> Commission on Social Determinants of Health. *Closing the gap in a generation – health equity through action on the social determinants of health*. Geneva, World Health Organization, 2008.

Strengthening (Tokyo, 3 and 4 November 2008), Almaty (2008), and WHO regional meetings; as well as the conferences on health promotion, including those in Ottawa (1986), Adelaide (1988), Sundsvall (1991), Jakarta (1997), Mexico City (2000) and Bangkok (2005);

Recognizing the need to revitalize primary health care and strengthen health systems, with the core values of equity, solidarity, universality and social justice, built upon the principles of multisectoral action and community participation;

Recognizing also the need for a comprehensive approach to primary health care based on the integration of vertical and horizontal health-care programmes that reduce fragmentation and improve the efficiency and effectiveness of existing health systems;

Concerned by the potential effects on health and health systems of the international financial and food crises and climate change;

Noting the growing consensus in the global health community, as exemplified at the G8 Summit in Hokkaido, that both disease-specific and health systems approaches are mutually reinforcing and contribute to achieving the health-related Millennium Development Goals;

1. URGES Member States:

- (1) to continue sustaining high-level political commitments and work with development partners to strengthen health systems based on the primary health care approach, by putting people at the centre of care, towards achievement of the Millennium Development Goals;
- (2) to secure and strengthen the commitment of political leadership at all levels to take responsibility for health system strengthening, and establish functional structures for multisectoral approaches to address effectively the social, economic, environmental, and cultural determinants of health throughout the life course;
- (3) to secure multisectoral action by incorporating health considerations within policies among all government sectors, such as by ensuring drinking water, safe food, decent work, a healthy environment, and adequate shelter for all;
- (4) to accelerate the progress towards universal and comprehensive health coverage through equitable public and private financing mechanisms, and by developing national capacity for assessing and developing health financing policy relevant to the national context, mindful of the need to protect health budgets in the wake of the current financial crisis;
- (5) to develop and improve the quality and quantity of health workforces by implementing, where appropriate, the WHO's code of practice and supporting global commitments;
- (6) to emphasize the need for integration of vertical and horizontal health-care programmes in the development of health systems;
- (7) to develop appropriate national mechanisms for providing essential medicines, health products, and appropriate technologies, including access to traditional medicines that are proven safe and effective, through equity-based health service networks, ensuring continuity and integration of people-centred care;
- (8) to develop and strengthen health information and surveillance systems for conducting research in health systems, enabling policy-makers to base their decisions on accurate health information;
- (9) to develop and implement health promotion strategies especially for those most vulnerable;

2. REQUESTS the Director-General:

- (1) to strengthen the capacity for health system strengthening based on the primary health-care approach to address the achievement of the health-related Millennium Development Goals, particularly in the areas of health workforce, health financing, and health information, across the Organization in order to provide better support to Member States by advancing knowledge and actively engaging appropriate bodies of the United Nations system and other international organizations;
- (2) to provide guidance to Member States towards the integration of vertical and horizontal health care programmes in the development of national health systems;
- (3) to facilitate the exchange of information on good practices in health system strengthening in collaboration with donor and partner countries, international organizations, foundations, development banks, the private sector, nongovernmental organizations, and civil society;
- (4) to provide support to enhance national capacities for assessing and developing health financing policy based on sound evidence;
- (5) to provide support to strengthen the capacity of Member States to plan, implement, and evaluate programmes to improve the health workforce;
- (6) to facilitate coordination and development of global and national health information systems to monitor and evaluate health systems and programmes;
- (7) to actively engage and provide guidance to the international community on coordinated and cohesive long-term technical support for strengthening health systems based on the primary health-care approach;
- (8) to improve alignment and coordination of interventions for health system strengthening based on the primary health-care approach, in collaboration with Member States, relevant international organizations, international health initiatives, and other stakeholders, in order to increase synergies between international and national priorities;
- (9) to report to the Sixty-third World Health Assembly, and subsequently to the Health Assembly every two years, through the Executive Board, on progress in implementing this resolution.

He also drew attention to a third draft resolution, on traditional medicine, proposed by China, which read as follows:

The Executive Board,

RECOMMENDS to the Sixty-second World Health Assembly the adoption of the following resolution:

The Sixty-second World Health Assembly,

Having considered the report on Primary health care, including health system strengthening;<sup>1</sup>

Recalling resolutions WHA22.54, WHA29.72, WHA30.49, WHA31.33, WHA40.33, WHA41.19, WHA42.43, WHA54.11 and WHA56.31;

Recalling the International Conference on Primary Health Care at Alma-Ata 30 years ago and noting that people have the right and duty to participate individually and

---

<sup>1</sup> Document EB124/8.



collectively in the planning and implementation of their health care, which may include access to traditional medicine;

Noting that the term “traditional medicine” covers a wide variety of therapies and practices, which may vary greatly from country to country and from region to region, and that traditional medicine may also be referred to as alternative or complementary medicine;

Recognizing traditional medicine as one of the resources of primary health care services to increase availability and affordability and to contribute to improve health outcomes, including those mentioned in the Millennium Development Goals;

Recognizing that Member States have different domestic legislation, approaches, regulatory responsibilities and delivery models;

Noting the progress of many governments to date in integrating traditional medicine into their national health systems;

Noting that progress in the field of traditional medicine has been obtained in a number of Member States through implementation of the WHO Traditional Medicine Strategy 2002–2005;<sup>1</sup>

Expressing the need for action and cooperation by the international community, governments, and health professionals and workers, to ensure proper use of traditional medicine as an important component contributing to the health of all people, in accordance with national capacity, priorities and relevant legislation;

Noting that the WHO Congress on Traditional Medicine took place from 7 to 9 November 2008, in Beijing, and that the Beijing Declaration on Traditional Medicine was adopted by the Congress on 8 November 2008;

Noting that African Traditional Medicine Day is commemorated annually on 31 August, in order to raise awareness and the profile of traditional medicine in that African region, as well as to promote its integration into national health systems,

1. URGES Member States:

- (1) to adopt and implement the Beijing Declaration on Traditional Medicine in accordance with national capacities, priorities, relevant legislation and circumstances;
- (2) to respect, preserve, promote and widely communicate the knowledge of traditional medicine, treatments and practices, appropriately based on the circumstances in each country;
- (3) to recognize the government’s responsibility for the health of their people, and to formulate national policies, regulations and standards, as part of comprehensive national health systems to ensure appropriate, safe and effective use of traditional medicine;
- (4) to take action to integrate traditional medicine into their national health systems based on national capacities, priorities, relevant legislation and circumstances;
- (5) to develop further traditional medicine based on research and innovation in line with the Global strategy and plan of action on public health, innovation and intellectual property adopted in resolution WHA61.21 – governments, international organizations and other stakeholders should collaborate in implementing the global strategy and plan of action;

---

<sup>1</sup> Document WHO/EDM/TRM/2002.

- (6) to establish systems for the qualification, accreditation or licensing of traditional medicine practitioners and to assist traditional medicine practitioners to upgrade their knowledge and skills based on national requirements;
- (7) to strengthen communication between conventional and traditional medicine providers and to establish appropriate training programmes for health professionals, medical students and relevant researchers;
- (8) to commemorate Traditional Medicine Day on days as individual Member States may decide, in order to provide education and understanding of traditional medicine as one of the resources of primary health-care services,

2. REQUESTS the Director-General:

- (1) to support Member States in implementing the Beijing Declaration on Traditional Medicine;
- (2) to update WHO's strategy on traditional medicine based on countries' progress and current new challenges in the field of traditional medicine;
- (3) to implement the Global strategy and plan of action on public health, innovation and intellectual property, particularly through starting the agreed parts of the plan of action related to traditional medicine without prejudice to the existing mandates;
- (4) to continue providing policy guidance to countries on how to integrate traditional medicine into health systems, step by step, especially to promote the use of traditional medicine for primary health care;
- (5) to continue providing technical guidance in order to support countries to ensure the safety, efficacy and quality of traditional medicine;
- (6) to strengthen cooperation with WHO collaborating centres, research institutions and nongovernmental organizations in order to share evidence-based information and to organize various training programmes for national capacity-building in the field of traditional medicine;
- (7) to provide support to the traditional medicine programme to implement above-mentioned requests.

Professor SOHN Myong-sei (Republic of Korea) said that the draft resolution proposed by China on traditional medicine in the context of primary health care did not overlap with the draft resolution on primary health care proposed by his country and 11 cosponsors, and could therefore be discussed separately. However, the first draft resolution did seem to be parallel. Confident that collaboration between the two sides would result in consensus, he proposed that an informal group should be formed to work on merging the two drafts.

Dr KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union, supported the proposal to merge the draft resolutions so that a strong resolution on primary health care would be sent to the Health Assembly. He emphasized, however, that the draft resolution on traditional medicine should be treated separately.

Dr OULD JIDDOU (Mauritania), speaking on behalf of the Member States of the African Region, supported the proposal to merge the draft texts. One or two members for African States should join the informal group to ensure that Africa's basic concerns were taken into account.

Dr AHMADZAI (Afghanistan), Dr BUSS (Brazil), Dr REN Minghui (China), Dr SERPAS MONTTOYA (alternate for Dr Larios López, El Salvador), Ms ROCHE (New Zealand), Dr MOHAMED (Oman), Dr GIMÉNEZ CABALLERO (Paraguay), Professor Aydin (Turkey),

Dr BIN SHAKAR (United Arab Emirates) and Dr WRIGHT (United States of America) expressed support for the proposal.

The CHAIRMAN drew attention to the report in document EB124/8.

Dr KÖKÉNY (Hungary) said that he spoke on behalf of the European Union and that the candidate countries Croatia, The former Yugoslav Republic of Macedonia and Turkey; the countries of the Stabilisation and Association process and potential candidates Albania, Armenia, Bosnia and Herzegovina, Montenegro and Serbia; the Republic of Moldova as well as Ukraine, aligned themselves with his statement. The European Union recognized the importance of WHO in coordinating global activities relating to primary health care. Measures were needed to address inadequate human resources and to provide sustainable financing in health, key factors in achieving the health-related Millennium Development Goals. The European Union encouraged well-coordinated and integrated action, notably regarding health determinants within primary health care. He emphasized the development of professional skills in the field of health promotion and disease prevention in order to deal with the contemporary health challenge of noncommunicable diseases. Strengthening primary health care was crucial to reducing health inequalities. The European Programme for Action, which aimed to deal with the shortage of health workers in developing countries, could serve as a model for regional cooperation and exchange of best practices with a view to improving national health systems.

Dr STARODUBOV (Russian Federation), welcoming the Director-General's support for primary health care, said that the Russian Federation prioritized primary health care, which would be fully funded despite the current financial crisis.

Given that importance, he was surprised that the report confined itself to recommending that the Board take note of the document. The absence of a draft resolution until the start of the Board's session called the purpose of the report into question. Was there really a need to reopen the debate on the principles of primary health care, which had been set out so clearly in Alma-Ata 30 years previously? The report did not seem to reflect fully the complexities of the situation at country level, nor was its analysis sufficiently detailed. Despite the Director-General's repeated emphasis, learning from the past was not mentioned in the report. Open and unbiased analysis, which explained the difficulties associated with primary health care, was needed in order to convince a new generation of health-care managers of the importance of learning from past lessons. Health systems should be effective and should respond to the needs of a changing world. Primary health care could do both.

A previous report to the Health Assembly had highlighted that a failure to develop primary health care could be attributed not only to lack of political will, resources and leadership, but also to unrealistic expectations.<sup>1</sup> That, together with different interpretations of primary health care, must be avoided. The same report had noted that many countries had then perceived primary health care as just one element of health policy. Six years on, the Secretariat's position on the issue must be clarified. Perhaps the inclusion of the strategic function of primary health care into national policy-making should be considered, even if operative matters were still decided locally.

Dr BIN SHAKAR (United Arab Emirates) said that the Member States of the Eastern Mediterranean Region reaffirmed their respect for the principles of equity, solidarity and social justice mentioned in the report and intended to ensure that the whole of society benefited from those principles. More than 20 million people of the Region had been provided with primary health-care services to which they had not had access before. The Member States had taken account of the social

---

<sup>1</sup> Document A56/27.

determinants of health and increased available resources; they had taken gender issues into account and improved the primary health care available to women.

In the United Arab Emirates, there were 200 primary health-care centres in operation, particularly in rural and remote areas. Additional programmes had emphasized maternal and child health, mental health, and health problems specific to the elderly. Remaining true to the principles of Alma-Ata, his country supported the four broad policy areas in the report's agenda for action. Carrying out that work would constitute an enormous challenge for the country, for all the Member States of the Region and would require cooperation between sectors and systems. There was no panacea, solutions would have to be tailored to the needs of each Member State, for which WHO could and should take a leadership role.

Ms ROCHE (New Zealand) commended the Director-General's leadership and the report on primary health care, and emphasized the thirtieth anniversary of the Declaration of Alma-Ata, improved health outcomes and cost-effective systems. As stated by the member for Hungary, primary health care had important links with the social determinants of health and with the strengthening of health systems. She supported the draft resolution on traditional medicine, which, while included under item 4.5, was sufficiently distinct to be considered separately.

Dr MOHAMED (Oman) thanked the Director-General for emphasizing the importance of primary health care. The four principles and directions for primary health care in the report would guide countries wishing to revitalize their systems, were relevant at all levels and sectors of economic development and should be adapted to each country's situation. The draft resolution should avoid the implication that primary health care was a matter for low-income and developing countries only: it was indeed a global issue. Countries expected the renewal of primary health care to lead to changes. The draft resolution should emphasize the leading role of WHO and the importance of primary health care in all countries and at all stages of development.

Professor HAQUE (Bangladesh), welcoming the report, said that the improved quality of life in most parts of the world owed much to primary health care, to which his country was fully committed. It had built a network of 12 000 community clinics, with the aim of one for every 6000 inhabitants, backed up by hospitals. A harmonized health system was needed, with an integrated approach and coordination with stakeholders and donors. However, countries like Bangladesh needed continued support to expand its infrastructure and services.

The alarming increase in cholera, with high fatality rates, called for a special focus where proper prevention and treatment were lacking. Only about 10% of cases were reported to WHO owing to lack of surveillance and the fear of sanctions. The lifting of embargoes on travel and trade in 2005 had gradually improved the situation. The prevention and control of cholera depended on public health tools, including affordable vaccines through cooperation between developing countries. The possibility of manufacturing such vaccines through the transfer of technology was being explored. Given the size of the problem, he urged the revival of the Global Task Force on Cholera Control established in the 1990s and the submission of a comprehensive report on the global situation, together with possible control measures, to the Sixty-second World Health Assembly. WHO support and technical assistance were needed by countries at risk in order to set up effective surveillance systems and to produce vaccines locally. A report from the Global Task Force would be helpful in guiding future work and Bangladesh wished to contribute actively to the process.

Ms TOELUPE (Samoa) commended the Director-General's visionary leadership in reviving global commitment to primary health care, whose principles and values were the most effective approach for Samoa's particular needs and essential to achieving the Millennium Development Goals. Its primary health care and national health system had recently focused on health financing, human

resources, health information, governance and delivery. A more harmonized approach to donor contributions was also being pursued with partners.

Dr ADITAMA (alternate to Dr Supari, Indonesia) said that the success of primary health care owed much to community participation, solidarity and social justice. His country supported the outcomes of the Regional Meeting on the Revitalization of Primary Health Care held in Jakarta in 2008. Indonesia had established a national programme of “Alert Villages” in which local communities took responsibility for maternal and child health, nutrition and basic surveillance, with a backbone of primary health centres. The system covered more than 70 000 villages and had strengthened the health system at the local level. A social system to provide for health security assisted low-income and middle-income communities in meeting their health service needs. The Director-General and Member States should maintain their commitment to primary health care, strengthening of health systems and the sharing of information nationally, regionally and internationally.

Dr OULD JIDDOU (Mauritania), speaking on behalf of the 46 States of the African Region, said that primary health care was closely linked to health systems and had been decisive in improving the health of the Region’s populations since the 1980s. The strengthening of primary health care and health systems constituted major challenges for countries of the Region. However, the goal of “Health for All” had not been attained, for reasons that included structural adjustment programmes, civil strife and natural or human-made disasters. Progress included declarations and resolutions on health financing, human resources and community involvement. With resolution AFR/RC56/R6, the Regional Committee for Africa had approved use of the primary health-care approach for revitalizing health services in order to speed up progress towards the Millennium Development Goals.

The Declaration of Ouagadougou, adopted in April 2008, on primary health care and health systems in Africa had subsequently been endorsed by the Regional Committee. Implementation would prioritize eight selected areas: leadership and governance for health; provision of services; human resources; funding; information systems for management; community involvement; partnerships; and research. The renewal of primary health care and traditional medicine would require the strengthening of fragmented health services weakened by the poor coordination and use of resources. Inappropriate approaches for strengthening community involvement, in the demand for health services and in their availability, accessibility and use, had been aggravated by inadequate funding. He looked forward to a proposed resolution, to be adopted by consensus, that would take into account new factors, such as the financial crisis and the need to safeguard health budgets. The countries of the African Region were ready to take part in drafting the resolution.

Mr TOURÉ (Mali) said that African health ministers, deeply concerned by the health situation in the Region, had agreed, through the Declaration of Ouagadougou, on the need to strengthen primary health care, with the participation of all parties concerned, since it was essential to the strengthening of health systems and accelerated achievement of the Millennium Development Goals. For that reason the key points of the Declaration should be taken into account in the proposed resolution, and the African group should be associated with its preparation, as suggested by the member for Mauritania. He invited all partners to join forces with African countries and tackle the priority areas listed in the Declaration.

Professor AYDIN (Turkey) suggested that, rather than primary health-care activities being performed in line with a policy-based definition, the health needs of societies should be determined on the basis of real evidence. The basis of primary health-care services was the provision of support through the health system as a whole, rather than support to just one or more areas. The global community had not yet succeeded in achieving the goals set in the Declaration of Alma-Ata, which had set out the general principles of primary health care in order to achieve “Health for All.” After 30 years of experience, WHO had documented the progress of primary health care, and *The world health report 2008* had highlighted the need for reforms in: universal coverage; service delivery,

reorganized around people's needs and expectations; public policy; and inclusive, participatory leadership, as required by the complexity of contemporary health systems.<sup>1</sup>

Dr WRIGHT (United States of America) said that primary health care was crucial to national health systems for developed and developing countries alike. His Government remained committed to promoting a primary health-care approach, particularly by developing national capacity and producing the data and evidence needed to inform future health policy. He encouraged all countries to expand primary health-care services in all communities. Renewed commitment to primary health care was needed, both financially and politically. However, many Member States lacked the resources and political will to enact many of the policy changes suggested in the report, which failed to determine how Member States could increase the domestic funding that they needed in order to expand health-care delivery systems and infrastructure. Nor did the report acknowledge that containment of costs was an issue for both high-income and low-income countries. He also questioned why the report did not specifically mention health research and the development of robust systems of health information. Many Member States lacked quality data when making decisions on public health priorities or improvements to health-care delivery and infrastructure. In addition, a number of the terms used in the report, such as "close-to-client networks", or "primary care teams", required additional explanation.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) expressed strong support for WHO's goal of universal health service coverage. To achieve that, investment in health systems must be increased and the barriers to use of health services, particularly financial, removed. The United Kingdom had supported a number of countries in their efforts to remove health user fees, which in every case had led to increased utilization of health services, with proportionately greater benefits for the poor. He encouraged other countries and donors to adopt the same approach. WHO's role in taking forward the International Health Partnership and Related Initiatives (IHP+) was central in reducing fragmentation and transaction costs in external assistance for health, and he supported the efforts of WHO and the World Bank in that regard. In addition, all Board members should engage in the work of the High Level Task Force for Innovative International Financing for Health Systems.

Any draft resolution on primary health care should emphasize its core values, especially equity; should request WHO to help Member States to apply equity as the test for deciding on policy options, particularly financing and delivery of health care; and should request the Director-General to monitor the Secretariat's effectiveness in its support to countries and to their implementation of primary health-care values, standards and approaches.

Dr DAHL-REGIS (Bahamas) said that strengthening health systems through primary health care would allow Member States to meet important health goals, and enable WHO to implement its strategic objectives and programme of work more effectively. More remained to be done and the report should provide quantitative evidence to demonstrate to governments and donors that investment in primary health care represented value for money, and reduced the need for curative interventions in the future.

Many positive policies, such as strengthening immunization infrastructure through the GAVI Alliance, had directly or indirectly helped to strengthen health systems. She encouraged WHO to lead the way in reforming or monitoring financing structures with major partners, which would assist with the realignment of resources needed to promote primary health care. A good communications strategy was essential in order to inform those with control of financial resources about the choices they must make.

---

<sup>1</sup> *The world health report 2008: primary health care - now more than ever*. Geneva, World Health Organization, 2008.

Dr REN Minghui (China) welcomed WHO's efforts at all levels to revitalize primary health care, strengthen health systems and eliminate health inequities. His Government had invested in primary health care that was adapted to the country's particular needs and challenges. Two 10-year plans had achieved good results in improving primary health care in rural areas. Universal access to primary health care was an important goal, as the protection of people's health and social equality was an essential responsibility of governments. All sectors should be involved in promoting primary health care, of which traditional medicine was an important part, and approaches should focus on national circumstances.

Dr ABABII (Republic of Moldova) said that primary health-care reforms in his country had improved health indicators and aided progress towards achieving the Millennium Development Goals. In emphasizing human and financial resources, he highlighted needs for: management training in primary health-care; greater participation by society in health-care programmes; and improved access by disadvantaged groups to basic services, for which social protection mechanisms should be devised, taking into account the disparities of living standards between urban and rural populations. Increasing differences in life expectancy and other health indicators between the two groups was a cause for concern.

He emphasized the lack of standardized indicators for accessibility, equity, quality and effectiveness of primary health care. Indicators varied from country to country, an issue that should be addressed in WHO's basic documents. He expressed support for WHO's initiative to allocate funds to priority areas as identified by countries. That would strengthen existing structures, reduce duplication and increase efficiency.

Mr VALLEJOS (Peru) said that progress in the twentieth century, in terms of life expectancy and infant mortality, had been significant, but less than the expectations in 1978, when the Declaration of Alma-Ata had been signed. Unequal access to health care in Peru, caused by socioeconomic, educational and ethnic factors, had led to increased mortality and morbidity rates, particularly among high-risk groups such as children, pregnant women and the elderly.

In Peru, as elsewhere, increased life expectancy and reduced infant mortality reflected better access to primary health-care services. Social programmes to improve access to decent housing, sanitation and nutrition would help to maintain progress. Access to treatment for parasitic and water-borne infections, tuberculosis and other diseases was helping to improve the health of the population. The participation of women as the main force for protecting family health had facilitated their access to primary health care, including health education, simple and economical treatment, reproductive health services and prescribed generic medicines.

Highlighting the importance of trained health professionals, he outlined the "family doctor" and "household doctor" strategies being implemented in Peru, which included medical consultations, house-to-house treatment, promoting action to prevent the spread of infections, and referrals that were mainly children and pregnant women. Such strategies aimed to reduce child mortality and morbidity through health promotion and thus relieve pressure on health services.

Dr GIMENÉZ CABALLERO (Paraguay) reaffirmed his Government's commitment to revitalizing primary health care. Implementing the strategy in a universal, integral and equitable manner would reduce social exclusion and facilitate access to health services. Revitalization should be comprehensive, from community health workers to more complex services, building on existing strengths and working towards a coherent whole. He highlighted challenges: balancing promotion and prevention; ensuring universal access to essential medicines; strengthening human resources; improving health information; and increasing participation. Specific technical resources and efforts should be directed towards revitalizing primary health care.

Dr JAYANTHA (alternate to Mr de Silva, Sri Lanka) said that his country's health system, which was based on primary health care, had achieved good results. In the face of the changing

disease burden, however, a revitalized approach was required. Increased incidence of noncommunicable diseases required the promotion of healthy lifestyles and good health practices and those must be incorporated into primary health-care systems. Given the difficulty of finding sufficient resources for health care, he commended the work of his Region in examining how self-care could be promoted and adopted in a rational manner. He urged WHO to pursue action in the four areas highlighted in the report.

Dr BUSS (Brazil) commended the Director-General's commitment to primary health care, and welcomed the consultative process undertaken in that area. Brazil had launched its family health programme in 1994: teams had been established across the country and currently covered nearly 90% of the population, leading to significant reductions in maternal and child morbidity and mortality, and improvements in quality of life. The programme was aimed at the entire population and included health promotion, disease prevention and intersectoral activities, such as action to improve the environment, as well as curative services. The family health teams in the public sector comprised a general practitioner, nursing staff and community health workers, and dentists in many cases, and were capable of resolving 90% of the health problems encountered, with referral of the remainder to other levels of the health system.

His Government was constitutionally obliged to provide services to the entire population and to prioritize primary health care. Developing those services at all levels had met with success Brazil had achieved extensive coverage for measles immunization and the second highest rate of organ transplantation in the world. He supported WHO in its efforts to encourage implementation of primary health-care strategies and to incorporate that element into all its programmes. He emphasized the overall strengthening of health systems, including primary health care, rather than focus on vertical programming. WHO should also emphasize decentralization within the Organization in order to strengthen its regional and country offices.

Mr MIGUIL (Djibouti) said that Djibouti had invested in primary health care and strengthened its health systems, particularly in the area of maternal and child health through increased numbers of trained health personnel; developing health promotion policies; and encouraging community involvement. However, nomadic and displaced people, and refugees, were all placing a great burden on the health system and distorting health indicators. As a small country surrounded by larger countries, in some of which security was uncertain, Djibouti found it difficult to obtain reliable data and to plan and coordinate primary health care activities, including immunization campaigns. He appealed to WHO to provide guidance on enhancing cooperation and collaboration in order to strengthen primary health-care activities.

Dr SADRIZADEH (Islamic Republic of Iran)<sup>1</sup> applauded the Director-General's commitment to the renewal of primary health care. Despite significant changes in the health field since the Declaration of Alma-Ata in 1978, most of those principles and values remained valid, and primary health care was still a priority. Progress in most countries required a reorientation of health systems to ensure that primary health-care services responded better to people's needs and were delivered through facilities embedded in the community. His country had significantly reduced mortality over the past 20 years through its community-based system. He supported the merger of the two draft resolutions on primary health care including health system strengthening and his country wished to be included as a sponsor of the resulting draft resolution.

Ms ARTHUR (France),<sup>1</sup> commending *The world health report 2008*, said that the international community was committed to the goal of universal access to health services. However, some 100 million

---

<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.



people were forced into poverty each year by payments for those services, and many more had no access at all. Increased coverage of health insurance and numbers of trained health personnel were essential in order to strengthen health systems in developing countries and support programmes to control communicable and noncommunicable diseases. The State was central to leading that process and to providing funding or co-funding, as concluded at the conference entitled “Social Health Protection in Developing Countries: Who Will Pay?” (Paris, May 2008). However, action could not be left to health ministries alone. In the spirit of the 2005 Paris Declaration on Aid Effectiveness, WHO should take action in mobilizing and coordinating all efforts to improve coverage of health insurance.

Ms BILLINGS (Canada)<sup>1</sup> welcomed the report and confirmed Canada’s renewed commitment to primary health care. Canada looked forward to participating in the drafting group that would merge the two draft resolutions on primary health care and strengthening of health systems. The revised text should be sufficiently flexible to accommodate countries such as hers, where responsibility for primary health care was shared or assumed by subnational authorities. She welcomed the increasing recognition given to strengthening health systems, notably in improved access to health care by disadvantaged population groups in developing countries. Canada would continue support to developing countries in response to their expressed needs.

Ms MATSAU (South Africa),<sup>1</sup> welcoming the renewed commitment, regretted that, despite progress in most countries in implementing primary health care, the ideals set out in the Declaration of Alma-Ata had not been fully realized. There had been many lost opportunities and Member States could have done better.

Two key aspects to strengthening health systems, namely human resources for health and health information systems, should be covered in the revised draft resolution. Some past failures had been due to lack of proper monitoring: only reliable data would indicate how well programmes were performing. There was room to improve equity in, and universality of access to, health services. Specific policies might improve delivery to vulnerable populations groups and bridge gaps in service accessibility. Appropriate governance structures and promotion of community ownership of primary health-care services were also required.

Dr ALVIÁREZ (Bolivarian Republic of Venezuela),<sup>1</sup> expressed support for the revised draft resolution and the strengthening of primary health care through improved community participation. The Constitution of his country recognized health as a fundamental social right. His Government had established primary health-care activities including training of community health workers to provide simplified medical care in remote areas; outpatient clinics with trained staff; and an expanded programme of immunization offering 14 vaccines. Efforts were being made to expand training of health personnel. The number of family practitioners, community doctors and health centres was increasing. Social policies were taking account of determinants of quality of life and covered, for example: disabled people; those with genetic disorders; indigenous peoples; housing; nutrition; education; and control of communicable diseases such as malaria. Those policies, financed by the State, had contributed to a significant fall in infant mortality and to a substantial increase in access to clean drinking water. Regional and global cooperation between countries also played an important role in ensuring successful implementation.

Dr KARAGULOVA (Kazakhstan)<sup>1</sup> drew attention to national and international events in 2007 and 2008 calling for the renewal of primary health care and organized in collaboration with WHO, including the international conference held in Kazakhstan to mark the 30th Anniversary of the

---

<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Declaration of Alma-Ata. She welcomed the report and thanked the Director-General for her efforts in promoting primary health care on a global, regional and national scale.

She supported the comments made by the members for the Russian Federation and Tunisia and agreed that both of the draft resolutions tabled could be merged to create one practical, usable resolution.

Mgr VITILLO (Holy See), speaking at the invitation of the CHAIRMAN, congratulated the Secretariat for its report, and highlighted the references to equity, solidarity and social justice; and the principles of multisectoral action and community participation, all of which were echoed in the teaching of the Catholic Church.

Organizations based on Church or faith, as well as civil society, had a key role to play in primary health care, frequently reaching communities in rural and isolated areas which had no access to primary health services. Those organizations implemented national health plans, and contributed to strengthening of health systems, but were regrettably excluded from policy-making and direct funding.

The Holy See affirmed the recommendation contained in *The world health report 2008* to enhance efforts to improve health by acting on the wider social, economic, and environmental causes of ill health and health inequalities. In his 2009 World Day of Peace Message, Pope Benedict XVI had promoted similar themes of “global solidarity”, through a “change of lifestyles, of models of production and consumption, and of the established structures of power”.

Dr MUÑOZ (Chile)<sup>1</sup> expressed support for a resolution based on the report to the next Health Assembly. The resolution should clearly mention the vital role of primary health care in social protection for all people. Provision of primary health care should be spread across all sectors of public policy related to social determinants of health, and should be carried out at the community level. He supported the request by representative of Canada to incorporate flexibility so that the resolution could be easily adapted to the situation in each country.

Mr SAMRI (Morocco)<sup>1</sup> thanked the Secretariat for the detailed report and praised the Regional Office for the Eastern Mediterranean for its excellent work in that area. WHO should remain vigilant to the global financial crisis which threatened primary health care, the keystone of all national health systems and central to reducing health inequities.

His country had prioritized primary health care by implementing measures including: obligatory health insurance; access for all people to primary health care; involving civil society; strengthening maternal, infant and child health programmes; regular vaccination campaigns; renewed training of health care workers; and public awareness campaigns, especially in rural areas.

He supported WHO's programme of action and highlighted international solidarity and a fair division of responsibility.

Professor RANTANEN (International Commission on Occupational Health), speaking at the invitation of the CHAIRMAN, welcomed the principles contained in the report and remarked on their link with occupational health. In order to improve overall health care and promote equity, vulnerable and high-risk groups should be targeted.

Workers in developing countries and countries in transition were most at risk from occupational health and safety hazards. More than two million deaths a year were directly caused by occupational health and safety factors, with considerable socioeconomic consequences.

In response to the health requirements of underserved working populations, his organization, with WHO and ILO, had launched Basic Occupational Health Services, an application of primary health-care policy in the field of occupational health. It was being piloted in several countries and areas, including China, Thailand, Viet Nam, the north-west of the Russian Federation, countries in south-east Europe and the east African community area, and it had already been implemented in various forms in other countries such as Brazil, Chile, Finland and the Netherlands.

He recommended the inclusion of basic occupational health services in primary health-care systems, and further pilot projects in other countries. WHO and its partners should assist countries in that regard. Finally, basic occupational health should be taught to primary health-care workers.

Professor GUNN (International Federation of Surgical Colleges), speaking at the invitation of the CHAIRMAN, expressed satisfaction at WHO's efforts to strengthen essential surgery within emergency and primary health care. Although some progress had been made, surgical disease was increasing at an alarming rate, especially in middle-income and lower-income countries, and the inclusion of essential surgery within primary health care remained inadequate.

Around 234 million major surgical procedures were performed each year, equating to double the number of births annually. There were significant inequities in the global coverage of surgical care, with the poorest third of the world's population receiving about 3% of the total. Surgical care was erroneously perceived as a luxury in developing countries.

The Federation was committed to making essential surgery an integral part of primary health care, and requested the Board to consider its inclusion in WHO's overall primary health-care concept and action.

Ms SHASHIKANT (Churches' Action for Health), speaking at the invitation of the CHAIRMAN, and delivering her statement jointly on behalf of the People's Health Movement, proposed an alternative version of the draft resolution.

**The meeting rose at 12:30.**