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Report of the Seventh Meeting of Health Secretaries of the Countries of WHO South-East Asia Region

SEARO, New Delhi, India, 24-26 April 2002

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The Report

Section 1

Introduction

The Seventh meeting of the Health Secretaries was held in World Health House, New Delhi on 24-26 April 2002.

The objectives of the meeting were to review:

- Implementation of the Programme Budget 2000-2001
- Status of implementation of the Programme Budget 2002-2003
- Overall managerial framework: Programme Budget 2004-2005 (Part I)
- Part II of the Proposed Programme Budget 2004-2005
- Review of the following selected agenda items of the Fifty-fifth World Health Assembly
  - Risks to health
  - WHO Medicines Strategy
  - Report of the Commission on Macroeconomics and Health
  - Global Fund to Fight AIDS, Tuberculosis and Malaria.
- Updates on:
  - Road accident injuries
  - Arsenic contamination of water
  - Development of database on reasonable pricing of imported essential drugs and those locally produced
  - Development of bulk purchasing arrangements for vaccines, medicines and raw materials for drug manufacture
  - Recommendation of the Sixth Meeting of Health Secretaries regarding the feasibility of health insurance schemes.

The Agenda of the meeting is at Annex 1.

The meeting was originally scheduled to be hosted by the Ministry of Health, His Majesty's Government of Nepal. However, in view of the developments in Nepal and in consultation with all concerned, the venue of the meeting was shifted to the South-East Asia Regional Office (SEARO) of WHO in New Delhi. It was attended by the Health Secretaries of Bangladesh, Bhutan, India, Indonesia, Nepal and Sri Lanka. The Directors-General of Health Services of Maldives and Myanmar, Deputy Permanent Secretary of the Ministry of Public Health of Thailand and the Second Secretary of the Embassy of DPR Korea in New Delhi also attended the meeting. (see Annex 2 for the List of Participants).

The meeting was inaugurated by Dr Uton Muchtar Rafei, Regional Director, WHO South-East Asia Region, New Delhi.

Section 2

Inaugural Session

DR UTON MUCHTAR RAFEI, Regional Director, WHO South-East Asia Region, New Delhi, in his inaugural address, recalled the health gains over the last 50 years and also reminded the participants of the unfinished agenda. At the same time, he highlighted the opportunities available for coping with the health challenges that lie ahead. In particular, he referred to the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) and the report of the Commission on Macroeconomics and Health (CMH). He underlined that the CMH sees investment in human resources as crucial to get out of the poverty trap and views health as a key factor in economic growth and social development. He said that the Commission has urged developing countries to establish a temporary national commission on macroeconomics and health to formulate a long term programme for scaling up essential health interventions within the overall framework of poverty reduction strategies.

The Regional Director also noted that the forthcoming World Summit on Sustainable Development is another milestone towards a world where every one can enjoy a healthy lifestyle, without undermining the ability of the future generations to do the same. He therefore urged that national governments must stress the central role of health in development at the Summit.

Dr Uton concluded by expressing the hope that the current meeting would further enhance regional solidarity and promote the interest of the countries of the Region. (For full text of the address, see Annex 3)

Section 3
Introductory Session

DR UTON MUCHTAR RAFEI, Regional Director, WHO, apprised the participants of the important developments and events that had taken place since their last meeting in February 2001.

Dr Uton recalled that the Fifty-fourth World Health Assembly had deliberated upon the General Programme of Work 2002-2005 and approved it. The Assembly had urged the Member States to ensure global compliance with the International Code of Marketing of Breastmilk Substitutes, undertake sustainable measures for reducing all forms of malnutrition in young children and women of reproductive age, ensure that HIV/AIDS was included as one of the highest priorities in their health and development agendas and reaffirm their commitment to public health interests to implement the WHO Medicines Strategy. The Assembly had also alerted governments against the activities of the tobacco industry aimed at subverting their role in implementing public health policies to combat the tobacco epidemic.

Dr Uton recounted that the 54th Session of the WHO Regional Committee had endorsed increased use of the intercountry mechanism to implement priority health programmes. He underlined that it had called for strong commitment by Member States to agree upon targets in order to fully utilize the WHO Programme Budget 2002-2003 in a timely manner. He also urged Member States to strengthen policies and programmes and community-based prevention and control efforts in order to meet the challenge of substance abuse, including alcohol. The Regional Director noted that the 109th Session of the WHO Executive Board had adopted resolutions on quality of care, patient safety, accessibility to essential medicines and infant and young childhood nutrition. He specifically highlighted that, in her statement to this session, the Director-General of WHO had emphasized the need to break the dependence of sports on tobacco. She called upon WHO to give maximal attention to countries, and commended the role of WHO and other UN partners in lowering the cost of and increasing access to medicines for HIV/AIDS at the recent Doha Ministerial meeting and the heightened focus on children during the current year.

Dr Uton also recalled the recommendations made by the Health Ministers at their 19th meeting in August 2001. He also referred to the 27th session of the Advisory Committee on Health Research and the Regional Conference of Parliamentarians on HIV/AIDS and Mental Health that was held in December 2001.

Mr Mahendra Nath Aryal (Nepal) and Dr Abdul Azeez Yoosuf (Maldives) were nominated as Chairman and Vice-Chairman respectively.

A drafting group, consisting of Dr Kyi Soe (Myanmar), Dr Setiawan Soeparan (Indonesia), Dr Benu Bahadur Karki (Nepal), Dr Ajit Fonseka (Sri Lanka) and Dr Amnuay Gajena (Thailand) was established. Dr M A L R Perera (Sri Lanka) joined the group.

Section 4

Business Sessions

4.1 Review of Implementation of the Programme Budget 2000-2001

As a result of the implementation of Resolution WHA51.31, which required the transfer of funds from the Americas, East Mediterranean, South-East Asia and Western Pacific Regions to the African and European Regions, the Programme Budget for WHO South-East Asia Region has been on the decline since 2000-2001. It is anticipated that, by the end of the period which this resolution covers, i.e. 2004-2005, the Regular budget for SEARO will have declined by 8.2%. It has to be noted, however, that this reduction was significantly less than the 3% per year maximum reduction provided in the resolution. At the same time, the flow of extrabudgetary funds increased dramatically and this helped to ensure that a full range of support is provided to the Member States. Income from extrabudgetary sources now surpasses the Regular budget funds.

A review of implementation of Programme Budget 2000-2001 reveals that after a slow start in the implementation of programme activities, the pace quickened midway through the biennium. As a result, 100% implementation was achieved by 30 June 2001. This represented a significant improvement over the previous biennium. At the same time, the liquidation (expenditure) rate achieved during the biennium was 87% (as compared to 83% in the previous biennium). Reserves of US$12.8 million carried forward to 2002 were the lowest in actual and relative terms. These reserves have to be spent on approved activities before 31 December 2002. The aim must be to continue to lower the level of reserves, as they call for considerable extra work by countries. In addition to the implementation of the current biennium budget, it is necessary to ensure that work commenced in the last biennium is completed in 2002, thereby preventing the surrender of unused funds.

Discussion

Countries expressed support for the approach adopted by the Regional Office in 2000-2001, but advised that financial implementation targets should be used with caution.

The possible danger of sacrificing quality in achieving the financial targets was mentioned. It was stressed on behalf of WHO that every effort was made to avoid this, including the use of the Directors' Group in the Regional Office to peer review proposals from the technical perspective.

Interest was expressed in the size of the Regular Budget allocation and the amount of extrabudgetary funds available to SEARO. It was noted that some Regions have been very successful in making donors aware of their needs and accordingly attract a high level of extrabudgetary funding. SEAR could learn from this. The experience of enhancing resource mobilization capacity at the national level in SEAR countries was also discussed.

Recommendations

(1) In future, a detailed analysis of the financial implementation during the previous biennium should be circulated to Member Countries in advance of the Health Secretaries' Meeting, to enable them to review and reflect on the data.

(2) SEAR Member Countries and the Regional Office should prepare a strategy to respond to the review of WHA Resolution WHA51.31 on the Regular Budget allocations to Regions, which has to be completed for the World Health Assembly in May 2004.

(3) Resource mobilization capacity at the national level should continue to be improved with WHO support, where possible.

4.2 Review of Status of Implementation of the Programme Budget 2002-2003

The recommendation of the Regional Committee in September 2001 that higher implementation targets should be set for the current biennium was underlined during the presentation of the status of implementation of Programme Budget 2002-2003. Achievement of 85% implementation at the end of the first year has been fixed for the current biennium, as against 75% in the 2000-2001. This calls for close cooperation between the Member Countries and WHO. To date, an implementation rate of 12% has been achieved. It is anticipated that a portion of

the remaining 15% of the country allocation for activities of the countries which do not reach the 85% implementation level by the end of December 2002 may be pooled and redirected. It was also recalled that the Regional Committee had requested the Member Countries to submit all requests for fellowships and supplies & equipment during the first year of the biennium to assist in achieving the 85% target.

Discussion

Some concern was expressed about the impact of the Regional Committee Resolution (RC54/R1) requesting WHO and Member Countries to achieve 85% implementation of Regular Budget by 31 December 2002. In working towards the 85% implementation target, some countries reported that certain activities, such as research and development-oriented work, required a long lead-in time and could not be put in to effect as quickly as procurement of S&E or fellowships.

4.3 Overall Managerial Framework: Global Programme Budget 2004-2005 (Part I)

The key features of PB/2004-05 could be summarized as follows :

- It sets out the DG's commitments vis-a-vis Member Countries for the next biennium, and as such is much more than simply a constitutional requirement prepared once every two years for the Organization's Governing Bodies.
- It is being developed jointly by the Regions and Headquarters, applying the logical framework and results-based budgeting principles.
- It uses a uniform programme framework of 35 strategic areas of work, disassociated from organizational structures in Regions or at HQ.
- It focuses on expected results and indicators in order to ensure transparency and accountability.
- It will provide a better focus for WHO's country programmes, through indicative estimates of planned country expenditures for all areas of work.
- It will provide more transparency of extrabudgetary resources, thus facilitating discussions and review by Governing Bodies on how and where such resources are being planned.

As far as organization-wide priorities were concerned, all eleven global priorities applicable during 2002-2003 had been retained for 2004-2005 with

the exception of "investing in change in WHO" which had been replaced by "health and environment". It was expected that the DG would also soon take a position on two additional priorities recommended to her by the 109th session of the Executive Board in January 2002, namely, "Child Health" and "Affordable Access to Essential Medicines".

Finally, an overview was provided of budgeted versus actual expenditures of extrabudgetary resources for the three biennia 1998-1999, 2000-2001 and 2002-2003.

4.4 Review of Part II of the Proposed Programme Budget 2004-2005

During the presentation, the principles pursued in the preparation of the Region-Specific Part II of Programme Budget 2004-2005 were highlighted.

The lessons learnt from the implementation of WHO's collaborative during the previous biennia would guide the formulation and implementation of the 2004-2005 programme budget. Adequate focus would be provided to high level advocacy necessary for adoption and implementation of sound national policies and strategies. Intercountry collaboration, especially cross-border collaboration, and technical cooperation among Member Countries would be strengthened. National centres of excellence and WHO collaborating centres would be used as effective mechanisms for addressing intercountry problems.

Partnerships with regional organizations, such as ASEAN and SAARC, would be further strengthened, especially in combating major endemic diseases, providing access to essential drugs and facilitating human resource development. Partnerships with nongovernmental and community-based organizations and the private sector would be enhanced as a means of effectively moving the national health development agenda forward.

The joint planning of the WHO collaborative programme, both at regional and country levels will be further strengthened as it significantly improved the implementation of the intercountry programme. At the country level, the Government/WHO coordination mechanism played a crucial role in guiding the planning, implementation, monitoring and evaluation of programmes. These mechanisms which helped in effectively blending the WHO collaborative programmes with the national health development efforts supported by other development partners will be continued to be supported.

The issues and challenges for WHO collaboration with Member Countries during the 2004-2005 biennium remained substantially unchanged despite the significant achievements made in the previous biennia.

The regional priorities were developed through intensive collaboration between the WHO Secretariat and the Member Countries. The Health Ministers, at their 19th meeting, held in Male in August 2001, reviewed: the regional and organization-wide priorities for 2002 – 2003; the common country priorities identified by the WHO Country Cooperation Strategies (CCS), and the 14 priority content areas for the supplementary intercountry programme (ICP-II) identified by the High Level Task Force for Intercountry Collaboration. Based on their review, the Health Ministers recommended priorities to the RD to guide the development of the Programme Budget. The Region-specific priorities are consistent with the WHO core functions and strategic directions and provide continuity with the current biennium.

Based on the comments of the Health Secretaries and the inputs received from the Member Countries, the document will be revised and forwarded to the 39th meeting of CCPDM for its review and the 55th session of the Regional Committee, to be held in September 2002, for noting.

Discussion

In 2000-2001, some ceilings were established for certain activity components in order to achieve efficiency savings. It was clarified that the same approach would be continued in the 2002-2003 biennium.

Rotation and mobility of WHO staff across all levels of the Organization should be promoted, which would go a long way towards maintaining and sustaining a high level of competence and professionalism. WHO's recruitment policy should encourage development of national capacity by recruiting technical experts from Member Countries.

The National Professional Officer mechanism in the WHO country office has been useful in the formulation, implementation, monitoring and evaluation of the WHO collaborative programme in the Member Countries. This mechanism should be strengthened.

Strengthening the capacity and capability of staff of WHO and Member Countries involved in the formulation and implementation of WHO collaborative programme and the Programme Budget was the key to successful programme delivery and ensuring quality of output.

A major cause for ill health was attributed to factors outside the health sector. WHO's strategies to address priority health issues should also take into account the influence of factors external to the health sector, and recent developments in epidemiological patterns of disease-causing viruses and pathogens.

'Health and Environment' has been included as a priority area of work in PB 2004-2005 which will address the factors contributing towards ill health, but falling outside the direct purview of the health sector. The High Level Task Force which finalized the priority content areas for intercountry collaboration also addressed these concerns and selected control of arsenic contamination as a priority intercountry programme for 2002-2003.

The CCS has provided useful inputs into the preparation of PB 2002-2003 and the priorities identified should be used as inputs during the preparation of PB 2004-2005.

Strengthening of human resources, sustainable development and child health should also receive adequate focus in the regional part of PB 2004-2005.

The trend to carry forward priority programmes beyond one biennium was welcomed, as the issues and challenges faced by the Member Countries cannot be addressed in a single biennium. However, having too many priority areas will dilute the importance accorded to them, given the meagre resources available. In developing priorities, their relevance, adequacy of resources and absorption capacity should be taken into account.

Recommendations

(1) A meeting of key WHO staff and national counterparts should be organized to begin the process of joint development of the detailed work plans for PB 2004-2005.

(2) WHO's partnership with WHO collaborating centres and national institutions of excellence should be strengthened.

(3) WHO should make more efforts towards strengthening human resources for health in the Member Countries.

4.5 Review of the provisional agenda of the Fifty-fifth World Health Assembly

4.5.1 Risks to Health

During the presentation, it was noted that the WHO Executive Board, at its 109th session in January 2002, recommended the theme "Risks to health" for the Round Tables at the Fifty-fifth World Health Assembly. This was in view of the challenges posed by multiple risks to health and the existence of effective preventive strategies.

The World Health Report 2002 would also be devoted to the issue of risks to health. The Report will indicate how the most important risks to health and their consequences can be identified, measured, and reduced. Risk to health is defined as "*a factor that raises the probability of adverse health outcomes*". The report will provide governments with a strategy to comprehensively assess health risks. It draws on a large amount of information on major risks to health and considers the new findings on the global distribution of mortality attributable to the priority risks.

The chances of being exposed to risks that may affect health are present throughout the course of human life (including foetal stage). Today, a majority of the world's population has a relatively low chance of exposure to infectious diseases due to the success of immunization programmes, effective drugs and advanced control measures. Noncommunicable diseases, such as cardiovascular diseases, cancers, diabetes mellitus, and degenerative conditions, and joint and bone diseases have become more prevalent.

Not all risks, however, contribute in a similar way to disease burden. Available preventive and control measures developed to address risks to health are not equally cost-effective and globally applicable. The World Health Report 2002 will address these important issues in detail. Based on strong evidence, the following nine clusters of risks to health (and 22 risk factors) have been selected in the World Health Report for thorough analysis.

- Socioeconomic status
- Addictive substances
- Environment
- Childhood and maternal undernutrition
- Other diet-related risks and physical inactivity
- Unsafe sex
- Unsafe health practices
- Abuse and violence

- Other causes of disease and injury.

To address issues of risks to health, some initiatives have been implemented in Member Countries. Examples of such programmes are; Tobacco Free Initiative (TFI), noncommunicable disease surveillance and prevention, integrated NCD prevention and adolescent mental health.

In conclusion, it was highlighted that at the country level, the following actions may be required:

- Identification of significant risks and cost-effective interventions;
- Identification and implementation of strategies to modify or minimize risk factors among the whole population;
- Development of a long-term strategy to minimize risks to health aimed particularly at children;
- Establishment and strengthening of risk surveillance mechanisms and
- Initiation of more research to identify country-specific risks to health.

Discussion

- Issues of risks to health have been overlooked, with disease control programmes giving priority to prevention of specific cause of a disease and provision of curative services. Some risks may lead to development of many diseases. Reduction of these risks will help in preventing many diseases at the same time.
- Risk assessment is an important tool to allow decision-makers of Member Countries to prioritize risk factors and plan the implementation of preventive programmes.
- Surveillance of risks to health is different from disease surveillance, an appropriate mechanism to obtain data and have them integrated into the national health information system.

Recommendations

(1) Member Countries should develop/strengthen national health promotion policy to reduce significant risk factors.

(2) Appropriate briefing on risks to health to delegates attending the Round Tables on Risks to Health at the WHA 55 should be provided.

(3) WHO should provide technical support to Member Countries on risk assessment, identification of cost-effective interventions and formulation of national plans for implementation.

4.5.2 WHO Medicines Strategy

The work of WHO in Essential Medicines is guided by the aim "to help save lives and improve health by closing the huge gap between the potential that essential drugs have to offer, and the reality that for millions of people, particularly the poor and disadvantaged, medicines are unavailable, unaffordable, unsafe or improperly used."

A partnership with the countries to identify the problems relevant to them is the beginning of this process. This is followed by planning and development of proposals for intervention. It was underlined that the WHO cooperation activities are focused on the four components of the Medicines Strategy, namely, Policy, Access, Quality and Safety, and Rational Use. These components were elaborated as noted below.

A National Drug Policy lays down a clear political commitment and a plan of action for medicines for the country. There should be an implementation plan with monitoring as an integral component.

Essential medicines should be accessible – they should be available in health facilities that are easy to reach and cost should not be a barrier to the poor. This is especially important for diseases such as malaria, tuberculosis and childhood illnesses.

The quality and safety of all medicines at the country level is ensured through proper regulation of medicines. The process begins during manufacture and registration and proceeds through all stages of the supply chain until the patient receives the medicine. The Drug Regulatory Authority of the country plays a crucial role in these activities.

Achieving rational use is the final part of the process. Providing independent and unbiased information on medicines is important for both the health care providers and the users.

Two issues in medicines that are important for the Region are:

(1) *Health aspects related to the Trade Related Intellectual Property Rights (TRIPS) agreement: (recently discussed at Doha).* A country has the right to implement public health provisions in trade through appropriate

national legislation: this is particularly relevant to pharmaceuticals. Compulsory licensing and parallel imports are the two important tools for enhancing access to essential medicines.

(2) *Purchase of Quality Essential Drugs through a Bulk Purchasing Scheme (BPS)* – The first priority is on quality through pre-qualified manufacturers and then purchase through BPS.

Discussion

- Member Countries are not fully familiar with TRIPS and World Trade Organization (WTO) and needed more information. The Regional Office should, therefore, support countries on these issues: the first step could be a national meeting, organized by the Ministry of Health, involving other relevant ministries such as Trade, Finance and Law.
- The history of strategic pool purchasing and the successes that have been achieved in other Regions, such as in the Caribbean where small countries have successfully banded together to procure pharmaceuticals and vaccines, were noted. Quality had been maintained at lower prices. It was noted that BPS by the government involved not only procurement but also a reasonable distribution system in order to match the efforts of the private sector. To ensure uniformity of quality, proper regulation and supervision were required. Quality control laboratories in the private sector that have been certified, could be a useful instrument in ensuring the quality of pharmaceuticals.
- The problem of patients being given expensive drugs despite the availability of much more affordable alternatives was noted. It was noted that the 30 Baht scheme of Thailand insists that drugs from the Essential Drugs list must be the first choice: if a doctor were to prescribe from outside the list, it had to be approved by another doctor. It was realized that patient empowerment through information is a solution.
- A specific problem in the border areas - illegal manufacturing and distribution – was noted. In August 2001, a bi-regional (WPRO and SEARO) meeting to discuss this problem was held: specific measures needed to be taken according to the situation in each country.
- On integration of traditional medicine into the system, it was noted that WHO is developing a strategy for traditional medicine.
- A note of caution was sounded on the WHO involvement in developing a list of manufacturers/suppliers of Essential Drugs. However, it was observed that some time ago, WHO had prepared a list of approved suppliers of HIV/AIDS drugs. All steps in this regard were taken in a transparent manner. A list of

eight pre-qualified suppliers of HIV/AIDS drugs was published a few months ago. If Regional Office were to be involved in preparing a list of suppliers of essential drugs, a similar procedure could be followed.

Recommendations

(1) Member Countries should take measures to include the public health provisions of the TRIPS WTO agreement in national legislation, with WHO support as required.

(2) WHO should further investigate the possibility of a BPS for limited number of quality essential drugs and report on the procedure as well as the results to the Health Ministers Meeting in September 2002.

4.5.3 Report of the Commission on Macroeconomics and Health

During the presentation on the report of the Commission on Macroeconomics and Health, it was highlighted that the Commission, on the basis of evidence, reached the following conclusions:

- Besides the inherent importance of health in its own right, it was central to economic development and poverty reduction.
- A few health conditions are responsible for a high proportion of health deficit.
- The level of health spending in developing countries is inadequate to address the health challenges.
- Investment in reproductive health and family planning are crucial accompaniments of investments in disease control.
- Increased health coverage requires greater financial investments and removing the non-financial constraints.
- Increased health investment would globally save 8 million lives a year and generate US$ 360 billion annually in 15 years.
- The interlinkages between health and economic growth, as also between health and poverty, were brought out and the following actions, which need to be taken, were underlined:
  - Access to essential health services for the poor should be scaled up.
  - Country programmes should focus on communicable diseases, maternal and perinatal conditions and nutritional deficiencies.
  - Special attention must be paid to HIV/AIDS control.

- Top priority should be assigned to close-to-client (CTC) system.
- The community should be involved in outreach programmes.
- Universal coverage of essential health interventions should be covered by public outlays.
- National programmes should be supported technically and financially.
- Investment in knowledge and improvement of technologies should be given attention.
- Partnership with civil society and political commitment must be strengthened.
- Non-financial constraints should be removed.

To ensure universal coverage, developing countries should raise domestic spending on health by 1% of GNP by 2007 and 2% by 2015. At the same time, from the current level of US$ 6 billion per year, donor support should increase to US$ 27 billion per year by 2007 and further to US$ 38 billion per year by 2015. Such efforts alone would raise the present average health spending of about US$ 24 per capita per year to the required US$ 30-40.

In conclusion, it was stressed that the action agenda outlined by the Commission required developing countries to establish temporary national commissions on macroeconomics and health, or its equivalent, to formulate a long term programme for scaling up essential health interventions as a part of the national framework for disease control and poverty reduction.

Discussion

- Generally, economists and decision-makers in the government believe that economic growth will lead to health development. Therefore, there is a need to disseminate the evidence-based role of health in economic development and poverty reduction.
- Much larger financial resources are required for scaling up essential health interventions. At the same time, it is equally necessary to ensure that the funds available are utilized efficiently and equitably. The real challenge is how to reach the poor and the vulnerable.
- In SEAR countries, such as India and Nepal, the annual per capita expenditure on health is a meagre US$ 4. Therefore, the gap between the desirable level of expenditure to ensure universal coverage of essential health interventions and the current level of expenditure is of the order of

US$ 30 per person per annum. Countries have ambitious plans to progressively raise the proportion of their national GDPs allocated to health – and the governments even adopt national health policies with such a mandate. But the reality somehow unfolds itself differently, at the annual allocation of budgetary resources. However, it was encouraging to note that in Thailand, the annual health budget this year received an increase of 40 per cent.

- The national health development plans and health policies of many Member Countries contain several statements and provisions which bear a remarkable similarity to the key findings and main recommendations of the report of the CMH. But, mainly inadequate budgetary allocations come in the way of translating those statements into action.
- The critical importance of donors' assistance was universally recognized. However, in the light of the experience that the current commitment to the Global Fund to fight AIDS, TB and Malaria has hardly reached the level of US$ 2 billion as against the vision of US$ 8-10 billion per year, it was felt that it would be welcome even if donors' assistance increases from the present level of US$ 6 billion and approximates over time to the figures visualized by the Commission. Further, a paradigm shift of donors' assistance from the present bilateral basis to a global basis where global social equity, in the larger process of globalization, forms the basis is required. WHO should foster linkages between the report of the CMH and the process of globalization. This point should be emphasized in the follow-up meeting being convened by WHO-HQ in mid June.
- Generally, the proposal for formation of National Commissions on Macroeconomics and Health was well received. However, it was felt that the exact mechanism of performing the tasks visualized for the NCMH will have to be different from country to country.
- The idea of implementing the key recommendations of the report of the CMH, particularly relating to universal coverage of essential interventions against the major diseases and conditions responsible for the current health deficit, in the evolving PRSP process was generally appreciated. However, it was also pointed out that the financial constraints and widespread poverty in many Member Countries are aggravated by the fact that many of them are not entitled to any debt relief under the PRSP process. Since they have been repaying their foreign debt on time, they are not categorized as heavily indebted poor countries (HIPCs).
- While the conclusions and recommendations of the report of the CMH are indeed well conceived, the real challenge lies in implementing them. Besides political commitment, multisectoral planning and action are required. This is so because health development is not the concern of the

ministry of health or the health sector alone. The determinants of health mostly lie outside the health sector.

Recommendations

(1) National decision-makers and development partners should be made aware of the contribution of investment in health to economic growth and poverty reduction.

(2) National Commissions on Macroeconomics and Health, or its variant, should be set up. WHO should provide required technical assistance to Member Countries in this regard.

(3) Innovative mechanisms, in addition to the established ones, should be utilized to progressively and significantly raise financial resources for investment in health – both from internal sources as also from the donors. At the same time, action should be taken to ensure that the funds available are efficiently and equitably utilized with focus on the poor and the vulnerable.

4.5.4 The Global Fund to Fight AIDS, Tuberculosis and Malaria

During the presentation, the status and progress relating to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), established at the initiative of the UN Secretary-General in January 2002, were reviewed. It was highlighted that the Fund is expected to enable developing countries tackle these communicable diseases, which are also linked closely with poverty, more effectively. The idea is to have a financial instrument to mobilize and rapidly disburse additional financial resources through a new public-private partnership. Of US$ 1.9 billion committed so far, US$ 800 million are available for disbursement during 2002.

In the South-East Asia Region, which has an extremely high burden of communicable diseases, the Fund represents a good opportunity to mobilize resources to enable countries substantially scale up the effective interventions to combat these priority health problems, and thereby also contribute to poverty reduction. It was recalled that the issue was discussed at the Health Ministers' meeting in Maldives, in August 2001. In accordance with the Health Ministers' recommendations, WHO/SEARO has established a Regional Task Force to guide country efforts and to ensure that the South-East Asia Region receives a fair share of GFATM resources on the basis of the disease burden and the vulnerability in the Region.

It was pointed out that following the call for applications on 4 February 2002, nine of the 10 Member Countries of our Region had prepared and submitted 28 country proposals and two multi-country proposal for the "quick start" funding

before the deadline of 10 March 2002. Technical support was provided by WHO in the preparation of applications to the Fund. WHO has also assisted GFATM in the composition of the Technical Review Panel by forwarding names of the experts from the Region and by keeping countries informed of the developments relating to the Fund. In conclusion, it was stressed that WHO remains committed to supporting countries during the implementation and monitoring of activities under the Global Fund.

Discussion

Thailand thanked countries for supporting its membership to the Board and shared the results on the first round of proposals announced after the Board meeting, 22-24 April 2002. The results show that 15 of 30 proposals submitted by SEAR countries have been approved for funding with an approximate budget of US$ 305 million with US$ 48 million of that amount being made available in the first year.

The participants appreciated the work carried out by countries in preparing proposals at short notice against a tight deadline. However, strong concern was expressed regarding some proposals which the GFATM Board did not recommend for funding. The meeting urged WHO to maintain technical competence in the area of TB, HIV, malaria and called for WHO's continued technical support to Member Countries not only in preparation of country proposals for the second round but also in implementation, monitoring and evaluation.

The Fund provides an opportunity to the Member Countries to mobilize additional resources. There is a need for clarity regarding disbursement of GFATM funds at country level and ensuring sustainability. Additional resources now available through the Global Fund should be used to build national capacities. Requests were made for ascertaining why certain proposals from the countries were not supported by the Board during its meeting in New York, 22-24 April 2002.

WHO support to Member Countries in preparation of country coordinated proposals and keeping them informed regarding the GFATM was greatly appreciated.

Recommendations

(1) The Regional Office should organize a meeting soon after the forthcoming WHA to review the progress made so far, share experiences and lessons learnt

from the first round, and to develop plans for the next round of applications for 2002.

(2) WHO and SEAR representatives on the GFATM Board should keep Member Countries informed regarding future developments relating to the Global Fund. In particular, they should ascertain the reasons why certain applications from SEAR countries were not approved in order to improve second round submissions. Issues relating to the disbursement procedures at country level and the role, if any, of WHO in this regard should be clarified.

(3) The Member Countries interested in submitting proposals to the Global Fund for the second round for review by the Board meeting in November 2002 should begin preparations now and WHO should actively support this process by providing technical assistance.

4.6 Updates on:

4.6.1 Road Accident Injuries

It was reinforced that injury is a major public health problem in the Region. While a few hundred cases of communicable diseases receive major media and policy makers' attention, thousands of cases of injuries and injury-related mortality remain unnoticed. Therefore, it was acknowledged that there is a need for policy advocacy both nationally and internationally, to support injury prevention. It was appreciated that there is sufficient information to act upon, provided appropriate capacity, infrastructure and support are available.

Recommendation

The capacity of countries in dealing with injury prevention should be strengthened and enforcement of known effective strategies urgently initiated.

4.6.2 Arsenic Contamination of Water

The update on the status of the WHO programme on arsenic mitigation in the Region was mainly concentrated in Bangladesh, West Bengal in India, and parts of Nepal and Thailand. About 30 million people are estimated to be exposed to arsenic and about 12 000 show signs of the related disease. It was pointed out that WHO was working with the affected countries of the Region in partnership with several other UN agencies, bilaterals and NGOs. WHO was focusing its effort primarily on the epidemiological dimension of the programme. Specifically, the focus is on three areas: response to the hazard, strengthening infrastructure, and capacity building.

It was pointed out that since 1997, WHO has produced guidelines, environmental criteria, and a monograph on arsenic; provided needed high level advocacy through convening national and international conferences; initiated health research; harmonized case definitions; provided guidance on management and surveillance; trained trainers, and developed arsenic testing kits.

Recommendation

WHO should, during the biennium 2002-2003, assist countries in developing national task forces for needed work in this area.

4.6.3 Development of Database on Reasonable Pricing of Imported Essential Drugs and those Locally Produced;

and

4.6.4 Development of Bulk Purchasing arrangements for Vaccines, Medicines and Raw Materials for Drug Manufacture

During the combined presentations on the above two related subjects, it was stated that the EDM Home Page has a section on Drug Price Information. Through this section, there are links to two types of databases. The first is price lists, with which WHO has been associated in developing. The second is country sites that have Drug Price Information. There is another site, namely, Market News Service, that has information on pharmaceutical raw materials. All other sites have prices of finished formulations.

India has a site from the National Pharmaceutical Pricing Authority, which lists the maximum prices for finished formulations of essential drugs. Malaysia also has a site with prices of specific brands. Drug prices being available on the Internet allow countries to access real time information and thus compare their prices with those in the other countries.

4.6.5 Recommendations of the Sixth Meeting of Health Secretaries Regarding the Feasibility of Health Insurance Schemes

Over the past biennia, WHO has received a few requests for technical support in undertaking feasibility studies for health insurance. Thus in translating the Health Secretaries' recommendation to assist Member Countries in undertaking studies and mindful of the limited utility of WHO commissioning studies which do not

enjoy broad support from the national authorities, the Regional Office has undertaken efforts in two broad areas.

(1) Advocacy for instituting and or expanding health insurance - recognizing that to be effective, advocacy has to build on common experiences as well as clear evidence demonstrating the value of such undertakings, specifically:

- Promoting the exchange of information on health insurance, one example being the technical support provided to "Asia-Pacific Summit On Health Insurance and Managed Care", May 22 – 24, 2002 being held in Indonesia sponsored by the Centre for Health Economics, University of Indonesia.
- Promoting the revisions of national health accounts in the Member Countries of the Region which will provide the necessary evidence of the need for health insurance - the most recent example is SEARO technical support for a Bi-Regional Meeting (WPRO/SEARO) on National Health Accounts to be held in Bangkok, tentatively in June 2002.

(2) Sensitization of concerned national authorities - Working with the WRs to sensitize the concerned national authorities on the issue of health insurance and encouraging national authorities to include the necessary studies in the WHO plans of action. In this regard, some of the countries, such as Indonesia, are developing proposal related to health insurance.

Section 5

Field Visit

THE HEALTH SECRETARIES and other officials attending the meeting visited Dr Ram Manohar Lohia Hospital, New Delhi, in the afternoon on Thursday, 25 April 2002, where they were received by Dr C P Singh, Medical Superintendent of the hospital and his team of doctors and Nursing Superintendent. They were taken to the Casualty Section of the hospital which caters to a large number of cases with road traffic accidents and other emergencies. Dr Singh briefed them about the inflow of patients, control room and resuscitation room in the casualty section. They also visited the section used in 'Disaster situations'. They later entered the Nursing Home complex and were shown the Dialysis Unit, Endoscopy Room, Yellow Fever Vaccination Centre, Whole Body Scan unit, Hyperbaric Oxygen Chamber and Neurosurgical Unit. Afterwards, a formal meeting was organized in the seminar room, at which Dr Singh briefly presented the history of the hospital, described the staffing pattern, services available and future plans for expansion. An interactive discussion followed in which questions were asked about allocations, process of procurement of equipment, finance and auditing. The visit concluded with a vote of thanks to Dr C P Singh and his team.

Section 6

Adoption of the Report

AFTER DUE DELIBERATIONS, the participants adopted this report along with the conclusions and recommendations as noted under Section 4.

Section 7

Closing Session

THE HEALTH SECRETARIES of all the participating countries thanked the Regional Director for organizing the meeting at the last minute so efficiently in SEARO. They also expressed their gratitude to the Regional Director for his guidance during the meeting and acknowledged his leadership in health for the Region and thanked him and his colleagues for their hospitality. They placed on record the contributions of the Chairman for conducting the proceedings of the meeting to a highly successful conclusion and the efforts of the drafting group in drafting a very concise yet comprehensive report.

The participants from Nepal expressed their disappointment at the meeting not being held in Kathmandu as originally planned due to the prevailing situation there. However, they offered to host the next meeting of Health Secretaries in Nepal.

Dr Uton Muchtar Rafei, Regional Director, expressed his happiness at the success of the meeting, as it fully achieved its objectives. He felt that necessary action should now be initiated by all concerned on the recommendations of the meeting. He appreciated the contribution of the Chairman and the Vice-Chairman to the success of the meeting.

The Chairman then declared the Seventh Meeting of Health Secretaries of the countries of the WHO South-East Asia Region closed.

Annexes

Annex 1

AGENDA

1. Inaugural Session
2. Introductory Session
3. Review of
   - Implementation of the Programme Budget 2000-2001
   - Status of implementation of the Programme Budget 2002-2003
   - Overall Managerial Framework: Programme Budget 2004-2005 (Part I)
   - Part II of the Proposed Programme Budget 2004-2005
4. Review of the provisional agenda of the 55th World Health Assembly
   - 4.1 Risks to Health
   - 4.2 WHO Medicines Strategy
   - 4.3 Report of the Commission on Macroeconomics and Health
   - 4.4 Global Fund to Fight AIDS, Tuberculosis and Malaria
5. Update on:
   - Road accident injuries
   - Arsenic contamination of water
   - Development of database on reasonable pricing of imported essential drugs and those locally produced
   - Development of bulk purchasing arrangements for vaccines, medicines and raw materials for drug manufacture
   - Recommendations of the Sixth Meeting of Health Secretaries regarding the feasibility of health insurance schemes
6. Field visit
7. Adoption of the Report
8. Closing Session

Annex 2

LIST OF PARTICIPANTS

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Annex 3

TEXT OF ADDRESS BY DR UTON MUCHTAR RAFEI, REGIONAL DIRECTOR, WHO-SEARO

IT GIVES ME great pleasure to welcome you to this seventh meeting of the Health Secretaries.

I also extend my greetings and a warm welcome to the distinguished participants. This is an important meeting being held at a time of great opportunities and challenges. It would, therefore, be appropriate to critically review our achievements and remind ourselves of what remains to be done.

Humanity has gained significantly from the unprecedented health gains over the last 50 years. Globally, life expectancy has increased from less than 47 years during 1950-1955 to over 65 years in 2000. This increase has been more pronounced in the developing countries. Our Region too has gained much from this revolution. After eradicating smallpox, our Region recently eradicated the guinea-worm disease. Now, leprosy is targeted for elimination. Together, we will soon eradicate polio.

Yet, vaccine-preventable diseases still pose a significant risk to the health of children in our Region. In the year 2000, measles alone struck an estimated 2-3 million children of whom about 10% died. Diphtheria and whooping cough still afflict children in underserved areas in many countries. Our Region contributes to over 40% of the global neonatal mortality. Our commitment to achieve the millennium goal of reducing infant and child mortality can be met only if we now assign a higher priority to neonatal mortality. Evidence-based essential newborn care is known to improve neonatal health and reduce neonatal mortality. This should therefore be a priority in the resolution of the forthcoming UN special session on children. The Director-General of WHO, Dr Gro Harlem Brundtland, speaking at the Global Consultation on Child and Adolescent Health, at Stockholm, made a plea for a special focus on saving the lives of millions of newborn babies who die during the first weeks of their lives.

The Region now has two opportunities to minimize the risk to children from vaccine-preventable diseases. The Global Alliance for Vaccines and Immunization (GAVI) provides an important opportunity. Over the next five years, GAVI will provide an estimated US$ 200 million to our Region to strengthen routine immunization and introduce under-used vaccines. The second

opportunity is the attention and awareness that polio eradication has brought to routine immunization.

Polio eradication efforts have made remarkable progress in reducing the burden of this dreaded disease. However, there were still 268 cases in 2001, primarily in the Indian states of Uttar Pradesh and Bihar. India has made laudable efforts to reach the present stage. The last push would undoubtedly ensure a polio-free Region.

Unfortunately, health concerns in the Region are beset by the re-emergence of tuberculosis and malaria as well as the rising incidence of noncommunicable diseases. HIV/AIDS is threatening to offset our hard-won health and socioeconomic gains.

The good news is that a Global Fund has recently been established to meet the devastating global impact of AIDS, TB and malaria. You will be pleased to know that out of almost two billion dollars already committed to this Fund, about 800 million dollars would be available for disbursement during 2002. It may be recalled that various dimensions of the Global Health Fund were discussed at the Health Ministers' Meeting in Maldives last year. In accordance with the Health Ministers' recommendation, I established a Regional Task Force to guide regional and country efforts to ensure that our countries receive a fair share of the Global Fund. It is gratifying to note that 9 out of the 10 Member Countries of our Region have timely submitted 18 country proposals and one multi-country proposal for "quick start" funding. WHO was privileged to provide technical support in the preparation of these proposals.

While the progress towards tobacco control made by different countries of the Region is gratifying, I think we must remind ourselves of what needs to be done now for adoption of the Framework Convention on Tobacco Control. At the last session of the Inter-governmental Negotiating Body, it became clear that our countries would need to involve all relevant sectors, such as trade and commerce, education, information and broadcasting, labour and agriculture, and foreign affairs and judiciary, into the mainstream of the negotiating process at the country level. As the Framework Convention is due to be adopted at the Fifty-sixth World Health Assembly in 2003, it would now be opportune for the ministries of health to intensify the building of alliances with all relevant sectors.

We have to address the unfinished agenda in the face of widespread poverty, illiteracy and gender bias against women. In the current and coming decades, population growth, rapid and unplanned urbanization and industrialization, as well as environmental risks to health will continue to pose serious challenges to health development. Poverty is the root cause of most of

these challenges. Fortunately, the growing recognition of the centrality of health in development provides a solid base for hope and optimism.

At this point, it may be recalled that fifteen years ago, the UN Commission on Environment and Development broke new ground by placing people at the heart of the development process. Now, the Commission on Macroeconomics and Health, consisting of eighteen of the world's leading economists and health experts, has presented its report. This provides a new global blueprint for development to narrow the gap between the rich and the poor and stimulate growth in developing countries.

The report, *Macroeconomics and Health: Investing in Health for Economic Development*, sees investment in human resources as crucial to overcome the poverty trap in developing countries. It sees health as a key factor in economic growth and social development.

The Commission has found evidence to show that extension of crucial health services to the world's poor to combat a handful of health conditions and diseases could save millions of lives, reduce poverty and spur economic development. The Commission has underlined that such an effort requires two initiatives. First, a significant scaling up of the resources currently spent in the health sector by poor countries and by donors. Second, tackling the non-financial obstacles that have limited the capacity of poor countries to deliver health services. The Commission urges each low and middle income country to establish a temporary national commission on macroeconomics and health to formulate a long-term programme for scaling up essential health interventions within the overall framework in poverty reduction strategies.

The World Summit on Sustainable Development, to be held in Johannesburg in August 2002, is another major milestone in the work towards a world where we all can live well and healthy, and with dignity, without undermining the ability of future generations to do the same. Health needs to have a more prominent role in the forthcoming Summit than it had in Rio. WHO and national governments must stress the central role of health in the development process and the linkages between health and poverty reduction. We must stress the health risks and determinants beyond communicable diseases, and the impact of environment and globalization on health.

Distinguished participants,

Problems are formidable but solutions exist. Interventions are available. Strategies to improve the situation are known. The call for action given by the

Commission on Macroeconomics and Health must be acted upon. We must reinforce intercountry cooperation and partnerships with one and all.

I have no doubt that the current meeting would further enhance regional solidarity and promote the interests of the countries of our Region. During this meeting, the Health Secretaries will deliberate and propose practical mechanisms to further strengthen intercountry cooperation in the context of the programme budget for 2004-2005. The Health Secretaries will also discuss Risks to Health, the report of the Commission on Macroeconomics and Health, the Global Fund to Fight AIDS, Tuberculosis and Malaria and WHO's Medicines Strategy. As these topics are on the agenda of the forthcoming World Health Assembly, our discussions here will prepare us well for effective participation in the deliberations of the Assembly. We look forward to the guidance of the Health Secretaries in these important areas. I am confident that, as in Bali in 1997 and Yangon in 2001, the Health Secretaries will recommend practical ways to ensure full utilization of WHO's Regular budget for 2002-2003.

I would, once again, like to thank the Health Secretaries for attending this meeting. I am confident that their deliberations would be productive and hope their stay in Delhi will be comfortable.

Thank you.