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SECTION I

*REPORT OF THE REGIONAL COMMITTEE

*Originally issued as "Draft Final Report of the Thirty-third Session of the WHO Regional Committee for South-East Asia", document SEA/RC33/27, on 6 September 1980, with some changes.
INTRODUCTION

The thirty-third session of the Regional Committee for South-East Asia was held in Male, Republic of Maldives, from 1 to 7 September 1980. It was attended by representatives from all Member countries of the Region. The session was also attended by representatives of the United Nations Development Programme and the United Nations Children's Fund, as well as representatives of three non-governmental organizations that have official relations with WHO (see Annex 1, for list of participants).

The session was opened, in the absence of the Chairman and the Vice-Chairman, by the Regional Director. In his opening address he referred to the important items on the agenda. Highlighting the main problems of the developing countries, he was optimistic that in this Region, with its abundance of political will and determination of the Member States, the prospects for accelerated health development were bright. He expressed happiness that nine out of ten countries in this Region would have signed the Charter for Health Development by the end of this session - a development of tremendous significance.

The session was inaugurated by Mr Maumoon Abdul Gayoom, President of the Republic of Maldives. In his address, he expressed his government's happiness that the Regional Committee had accepted the invitation to hold its 33rd session in Male. Recalling WHO's momentous declaration of the goal of "Health for All by 2000", he said that this Regional Committee session was being held at a time when there was a universal collaborative effort to achieve this goal. He referred to the endeavours of his government to provide basic health services to all citizens through the primary health care approach, saying his government is fully committed to the goals of the International Drinking Water Supply and Sanitation Decade. Referring to the current special session of the UN General Assembly to usher in a new economic order, he affirmed that a positive outcome in this regard would depend upon the active promotion of international economic cooperation among Member States and particularly exchange of technology and experience among developing countries. He paid tribute to the Regional Director for his sincere efforts in assisting the countries in solving many problems and for his understanding, compassion and cooperation. He also expressed his appreciation and gratitude to the Director-General for the initiative and efforts of WHO in formulating strategies and in assisting countries in their implementation.

The inaugural meeting was also addressed by Mr Mohamed Musthafa Hussain, Minister of Health, Maldives. He stated that the signing of the Charter for Health Development by his President jointly with the Director-General of WHO at the inaugural session was a manifestation of his country's political commitment to the world-wide movement of health for all. Mr Musthafa Hussain also made reference to the "legendary and dedicated services and untiring efforts" of Dr Gunaratne in assisting Member States in providing better health to the people.

The Director-General of WHO, Dr Mahler, also addressed the gathering and said that his visit to Maldives had convinced him of the truth of the saying that "small is beautiful". He declared that the meaning of health for all was not the provision of sophisticated medical care for
the privileged few but the sharing of resources and opportunities for better health by all, whether they belonged to small, big, developed or developing countries. He referred to the traditional and spiritual heritage of this region and hoped that it would set an example to the developed world. He complimented the Minister of Health for his earnest endeavours to accelerate the pace of health development in Maldives. Referring to Dr Gunaratne's retirement, he felt that this would create a void which would be hard to fill.

Mr Christian Lemaire (UNDP) pledged his Organization's continued support to the development of health services through tripartite projects with WHO. Mr David P. Haxton, UNICEF Regional Director for South Central Asia, requested the delegates to give particular attention in their deliberations to the health needs of children.

The Minister of Health proposed a vote of thanks.

At the first plenary meeting, a Sub-Committee on Credentials was appointed, consisting of India, Mongolia and Sri Lanka. Mr N.R. Laskar (India) was elected Chairman of the Sub-Committee, which held two meetings and presented its reports (SEA/RC33/24 and Add.1) recommending the recognition of the validity of the credentials presented by all the representatives.

The Regional Committee elected the following office-bearers:

Chairman : Mr Mohamed Musthafa Hussain (Maldives)
Vice-Chairman : Dr Soejoto (Indonesia)

The Committee established a Sub-Committee on Programme Budget consisting of representatives from all countries and adopted the terms of reference for this Sub-Committee (SEA/RC33/4). Under the chairmanship of Dr Prakorb Tuchinda (Thailand), the Sub-Committee held three meetings and submitted a report (Annex 3). The Committee endorsed this report (Resolution SEA/RC33/R10).

The Regional Committee elected Dr L. Poudayl (Nepal) as Chairman of the technical discussions, which were on "Health Manpower Planning and Community Participation for Primary Health Care", and adopted the agenda for these discussions (SEA/RC33/5 and Add.1). The discussions were held on 4 September, and the conclusions and recommendations arising out of these discussions (Annex 4) were presented to and endorsed by the Regional Committee.

The Director-General, Dr Mahler, delivered a keynote address to the Regional Committee, in which he emphasized the essential element of continuity of the strategies of health for all and the need to avoid inflexibility in the approaches adopted. He focused on health reforms as the essentials of a strategy. The health delivery system must be geared to pay greater attention to the underprivileged, and priorities in this regard had to be drawn up in the light of epidemiological, social and economic situations in each country. Community involvement was most crucial for the betterment of the health of the people. He focused on the high priority programmes such as safe drinking water, nutrition, immunization of children and provision of essential drugs.
Extensive health systems research was needed to find out the best ways of delivering these programmes and to integrate them within the health infrastructure. He referred to the role of WHO in the formulation of strategies and in assisting Member States in their implementation, focusing attention on the genuine partnership between Member States and WHO. He also referred to WHO's efforts for the mobilization of resources and the establishment at Geneva of a Health Resources 2000 Group whose prime objective was to match resources with requirements. He concluded by stressing that proper use of WHO by Member States in accordance with the constitutional role of the Organization could greatly contribute to health development throughout the world.

The Regional Committee established a sub-committee to draft resolutions, consisting of representatives from India, Indonesia, Sri Lanka and Thailand.

The Regional Committee met in a private session to nominate a successor to Dr Gunaratne. The Director-General announced at the plenary meeting the decision of the Regional Committee nominating Dr U Ko Ko (Burma) as Regional Director for a term of five years from 1 March 1981 (resolution SEA/RC33/R1).

Recognizing the significant contribution made by Dr V.T.H. Gunaratne to international health work, the Committee declared him "Regional Director Emeritus" of the World Health Organization (resolution SEA/RC33/R2).

The Regional Committee accepted the suggestion of the Thirty-third World Health Assembly to hold technical discussions during the thirty-fourth session of the Committee on "The Role of Ministries of Health as Directing and Coordinating Authorities on National Health Work" (resolution SEA/RC33/R13).

The Committee accepted with appreciation the invitation from the Government of the Republic of Indonesia to hold its thirty-fourth session in Indonesia in August/September 1981 and from the Government of the People’s Republic of Bangladesh to hold the thirty-fifth session in that country in 1982 (resolution SEA/RC33/R12).

In the course of seven plenary meetings, the Committee adopted 14 resolutions.

Parts II, III and IV of this report are devoted to summaries of important matters raised in the discussions. A complete list of documents is given in Annex 5. The Agenda for the session is given in Annex 2.

After the inaugural session, at a special ceremony, the President and the Health Minister of the Republic of Maldives, and the Director-General and Regional Director of WHO signed the Charter for Health Development in the presence of a large gathering, including members of the Cabinet of the Government of Maldives.
PART I

RESOLUTIONS

The following fourteen resolutions were adopted by the Regional Committee (The references to the "Handbook" are to the Handbook of Resolutions and Decisions of the WHO Regional Committee for South-East Asia, seventeenth edition, 1948-1975, and its supplement):

SEA/RC33/R1 NOMINATION OF THE REGIONAL DIRECTOR FOR SOUTH-EAST ASIA

The Regional Committee,

Considering Article 52 of the Constitution, and

In accordance with Rule 49 of its Rules of Procedure,

1. NOMINATES Dr U Ko Ko as Regional Director for South-East Asia, and

2. REQUESTS the Director-General to propose to the Executive Board the appointment of Dr U Ko Ko for a period of five years from 1 March 1981.

Handbook 6.3.1

SEA/RC33/Min.2
Second Meeting, 1 September 1980

SEA/RC33/R2 REGIONAL DIRECTOR EMERITUS -
 DR V.T. HERAT GUNARATNE

The Regional Committee,

Noting that Dr V.T. Herat Gunaratne will be relinquishing his office on 28 February 1981 after serving this region as Regional Director for thirteen years,

Recognizing that the significant contributions made by him to international health work in this region and especially in the formulation and promotion of the Charter for Health Development for the countries of this region, deserve recognition on the part of the World Health Organization and the Member States of the South-East Asia Region,

1. PLACES on record its deep appreciation of Dr Gunaratne's qualities of leadership and outstanding services to the Member States in this region, and

2. DECLARES Dr V.T. Herat Gunaratne Regional Director Emeritus of the World Health Organization.

Handbook 6.3.1

SEA/RC33/Min.2
Second Meeting, 1 September 1980
The Regional Committee,

Having reviewed the Regional Director's Annual Report, which fully reflects the activities of WHO in the South-East Asia Region during the period 1 July 1979 - 30 June 1980 (document SEA/RC33/2 and Corr.1),

1. NOTES with satisfaction the sustained efforts made and the initiatives taken for the attainment of the goal of health for all by the year 2000, and

2. PLACES on record its deep appreciation of the work accomplished by the Regional Director and his staff in providing technical cooperation to the Member States during the period under review.

Handbook 2.3 Sixth Meeting, 6 September 1980 SEA/RC33/Min.6

The Regional Committee,

Reaffirming World Health Assembly resolutions WHA30.43, WHA32.24 and WHA32.30 and its own resolution SEA/RC32/R1, which clearly underline the determination of the Member States to attain the cherished goal of health for all their people by the year 2000,

Taking into account the fact that the principles of primary health care contained in the Alma Ata Declaration have increasingly led to national programmes with the primary health care approach,

Noting with satisfaction the intensive preparatory activities at the national and regional level for formulating national and regional strategies,

Having carefully considered document SEA/RC33/19 on Regional Strategies for Health for All by the Year 2000, and

Appreciating the initiative taken by the Regional Director in this regard,

1. URGES Member States

   (i) to develop a plan of action in accordance with the formulated national and regional strategies for health for all by the year 2000 and commit themselves fully to its implementation;

   (ii) to take individual and collective steps to update the national and regional strategies annually, and
(iii) to set up mechanisms at the national level to monitor and evaluate the implementation of the strategies, and

2. REQUESTS the Regional Director

   (i) to assist Member States in updating the national strategies as well as in the monitoring and evaluation of their implementation;

   (ii) to evolve an overall regional strategic plan;

   (iii) to ensure the updating, monitoring and evaluation of the regional strategies, and

   (iv) to take necessary steps to reorient WHO's technical cooperation programme with Member States in consonance with the national and regional strategies to achieve the goal of health for all by the year 2000.

Handbook 1.2       SEA/RC33/R5
Sixth Meeting, 6 September 1980     STUDY OF WHO'S STRUCTURE IN THE LIGHT OF ITS FUNCTIONS
SEA/RC33/Min.6

The Regional Committee,

Recalling World Health Assembly resolution WHA31.27, on the basis of which the Director-General initiated a study of WHO’s structures in the light of its functions with a view to ensuring that activities at all levels promote integrated action, and resolution SEA/RC32/R7 endorsing a study conducted in this region by a Sub-Committee appointed by the Regional Committee at its thirty-first session,

Noting that the Thirty-third World Health Assembly, having considered a comprehensive report by the Director-General including the South-East Asia Regional Study as well as others, recommended a series of actions detailed in its resolution WHA33.17,

Appreciating the fact that such actions need to be urgently implemented for attaining the goal of health for all by the year 2000, and

Having considered a detailed Plan of Action prepared by the Director-General in this regard as well as a document (DGO 80.3) outlining the concept of technical cooperation,

1. ENDORSES the Plan of Action proposed for implementing the recommendations contained in resolution WHA33.17,

2. AGREES with the concepts of technical cooperation as contained in document DGO 80.3,
3. URGES Member States

(i) to initiate actions on the recommendations in operative paragraph 2 of resolution WHA33.17, especially that relating to strengthening of the role of ministries of health at the national levels;

(ii) to strengthen the role of the Regional Committee in the light of the new tasks devolving on it for the attainment of the goals of health for all by the year 2000;

(iii) to ensure representation at the highest level from the Ministry of Health, preferably the Minister of Health, at the Regional Committee, and

4. REQUESTS the Regional Director

(i) to initiate necessary actions to carry out studies to bring about the restructuring and reorientation of the Organization at the regional level in the light of the guidelines contained in the Plan of Action;

(ii) to strengthen the functioning of the Organization at the country level, and

(iii) to take steps to redesignate the WHO programme coordinators as WHO representatives.

Handbook 5.6  Sixth Meeting, 6 September 1980
SEA/RC33/Min.6

SEA/RC33/R6  PERIODICITY OF THE WORLD HEALTH ASSEMBLY

The Regional Committee,

Having considered document SEA/RC33/15 on the "Study of WHO's structures in the light of its functions",

Taking into consideration the plan of action for implementing the recommendations of the study proposed in document DGO/30.4,

Keeping in mind the Health Assembly resolution WHA33.19 on the periodicity of Health Assemblies,

Recognizing the importance of, and advantages resulting from, holding the Health Assembly annually in the context of the development, implementation and evaluation of strategies for the attainment of goals of health for all by the year 2000,

Realizing that with some streamlining of the procedures, the effectiveness of the Assembly could be maximized,

1. AGREES unanimously that the World Health Assembly should continue to meet annually, and
2. REQUESTS the Regional Director to bring this decision to the attention of the World Health Assembly through appropriate channels.

Handbook 5.5
Sixth Meeting, 6 September 1980
SEA/RC33/Min.6

SEA/RC33/R7
REIMBURSEMENT OF TRAVEL COSTS OF REPRESENTATIVES TO REGIONAL COMMITTEES

The Regional Committee,

Having considered the proposal for financing the travel costs of representatives to Regional Committees,

Taking into account the views expressed by the members of the Executive Board at its sixty-fifth session in January 1980 (resolution EB65.R2), and

Recognizing the importance for all Member States of the Region to be involved in the deliberations of the Regional Committee,

RECOMMENDS to the Executive Board, and through it to the World Health Assembly, to authorize financing the cost of travel by economy class and daily subsistence allowance of one representative from each Member State of the South-East Asia Region to attend sessions of the Regional Committee every year.

Handbook 4.4
Sixth Meeting, 6 September 1980
SEA/RC33/Min.6

SEA/RC33/R8
REAL ESTATE FUND

The Regional Committee,

Noting the report of the Regional Director (document SEA/RC33/14) concerning the additional accommodation required to be financed from the Real Estate Fund,

Recognizing that it is necessary for the Regional Office to undertake an extension to its existing building,

1. ENDORSES the proposal for the construction of an extension and the installation of a new air-conditioning plant and an electric sub-station, and

2. REQUESTS the Regional Director to transmit the proposal to the Director-General for inclusion in his report on the short-term and long-term accommodation requirements of the Organization, to be submitted to the sixty-seventh session of the Executive Board for obtaining an authorization for this undertaking from the Thirty-fourth World Health Assembly.

Handbook 6.4.3
Sixth Meeting, 6 September 1980
SEA/RC33/Min.6
The Regional Committee,

Having considered the Report of the Regional Director on the "Preparatory Activities for the International Drinking Water Supply and Sanitation Decade" (document SEA/RC33/9),

Being aware of the role of the Organization and the substantial support provided by UN, bilateral and other agencies in promoting the provision of safe water and sanitation during the Second United Nations Development Decade and keeping in mind the adoption of the Mar Del Plata Action Plan for attaining the goal of clean water and sanitation for all by 1990 during the International Drinking Water Supply and Sanitation Decade (1981-1990),

Bearing in mind the constraints of manpower, materials and finance faced by Member States in attaining the Decade goals, and

Taking note of the importance of safe water and sanitation for the attainment of the goal of health for all by the year 2000,

1. RECORDS with appreciation the support provided by WHO to the programmes of Member States;

2. URGES governments of the Region to:

   (i) make a declaration of, and commitment to, the national goals for the International Drinking Water Supply and Sanitation Decade at the highest decision-making level, prior to the official launching of the Decade at the special session of the United Nations General Assembly on 10 November 1980;

   (ii) prepare, in addition to their annual and five-year plans, a prospective programme-plan document for water supply and sanitation for IDWSSD, to provide the framework for national plan allocations and to attract external investments;

   (iii) accord, in their Decade programme plans, priority to those populations deprived of the basic amenities of safe water and sanitation, and to involve them actively in the planning, implementation and management of these programmes as an integral part of primary health care, and

   (iv) identify and formulate priority projects within the programme-plan for the Decade, to attract investment, and

3. REQUESTS the Regional Director to:

   (i) augment WHO's inputs towards the development and implementation of Decade programmes for water and sanitation;
(ii) collaborate closely with other organizations involved in the sector and provide sustained support to UNDP in its role of promoting the development of water supply and sanitation as part of overall socio-economic development, and

(iii) promote the mobilization of external assistance from multilateral and bilateral agencies and institutions for the programmes and projects of Member States of the Region for the Decade.

Handbook 1.4.5.  

Sixth Meeting, 6 September 1980
SEA/RC33/Min.6

SEA/RC33/R10  
PROPOSED REGIONAL PROGRAMME BUDGET FOR 1982-1983

The Regional Committee,

Having considered the proposed programme budget for 1982-1983 (document SEA/RC33/3 and Rev.1) and the report of the Sub-Committee on Programme Budget (document SEA/RC33/25),

Recognizing that WHO's programme provides support to Member States to enable them to achieve health for all by the year 2000,

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

2. NOTES the proposed regional programme budget for 1982-1983;

3. REQUESTS the Regional Director to transmit the proposals to the Director-General for inclusion in his proposed programme budget for 1982-1983, and further

4. REQUESTS the Regional Director to establish a small committee to:

   (i) Review existing terms of reference of the Sub-Committee on programme budget and frame revised terms which are harmonious and relevant to present and future budgetary concerns;

   (ii) Review existing guidelines and criteria for the establishment of inter-country projects and to recommend a revised framework, and

   (iii) Analyse all regular and extra-budgetary programme proposals including the detailed proposals for 1982-1983, prior to each session of the Regional Committee and present its findings to the Regional Director.

Handbook 3.3  

Sixth Meeting, 6 September 1980
SEA/RC33/Min.6

1 Reproduced as Annex 3 to this document.
REPORT OF THE REGIONAL COMMITTEE 11

SEA/RC33/R11 UNDP REGIONAL PROGRAMME FOR 1982-1986

The Regional Committee,

Having considered the proposals for submission to UNDP (SEA/RC33/PB/WP2) for inclusion in the Regional Programme of Technical Cooperation for Asia and the Pacific covering the period 1982-1986 representing the UNDP third programming cycle and the report of the Sub-Committee on Programme Budget (document SEA/RC33/25)1,

Noting that these proposals will enhance technical cooperation among developing countries and are intended to solve the main problems of a regional nature arising out of the development situation in the Region,

Emphasizing that the proposals flow as a natural corollary to the national and regional strategies for attaining the goal of health for all by the year 2000 with primary health care as the key approach, endorsed by the Regional Committee in its resolution (SEA/RC32/R1),

1. ENDORSES the proposals in principle;

2. URGES Member States that their national coordinating authorities support these proposals when formulated, at the appropriate fora, and

3. REQUESTS the Regional Director to forward these proposals to UNDP and take such further action as may be necessary.

Handbook 3.2 Sixth Meeting, 6 September 1980 SEA/RC33/Min.6

SEA/RC33/R12 TIME AND PLACE OF THIRTY-FOURTH AND THIRTY-FIFTH SESSIONS OF THE REGIONAL COMMITTEE

The Regional Committee

1. THANKS the Governments of Indonesia and Bangladesh for their invitation to hold the thirty-fourth and thirty-fifth sessions of the Regional Committee respectively in their countries, and

2. DECIDES to hold its thirty-fourth session in Indonesia in August/September 1981 and the thirty-fifth session in Bangladesh in 1982.

Handbook 4.2.2 Sixth Meeting, 6 September 1980 SEA/RC33/Min.6

SEA/RC33/R13 SELECTION OF TOPIC FOR THE TECHNICAL DISCUSSIONS

The Regional Committee,

Taking note of the World Health Assembly Resolution WHA33.17 urging Member States to review the roles of ministries of health, and to highlight the vital importance of inter-sectoral collaboration at the country level,

1 See Annex 3
1. DECIDES to hold technical discussions during its thirty-fourth session in 1981 on the subject of "The role of ministries of health as directing and coordinating authorities on national health work";

2. REQUESTS the Regional Director to take appropriate steps to arrange for these discussions and to place this item on the agenda of the thirty-fourth session of the Regional Committee, and

3. URGES governments of the Region to include suitable representation in their delegations to the thirty-fourth session.

Handbook 4.3 Sixth Meeting, 6 September 1980 SEA/RC33/Min.6

SEA/RC33/R14 RESOLUTION OF THANKS

The Regional Committee

1. WISHES to convey its sincere thanks and gratitude to the people and the Government of the Republic of Maldives, and especially to the Ministry of Health for their warm welcome and the generous hospitality extended to all participants and the members of the WHO secretariat, as well as for the excellent arrangements made for the session;

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

3. PLACES on record its deep appreciation to the Director-General, Dr Halfdan Mahler, for his presence and participation which greatly enriched its deliberations.

Handbook 4.4 SEA/RC33/Min.7 Seventh Meeting, 7 September 1980
In presenting his annual report, the Regional Director, Dr V.T.H. Gunaratne, expressed his mixed feelings - happiness over the impressive strides made in health development in the Region during the past 13 years of his tenure, and sadness about the immense magnitude of the problems still to be overcome.

He recalled that, in recent years, WHO was witnessing an upsurge in health development. This was mainly because the Organization had of late been able to focus on the basic issues involving health development to arouse the collective conscience of the Member States to meet the challenges. This had lent, both to the Organization as well as to its Member States, not only a sense of direction but a social purpose for collective and individual action. Emphasizing the formidable problems facing the countries of the South-East Asia Region, he drew attention to the low levels of literacy, an overwhelmingly large and growing population, the majority of which lived in rural areas, inadequate basic amenities and high unemployment. The outmoded health service systems further contributed to the constraints in improving the low coverage. Despite such a situation, most of the countries had, in the post-independent era, attained commendable achievements by virtue of their determination and perseverance.

It was now widely realized that health development could only take place as a part and parcel of the totality of national socio-economic development and that political will, together with coordinated multi-sectoral efforts, were key factors for ensuring progress. National and regional strategies were formulated by taking this fundamental factor into consideration.

There was increasing political commitment in the Region to health development, of which the signing of the Charter for Health Development was an important manifestation. The countries had met together under the aegis of WHO and UNICEF from the pre-Alma Ata phase onwards periodically to chalk out various actions culminating in national and regional strategies in a number of areas which needed careful thought and concerted action, such as community involvement and participation, inter-sectoral collaboration and the development of managerial processes. To assist the countries in their efforts adequately in this regard, WHO was undergoing a process of self-introspection to gear itself to respond readily to the needs of the Member States. He believed that efforts already initiated by the governments in the Region would gather increasing momentum in the coming years and, given the will and determination, the objective of health for all would be attainable.

He expressed his sincere gratitude to all Member States for their cooperation and paid tributes to Dr Halid man Mahler for his imaginative leadership. He congratulated Dr Ko Ko on his nomination and wished him Godspeed in his work and added "It will now be his task to foster the splendid partnership happily existing between Member States and the Organization and endeavour to attain new heights in WHO's relentless pursuit of the goal of health for all."
During the general discussions on the annual report, reference was made to the impressive achievements of the Region and the important role played by WHO towards this end. It was pointed out that multi-disciplinary teams needed to be involved in health services research, which could not be confined merely to the medical scientists. The need for developing mechanisms for making the regional committees more productive was stressed. Certain suggestions were made for improving the presentation of the annual report in the coming years.

It was pointed out that the South-East Asia Region, where those in need of basic environmental health services constitute 41% of the world's population, does not get its share of extra-budgetary resources for these programmes. Responding to this feeling, the Director-General stated that while WHO has been trying to find mechanisms to mobilize as much resources as possible, the constraints of allocation and of managerial absorption capacity in the recipient countries have impeded this effort to some extent. If the Organization, in collaboration with its Member States, was able to demonstrate the visible health impact of the assistance received, such assistance would be further sustained and enhanced. Attention was also drawn to certain other constraints, such as there being fewer countries in this region and also the fact that some of them were large countries where the magnitude of resources required is huge.

The Regional Committee then went on to review the report section by section. Certain corrections to the report were suggested and noted. In regard to the section on planning and development of health services, it was pointed out to the Committee that the sections on programme areas followed in the report were related to the programme classification structure adopted in the Sixth General Programme of Work of the Organization.

It was also stated that the Member States would get an opportunity to reclassify the programmes during the preparation of the Seventh General Programme of Work to ensure that such a classification was more suited to the needs and priorities of the developing countries. A reference was made to the resolution of the World Health Assembly on infant and young child feeding, and the Committee expressed concern regarding the outcome of this vexing problem.

It was felt that WHO should further intensify coordination of its work with that of other international and bilateral agencies in order to mobilize the necessary resources as well as public opinion for the promotion and support of activities related to the utilization of weaning foods. Reference was made to newspaper reports of certain defaults from the Code which had been developed by WHO and UNICEF jointly and endorsed by the World Health Assembly last year. The Director-General clarified that WHO had taken the initiative, along with UNICEF, to have a dialogue with Member States, representatives from industry and non-governmental organizations not only to evolve a common Code but to ensure that after the Code was endorsed by the governing bodies of the agencies concerned, it was followed by all. The Code could make a significant contribution only if taken seriously by the Member States, as appropriate legislative and other steps would be required at country level. A suitable monitoring machinery would have to be set up for the implementation of the Code.
The importance of health education through orientation courses and continuing education, not only for health workers but also Community leaders and citizens, was underlined. It was pointed out that such an education was necessary to reduce the costs of programmes such as water supplies, as well as for their maintenance and optimum utilization.

In the discussion on supplementary agenda item 4 on nutritional survey patterns in the South-East Asia Region, introduced by the Government of India, it was pointed out that the importance of nutrition for the achievement of the objective of health for all could not be over-emphasized. Nutrition problems were some of the most difficult and the health sector alone would not be able to tackle them. In this regard, the Committee was informed of the initiative taken by the Regional Office in developing a research-cum-action programme in nutrition with particular emphasis on primary health care. Concern was expressed that programmes in such critical areas as health education and nutrition education met with failures. In this connexion, the key role of women in ensuring the success of the programme was underlined.

As regards drug policies and management, it was pointed out to the Regional Committee that WHO had taken certain steps and had identified lists of essential drugs that could satisfy the health care needs of all the countries. Further, as part of its technical functions, WHO was also providing the Member States with technical support to promote rational drug policies at the country level as well as to improve pharmaceutical supply systems. The Organization was also engaged in a constructive dialogue with the drug industry in an attempt to bring down the prices of most essential drugs to a level that any developing country could afford for their use in primary health care programmes. The Committee was informed of the progress achieved by individual countries in this area. Reference was made to a proposed Consultation on Pharmaceuticals to be organized by the Regional Office in October 1980 as a preparatory activity to a global meeting on the subject later this year. The new policy of the Asian Development Bank to assist the countries in this region in the field of drugs was mentioned. The Bank had been working in close cooperation with the Regional Office to promote self-reliance in drug policies and management among some of the countries in this region. It was pointed out that this is an area where there was much scope for the Member countries to collaborate fully with each other using WHO as a neutral platform; examples from other regions where such initiatives had been taken were cited.

In the discussion on communicable diseases, a question was raised regarding the effectiveness of BCG vaccination and the policy to be followed in view of certain trials conducted in India which had raised doubts about the efficacy of the vaccination. It was clarified that this trial, which was a remarkable one, had been thoroughly and critically reviewed by experts and the net conclusions indicated that the findings of the trial should not alter the basic immunization policy with regard to BCG. There was no doubt that BCG was effective in an uninfected child.

The difficulties experienced in the control of leprosy, where detected cases required long-term treatment, were pointed out. The need for an assured and regular supply of dapsone for use in the countries was emphasized.
The Committee, commending the glorious victory over smallpox which had been made possible as a result of concerted action between Member States and WHO, felt that the lessons learned from smallpox eradication were very relevant for the attainment of the objectives of health for all. A vigorous and realistic approach, improvement of adequate managerial capability and full-fledged involvement of the health systems would be key factors in this regard.

The Regional Committee noted that a uniform policy regarding vaccination against smallpox was needed. At present smallpox vaccination, according to available information, continued to be given to certain personnel such as those in the defence services in some countries.

The public health importance of diarrhoeal diseases in many countries of this region was underlined. The Committee was informed that a working group on diarrhoeal diseases had been set up by the Regional Advisory Committee on Medical Research to advise on the development and implementation of a service-cum-research programme on the control of diarrhoeal diseases. The first meeting of this group would be held in November 1980 to review research protocols on operational research. Two WHO collaborating centres for the control of diarrhoeal diseases had been designated in two countries of the Region to facilitate the development of the research programme.

A question was raised as to whether in view of the importance of diarrhoeal diseases, this should not be included as part of the WHO Tropical Diseases Research Programme (TDR). The Committee was informed that when TDR was formulated, this question had been gone into and it had been felt that this would become an unwieldy programme if it included too many subjects. However, the importance of supporting this area for research was readily recognized and it was stated that there would be no dearth of resources for this purpose.

Malaria continued to be a problem of prime public health importance and the difficulties in its eradication/control were reviewed. The lack of coordination between the ministries of health and agriculture contributed to the emergence of resistance of vectors to different insecticides. It was pointed out that by the rational use of alternative insecticides and the avoidance of indiscriminate spraying, headway could be made in this area.

As regards the expanded programme on immunization, questions were raised regarding the advisability of including polio vaccination. The need to formulate plans for the countries with paucity of manpower and financial resources to carry out polio immunization as part of the expanded programme on immunization was stressed. It was pointed out that it was for each country to decide on the immunization to be included in the expanded programme on immunization, keeping in view the availability of manpower, accessibility in different places, the infrastructure and, above all, the epidemiological situation.

The Regional Committee recognized the growing importance of veterinary public health and was informed that the Regional Office, through external resources, was able to strengthen its capability in this area. This would facilitate WHO technical cooperation in the countries in such fields as
rabies which were of some importance as public health problems in certain countries of this region.

While discussing non-communicable diseases, the Committee noted that the incidence of cancer was rising in some countries and there was a need for better detection methods. In this regard, it was pointed out that the clinical approach to the problems needed to be replaced by a true epidemiological approach for the benefit of the larger community. The Committee was informed that WHO had already initiated the epidemiological approach in its cancer programmes to render them community based.

Certain areas for WHO assistance in research in cardiovascular diseases, such as pulmonary hypertension and long-term cardiovascular complications after vasectomy were pointed out. The problem of poisoning by snake bite, which was a health problem in a few countries of the Region, was raised. It was stated that WHO was developing a programme in the Region for the countries where this was a problem.

In its discussion on environmental health, the Committee, while appreciating the efforts of WHO in making the resources available with all United Nations and other agencies for this programme, considered that there was a need to get much more resources than what this region was sharing at the moment, especially from UNDP. What was required was not to attempt to achieve a big target, but to have a compact, lower target and try to achieve it.

There should also be adequate education and involvement of the beneficiaries in the planning and implementation so that the management of water supply and sewage work could be done more effectively. As the people were living in different social environments, the Regional Office could pay more attention to the change of social environment which the countries were going to face in the year 2000.

The Committee recognized that the deliberations on the various facets of the environmental health programme indicated that it was a very complex one. It was stated that the points mentioned by the representatives and the Director-General, such as external resources, social environment, community participation, etc., would be kept in mind by the Regional Office. While the importance of financial resources could not be denied, it was equally necessary to see that the content of the programme was not just piped water supply, but also included human involvement, which was particularly important in view of the International Drinking Water Supply and Sanitation Decade.

The Committee affirmed that the declaration of the International Drinking Water Supply and Sanitation Decade was a step in the right direction and its success was crucial for achieving the goal of health for all.

The Regional Committee then discussed the section on health information and statistics and also considered item 3 of the Supplementary Agenda on Health Indicators for Developing Countries. The importance of health indicators, which were also related to the subject of health information and statistics, was pointed out. It would be essential to have two kinds of indicators, both positive and negative, which could be used for monitoring progress towards the goal of health for all. The Committee
noted that in addition to various health indicators, other indicators such as those measuring the physical quality of life, also merited attention. Attention was also focused on the methods of collecting and analysing the information so that the processed data could be used in the decision-making process. The Committee was informed that WHO had taken the initiative to prepare a document on health indicators. As health development picked up pace, the need for indicators would surface increasingly. These indicators had to be adopted in each country on the basis of selectivity. In addition to the conventional indicators, attention also needed to be focused on intersectoral indices as well.

There was also a discussion on the section on health manpower development.

On the subject of research promotion and development, reference was made to the need for giving incentives to health workers to undertake research at country level. The Committee was informed that the situation varies from country to country. In some countries, financial incentives could not be accepted while, in others, facilities such as equipment and transport are needed. The Committee was assured that WHO would certainly respond to specific country circumstances to promote maximum research.

The meeting was informed that this year the Regional Advisory Committee on Medical Research would be completing five years of existence and a committee had been formed to review the research programme. Based on its report, it would be possible to set new priorities or to redefine the earlier priorities. The next session of the Regional Advisory Committee on Medical Research would review this when research work in the Region would be geared towards meeting the objective of health for all.
A Sub-Committee on Programme Budget was, in accordance with the usual practice, established to review, inter alia, the proposed programme budget for 1982-1983. The Sub-Committee met on 1 and 4 September 1980 and submitted its report to the Regional Committee (see Annex 3).

The Sub-Committee noted that the proposed programme budget for 1982-1983 had been prepared in accordance with the new programme budget procedure and based on the Sixth General Programme of Work and other relevant policy guidelines. The Sub-Committee therefore endorsed the proposals and made certain recommendations on ways of improving its future work.

A working paper on the financial implementation of the 1979 programme under the regular budget was reviewed and suggestions were made to improve the contents of future working papers.

The Sub-Committee discussed in depth the proposed UNDP regional programme for 1982-1986 and endorsed the same in principle as reflected in resolution SEA/RC33/R11.

The Regional Committee approved the report of the Sub-Committee on Programme Budget and also requested the Regional Director to establish a small committee to (i) frame revised terms of reference for the Sub-Committee on Programme Budget, (ii) recommend revised guidelines and criteria for the establishment of inter-country projects and (iii) analyse future programme proposals prior to the session of the Regional Committee and present its findings to him (resolution SEA/RC33/R10).
1 Consideration of Resolutions of Regional Interest Adopted by the World Health Assembly and the Executive Board

In all, fifteen resolutions of regional interest adopted by the Thirty-third World Health Assembly and two by the Executive Board at its sixty-fifth session were brought to the attention of the Regional Committee. Of these, the following were considered along with the relevant sections of the Regional Director's Annual Report:

- Declaration of Global Eradication of Smallpox (WHA33.3)
- Global Smallpox Eradication (WHA33.4)
- Development and Coordination of Biomedical and Health Services Research (WHA33.25)
- Workers' Health Programme (WHA33.31)
- Infant and Young Child Feeding (WHA33.32)

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

- Study of the Organization's Structures in the Light of Its Functions (WHA33.17)
- Periodicity of Health Assemblies (WHA33.19)
- Organizational Study on the "Role of WHO Expert Advisory Panels and Committees and Collaborating Centres in Meeting the Needs of WHO Regarding Expert Advice in Carrying Out Technical Activities of WHO (WHA33.29)
- Formulating Strategies for Health For All by the Year 2000: Health as an Integral Part of Development and of the New International Economic Order (WHA33.24)
- Reimbursement of Travel Costs of Representatives to Regional Committees (EB65.R2)

The remaining six resolutions were noted by the Committee.

2 Technical Discussions

Technical discussions on "Health manpower planning and community participation for primary health care" were held during the Regional Committee's thirty-third session (document SEA/RC33/13). The
Committee then considered the report on the technical discussions and the recommendations arising out of them.

The following were the recommendations:

(1) In view of the crucial importance of primary health care, there is a need to formulate appropriate policies to provide for health education, information and effective communication techniques to secure community involvement and participation at all stages of primary health care development.

(2) Health education is an essential component of primary health care and should form an integral part of the work of all health personnel, including those at the supervisory and supporting levels.

(3) Where such personnel have not received sufficient training in educational techniques, motivation and communications, in-service training and continuing education need to be provided to make them competent in educational functions for community involvement and participation.

(4) Where the present curricula for the training of different categories of health personnel are not relevant to the needs of the country or lacking in behavioural sciences and educational aspects, the curricula should be reviewed and revised suitably.

(5) In the planning, implementation and evaluation of educational efforts in support of primary health care, adequate attention must be given to the social, cultural and economic aspects of community life and, in keeping with them, appropriate approaches, methods and materials for education should be developed.

(6) In the training of health personnel, greater emphasis should be placed on learning by doing in the community they are supposed to serve instead of classroom learning.

(7) To assess further the manpower requirements of each country, appropriate studies, both immediate and long-term, need to be carried out. WHO should promote and support the exchange of experience and information among Member countries of the Region for mutual benefit. Likewise, "success stories" of community involvement and participation should be widely disseminated among the Member countries.

(8) There is a need to establish mechanisms at each country level to bring about collaboration in manpower planning, training and service in the context of the concept of health manpower development.

(9) Member countries need to establish/strengthen facilities for the training of trainers to improve national capability in educational technology and the production of appropriate teaching-learning materials.

(10) Attention needs to be given to the employment policies, service conditions, career structures and reward systems as they apply to health manpower.
(11) There is a need to promote and support activities and stimulate and sustain community participation, especially those undertaken by non-governmental and similar organizations.

(12) WHO should guide, assist and support in the planning, management and evaluation of country activities necessary for the implementation of the above recommendations.

3 Reimbursement of Travel Costs of Representatives to Regional Committees

The subject of reimbursement of travel costs of representatives to regional committees was discussed at length by the Regional Committee, which recommended to the Executive Board that the Organization reimburse the cost of travel and daily subsistence allowance of one representative of each country attending the sessions of the regional committees.

4 Review of the Organization's Inter-Country Collaboration

The Regional Committee decided to refer the report of the Sub-Committee on inter-country and inter-regional projects to the Sub-Committee on Programme Budget. The subsequent conclusions of the Sub-Committee are contained in the report of the Sub-Committee on Programme Budget (Annex 3).

5 Strategies for Health for All by the Year 2000

The Regional Director, introducing the document on the subject (SEA/RC33/19), underlined the intensive activities at national and regional levels undertaken by Member States individually and collectively in collaboration with the Organization for the formulation of national and regional strategies. A reference was made to the growing political commitment in this region, as evidenced by the ratification of the Charter for Health Development by most countries in this region. The establishment of high level inter-ministerial committees under the chairmanship of decision-making authorities and increasing budgetary allocation to the development of rural health services indicated the growing recognition of the importance of health development. The Committee noted with appreciation the Regional Director's proposal to establish a multi-sectoral Regional Health Development Advisory Council to support national strategies for securing inter-sectoral collaboration. The Council would not only help mobilize collective support to health for all by the year 2000 activities, but also serve as a broad-based advisory group to the Regional Director.

A reference was also made to a number of strategies proposed in diverse areas in health development using the mechanism for the promotion and implementation of technical cooperation among developing countries, strengthening of managerial processes at national level and for support of key programmes related to primary health care.
The Committee was informed that the time was ripe for concrete action at national, regional and global levels, including a plan of action. While the Committee appreciated the initiatives of the Regional Office in compiling the strategies formulated at national and regional levels, it was felt that a strategy framework encompassing the entire regional actions needed to support health for all objectives would be useful.

The progress made by the Member States in the formulation and implementation of strategies was outlined. The Committee took note of using key areas which needed emphasis: reorganization of health systems, promotion of the community-based care approach in place of the institution-based curative approach, reorientation of technical education systems, including medical education, and priority support to health services research. The question of resources was also all important, and continued efforts were necessary for mobilizing additional resources from budgetary and extra-budgetary resources. Equally important was the key area of technical cooperation among developing countries where an action programme was urgently needed.

The Committee noted that vigorous and continued efforts were needed to focus attention on the fact that health was an integral part of development. The need to bring out attitudinal changes among key personnel was emphasized. It was pointed out that for the successful attainment of health for all objectives, the partnership between WHO and its Member States must assume greater importance and it was of crucial importance that Member States extract the best that WHO was capable of giving in fulfilling its mandate of technical cooperation and coordination in the field of international health.

6 Progress Report on the Preparation of the Seventh General Programme of Work

The Committee was informed of the progress made in the preparation of the Seventh General Programme of Work and also the work plan adopted for its implementation. Subsequent to the endorsement by the Regional Committee at its thirty-second session of the nature, structure and presentation of the Programme, the Regional Office had initiated data collection as a part of the preparation. Member States had been kept informed of the general progress by distributing to governments, in early 1980, three working papers on the Seventh General Programme of Work.

The Committee reaffirmed its endorsement of the nature and structure of the Programme and the work plan as agreed to earlier. It was happy to note that the contents of the Programme would be based on the strategies for health for all by the year 2000, reflecting the principles contained in the Alma-Ata Declaration and that the detailed contents would be elaborated upon subsequently in consultation with the Member States. The draft of the Seventh General Programme of Work, in its final shape, will be submitted to the thirty-fourth session of the Regional Committee in 1981 and, along with contributions from other regions, will be synthesized as the Global Seventh General Programme of Work and submitted to the Thirty-fifth World Health Assembly in May 1982.
7 Real Estate Fund

After reviewing the report of the Regional Director concerning additional accommodation as well as service facilities required for the Regional Office, as contained in document SEA/RC33/14, the Regional Committee agreed to the proposals made by the Regional Director for extension of the office building and for the installation of a new air-conditioning plant and an electric sub-station. The Regional Director was requested to forward the proposal to the Director-General for approval by the Executive Board and the World Health Assembly.

8 WHO's Structures in the Light of Its Functions

The Committee took into account the contents of documents SEA/RC33/15 and SEA/RC33/16 and noted that it was necessary to have an integrated concept of the twin roles of WHO, viz., direction and coordination of international health work and technical cooperation. It reviewed the document (SEA/RC33/16) prepared by the Director-General on the meaning of technical cooperation in WHO and endorsed the concept of technical cooperation elaborated therein.

The implications of the Thirty-third World Health Assembly's resolution on the periodicity of the Health Assemblies was also discussed (document SEA/RC33/19), and the Committee was of the opinion that it would be advantageous to continue the present practice of the Health Assembly meeting every year.

The importance of strengthening the Organization at the country level was underlined. The Committee was of the opinion that it would be helpful if the original designation of "WHO Representative" was restored in place of the current title of WHO Programme Coordinator, and a resolution (SEA/RC33/R5) to this effect was adopted. The need for appropriate decentralization at all levels of the Organization was also emphasized. As regards the question of restructuring and redefining the functions of the Regional Office, the Committee was informed that a study would be undertaken in the Regional Office in keeping with the plan of similar studies in other regions as well as in Headquarters. This study would also include WHO programme coordinators' offices. The Committee generally endorsed for implementation the actions indicated in the Headquarters document on the implementation of World Health Assembly resolution WHA33.17.

9 Preparatory Activities for the International Drinking Water Supply and Sanitation Decade

The Committee was informed of the special significance of the International Drinking Water Supply and Sanitation Decade in the programme of health for all by the year 2000 for two reasons: safe water and sanitation constituted a vital element in the basic health service package, and the experience gained from the efforts of the Water Decade would provide an important basis for the strategies for health for all. The importance of political commitment at the highest level for such a massive undertaking could not be overstressed. In most countries of the Region, Water Supply and Sanitation Decade programmes
were already being planned and were ready for take off in 1981. The Committee stressed the importance of the public health aspect of the water programme, which should not be looked upon merely from the point of view of physical facilities. The importance of socio-economic aspects and human and anthropological factors in the water programme was emphasized. The special problems prevailing in certain countries were also highlighted: salinity of the water in Maldives, the difficulty of the terrain in the water supply programme in Nepal, and the special situation of Mongolia, where extreme climatic conditions created difficulties in the construction of water supply and sewerage systems. The importance of international collaboration in this programme was underlined and Member States appreciated the efforts of WHO, UNDP, UNICEF, the World Bank and a number of bilateral agencies in supporting the Water Decade programme. It was, however, observed by many delegates that the extra-budgetary resources made available in the South-East Asia Region for this purpose were inequitably meagre compared with its population size and needs. Sustained efforts would be needed on the part of national authorities and WHO to mobilize the available resources, both nationally and internationally, to supplement the national inputs in this programme.

10 Health 2000 Resources Group – Nomination of an Additional Member

Consequent on the increase in the membership of this group, and the availability of one more position to the South-East Asia Region, the Committee elected India as the additional country which would nominate a person to be a member of this group for a period of two years.

11 Selection of a Subject for the Technical Discussions to be held During the Thirty-fourth Session

The Thirty-third World Health Assembly had suggested that the regional committees, during their sessions in 1981, might hold technical discussions on "The Role of Ministries of Health as Directing and Coordinating Authorities on National Health Work". The Committee gave serious consideration to this suggestion and decided to accept it, but to limit the scope of the discussions to inter-sectoral coordination in national health work.

12 Time and Place of the Thirty-fourth and Thirty-fifth Sessions of the Regional Committee

The Regional Committee accepted with thanks the invitation of the Government of the Republic of Indonesia to hold its thirty-fourth session in Indonesia in 1981. The Government of Bangladesh invited the Committee to hold its thirty-fifth session in Bangladesh in 1982, and the Committee accepted this also with appreciation.

13 Special Programme for Research and Training in Tropical Diseases – Membership of the Joint Coordinating Board

Thailand was nominated as a member of the Joint Coordinating Board to the UNDP/World Bank/WHO Special Programme for Research and Training in
Tropical Diseases under 2.2.2 of the Memorandum of Understanding for three years effective 1 January 1981 succeeding Burma, whose tenure on the Board would terminate by December 1980.

14 Other Subjects

The following items of the agenda were taken up for discussion along with the relevant sections of the Regional Director's Annual Report:

- Nutritional Survey Pattern of the South-East Asia Region (Supplementary Agenda item 4)

- Health Indicators for Developing Countries (Supplementary Agenda item 3)

Supplementary Agenda item 2, "Review of the draft provisional agenda of the sixty-seventh session of the Executive Board and of the Thirty-fourth World Health Assembly", was considered along with item 4 of the agenda, "Adoption of provisional and supplementary agenda" of the Regional Committee.
ANNEXES TO THE REPORT
Annex 1

LIST OF PARTICIPANTS*

1. Representatives, Alternates and Advisers

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REPORT OF THE REGIONAL COMMITTEE

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NEPAL

Representative: Dr L. Poudayl
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Kathmandu

SRI LANKA

Representative: Mr P. Gunasekera
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Ambassador for Sri Lanka in the Republic of Maldives
Male

Dr H.A. Jesudasan
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- Mr Christian Lemaire  
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- Mr David P. Haxton  
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- Dr (Mrs) M.J.H. Wijemanne  
  Programme Officer  
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3. **Representatives of Non-governmental Organizations**

**International Federation of Obstetrics & Gynaecology**

- Dr Raman M. Nadkarni  
  36, Jawahar Nagar, Sarkhej Road  
  Ahmedabad (Gujarat)

**World Federation of Occupational Therapists**

- Mrs V. Bole  
  F-41 Ansari Nagar  
  New Delhi

**World Federation of Proprietary Medicine Manufacturers**

- Mr V.R. Navelkar  
  Richardson Hindustan Ltd.  
  Tiecicon House  
  Dr E. Moses Road  
  Bombay 400011
REPORT OF THE REGIONAL COMMITTEE

Annex 2

AGENDA*

1. Opening of the Session

2. Sub-Committee on Credentials
   2.1 Appointment of the Sub-Committee
   2.2 Approval of the report of the Sub-Committee

3. Election of Chairman and Vice-Chairman

4. Adoption of provisional and supplementary agenda
   (SEA/RC33/1 and Add.1)

5. Appointment of the Sub-Committee on Programme Budget and adoption of its terms of reference
   (SEA/RC33/4)

6. Adoption of agenda and election of Chairman for the technical discussions
   (SEA/RC33/5 and Add.1)

7. Thirty-second Annual Report of the Regional Director
   (SEA/RC33/2 and Corr.1)

8. Nomination of the Regional Director

9. Consideration of resolutions of regional interest adopted by the World Health Assembly and the Executive Board
   (SEA/RC33/17)

10. Technical discussions: "Health manpower planning and community participation for primary health care"
    (SEA/RC33/13)

    (SEA/RC33/3)
    11.1 Consideration of the report of the Sub-Committee on Programme Budget
    (SEA/RC33/25)

12. Consideration of the recommendations arising out of the technical discussions
    (SEA/RC33/26)

13. Reimbursement of travel costs of representatives to Regional Committees
    (SEA/RC33/6)

14. Review of Organization's inter-country collaborative programme - Report of the sub-committee on inter-country and inter-regional projects
    (SEA/RC33/7)

*Originally issued as document SEA/RC33/1 Rev.1 on 5 September 1980.
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**SUPPLEMENTARY AGENDA**

1. Special Programme for Research and Training in Tropical Diseases - membership of the Joint Coordinating Board | (SEA/RC33/12) |
2. Review of the draft Provisional Agenda of the sixty-seventh session of the Executive Board and of the Thirty-fourth World Health Assembly | (SEA/RC33/20) |
3. Health indicators relevant to developing countries (item proposed by the Government of India) | (SEA/RC33/21) |
4. Nutritional survey pattern of the South-East Asia Region (item proposed by the Government of India) | (SEA/RC33/22) |
REPORT OF THE SUB-COMMITTEE ON PROGRAMME BUDGET

1 Introduction

The Sub-Committee on Programme Budget held a preliminary meeting on 1 September 1980. Dr Prakorb Tuchinda was elected Chairman. At this meeting the proposed programme budget for 1982-1983 (document SEA/RC33/3 and Rev.1) as well as other background papers were introduced and explained. The Chairman explained that the usual procedure for the work of the Sub-Committee in accordance with the terms of reference SEA/RC33/4 would be followed.

The Sub-Committee met again on 4 September 1980 to carry out its work and to finalize its report.

The meetings were attended by the following:

Dr U Than Win .. Burma
Dr Chang Yong Pyo .. DPR Korea
Mr Kwon Sung Yon .. DPR Korea
Mr N.N. Vohra .. India
Dr Hapsara .. Indonesia
Dr Abdul Samad Abdulla .. Maldives
Professor G. Jamba .. Mongolia
Mrs S. Narantuya .. Mongolia
Mr W.M.C. Abeyaratna .. Sri Lanka
Dr Prakorb Tuchinda (Chairman) .. Thailand
Dr Samlee Plianbangchang .. Thailand

2 Review of the Proposed Programme Budget for 1982-1983

The Sub-Committee was advised that the document showing the proposed programme budget for 1982-1983, including the revision relating to the programme of DPR Korea, reflected the programme allocations requested by the Member States. Detailed activities would be developed subsequently and presented to the Regional Committee in 1981. In this exercise, there would be scope for making justified deviations from the programme allocations now presented.

Referring to the terms of reference, paragraph 1.1 and 1.2, the Sub-Committee felt that it was not possible, within the time at its disposal, to carry out the necessary review. On the other hand, the new programme budget procedures at the country level should guarantee that the programme proposals would meet the needs of the countries. The proposals were in consonance with the Sixth General Programme of Work and other policy guidelines as the programme had been formulated on the basis of these principles. The Sub-Committee was therefore satisfied that the requirements under paragraph 1.1 and 1.2 of the terms of reference had already been complied with.

*Originally issued as document SEA/RC33/25 on 4 September 1980.
With reference to the inter-country proposals, the Sub-Committee decided that the detailed project activities to be developed by the Regional Director should be reviewed before finalization by a Sub-Committee to be established as per recommendations contained in paragraph 6 below.

In this connexion, it was also stated that future reviews of programme budget proposals should concentrate on the totality of the programmes, the programme trends and the growth of programme resources for the Region.

3 Examination of the 1979 Financial Implementation

The Sub-Committee commended the usefulness of the working paper that had been prepared. A suggestion was made to improve the working paper for future by giving more information in the introduction and to include a narrative programme analysis in Part I. It was further suggested that this document be circulated to Member States prior to the Regional Committee meeting to allow a full review of the same.

4 Consideration of the Proposals for UNDP Regional Programme for 1982-1986

The Sub-Committee discussed in depth the proposed UNDP regional programme for 1982-1986. It was emphasized that these proposals should flow as a natural corollary to the national and regional strategies for attaining the goal of health for all by the year 2000, with primary health care as the key approach. Some concern was expressed at the administrative and management aspects of the proposals.

The Sub-Committee noted that the programme proposals were based on the strategies for health for all by the year 2000 as formulated in June 1980. The Sub-Committee therefore endorsed the proposals in principle and prepared a resolution on the subject for consideration by the Regional Committee.

5 Review of the Organization's Inter-Country Collaboration

The Sub-Committee reviewed the report of the Sub-Committee on Inter-country and Inter-regional Projects, and endorsed its recommendations.

6 Conclusions

In addition to the resolution mentioned in paragraph 4, on the UNDP regional programme for 1982-1986, the Sub-Committee proposed a second resolution recommending that the proposed programme budget proposals for 1982-1983 be forwarded to the Director-General for inclusion in the consolidated programme budget and that the Regional Director establish a small sub-committee to:

(i) Review existing terms of reference of the sub-committee on programme budget and frame revised terms which are harmonious and relevant to present and future budgetary concerns;
(ii) Review existing guidelines and criteria for the establishment of inter-country projects and to recommend a revised framework, and

(iii) Analyze all regular and extra-budgatary programme proposals including the detailed proposals for 1982-1983, prior to each session of the Regional Committee and present its findings to the Sub-Committee on Programme Budget.
Annex 4

REPORT ON THE TECHNICAL DISCUSSIONS ON
HEALTH MANPOWER PLANNING AND COMMUNITY
PARTICIPATION FOR PRIMARY HEALTH CARE*

1 Introduction

The technical discussions were held under the chairmanship of Dr L. Poudayl, on 4 September 1980, the subject being "Health Manpower Planning and Community Participation for Primary Health Care". Dr H.A. Jesudasan of Sri Lanka and Dr M.D. Saigal of India were nominated as rapporteurs.

Opening the discussions, the Chairman focused on the subject in the context of health for all by the year 2000 with primary health care as an essential means of attaining it. Health manpower planning and community participation were essential components of primary health care; therefore, the discussion on this subject was most timely. Presenting document SEA/RC33/13, the Chairman invited comments from participants as individual experts and not as representatives from the countries of the Region.

2 Discussions

At the outset, the group noted that various reforms, both in the health and non-health sectors, were required in efforts to achieve health for all by 2000. In these efforts, the participation of individuals, groups and communities was essential. It was, therefore, considered necessary to promote, inform, advise, stimulate and support community participation. It is here that health education and communications science could play a crucial role.

The numerous problems in correctly assessing manpower needs were discussed. In this regard reference was made to efforts in different countries to secure the participation of the private, voluntary and other sectors. Besides health manpower in the government sector, there was a corresponding manpower component in the private and voluntary sectors. All of them, however, had educational responsibilities to perform to secure community involvement and participation. Although there were excellent examples of community participation in primary health care in the Region, some aspects, such as community involvement in the planning and implementation of primary health care programmes, were still difficult areas, because in the past, the general tendency was to plan and administer programmes centrally and hand them down to the communities. The crucial fact that successful implementation of primary health care required the sharing of power and responsibility in decision-making with the communities themselves for detailed planning at the village level, was not sufficiently appreciated.

It was recognized that the problem of health manpower planning varied from country to country. However, basic to all countries was the

*Originally issued as document SEA/RC33/26 on 5 September 1980.
fact that health manpower was needed for the qualitative development of individuals and the country concerned.

In general, it was felt that the traditional approach to health care had been disease-oriented and institution-based. In consequence, as much as 10% of the GNP of some countries was spent on medical care. What was now essential was to "raise the ability of the people" to help themselves as far as possible, for their own health development, and to make them less dependent on the conventional health care systems. This called for the communities to develop their own primary health care systems and to require the health and related sectors to participate in these systems and vice versa. In this context, manpower planning had a broader connotation in that health manpower included mothers and other family members, community and religious leaders, indigenous medical practitioners and others, in addition to the conventional health care personnel. It was necessary to recognize that there was a dynamic pattern in health manpower from place to place and level to level concerning individuals, groups and communities.

Training of health manpower to equip them for their educational responsibilities for community involvement and participation was an important aspect of manpower development. Here, it was necessary for basic health services as well as educational services to go hand in hand. This was the essence of the health services manpower development (HSMD) concept. In some countries, education had made greater progress while the services had lagged behind. Education must therefore cater fully to the needs and demands of the health services. One of the crucial needs of the health services in most developing countries was the development of preventive and promotive health care.

It was observed that in some countries as much as 60 - 70 per cent of the health care budget was spent on institutions which catered to only 20 - 30 per cent of the population. In consequence, more than 70 - 80 per cent of the rural population was left without services. There were not enough resources for preventive and promotive health services. Hence there was a need to reallocate budgetary resources to enable an adequate share for primary health care. To overcome this problem and, in the context of primary health care, the training and mobilization of health personnel such as assistant medical practitioners instead of full-fledged doctors, public health nurses, public health inspectors and public health midwives was being accelerated in some countries. Thus, with the health problems, as they were, and the appropriate technology available to deal with them, it was possible to intensify increasingly efforts to prevent diseases and promote health. Along with these developments had emerged the recognition, in some countries, that it was not enough to develop health services, but it was more important to educate and involve people as full partners in health care processes. Examples of the utilization of village health volunteers to deliver an essential package of primary health care with the participation of communities and the impact they had made in some countries were cited. It was recognized in this regard that certain policy decisions were basic to community participation. As community participation
was essential for health care progress, it was necessary to determine, in the first instance, whether the governments were willing to decentralize and involve people in real terms and not merely to persuade them to accept the proffered services. Additionally, apart from the political will necessary, there was a need for the motivation and commitment of technocrats, middle-level health officials and the communities themselves. Here, policy decisions should also provide for the dissemination of essential information, motivation and generation of essential skills. There should also be a corresponding policy to reallocate funds for primary health care.

Apart from these, additional policies related to the functions of doctors who would be required to play the role of team leader, planner, manager and evaluator were called for. Besides, policies that allowed for decentralized planning and management, with implications for training, were required. The policy should also provide for the training of a variety of health personnel, both government and non-government, all contributing to the development of primary health care.

It was stated that primary health care, with its connotations of training of a health team consisting of a variety of health personnel, was an accepted policy in the Region. Efforts were being made to train them for primary health care functions with the emphasis on health education. In the non-health sector, corresponding efforts, such as canal digging to improve agricultural production, mass literacy campaigns and family planning programmes, were being undertaken.

The group recognized that greater community involvement and participation would come from the identification of problems by the people themselves, development of strategies to solve the problems identified, implementation of programmes and their evaluation. It was re-emphasized that in each component of primary health care, there was an individual, family or community involvement and participation dimension and, by implication, an educational dimension as well.

Some of the limitations to community participation were identified. One of them was the continued tendency to plan programmes centrally and to require people to participate or cooperate with such programmes. Conversely, primary health care called for community participation at every stage of its development. As was repeatedly emphasized, this meant that certain information, attitudes and skills on the part of the people themselves were required. Education must seek to generate this information, attitudes and skills.

The group considered that it was necessary to understand the social, cultural and economic aspects of the community before it could be involved in health action. This was because of the fact that participation could be sought only in terms of existing conditions and change could only come slowly. Even when this was done, health being what it is, it was difficult to demonstrate results quickly, making participation more difficult.
In order to bring about community participation, it was often necessary for the primary health care workers to intervene educationally, and for this purpose, to train them adequately. Since traditional training approaches were inadequate, some countries had explored alternative methodologies in place of the traditional ones. In one country, the larger part of a 3-month training period was devoted to living and working in the community, thus learning from experience rather than from classroom teaching.

It was recognized that inter-sectoral collaboration, though vital to health for all and primary health care programmes, presented some difficulties. However, the need to utilize existing, but different mechanisms in each country was recognized. At this stage, however, it was felt that inter-sectoral collaboration had to be built up gradually. Since primary health care workers must necessarily perform functions to bring about inter-sectoral collaboration, training programmes for them must be planned accordingly. The group discussed other aspects of health manpower development and training, including the question of career development. Although difficulties were encountered, the problem was recognized as an important one and increasingly career development opportunities were being provided for them.

3 Recommendations

At the conclusion of the technical discussions, the group took note of the suggestions contained in the technical paper on Health Manpower Planning and Community Participation for Primary Health Care, and made the following recommendations. It also felt that in all the actions involved in these recommendations WHO could collaborate actively with Member States for implementation.

(1) In view of the crucial importance of primary health care, there is a need to formulate appropriate policies to provide for health education, information and effective communication techniques to secure community involvement and participation at all stages of primary health care development.

(2) Health education is an essential component of primary health care and should form an integral part of the work of all health personnel, including those at the supervisory and supporting levels.

(3) Where such personnel have not received sufficient training in educational techniques, motivation and communications, in-service training and continuing education need to be provided to make them competent in educational functions for community involvement and participation.

(4) Where the present curricula for the training of different categories of health personnel are not relevant to the needs of the country or lacking in behavioural sciences and educational aspects, the curricula should be reviewed and revised suitably.
(5) In the planning, implementation and evaluation of educational efforts in support of primary health care, adequate attention must be given to the social, cultural and economic aspects of community life and, in keeping with them, appropriate approaches, methods and materials for education should be developed.

(6) In the training of health personnel, greater emphasis should be placed on learning-by-doing in the community they are supposed to serve instead of classroom learning.

(7) To assess further the manpower requirements of each country, appropriate studies, both immediate and long-term, need to be carried out. WHO should promote and support the exchange of experience and information among Member countries of the Region for mutual benefit. Likewise, "success stories" of community involvement and participation should be widely disseminated among the Member countries.

(8) Each country should establish mechanisms to bring about collaboration in manpower planning, training and service in the context of the concept of health services manpower development (HSMD).

(9) Member countries need to establish/strengthen facilities for the training of trainers to improve national capability in educational technology and the production of appropriate teaching-learning materials.

(10) Attention needs to be given to the employment policies, service conditions, career structures and reward systems as they apply to health manpower.

(11) There is a need to promote and support activities and stimulate and sustain community participation especially those undertaken by non-governmental and similar organizations.

(12) WHO should guide, assist and support in the planning, management and evaluation of country activities necessary for the implementation of the above recommendations.
Annex 5

LIST OF OFFICIAL DOCUMENTS OF THE THIRTY-THIRD SESSION*

SEA/RC33/1 Rev.1 Agenda
SEA/RC33/2, Corr. 1 & 2 Thirty-second Annual Report of the Regional Director
SEA/RC33/3 Rev.1 Proposed Programme Budget for 1982-1983
SEA/RC33/4 Suggested terms of reference for the Sub-Committee on Programme Budget
SEA/RC33/PB/WP1 Financial implementation of the 1979 programme under the Regular budget
SEA/RC33/PB/WP2 Regional programme/project proposals for UNDP support, 1982-1986
SEA/RC33/5 Proposed agenda for the technical discussions on health manpower planning and community participation for primary health care
SEA/RC33/5 Add.1 Proposed annotated agenda for the technical discussions
SEA/RC33/6 Reimbursement of travel costs of representatives to Regional Committees
SEA/RC33/7 Report on the meeting of the Sub-Committee to review the Organization's inter-country collaborative programme, SEARO, New Delhi, 7-8 February 1980
SEA/RC33/8 Election of an additional representative from the South-East Asia Region to the Health 2000 Resources Group
SEA/RC33/9, Corr. 1 & 2 Preparatory activities for the International Drinking Water Supply and Sanitation Decade
SEA/RC33/10 Progress report on the preparation of the Seventh General Programme of Work
SEA/RC33/11 Selection of a subject for the technical discussions at the thirty-fourth session of the Regional Committee

*Originally issued as document SEA/RC33/28 on 7 September 1980.
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 SEA/RC33/26  Report of the Technical Discussions on "Health manpower planning and community participation for primary health care"

 SEA/RC33/27  Draft final report of the thirty-third session

 SEA/RC33/28  List of official documents of the thirty-third session

 MINUTES

 SEA/RC33/Min.1 & Corr.1  First meeting, 1 September 1980, 9.00 a.m.

 SEA/RC33/Min.2 & Corr.1  Second Meeting, 1 September 1980, 2.00 p.m.

 SEA/RC33/Min.3  Third Meeting, 2 September 1980, 9.30 a.m.

 SEA/RC33/Min.4 & Corr.1  Fourth Meeting, 2 September 1980, 2.00 p.m.

 SEA/RC33/Min.5 & Corr.1  Fifth Meeting, 3 September 1980, 7.30 a.m.

 SEA/RC33/Min.6  Sixth Meeting, 6 September 1980, 7.30 a.m.

 SEA/RC33/Min.7  Seventh Meeting, 7 September 1980, 8.00 a.m.

 RESOLUTIONS

 SEA/RC33/R1  Nomination of the Regional Director for South-East Asia

 SEA/RC33/R2  Regional Director Emeritus - Dr V.T. Herat Gunaratne

 SEA/RC33/R3  Thirty-second Annual Report of the Regional Director

 SEA/RC33/R4  Formulation of Strategies for Health for All by the Year 2000

 SEA/RC33/R5  Study of WHO's Structures in the Light of Its Functions

 SEA/RC33/R6  Periodicity of the World Health Assembly

 SEA/RC33/R7  Reimbursement of Travel Costs of Representatives to Regional Committees

 SEA/RC33/R8  Real Estate Fund

 SEA/RC33/R9  Safe Water and Sanitation for All by 1990

 SEA/RC33/R10  Proposed Regional Programme Budget for 1982-1983
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## SUMMARY MINUTES*

**First Meeting, 1 September 1980, 9.00 a.m.**

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*Originally issued as document SEA/RC33/Min.1, on 1 September 1980.*
## Annexes

1. **Text of Address by the Regional Director**

2. **Text of Address by His Excellency the President of the Republic of Maldives**

3. **Text of Address by the Minister of Health, Maldives**

4. **Text of Address by the Regional Director, UNICEF**

5. **Text of Address by Dr H. Mahler, Director-General, WHO**
1 Opening of the session (item 1 of the Agenda)

The REGIONAL DIRECTOR opened the thirty-third session of the Regional Committee in the absence of the outgoing Chairman and the Vice-Chairman.

2 Address by the Regional Director

The Regional Committee was meeting in Maldives for the first time and he thanked the Government of the Republic of Maldives for hosting it. He also thanked the President of the Republic, Mr Maumoon Abdul Gayoom, for having consented to inaugurate the session. He welcomed the delegates, the representatives of international agencies and non-governmental organizations, and guests. He considered the thirty-third session a momentous one as it would be deliberating upon such important items as strategies for health for all by the year 2000, the study of WHO’s structures in the light of its functions, the International Drinking Water Supply and Sanitation Decade, and other topics. In addition, it would also be nominating a successor to him. He added that the presence of very senior representatives from Member States, coupled with the presence of Dr Mahler, the Director-General of WHO, would undoubtedly enrich the proceedings of the Regional Committee.

The Regional Director reiterated that the widening gap between the "haves" and the "have-nots" called for concerted action through mutual cooperation among Member States in the spirit of technical cooperation among developing countries. It was heartening, however, that ever since the clarion call of the Thirtieth World Health Assembly for the attainment of health for all by the year 2000, Member States of this region had formulated their national strategies towards this end, and had displayed earnest political commitment which, he felt, was more than half the battle won.

He announced that, following the inaugural session, the President of the Republic of Maldives would be signing the Charter for Health Development, and, with that, nine out of ten countries would stand firmly committed, at the highest political level, to accelerated health development in the Region, and to mutual cooperation for its attainment. He concluded by saying that having developed the idea of the Charter in the first few years of his assuming office, witnessing the fruition as he was about to relinquish office, was to him personally gratifying and immensely satisfying (for full text, see Annex 1).

3 Inaugural Address by the President of the Republic of Maldives

H.E. MR MAUMOON ABDUL GAYOOM, welcoming all those present, said that his government was happy that the Regional Committee had accepted its invitation to hold its thirty-third session in Malé. This was the first time that such an important meeting was being held in his country. He recalled WHO’s momentous declaration of "health for all by the year 2000", adopted in 1978, and said that the Regional Committee session was being held at a time when there was a universally collaborative effort to achieve this praiseworthy goal. Health was the birthright of every individual and it was the moral duty of every government to
organize a comprehensive health service which would reach out to the ordinary citizen everywhere. No efforts must be spared in improving the health status of the general population of a country.

In the vital area of public health, his government was endeavouring for the provision of an overall distribution of basic health services to all citizens through the primary health care approach in keeping with WHO's aims of "health for all by the year 2000". Maldives, however, was a nation of scattered islets where lack of adequate transport facilities posed a major problem in taking health care to all the population. It was necessary to find practical solutions to this problem in order to ensure that health services reached the majority of the people.

Another serious problem was the lack of uncontaminated drinking water in the islands. It was essential to coordinate the strategies for improving water supply and sanitation facilities to ensure better health and freedom from disease. Top priority should be given to this area in the health programmes of developing countries in the context of the International Drinking Water Supply and Sanitation Decade.

Referring to the special session of the United Nations General Assembly which was being held in New York for the establishment of a New Economic Order, he said that in order to achieve positive results all the countries of the world should adopt a give-and-take outlook and promote international economic co-operation. In this context he referred to the exchange of technology and experience among the developing countries. The eradication of disease should be a vital objective in any co-ordinated programme of national development. His government's commitment to the adequate extension of health services in the country was in accordance with the principles and policies of WHO which found expression in his government signing the Charter for Health Development.

He paid tributes to the Regional Director for his sincere efforts in collaborating with the countries in solving many problems and for his understanding, compassion and cooperation. He also expressed his appreciation and gratitude to the Director-General for the initiative and efforts in not only formulating strategies but in assisting countries in implementing them (for full text, see Annex 2).

Address by the Minister of Health

MR MOHAMED MUSTAFA HUSSAIN termed the hosting of the thirty-third session of the Regional Committee for South-East Asia as an important historic occasion for his country and said that it was a great personal honour and privilege for him to address the meeting.

The Minister said that Maldives, which had been a mere passive recipient in the international arena, would now have the opportunity to share their unique experience to improve the quality of life and to build a storehouse of knowledge through this meeting. He further stated that the signing of the Charter for Health Development by
their President, jointly with the Director-General of WHO, at the inaugural session, displayed a true facet of his country's political commitment towards the global march of health for all by the year 2000.

Mr Mustafa Hussain paid handsome tributes to the WHO Regional Director for his legendary, dedicated services and untiring efforts of over a decade in providing better health in the WHO South-East Asia Region and felt sad at the thought of losing a man of his calibre from the active arena of the Region.

Mentioning the problems of the International Economic Order, detente and health for all by the year 2000 as a few of the longstanding and complex inter-related questions, he said that these could be solved only through integrated efforts at national and international levels. The ever-widening gap between the "haves" and the "have-nots" could only be bridged by dedicated commitment and proper understanding on the part of all countries of the world. He felt that the presence of WHO's dynamic Director-General would inspire the Committee's deliberations and prove a valuable opportunity for voicing the burning problems of the Region (for full text, see Annex 3).

5 Address by the Director-General

The DIRECTOR-GENERAL said that he was very happy to be present at this important session of the Regional Committee, which would be discussing crucial issues such as formulating strategies for attaining the goal of health for all by the year 2000. This was his first visit to Maldives and during the visit he understood better as nowhere else the truth of the saying that small is beautiful. All countries, whether small or big, developed or developing, had basic rights for equality, and in a vast organization such as WHO equal participation and access to facilities were necessary. That was the meaning of health for all - not sophisticated medical care for the privileged few, but the sharing of experience, resources, etc., for the benefit of all.

He sincerely hoped that the special session of the United Nations General Assembly, to which a reference had been made by the President, would yield some concrete results for a number of developed countries. He hoped that the countries of this region would, with their traditional spiritual heritage and mental attitudes, set an example to some of the developed countries in the philosophy of give and take.

He complimented the Minister of Health and the Government of Maldives for their efforts to bring about a suitable climate for the mental, physical and social well being of the people of the country.

Referring to the Regional Director's retirement, he stated that this would create a void which was hard to fill but added that Dr Gunaratne would continue to be associated with the activities of the Organization even after relinquishing his office.
6 Statement by the Representative of UNDP

MR CHRISTIAN LEMAIRE (UNDP), conveying the greetings of the UNDP Administrator, stated that in UNDP's third joint programming cycle, he hoped that special attention would be paid by the governments of this region to earmark adequate resources for the health sector. Special emphasis might be laid on health manpower planning and management, and UNDP would support any such basic government programmes in collaboration with WHO. UNDP would also spare no efforts to concentrate on projects for locating, utilizing, conserving and cleansing water resources, while follow-up investments would focus on such fields as improving rural and urban water availability, building up irrigation networks, and constructing hydro or geothermal power facilities. He also assured UNDP's full support to make the International Drinking Water Supply and Sanitation Decade a success.

7 Statement by the Representative of UNICEF

MR DAVID P. HAXTON (Regional Director, UNICEF South Central Asia Region) assured the governments of UNICEF's full cooperation, wherever possible, to improve the quality of life for all. Key areas for UNICEF support included the extension of maternal and child health services as a component of PHC, the provision of safe drinking water and adequate nutrition, and the development of indigenous capability to produce essential medicines and vaccines. In such efforts UNICEF would support not only national initiatives but also the sharing of experience among countries engaged in similar activities (for full text, see Annex 4).

8 Vote of Thanks

MR MOHAMED MUSTAFA HUSSAIN (Minister of Health), proposing a vote of thanks, said that the present occasion should be written in letters of gold in the annals of Maldivian history.

He thanked the President, the Ministers and the WHO Director-General for sparing so much of their valuable time to be present at the session, which would stimulate the delegates in their deliberations. He specially thanked Dr Gunaratne, who had been at the helm of affairs for the past 13 years, for his dynamic and untiring efforts to improve the health of the peoples of this region; also the people who had worked behind the scene very hard to make this historic meeting a reality. Finally, he thanked the representatives from Member countries and hoped that the deliberations at the Regional Committee meeting would be fruitful and their stay pleasant.

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

On the proposal of the REGIONAL DIRECTOR (as Chairman), the Committee agreed that the representatives of India, Mongolia and Sri Lanka should constitute the Sub-Committee on Credentials.
10 Closure of the inaugural meeting

The inaugural meeting was then closed.

11 Approval of the Report of the Sub-Committee on Credentials (item 2.2)

When the meeting was resumed, MR N.R. LASKAR (India), who had been elected Chairman of the Sub-Committee on Credentials, read out the report of the Sub-Committee (document SEA/RC33/24) recommending recognition of the validity of the credentials presented by the representatives of Burma, DPRK, India, Indonesia, Maldives, Mongolia, Nepal, Sri Lanka and Thailand. The report was adopted.

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

On the proposal of MR ABEYARATNA (Sri Lanka), seconded by DR PRAKORE TUCHINDA (Thailand) and DR SOEJOTO (Indonesia), Mr Mohamed Mustafa Hussain, Representative from Maldives, was elected Chairman.

On taking the Chair, MR MOHAMED MUSTHIFA HUSSAIN thanked the delegations for the honour done to him and his country in electing him Chairman.

DR U KYAW MAUNG (Burma), seconded by DR ALI RASHEED (Maldives), proposed the name of Dr Soejoto, Representative from Indonesia, for the office of Vice-Chairman. The proposal was accepted.

13 Adoption of provisional and supplementary agenda (item 4)

The REGIONAL DIRECTOR said that since the approval of the provisional and supplementary agenda by the outgoing Chairman, two items proposed by the Government of India had been received and these had been included in the revised supplementary agenda. The Committee then adopted the provisional and revised supplementary agenda (documents SEA/RC33/1 and SEA/RC33/1 Rev.1), after taking note of the document on the tentative provisional agenda of the Sixty-seventh session of the Executive Board and of the Thirty-fourth World Health Assembly (document SEA/RC33/20).

14 Appointment of the Sub-Committee on Programme Budget and adoption of its terms of reference (item 5)

The REGIONAL DIRECTOR suggested that the Sub-Committee on Programme Budget, being an important one, should consist of, as far as possible, representatives from all the Member countries. In pursuance of the suggestion made by the Sub-Committee on Programme Budget at the thirty-second session, he had established a sub-committee to develop an effective mechanism for the formulation, monitoring and evaluation of inter-country projects and, at the same time, to review the criteria for the establishment of inter-regional programmes in the South-East Asia Region. This sub-committee had met in the Regional Office on 7 and 8 February 1980 and its report (document SEA/RC33/7) had been distributed to the delegations for discussion under item 14.
of the agenda. He suggested that the Sub-Committee on Programme
Budget be requested to review this report and submit their recommend-
dations to the plenary session. The Committee agreed with the
suggestions made by the Regional Director. The suggested terms of
reference of the Sub-Committee, as outlined in document SEA/RC33/4,
were then approved, and the Committee also agreed to the suggestion
regarding agenda item 14.

15 Adoption of agenda, and election of Chairman,
for the Technical Discussions (item 6)

On the proposal of MR VOHRA (India), seconded by DR SAMLEE
PLIANBANGCHANG (Thailand), Dr L. Poudyal, Representative from Nepal,
was elected Chairman of the technical discussions. The proposed
agenda for the technical discussions (SEA/RC33/5 and Add.1) was then
adopted.

16 Keynote Address by the Director-General

DR HALFDAN MAHLER, Director-General of WHO, in his keynote address
to the Regional Committee, emphasized that the strategies for health
for all that the Member countries were working on, had an essential
element of continuity. It was important to avoid inflexibility in
the formulation of strategies.

Outlining the essentials of a strategy, Dr Mahler focused on health
reforms: "These cannot be restricted to the health sector alone".
Reforms of a political, social and economic nature were required.
Ultimately these reforms had to result in the upward thrust of human
development.

Referring to the health delivery system, he said that it had become
a neglected child. Urgent action was needed to pay greater attention
to the under-privileged. With the crystallization of the primary
health care approach at Alma-Ata, the reorganization of the health
infrastructure could now be undertaken. The Alma-Ata Declaration
had also defined the priorities, but further identification of
priorities within priorities would be required in the light of
epidemiological and socio-economic circumstances in each country.
It was equally important to bring about the involvement of the
communities, provide them with the right information, stimulate
them, advise them and support them. Community self-reliance should
never be confused with abandoning the responsibilities of the health
system.

Outlining a few of the high priority programmes which could be
progressively organized within the health infrastructure, he
referred to the provision of safe drinking water. The emphasis
here should be on people and not on pipes. He focused on the
importance of local initiative and community involvement for the
success of this programme.
Nutrition was another area where intelligent use of existing knowledge could find solutions. With proper family spacing, adequate nutrition and provision of safe drinking water and environmental sanitation, the care of pregnant women and infants could in most cases be handled by the women themselves with help from the community health workers. It was important that the first referral level of the health system must guide and intervene when necessary.

Immunization of children had to be made a permanent feature of primary health care and as such had to be dealt with by the primary health care infrastructure. As to the control of local endemic diseases, health education was extremely important. If people knew the "why" and "how" of the disease problems the programmes were more likely to succeed.

He also emphasized the importance of the provision of essential drugs and vaccines. The logistics of supplies, he stated, was one of the most neglected in the health system. Apart from providing the material needed for health care delivery, it could also provide information for community action.

Extensive health systems research was needed to find the best ways of delivering these programmes, and to integrate them within the health infrastructure.

Emphasizing a pragmatic approach to inter-sectoral collaboration, he stated that collaboration, whenever and wherever needed, in a selective manner, was important. Dealing with the role of ministries of health, he underscored the importance of strengthening health ministries to become the directing and coordinating authorities on national health work in much the same way as WHO was the directing and coordinating authority on international health work. It was only when health ministries played this role that the national planning process could be influenced to ensure health development as part of social and economic development. He enumerated the importance of such imaginative strategies as national health councils, national health development centres and so on.

Defining the role of WHO in providing strategies for health for all, he focused on the genuine partnership between Member States and WHO as the key to attaining the common goal. If WHO was used imaginatively to translate the collective resolves that the Member States made in the governing bodies, such as the World Health Assembly and the regional committees, much headway could be made. Such collective decisions could also be the starting point for technical cooperation amongst developing countries. There were many areas which lent themselves well to such collaboration. Joint research for low-cost water technology, joint training in health management, joint purchase and quality control of essential drugs, and collective efforts to create a primary health care industry were but a few of the important areas for this purpose.
Referring to global actions in the field of essential programmes related to the primary health care package, he outlined activities in the United Nations system and diverse fields such as the International Drinking Water Supply and Sanitation Decade, global action on nutrition, where WHO was fighting a bitter battle to restore breast-feeding to its rightful place, joint collaboration with UNICEF for the production of vaccines and cold chain equipment and similar action in the field of essential drugs. Similarly, he outlined how Member States could get the best out of WHO by defining their own priorities and indicating areas for support in different programmes such as strengthening of the health infrastructure, strengthening of ministries of health as envisaged by the World Health Assembly and the mobilization of resources. He mentioned that a Health Resources 2000 Group had been established under the aegis of WHO and that large sums of money were at stake, about $2 000 million a year. The question was one of using WHO as an agent to match the requirements, and success would depend on the involvement of Member States. He emphasized the importance of making a proper use of the mechanisms such as programme budgeting at the country level, which permitted Member States to define detailed requirements as near the operational period as possible. He also stated that the Seventh General Programme of Work (1984-1989) was being formulated and it was important that Member States contributed to and used the Programme in support of their strategies.

He concluded by focusing on his main theme of how in the era of health expectations, WHO could be of use to Member States by fulfilling its directing and coordinating role in international health (for full text, see Annex 5).

17 Intervention by the Director-General

The DIRECTOR-GENERAL informed the Committee that through a telephone conversation between the WHO Programme Coordinator, Sri Lanka, and the Acting Director, Support Programme, the Secretariat had been given to understand that the delegate of Bangladesh was not able to attend the meeting today. He was in Colombo and would try to reach Male as quickly as possible. The earliest possibility would be on Wednesday morning. The WHO Programme Coordinator, Sri Lanka, had also communicated that the delegate of Bangladesh had requested that item 8, relating to the nomination of the Regional Director, as well as item 22, concerning the time and place of forthcoming sessions of the Regional Committee, be postponed until after his arrival. He said that he just wanted to communicate this piece of information to the Regional Committee.

PROFESSOR LOEDIN (Indonesia) enquired whether, since the Committee had already adopted the agenda, it would have to reconsider the agenda.
Announcement regarding the private meeting for the nomination of Regional Director (item 8 of the Agenda)

The CHAIRMAN said that unless the representatives felt otherwise, item 8 would be taken up at 2 p.m. today, and asked for observations. As there were none, he announced that item 8 would be taken up at a private meeting at 2 p.m. today, as originally scheduled.

The DIRECTOR-GENERAL informed the Committee that only the representatives of Member States, their alternates and advisers, the representative of the United Nations Secretary-General and a limited staff to assist the Director-General could attend the private meeting.

Adjournment

The meeting was then adjourned.
I consider it a great privilege and honour to welcome His Excellency the President of the Republic of Maldives who, despite his heavy duties of State, has very kindly consented to inaugurate this session. His presence here today, amongst us, is a manifestation of his government's abiding interest in the activities of the Organization, as well as his own concern for and interest in the health and well-being of the peoples of the countries of this region. I am also very happy to welcome Hon'ble Mr Mohamed Musthafa Hussain, Minister of Health, who, I am glad to note, will be leading the Maldivian delegation. We are also fortunate to have with us the Director-General of WHO, Dr Halfdan Mahler, whose presence, as the principal architect of the worldwide movement of Health for All by the Year 2000, will undoubtedly enliven the proceedings of the Regional Committee. May I take this opportunity to extend a very warm welcome to the distinguished representatives, alternates and advisers from our Member States. It is particularly gratifying to see such a high level representation from Member States at this session of the Regional Committee. I would also like to extend a hearty welcome to the Representatives of the United Nations and its specialized agencies. I have also pleasure in welcoming the representatives of governmental and non-governmental organizations and other distinguished guests who are here today.

This session is indeed a momentous one. During the next few days, the Regional Committee will be deliberating upon very important items which include Strategies for Health for All by the Year 2000, the Study of WHO's Structures in the Light of its Functions, the International Drinking Water Supply and Sanitation Decade, and other topics. In addition, this august body will be nominating my successor.

This is the first time that we are holding a meeting of the Regional Committee in this beautiful archipelago - Maldives, which derives its name from the Sanskrit, 'Mala Dweep', meaning a garland of islands. Interspersed across the sea over a vast expanse, the 1800-odd islands, with their coral reefs, palm trees and beautiful beaches, indeed form an enchanting garland adorning the Indian Ocean.

Very often, this country is referred to as South-East Asia's field laboratory for health development. Truly, the remarkable headway made here in health and development despite its difficulties of communication, logistics, limitations of manpower and material resources, is praiseworthy. This is entirely due to imaginative leadership, backed by abundant political commitment. This is particularly true in recent years, especially since the assumption of office by the new Government under His Excellency Mr Maumoon Abdul Gayoom, President of the Republic of Maldives. As for the health field, we are all fully aware of the impressive strides that Maldives has been able to make under the leadership of Hon'ble Mr Mohamed Musthafa Hussain, who talks about health for all by the year 1990 rather than 2000. I do think that such an endeavour is well
within the realm of possibility, given the necessary political will, commitment and determination as well as support from the international community by way of technical cooperation and material resources.

Your Excellency, ladies and gentlemen: These are critical times; the world today is in a turmoil. The gaps between the 'haves' and the 'have nots', despite the earnest efforts of a well-meaning few, appear to be widening. On the one hand, the stupendous breakthroughs in science and technology have provided man with the power to shape his own destiny as never before, but at the same time, ironically, millions of people on this planet are still deprived of the bare basic necessities of life, including minimal health care. In this paradoxical situation, the governments and peoples of the developing countries and international organizations such as WHO are faced with a challenge of unprecedented proportions to work together for the betterment of the vast multitudes of people. In the circumstances, the answers to these challenges lie in concerted action and mutual cooperation of our Member States in the spirit of technical cooperation among developing countries. There are no technological barriers; what is needed is political will, as well as mutual cooperation, earnestness of purpose and real hard work. Despite the enormity of the task ahead and the formidable problems we have to overcome, I, for one, am positively optimistic. Ever since the clarion call issued by the Thirtieth World Health Assembly for the attainment of Health for All by the Year 2000, the Member States of this region have individually and collectively applied themselves assiduously to this task and have taken the first few crucial steps in the right direction firmly and purposefully. They have assessed the situations prevailing in their countries critically, have reviewed their health systems and formulated their strategies for health development as an overall part of national development. There is earnest political commitment in this region which, in my opinion, is more than half the battle won.

Ladies and gentlemen: Before I conclude, I must refer to an important ceremony that you will be witnessing soon after the inaugural session, when His Excellency, the President of Maldives, will be signing the Charter for Health Development, which will be the Magna Carta of health development of the countries of this region. In the context of the movement for health for all, the vital significance of this ceremony cannot be over-emphasized. With the ratification of the Charter by Maldives, nine out of ten countries stand firmly committed, at the highest political level, to accelerated health development in our Region, and to mutual cooperation for its attainment.

For me personally, this is a cause for overwhelming gratification and immense satisfaction. The idea of a Health Charter was developed in the first few years after I took over, and after several years of work and when I am about to relinquish my office, I have the satisfaction of witnessing the fruition of our joint efforts.

Before I conclude, I must express to the Government of the Republic of Maldives our sincere gratitude for hosting the thirty-third session of the Regional Committee, and to you, Mr President, our thanks for gracing the occasion.
TEXT OF ADDRESS BY HIS EXCELLENCY THE PRESIDENT
OF THE REPUBLIC OF MALDIVES

The Director-General of the World Health Organization,
the Regional Director for South-East Asia and
Distinguished Delegates,

It is with great pleasure that I welcome you to the Republic of Maldives.
I am indeed happy that you have all accepted the Maldives Government's
invitation to hold the 33rd session of the Regional Committee of the
World Health Organization for South-East Asia in Malé.

I would like to wish you an enjoyable stay in Malé, and express my
earnest hope that your deliberations will further enhance our combined
efforts to attain the goal of a better life for millions of people in
our region.

As I greet all the participants in this meeting on behalf of the Govern-
ment and people of the Republic of Maldives and in my own name, I am
particularly pleased to welcome the Director-General of the World Health
Organization, Dr Halfdan Mahler, and the Regional Director for South-East
Asia, Dr V.T.H. Gunaratne. Dr Mahler's dedication to his difficult task
and his tireless efforts in working out and implementing strategies for
expanding the services of the important world organization that he heads
are fully appreciated by my Government.

I should like to pay a special tribute to our Regional Director,
Dr V.T.H. Gunaratne, who is vacating his post after thirteen years of
invaluable service. We in the Maldives are indeed grateful to him for
taking such a keen personal interest in providing advice and assistance
to this country. When he relinquishes his responsibilities early next
year, we will not only be losing the services of an excellent regional
administrator but also the understanding, the compassion and the wise
counsel of a good friend. On behalf of my Government and my people,
I wish Dr Gunaratne happiness, good health and many more rewarding years
of work or leisure as he may choose.

This is the first time that a meeting of this magnitude is being convened in
Malé. But even from the modest standpoint of a very small nation, we are
fully aware of the importance of this meeting and its noble aspirations
of waging war on misery and disease.

As I face you across this hall, I recall the World Health Organization's
momentous declaration of 1978 - "Health for all by the year 2000". It
is of special significance that this meeting is being held at a time when
there is a universally collaborated effort to achieve this praiseworthy
goal. We are all too conscious of the fact that health is the birthright
of every individual, whether his habitation is confined to frozen wastes,
to tropical deserts, or oceanic archipelagoes. It is, therefore, the
moral duty of every government to organize a comprehensive health service
and translate it from a lofty ideal to a commonsense reality which would reach out to the ordinary citizen everywhere. No efforts must be spared, however arduous or demanding they may be, in improving the health status of the general population of a country.

For us in the Maldives, this meeting has an added importance because our faith, Islam, advocates the attainment of the fullest degree of both physical and mental health. While the fundamental religious obligations in Islam require absolute personal cleanliness, certain dietary restrictions are meant to ensure the highest standards of physical well-being and mental alertness at all times.

Distinguished Delegates,

The policy of my Government in the vital area of public health is to endeavour for the provision of an overall distribution of basic health services to all citizens through the primary health care approach in keeping with the aims of the "Health for all by the year 2000" Declaration.

The basic component of our country health programme, which was launched with invaluable assistance from WHO, may be summed up as the translation of "Health for all Maldivians" in terms of upgrading and expanding our health services through the effective development of the Maldivian primary health care approach. Fortunately, or unfortunately, we are a nation of scattered islets where the lack of adequate transport facilities may be pinpointed as the major problem that impedes the efficient delivery of health care to all citizens. It is of vital importance, therefore, that practical solutions are found to ensure that health services will reach the majority of the people who live in the widely dispersed islands, and that health care becomes an essential ingredient of their everyday existence.

One of the biggest health problems in the Maldives is the lack of uncontaminated drinking water in any of the islands. The World Health Organization estimates that 80% of all diseases in the world are water-related. In the light of this, the problem of water and sanitation becomes of paramount significance to all of us. The United Nations has, with foresight, declared the years 1981-1990 as the International Drinking Water Supply and Sanitation Decade. With such a future target, we must co-ordinate our strategies for improving our water supply and sanitation facilities to enhance better health and greater resources for development.

In developing countries, in particular, where the problem of safe drinking water is more acute, top priority should be given to this area in their health programmes and in establishing development targets for the decade 1981-1990.

Distinguished Delegates,

At this moment, a special session of the United Nations General Assembly is being held in New York to consider the important issue of international economic development. If this special session is to achieve any positive results, a more effective formula must be found to implement the resolution adopted by the General Assembly at its Sixth Special Session in
May 1974, calling for the establishment of a New International Economic Order. All of us gathered here today must admit that unless a new international economic order is evolved in place of the existing colonial economic discipline, the liberation of man from poverty and pain, especially in the third world, will remain an eternal dream. The fundamental contradiction in the world today arises from the fact that the existing world economic system creates wealth and privilege for a few and agony and poverty for the vast majority. If this inequality is allowed to continue, it would mean the perpetuation of poverty for the majority of the world's population. Such a fate is to be battled against, whatever the odds. It is imperative, therefore, that all countries of the world, irrespective of size, wealth or population, adopt a more give-and-take stance and promote international economic co-operation in order to establish a truly just and equitable international economic order.

In this connexion, I would also like to mention the programme of technical co-operation among developing countries. It is by such exchange of technology and experience that our struggle for economic independence and progress can become a tangible reality. While pursuing economic development, we must not forego the fact that it must be simultaneous with health promotion. The eradication of disease should be a vital objective in any co-ordinated programme of national development, especially in the third world.

Before concluding my remarks, I should like to perform the pleasant duty of thanking the World Health Organization and its Director-General, Dr Halfdan Mahler, on behalf of all the participants in this meeting for the inestimable services rendered by that world body to promote good health and a better life for mankind. The Organization's policies have been shaped at global and regional levels in the light of changing world health needs. I am sure that all of us present here recognize the substantial work it has done over the past three decades to achieve its objective of eliminating the threat of disease and suffering faced by the majority of the world's population.

I am happy to announce that the Maldives' commitment to the adequate extension of health services in the country in accordance with the principles and policies of the World Health Organization will find expression in our signing the Charter for Health Development today in this inaugural meeting.

Distinguished Delegates,

I earnestly hope that as a result of this Regional Committee meeting, there will emerge a set of sound decisions and strategies for the emancipation of the people of South-East Asia from the plague of malady and death.

Let us remember the Arabian proverb, "He who has health, has hope; and he who has hope, has everything".

Let every human being be free of economic shackles!
Let every human being be safe from the threat of disease!

Let every human being enjoy the blessings of good health!

Let all present here today unite as one to ensure the continuation of this meritorious struggle to enable everyone of us to live in peace, harmony and freedom.
Mr Chairman,
Your Excellency President Maumoon Abdul Gayoom,
Director-General of WHO,
Distinguished Delegates,
Colleagues and Friends,

This hosting of the thirty-third session of the WHO Regional Committee for South-East Asia is indeed an important historic occasion for our country and as such it is a great honour and privilege for me to address this august body on this momentous occasion.

Today Maldives is yet again taking a step closer to the forefront of the nations of the world; to join hands in the overall moulding of a healthy and prosperous world to live in.

It certainly is a giant step for us as we move from the position of a mere passive recipient in the international arena to that of an active participating contributor. We in Maldives have not been fortunate enough in the past to share our unique experience more fully with our friends and neighbours. Through this meeting, however, a beginning could be made in this direction; to strengthen friendship with the countries of the world, to reinforce our dedicated efforts in an endeavour to improve the quality of life and to build a storehouse of knowledge through exchange of views amidst our friends in our own home environment.

The Regional Committee meeting has brought with it to Maldives several important events that require noteworthy mention.

We have amongst us our beloved President, a dedicated and dynamic leader our country is proud of, who will in a few moments sign on behalf of the Government and the people of Maldives the WHO Charter for Health Development, displaying a true facet of our nation’s political commitment towards the global march of health for all by the year 2000.

We have amongst us the father of this noble movement, our charismatic Director-General of the World Health Organization, to sign this Charter jointly on behalf of WHO.

We have amongst us our Regional Director, Dr Harat Gunaratna, who has won the love, admiration and respect of the WHO South-East Asia Regional countries for his legendary dedicated services and untiring efforts of over a decade in providing for better health in our Region. It is indeed a sad moment when one ponders upon the thought of losing a man of his calibre from the active arena of our WHO Region.

We have amongst us four important people representing four countries of our Region who are seeking election to take over the mantle of this challenging role established by a health giant over a period of 13 years.
These observations and more make this 33rd Regional Committee of the WHO South-East Asia Region a historic combination of events for a country which hosts for the first time an international event of this magnitude.

Having said all this, I take the liberty to welcome you all to this gathering.

Mr President, Excellencies, Colleagues and Friends,

Today the world is faced with several complex problems, problems that are all interrelated, problems whose solutions can be brought about only through integrated effort that must take effect at the national and international levels.

Just to mention a few, the International Economic Order, detente, Health For All by the Year 2000, the North-South dialogue, etc., have been with us for quite a long time and are still with us with hardly any gains made that could bring a lasting solution to the needs of the world.

Such a challenging situation requires undaunted efforts from all countries of the world, large or small, rich or poor, old or new, undaunted efforts laced with genuine political and national will. No one country of the world can blame or frown at a select group of countries or a single country for not supporting or for not contributing, or for not complying with global demands, for all global problems can only be solved by dedicated commitments and proper understanding of all countries of the world through a joint effort. The ever-widening gap in the disparities between the haves and the have-nots can only be bridged by such an effort.

Mr Chairman,

I will not dwell any further on these topics as I am more than confident that in the deliberations of the next seven days you will discuss these topics in greater dimension and will prove a valuable forum for the voicing of the burning problems of our nations and our Region. I am more than sure that you will, inspired by the presence of our WHO's dynamic Director-General, be able to take yet another valuable step toward the noble goal of global health.

Finally, it is my fervent hope that your short stay in Maldives will be a pleasant one; that our environment will inspire you rather than distract you to constructive thinking so that this 33rd meeting of the WHO South-East Asia Regional Committee will be yet another historic one.

Thanking you all.
I am pleased to be present at this 33rd session of the WHO's Regional Committee for South-East Asia, and I thank you for giving me this opportunity to share my thoughts with you. We are here to address ourselves to the daunting task of re-examining national policies and assessing manpower needs and resources that can take people and nations in this region further towards the goal of protecting under-served sections of the Asian population from the hazards of sickness and deprivation.

I am glad to be here in the Maldives, where heartening work is under way to remove these hazards from these beautiful islands. I know you face many problems, but I am sure your people have the will to solve them.

The world no longer seriously disputes the argument that health is a crucial factor in socio-economic development. Yet the health status of hundreds of millions of the world's people continues to be grim. In Asia, as in other countries, neither the standards nor the dimensions of health care are proving equal to this challenge. This is not for lack of medical knowledge; we now know how to prevent and cure many diseases that were once considered insuperable. It seems to be for lack of outreach — and for lack of the perception of how to achieve that outreach.

The people who need health care most are not getting it. They continue to suffer and die of ailments for which the remedies have been known for more than a generation. Foremost among the victims are the hapless children of developing countries. There are undoubted improvements in mortality rates and life expectancy, thanks to modern medicine and expanded social services. But high morbidity and mortality rates persist, preventible sickness continues to take a heavy toll of young lives, and diseases that had been subdued have reappeared deadlier than before. Water-related infections and malnutrition continue to kill millions of children every year, and undermine the potential of countless more.

Why should this state of affairs persist? The problem seems to lie in the way health care is sought to be delivered to the people. The answer, in UNICEF's view, does not lie in the health sector. Nor does it lie in the mere quantum increase of conventional services. The challenge of health cannot be solved in isolation because it is only one facet of the overall challenge of human resource development. It cannot be solved by vertical and sectoral services operating inflexibly from the 'top' down. For one thing, such services do not reach far enough. Moreover, they also bypass — or fail to establish — the linkages with other services that also influence health.
Most national health care strategies have been restrictive, relying heavily on curative institutions, and arrogating even the simplest health care duties to their professional cadres. The medical care needed at the primary or front-line level does not really require the professional services of a doctor. What it does require is the mobilization of self help, with a gradual advance from curative to preventive approaches. It is because this is being progressively recognized that the concept of primary health care by the community for the community has come into its own. Good health hinges on many factors that have little to do with the conventional functions of doctors and clinics, factors such as food production, drinking water supply, environmental sanitation, more equitable land distribution, and greater self-reliance in identifying and fulfilling local needs.

This is the dynamic view not only of primary health care but of a people-oriented, community-based pattern of socio-economic development. It involves some structural changes, considerable re-thinking on the allocation and use of resources, and planned and coordinated inter-sectoral action to combat the many variables that combine to undermine the quality of life. It rests firmly on the interest and involvement of the community, which is no longer the periphery of the development process but its core.

Such a pattern, UNICEF believes, can effectively meet the essential human needs of those millions of children, and their mothers, who are now so poorly served by conventional programmes, and whose condition so chronically teeters on the thin line between deprivation and crisis.

Health is one of the essential human needs, perhaps the most pivotal one. This is all the more reason for national planners to realize that the road to health lies in the integrated enlargement of basic services. Primary health care planning must therefore broaden its horizons. This is an approach embodying many challenges. One challenge implicit in applying the basic services concept to primary health care is that the medical profession might consider healing itself, by adjusting its attitude towards health and health care. There is ample evidence that "health by the people" is feasible. There is no doubt that community volunteers and workers must forge links with services outside the health sector. This calls for the will not only to allow, but to facilitate such linkages. As a recent study of primary health care in Asia suggests: "medical professionals can -- if they so choose -- become respected new entrants into social action." Will they choose to? A reform of this kind would encourage the full use of the medical profession for medical and public health purposes at the same time as it would promote real auxiliary care by front-line community workers. It would also create a healthier climate for the use of indigenous remedial skills.

In another sense, it is imperative to focus primary health care efforts more sharply on those most in need. Health for all is a broad objective, but the developing countries of Asia must make the best use of scarce resources for the optimum result. UNICEF stands by the conviction that children deserve to be at the top of the priority list.

UNICEF's advocacy of basic services, and indeed its support of the underlying philosophy of primary health care, is based on its perception that the child is a worthy subject of investment, and that any nation's commitment to improve the quality of life must pass the test of helping its children, beginning with the most deprived child. What we face in developing countries is an implementation gap. To assist in bridging it, UNICEF is pledged to continuing promotion of the integrated approach to primary health care, to supporting inter-sectoral planning and coordination of health development from the national to the intermediate and local levels of government, to strengthening training, research and advisory services, and to encouraging the introduction of primary health care into all development programmes offering entry points.

Key areas of UNICEF support, in this and other continents, are the extension of maternal and child health services as a component of PHC, the provision of safe drinking water and adequate nutrition as major preventives in the fight for health, the development of indigenous capability to produce essential medicines and vaccines and to organize effective 'cold chain' systems. To this end, we support not only national initiatives, but the sharing of experience among countries engaged in the same massive endeavour.

Intrinsic to our advocacy is the encouragement of local self-reliance. We stand for the active integration not only of needed services but of the energies of the citizen and the State.

We do this because we believe that the simple but vital services needed by every community, every family, must converge in order to have required impact. We believe that communities can be mobilized to accelerate and strengthen this process. And we believe that this can happen when national policies and strategies move closer to acknowledging the human being as a development resource, so that national planning at the highest level, and national programmes all the way to the grass-roots, become people-oriented.

In advocating the cause of the child, UNICEF has a very special mandate for people. During 1979, when world attention turned to the condition of children, the importance of this mandate became better understood. Nations looked at themselves, and at others, to identify the unmet needs of millions of children. The future depends on not losing that belated focussing of attention. In working for health, for welfare, for all the imperatives of human dignity and progress, we have to keep tomorrow. I do not need to remind you that tomorrow belongs to today's child.
use your who

strategies for health for all

1. You are now working on your strategies for health for all by the year 2000. I purposely say "you are working" in the continuous form, because we must never imagine that a strategy that is to take us to the year 2000 can be finalized in all its detail in 1980. The main lines of action can certainly be defined, but ample scope must be left to act in many different ways along those lines. So I hope you will consider your national strategies, as well as the regional strategy that you will be adopting at this session, as guides for further action to attain health for all, and not as strait-jackets to be lived in for 20 years.

the essentials of a strategy

2. It would be presumptuous of me to try to outline your health strategies, and in any event these will vary widely with your differing needs. Nor would I wish to repeat the guiding principles for formulating these strategies that were issued by the Executive Board. But I would like to drive home a few main points - some of the essentials of a national strategy as I see them. I will start with health reforms. These cannot be restricted to the health sector. Reforms of a political, social and economic nature may be required. This does not mean that we can fold our arms and wait until these have taken place. A more equitable distribution of resources for health can be the first of a series of such reforms in all sectors. Indeed, action in the health field can be instrumental in bringing about reforms in other social and economic fields. These in turn can lead to further health reforms. This is the upward thrust of human development. I shall now concentrate on action in the field of health that can help set that upward thrust in motion.

3. The health delivery system has become a neglected child. In keeping with the principle of paying greater attention to the under-privileged, urgent action is needed to change that situation. It is understandable that we should have neglected the health delivery system when the kind of health care it should be delivering was not at all clear. Now that we have agreed at Alma-Ata what that kind of care should consist of, and have summarized it in the Alma-Ata Report, we can turn to the reorganization of the health infrastructure. If you allow all your programmes to develop separately, using the health infrastructure as a passive receptacle for them, you will never achieve a balanced delivery system at a cost you can afford. The health infrastructure must therefore play a leading role in forging together the different health programmes into one unified system, however tough the struggle will be. And it must do so not only in the big cities - that is difficult enough; but also, and particularly, in rural areas and urban slums.

4. You may think that the Declaration of Alma-Ata has narrowed down priorities sufficiently by identifying eight essential elements of primary health care, but I am afraid many of you may find it necessary to decide on priorities within those priorities, starting with the most essential in the light of your epidemiological and socio-economic circumstances. For example, you could decide on top priority geographical areas or social groups, and
ensure all the elements of primary health care for them in the first instance, progressively covering the whole population. Or, you could decide on top priority programmes for the whole population, progressively adding additional programmes until all essential elements are included.

5. Are you serious about the involvement of communities? Then take risks, trust them, but at the same time provide them with the right information, stimulate them, advise them, and support them. Make it clear what they can and cannot do, and for which matters they need the support of the rest of the health system. I hope the accusation will never be substantiated that in advocating community self-reliance in health matters we are merely abandoning our responsibilities and transferring them to the powerless. Of course this danger exists. The antidote consists of providing communities with the means to organize their own primary health care, encouraging them to exert pressure on the next level of the health system to provide them with support, and making sure that this first referral level is capable of doing so.

6. Let me now comment on how a few high priority programmes might be progressively organized within the health infrastructure by that infrastructure. I shall start with safe water. The emphasis should be on people, not pipes. If we wait for long distance pipes for all, I am afraid we will be indulging in long-term pipe dreams for all. Local initiative and community research aimed at immediate solutions have to be stimulated and supported—financially and technically. This is community involvement in practice. And the involvement of people in ensuring their source of safe water has to be exploited so that they know how to use water as a source of health, not of disease, and how to dispose of it, as well as excreta and other wastes, without giving rise to nuisance or disease.

7. Now for nutrition. Food and water go together. This is another area where intelligent use of existing knowledge could go a long way to finding solutions. Breastfeeding? Of course! But mothers must have adequate food. The use of local foods? Certainly! And community intervention studies combining social, nutritional and agricultural efforts can help to make sure that the best use is made of local foods.

8. With proper family spacing, enough to eat, sufficient water to keep the homes clean and provide safe drinking water, and decent waste disposal, the care of pregnant women and infants can in most cases be handled to a large extent by women themselves with the support of community health workers. But both the women and the community health workers have to be able to rely on the guidance, and intervention if necessary, of more skilled people at the first referral level of the health system. These people have to be made responsible for giving this guidance and for responding to the calls of communities and their health workers. You can call this professional involvement in community health if you like. In most countries, ensuring this involvement will imply reshaping the functions of the health centre and hospital infrastructure. So if you start with your health infrastructure and use it to strengthen the delivery of your health programmes, you will find yourselves strengthening your infrastructure. This will in turn permit you to deliver more and better health programmes, and so on. The interplay between infrastructure and programme can thus become mutually reinforcing, whereas at present it all too often consists of an open clash.
9. The immunization of children also has to be made a permanent feature of primary health care, and therefore has to be taken over by the primary health care infrastructure if this is going to have lasting effects. Gone are the illusions of permanent results from separate campaigns. But to get parents to bring their children to be immunized, the primary health care infrastructure must gain their confidence by looking after all members of the family when they are sick or injured.

10. This brings me to the control of local endemic diseases. Explain to people what they are all about and get them to take over as much as possible of their control, providing them with the support they require. Let us take the case of malaria control as an example. If you explain to people how it is possible to control it, you can get communities to organize the distribution of chloroquine, as well as their own indoor spraying if that is to be used. But at the same time you must make sure that your logistic system supplies the chloroquine, the sprays and the insecticides on time throughout the whole year, and your community health workers must show the people how to use these control tools.

11. Last but not least, I come to the provision of essential drugs and vaccines. Start at the end, namely a short list of the most essential drugs for primary health care, but make sure you can get them to the people whenever they need them. In attempting to do so, you will reinforce your infrastructure, which will then become progressively capable of supplying additional items to all parts of the health system.

12. I have mentioned supplies in relation to a number of programmes. The logistics of supply is one of the most neglected of the health system's neglected children. In its absence, the health infrastructure is a lifeless skeleton; if properly organized, it can be a vital nerve apparatus for the whole infrastructure. In addition to providing material, it can provide information for action and can receive information in return to keep that action on the right track as seen from the perspective of the communities being served by it. So you surely must build up your logistic system as an inseparable part of your health infrastructure.

13. Also, to identify the most appropriate form of technology for each programme under the local circumstances, to find out the best way of delivering these programmes, and to integrate their delivery within the health infrastructure, will require extensive health systems research. This kind of research means trying different ways and trying again. That explains my obsession with it, because trying to make the most of people, other resources, and technology, and keeping an open mind throughout, is what building up a health system is all about.

14. I have outlined a way of dealing with problems from the perspective of the needs of people. This entails gradually strengthening the capacity of the health care delivery system to meet these needs by progressively introducing and expanding through it specific programmes based on appropriate technology, and mobilizing people to apply this technology as much as they can. If you use this approach, I think you will find it easier to help people to understand what they can do to care for themselves, how to do it, and when to rely on the health care delivery system. This approach should certainly help you to train health workers in close relationship with the jobs they will have to do; the all too prevalent practice of divorcing the education and training of health workers from the service really required of them surely must come to an end.
15. There is nothing new in much of the action I have indicated, but I thought it worth recapitulating. Much of it will mean working together with people in other sectors. Again, may I suggest that you adopt a pragmatic approach to this kind of intersectoral collaboration. There is no need to jump into the turbulent waters of total intersectoral collaboration for integrated socio-economic planning. You are only likely to be drowned. So be selective, ensuring this collaboration whenever and wherever it is needed. Keep insisting on communities doing likewise when they are developing their primary health care. If you get the intersectoral ball rolling in this way it will gather its own momentum.

16. You will have to control its direction. You will have to control the direction your communities are taking in developing their primary health care. You will have to control the direction the rest of the health system takes in providing support to primary health care. To do so will mean that ministries of health will have to function in a way that is quite different from the way they function in most countries. They will have to become the directing and coordinating authorities on national health work, in much the same way as WHO is the directing and coordinating authority on international health work. They will have to coordinate activities for health not only within the health sector but also within other sectors. They will have to influence national planning authorities to give proper consideration to health development as part of social and economic development. They will have to influence them to allocate adequate resources to national strategies for health for all, to channel external resources into these strategies, and to ensure that these external resources are used to strengthen further the country's internal resources.

17. National health councils can strengthen ministries of health by providing them with political, social and technical support, both from inside and from outside the health sector. These councils are in no way intended to usurp the functions of ministries of health; quite the contrary, they are intended to strengthen their hand.

18. I have heard misgivings too about national health development centres, as though they were intended to replace the functions of ministries of health. Again, it is quite the contrary. They were advocated so that ministries of health could put to work all the people and institutions who could possibly help to do the staff work needed to organize and reorganize the health system based on primary health care. In particular, they could be useful to ensure the optimal development and application of your managerial process for working out and carrying out your health strategies. In doing so, they could start off and sustain the process of health systems research I mentioned a few minutes ago. So please, do not let any sense of prestige based on false assumptions allow you to miss the opportunity of mobilizing for your ends all the intellectual resources your country possesses.

WHO in support of strategies for health for all

19. Where does WHO come into all this? You now have a guide as to how to make the most of your WHO in the form of the resolution (WHA33.17) that the World Health Assembly adopted this year after it had reviewed the Study of WHO's Structures in the Light of Its Functions. The Health Assembly decided that WHO should concentrate its activities on support to strategies for attaining health for all, and that it should take action for health in addition to indicating how such action might be carried out. In adopting this resolution,
the Assembly took the process of democratizing WHO a further step forward by spelling out what it expected of Member States individually and collectively in accordance with the Organization's Constitution. These responsibilities include the monitoring and control of the Organization's activities as a collective effort of Member States - surely a manifestation of democracy if ever there was one. As another example of democratic procedure, the Assembly urged you, the Regional Committees, to take a more active part in the work of the Organization.

20. Are these merely words, or are we going to act upon them together to make full use of WHO in support of your individual and collective strategies for health for all? Your Organization is gearing itself up for this. It is for you to use it properly, and to make sure that it keeps geared up to provide you with the support you need.

21. For genuine partnership between you and WHO is the key to attaining our common goal. Let us look at how such partnership could help you to get where you want to go. As usual, I shall start off in countries, because that is where action is most needed, and that is where it will have most impact.

22. You, the representatives of your governments, have to be two-way ambassadors - your governments' ambassadors to WHO so that we know what your requirements really are, and WHO's ambassadors to your countries, so that we get the right messages across to them. For it is not enough that you should be convinced of the way to attain health for all your people in the spirit of the policies you have adopted in WHO; you will have to convince your governments, and your colleagues, and your public, if your people as a whole are to benefit from the partnership.

23. I know the obstacles you have to face when you return to the realities of your countries. But that is all the more reason for using your WHO as a source of reference to rally round, or, if you like, without appearing to be immodest, a source of inspiration. Use it as a source of collective political resoluteness and moral support to bring about in your country the health reforms you dream about, and talk about in WHO. This may seem a very intangible way of using an international organization, but it is a very powerful one; from my travels in your countries I have become more and more convinced of the potential political power in individual countries of the decisions you have taken collectively in WHO. But power is only powerful if it is used; so use your WHO to strengthen your power in your own country to make sure that your strategies for health for all get the political backing they require and are pursued relentlessly.

24. Knowledge is power too. So use in your own country the ideas and information that you are forging collectively in WHO. And make sure that all those working with you use them too, no matter how prestigious they are in their own country or organization, or no matter what influential financial interests they represent. In this way you will ensure that your technical cooperation with WHO, or with any other organization, is making the most of the policies, ideas and information that the Member States of WHO collectively have to offer.
25. How can you best use WHO in practical terms to support the development and implementation of your national strategies? You can start by deciding collectively to pursue as priorities in those strategies the kind of activities I have just outlined. You can then use the very existence of such a collective decision to initiate activities of this nature in your own country, and to help you overcome the obstacles that always face those trying to bring about change in an existing order.

26. Your collective decisions in WHO can also be the starting point for technical cooperation among yourselves. Use your WHO to identify those issues which you would like to pursue together with other Member States. Then use it to facilitate such cooperation among yourselves. Use WHO not only to exchange ideas and information, but also to reach practical agreements. I will mention only a few examples. You could reach agreements on joint research for low-cost water technology based on successful experiences; on joint training in health management, using whatever facilities are proving to be most fruitful; on joint purchase and quality control of essential drugs; and on commercial exchanges as part of a new drive to create a primary health care industry that subserves not only health development, but also economic development, by opening up vast new markets.

27. I shall now give you a few examples to illustrate how the Organization is gearing itself up to support you in new ways, quite apart from the kind of support with which you are already familiar.

28. Safe water and sanitation. The United Nations system has established a Steering Committee for the Drinking Water Supply and Sanitation Decade. We have accepted the responsibility of acting as its secretariat, while the resident representatives of the UNDP are coordinating United Nations activities on this matter in countries. We accepted this responsibility to ensure the principle of water development for people. Use us! We can support you to develop socially relevant drinking water and sanitation programmes in your country as part of primary health care, and can influence the whole United Nations system to mobilize massive resources for you if you have such programmes.

29. Now for nutrition. As you know, in the face of powerful interests your Organization is fighting a bitter battle to restore breastfeeding to its rightful place. We have also been working on protocols for community research aimed at improving nutritional status by making the most of local foods. We have secured funds for this research, and large additional sums are potentially available. Yet very few countries seem to be interested. Is it less relevant than we had judged? If you do think such intervention studies can be of use to you, just let us know and we will be happy to support you in carrying them out. If not, what large scale nutritional support do you require? We cannot help you directly to obtain additional food, but we can help you to make the most of available food.

30. Our Expanded Programme on Immunization is concentrating on building up national capacities for organizing country-wide immunization programmes for delivery through primary health care. Manuals have been prepared; national centres are being designated as regional research, training and demonstration centres. If you want to use them and need more of them we can add to their number. We are discussing with UNICEF how best to ensure vaccines and cold-chain equipment for all governments who need them and cannot afford them, and
yet are trying to introduce country-wide programmes aimed at providing immunization through primary health care to all their children by 1990. We are ready to help you work out such programmes, both by direct cooperation with you and by facilitating cooperation among yourselves. But all this will only materialize fully if you make demands on us; your pressure will stimulate us to take further action and to find for you the resources you require.

31. I mentioned UNICEF. We are discussing with them and with the World Bank an ambitious scheme to ensure the provision of a selected list of about 20 essential drugs to all in need as part of national strategies for health for all based on primary health care. This list includes drugs for most of the diseases of major public health importance encountered in primary health care. Surely, this is one of the things the Assembly meant when it decided that we should take action for health. Challenge us! Specify your requirements, use these as a basis for developing your logistic system; we are ready to help you work that out too as part of the provision of essential drugs. These are for people, not for warehouses.

32. Do you want to strengthen your health infrastructures in the manner I have outlined? We have not ready-made answers, and there are no ready-made answers. But we are ready to work with you and to support you in working among yourselves to this end. In particular, we are ready to support you in all possible ways if you are interested in expanding your health systems research and building up your capacities to do so. Quite apart from the infrastructure for primary health care itself we could start working together on the first referral level. For example, in collaboration with a number of non-governmental organizations we are studying ways of converting first line hospitals into the kind of first referral level support outlined in the Alma-Ata Report. We have challenged the international surgical community to agree on a limited list of essential surgical procedures with the related equipment and supplies, and to train health workers to perform them. Will you do what you can to ensure that your surgeons give their full support to this initiative?

33. Talking of training, we are providing modest support to about a dozen medical schools with innovative teaching programmes. Are you ready to influence your medical schools to join this group and swell the ranks of those trying to provide medical education that is relevant to the attainment of health for all? If you are, we will increase our support. We have started to provide learning material for community health workers in local languages. We are also preparing diagnostic flow charts for training and for practical use. Make the most of these facilities. If you increase your demands for health learning material we will be stimulated to seek further resources to supply them.

34. Do you want to strengthen your ministries of health in the way the Health Assembly prescribed, that is as directing and coordinating authorities on national health work? I am sure you do; but I am also sure that many of you will encounter enormous obstacles in the attempt. Do your ministries of health need the support of national health councils and health development centres to establish and maintain your health strategies? Use your WHO to work out together how best to deal with these issues. Then put into practice in your own country what you have worked out together in WHO. If you are not
afraid to start the process, I promise you that WHO will do all it can to
give that process full momentum. It will do so both by providing a political
forum and by working as an active intermediary to ensure that the inter-
national community participates in providing the resources required.

35. Talking of resources, a Health/2000 Resources Group has just been
established under the aegis of WHO. Its purpose is to rationalize the
transfer of resources to support the developing countries in carrying out
their strategies for health for all. Large sums of money are at stake - about
2000 million dollars a year. We are not looking for additional funds for
WHO's programmes. We are using WHO as an agent to match resources with
requirements and thus make the most of whatever can be made available in
favour of those most in need. Success will depend on your involvement, first
of all by developing sound strategies, and then by identifying what resources
you really require to give these strategies a push in the right direction
until you can eventually take over entirely by yourselves.

36. Mechanisms do exist to help you work out how best to use your WHO.
You have a highly flexible process of programme budgeting at the country
level. You need not decide on specifics too far in advance. You can define
your priority needs in terms of broad programmes, deferring until nearer the
operational period your detailed requirements both to develop and to implement
these programmes. You therefore have a golden opportunity to develop with
WHO genuine technical cooperation programmes, but I am sorry to say that you
are still not using that process to the best advantage. You still appear to
be making use of WHO's resources for fragmented activities that cannot possibly
have a lasting effect on your national strategies. So please use the programme
budgeting process as it was planned - for you to use your WHO in your best
interests.

37. The Executive Board is in the course of preparing the Seventh General
Programme of Work for the period 1984-1989. Make sure that your Organization
uses that Programme to support your strategies, by defining clearly what each
and everyone of us should do and how we should do it - who should systemati-
cally work to strengthen the health infrastructure and how this should be
done; who should devote themselves to the scientific and technological
endeavours required to ensure health technology that is indeed appropriate,
and how this should be done; who should deal with the related health systems
research, and how best to deal with this; and who should ensure the political,
social, financial and managerial support, and how best to ensure it.

38. Mr Chairman, honourable representatives, I have tried to illustrate
how in this era of health expectations WHO can be of use to you by fulfilling
its directing and coordinating role in international health work. I have
also tried to illustrate how it can be of use to you by fulfilling its
closely related roles of generating ideas and information, using these in
its technical cooperation with you, and facilitating technical cooperation
among yourselves. Please make use of WHO in all these roles to the maximum.
Your Organization is geared up to be made use of by you in an unprecedented
way. It is in a unique position internationally. You have made it that way.
Please use it that way.
SUMMARY MINUTES*

Second Meeting, 1 September 1980, 2.00 p.m.

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ANNEX

Text of the Regional Director's Address Introducing his Annual Report for the Year 1979-80

*Originally issued as document SEA/RC33/Min.2, on 2 September 1980.
1 Nomination of Regional Director (item 8)

After the item concerning the nomination of the Regional Director had been considered by the Regional Committee in camera, the Committee reconvened in plenary session, and the CHAIRMAN invited the Director-General to speak on this item.

The DIRECTOR-GENERAL read out the following resolution approved by the Committee (SEA/RC33/R1):

"The Regional Committee,

"Considering Article 52 of the Constitution,

"In accordance with Rule 49 of its Rules of Procedure,

"1. NOMINATES Dr U Ko Ko as Regional Director for South-East Asia, and

"2. REQUESTS the Director-General to propose to the Executive Board the appointment of Dr U Ko Ko for a period of five years from 1 March 1981."

He congratulated Dr Ko Ko on his nomination and wished him success. Referring to Dr Gunaratne's association with WHO, he said that he had been like a father figure to the countries and a source of great encouragement. To him personally Dr Gunaratne had been the single greatest source of inspiration. He had constantly tried to make the Organization a meaningful one and relevant to the countries' problems, and was a proponent of opening up new vistas of success and vision.

PROFESSOR LOEDIN (Indonesia) stated that on behalf of the Indonesian delegation as well as his government he would like to pledge his loyalty and support to Dr Ko Ko in his new assignment. He expressed the hope that all the Member States of the Region would come together for mutual benefit. In the field of health, as in any other, it was the cooperation among the Member countries that yielded the final result. He recalled the association of his Health Minister with Dr Gunaratne and stated that the Minister had personally asked him to convey his greetings to Dr Gunaratne, whom he wished a long and happy life.

MR LASKAR (India) stated that this was a historic occasion in the life of the WHO Regional Office, and associated himself and his delegation with the sentiments expressed by the Director-General. He said that his country had had the happiest of associations with the Regional Office and Dr Gunaratne, whom he described as basically a modest and most soft-spoken gentleman. Coming as he did from a developing country, Dr Gunaratne understood the problems of South-East Asia and had made sincere efforts to motivate the Member States towards the solution of their fundamental problems. He was happy that even after his retirement Dr Gunaratne would continue his association with the Organization.

DR POUDAYL (Nepal) congratulated Dr Ko Ko on his nomination and pledged him the support of his Government. He wished him success in
his new appointment. He recalled the Director-General's tribute to Dr Gunaratne and stated that his country had benefited immensely during his tenure as Regional Director.

MR SHAREEF (Maldives) congratulated Dr Ko Ko on his own behalf and on behalf of his delegation. He was sure that Dr Ko Ko would discharge his duties to the best of his ability.

DR PRAKORB (Thailand) offered his felicitations and those of his delegation to Dr Ko Ko on his nomination and offered his country’s fullest cooperation. He paid rich tributes to Dr Gunaratne for his distinguished service with WHO and wished him a happy and long life.

DR U KYAW MAUNG (Burma) wished to thank all the delegations sincerely for having nominated a national of his country as Regional Director. Dr Gunaratne had been a sincere friend of Burma and had rendered valuable help and advice, which was highly appreciated.

MRS NARANTUYA (Mongolia) stated that she wished to express her Government’s gratitude to Dr Gunaratne, who was a very sincere friend of Mongolia and who had done much for health development in South-East Asia. She also wished to congratulate Dr Ko Ko on his nomination.

DR JESUDASAN (Sri Lanka) congratulated Dr Ko Ko on his nomination as the next Regional Director and said that Dr Ko Ko, who had been with WHO since 1969, would prove to be a worthy successor to Dr Gunaratne.

Paying tributes to Dr Gunaratne for all that he had done for the countries of the Region, he said that Sri Lanka was proud of his achievements. From the post of Director of Health Services in Sri Lanka, Dr Gunaratne had risen to be the Regional Director, which post he had held for the past 13 years. He wished him health and happiness during his retired life. He was happy that Sri Lanka would now have an adviser at hand whenever any problem arose.

MR KWON SUNG YON (DPRK) said that Dr Gunaratne had done a great job as Regional Director for this region. On behalf of his delegation and on his own behalf he congratulated Dr Gunaratne for his zeal to achieve a better standard of health for the peoples of the Region during the past 13 years. He congratulated Dr Ko Ko for having been nominated as the next Regional Director, and hoped that he would prove to be a true successor to Dr Gunaratne.

The CHAIRMAN said that he would like to describe Dr Gunaratne as a "health giant" who never defied any country, or better still, as a saintly giant. He then moved a resolution appreciating the services rendered by Dr Gunaratne for the improvement of health in the Region and proposing that he be declared "Regional Director Emeritus". The resolution was seconded by MR LASKAR (India), DR U KYAW MAUNG (Burma) and DR POUDAYL (Nepal) and passed unanimously (SEA/RC33/R2).

DR KO KO thanked all the delegations for nominating him as Regional Director and said that although the office of Regional Director
entailed heavy responsibilities, he would try his best to prove worthy of their trust and confidence.

DR GUNARATNE offered his good wishes to Dr Ko Ko on his nomination as Regional Director. He said that he felt embarrassed by the sentiments expressed by the representatives. He owed a debt of gratitude to Dr Mahler, with whom he had had the pleasure of being associated for the past many years, not only as Director-General but earlier as Assistant Director-General. The theories that Dr Mahler had enunciated at meetings of the World Health Assembly had given great encouragement to all and especially to SEARO, and both the Regional Office staff and the WHO Representatives in the countries had always taken up the challenge confidently. Of course, the tasks could not have been achieved without the greatest possible cooperation of the Member countries. The Director-General was therefore the guiding star who had given all of them opportunities of trying to pursue the new approaches. He expressed the hope that under Dr Mahler's able leadership during the next several years, the Organization would have a wonderful future. His own thoughts would be concentrated on the forward-looking policies of WHO under his dynamic leadership.

He also wished to thank the representatives from the Member countries for their sentiments and said that it had been a great pleasure working with various officials at different levels in the countries. He was sure that his successor would also have the cooperation and assistance that had been extended to him by the Director-General and the staff at WHO Headquarters.

2 Thirty-second Annual Report of the Regional Director
(item 7)

Presenting his report for the last time as Regional Director, DR GUNARATNE said that he had mixed feelings, of gratification and of sadness. He was happy at the achievements during the twelve years of his tenure, but sad because millions in the Region were still beyond the reach of even minimum health care. Yet he was greatly optimistic as the countries had achieved impressive progress against many odds.

At the time of his taking over as Regional Director, the Organization had been concentrating its efforts on the control and eradication of communicable diseases, though there were projects related to the strengthening of health services, water supply and sanitation, etc. It had been felt that despite all these efforts, something significant was missing - a relevance, a grasp of the whole mission of development. He clarified that he was not belittling the efforts of WHO in building up the health infrastructures of the countries concerned, training different categories of health workers and coping with communicable diseases. It was against the slow pace of health development of those days that the current upsurge of health development had to be seen.

WHO was able to focus and articulate the basic issues involved in health development arousing the collective conscience of the Member
States to come to grips with the challenges. The Organization's Constitution, in its farsightedness, proclaimed that the health of all people was fundamental to the attainment of peace and security, the key word being "all". The prime question was "what, then, should the countries do to achieve this goal?" The response from the countries to this question had ushered in "the Mahler era". This dialogue, for the first time, provided not only a sense of direction but a social purpose for collective and individual action by Member States.

WHO's South-East Asia Region, with over a billion people, faced a grim situation on different fronts: low levels of literacy, an overwhelming rural population, inadequate basic amenities, and high unemployment. In the health sphere, the outmoded health service system contributed to the low coverage of populations.

Despite the adverse conditions, most countries in their post-independence era had attained commendable achievements with grit, determination and perseverance.

The Member States of this region were fully conscious that health development could be conceived in the totality of national socio-economic progress, and for this an unwavering political will and coordinated multi-sectoral efforts were absolutely essential. An awareness of the limitations of the prevailing health system had led to far-reaching, innovative experiments that contributed to the concept of primary health care, crystallized at the historic Alma-Ata Conference in 1978. It was in the light of these factors that the countries in the Region had formulated their national strategies for the attainment of the goal of health for all by the year 2000.

The Regional Director further stated that there had been increasing political commitment in recent years to health development, which was reflected in the declaration of national policies, and the high priority that was being given to rural development, including health. He mentioned that the signing of the Charter for Health Development by nine countries of the Region was an important manifestation of the political commitment to health development. He pointed out that the political climate for development could not have been more conducive than today to evolve national and regional strategies for health for all by the year 2000. The different meetings starting with the pre-Alma-Ata phase to chalk out various actions focused attention on the subject. During his visits to Member States, he was convinced that they were fully committed to achieving the social goal of health for all by the year 2000, as part of their overall socio-economic development. Steps were being taken to secure multi-sectoral support to health - not only at the national level, but at the regional and global levels as well. The subject would be discussed fully as a separate item of the agenda.

He cited examples of strategies and mechanisms being adopted and said that there were many important areas which needed careful thought and concerted action, such as a review of community involvement and community participation. Commensurate with these national efforts, the Organization had also been involved in a self-
introspection to see how best it could gear its structures and processes to respond readily and adequately to the needs of the Member States. A study of WHO's structures in the light of its functions had been initiated in 1978, in response to the call of the Thirtieth World Health Assembly, and the outcome of the study and the resolution of the Thirty-third World Health Assembly would be discussed at the current session of the Regional Committee.

The Regional Director was inclined to believe that the efforts already initiated by the governments in the Region would undoubtedly gain greater momentum at both the national and regional levels, and there was no turning back from this voyage towards health for all. He was optimistic that it would be possible for all those involved to complete the voyage successfully. His optimism was based on the developments taking place in the Region in the field of health. In this connexion, he referred to the publication, "Voyage Towards Health", released by the Director-General earlier in the day.

In conclusion, he expressed his sincere gratitude to all the Member States for the consideration, kindness and unstinted cooperation extended to him during his tenure. He paid tributes to Dr Mahler for his imaginative leadership of WHO at a most crucial juncture in the history of the Organization (see Annex for full text).

MR VOHRA (India) commended the Regional Director on his very valuable, well-documented and useful report. He had deviated in his Introduction to look back at the entire span of his tenure as Regional Director. The achievements of the Region had been of a high order and significance. However, some points needed to be looked into. One was that non-medical personnel such as social scientists, economists and programme implementors needed to be involved in programmes such as health service research. It should not be left entirely to the medical scientists. The programme development strategies and the inputs that the Region could contribute to the global programme would have to be looked into afresh to see what reorganization needed to be made. The role of the Regional Committee could become more meaningful only if the functioning of the programme committee at the regional level became more related to it. It would perhaps be useful if the Regional Committee meetings could be preceded by a small group meeting which could make a very detailed analysis of the contents of the Annual Report and the budget document and could make detailed proposals for examination by the Regional Committee. He suggested that instead of the conventional method of allocating money for various components such as short-term consultants, long-term staff, supplies and equipment, a bulk allocation should be made for a big component such as primary health care, and governments should be allowed to make use of it in the programme they deemed fit, even if it be for the construction of buildings, etc. connected with that programme. To see whether countries were making the best use of the allocation from WHO, evaluation and monitoring of budgetary inputs should be done at the country level first. Certain areas of inter-country projects were out of tune with the present needs.
The present budgetary approach to the planning of projects and staff was very well documented. He expressed appreciation of the analysis of the fellowships on page 103 of the report and desired that a similar regional analysis of supplies and equipment should be included in the report. Referring to the tabular statement on personnel employed by WHO, he said that the percentage of staff members from the countries of the South-East Asia Region in relation to the total staff employed by the Organization worked out to 8%. It was rather unfortunate that a growing and populous region like South-East Asia had to keep on thinking of getting experts from other developed countries. In spite of the guidelines developed by the United Nations General Assembly, the WHO Executive Board and the World Health Assembly, it would be advisable to have experts from this region, because they knew the local situation and the prevalent problems.

Referring to the tabular statement showing the implementation of the 1979 programmes as a percentage of the revised budget, he said that it was very useful and interesting and suggested that the percentage they represented in the total revised budget might be shown.

3 Timings of the plenary session

On a proposal from MR VOHRA (India), and seconded by DR JESUDASAN (Sri Lanka) and DR POU DAYL (Nepal), the Committee agreed that the timing of the plenary sessions from Wednesday, 3 September, onwards would be from 7.30 a.m. to 1.30 p.m.

4 Adjournment

The meeting was then adjourned.
I have great pleasure in presenting to you the Annual Report of the Regional Director for 1979-80. This year, I am taking the liberty of sharing with you some thoughts concerning health development in this region over the last 12 years, a period during which I have had the honour of serving you as Regional Director.

On this occasion, I have mixed feelings - one of gratification and a tinge of sadness. Gratification because of what we have been able to accomplish through close collaboration with Member States. Our achievements during these years have indeed been remarkable in the face of heavy odds. Yet, sadly, millions in our Region continue to live beyond the pale of even minimum health care. Even today, as man scales new heights in technological achievements, millions of children do not live to see their first birthday and tens of thousands go blind needlessly for want of attention. It is to these unserved, underserved and underprivileged that we must address ourselves if Health for All is not to remain an empty slogan. As I address this august gathering on the eve of my relinquishing office as Regional Director, I am not despondent. On the contrary, I am confident that given the political will, determination and commitment of the Member States to the social goal of Health for All by the Year 2000, the future will be one of hope and promise.

Twelve years is perhaps a long period in an individual's life but in the life of an organization or a country, it is but a short time span. Yet, the last twelve years have been, both for WHO as well as for many developing countries, a period of great awakening. By a happy coincidence of history, WHO came into existence at about the same time as most countries in this region achieved their independence. It is this historical coincidence as well as WHO's unique constitutional mandate that binds the Organization and its Member States inextricably in a meaningful partnership, which augurs well for the future.

In the late sixties, when I took over as Regional Director, the Organization had limited technical scope, the focus being on the control and eradication of communicable diseases. We did, of course, have projects dealing with the strengthening of health services, water supply and sanitation and so on. Yet, something was missing, which, in retrospect, we can identify as an overall purpose - a relevance and a grasp of the whole mosaic of development - in short, the prime mission of WHO's existence, to fulfil its constitutional mandate, which clearly transcended the narrow technical functions it was subserving.

It is far from my intention to suggest that these early efforts were not worthwhile. They indeed contributed substantially to many components of health development enabling Member States to undertake a number of meaningful activities in building their health service infrastructure, in training different categories of health workers and in coping, to some degree, with the tremendous problems of
communicable diseases. But the pace of health development was generally slow owing to the rather limited awareness of its key determinants. It is against this background that the current upsurge of health development is to be perceived.

WHO was able to focus and articulate the basic issues involved in health development and thus arouse the collective conscience of its Member States to come to grips to face the challenges. WHO's farsighted Constitution served us well in providing a proper perspective. It proclaims in unequivocal terms that the health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and States. Every word of this important clause of the Constitution deserves our attention. The word 'all' is the key word. If the health of all peoples is the objective to be attained, what then requires to be done? It is the challenge posed by this question and the response from the Member States which ushered in what I may call "the Mahler era". For the first time, it provided not only a sense of direction but a social purpose for the collective as well as individual action of Member States. All the various other developments, the initiation of perspective planning for Health for All by the Year 2000, the development of all-important strategies, plans of action and the growth of the primary health care approach, stem from this basic development.

As far as the Member States in the South-East Asia Region are concerned, these developments have not come a moment too soon. This region, which is one of the most populous, with over a billion people - constituting a fourth of the population of this planet - has been facing a grim situation resulting from widespread poverty, low levels of socio-economic development and formidable health problems. With more than 80% of the people living in rural areas and subsisting on an agricultural economy, the basic amenities, including health, available to most people are extremely inadequate. Coupled with the slow pace of development are low levels of adult literacy, high unemployment ratios, a high dependency rate and unacceptable levels of indicators of health development such as infant and maternal mortality as well as a low life expectancy at birth. Unsuitable or inappropriate health service systems as well as health manpower development patterns with attitudinal aberrations inherited mostly from the colonial era, have contributed to the prevailing low coverage of populations by the existing health services. The inequitable distribution of available services to the people has further aggravated the situation.

Despite such a discouraging picture, most countries in their post-independence era courageously faced these problems and made commendable headway. Such glorious achievements in their march towards health development as the elimination of yaws, the control and containment of human plague and, above all, the eradication of smallpox, are but manifestations of their grit, determination and perseverance.

The awareness of the limitations of the health systems also led to far-reaching, innovative experiments which substantially contributed to the emergence of the concept of primary health care, crystallized at the historic Alma-Ata Conference in 1978.
As a result, all the Member States of this region are now fully conscious of the fact that health development can only be conceived in the totality of national socio-economic progress and, therefore, an unwavering political will and coordinated multi-sectoral efforts are absolutely essential. Many key factors which determine the level of health of the people are, however, entirely beyond the scope and function of health ministries. Water supply and sanitation, food and proper nutrition, housing, education and the provision of drugs need such a multi-sectoral collaboration, and the activities of the health sector alone are woefully inadequate to achieve a significant breakthrough.

It is with a full understanding of these basic facts that our Member States have conceived and formulated national strategies for the attainment of the goal of Health for All by the Year 2000.

The last few years have witnessed increasing political commitment to health development. The manifestation of such political will is widely seen in national policy pronouncements, the high priority accorded to rural development and other social sector activities, and the shift in emphasis from pure economic development to a concern about improving the quality of life, particularly of the underserved and unserved.

Mr Chairman, yet another concrete manifestation of the growing political will has been the acceptance and ratification of the Charter for Health Development by our Member States. Nine of the ten Member countries of the Region have signed the Charter at high decision-making level. The Health Charter is not a mere declaration of intent; it commits Member States not only to harnessing national efforts to accelerate the pace of health development but also to cooperate among themselves to build up individual self-reliance and collective self-sufficiency. It also paves the way for potent mechanisms to mobilize external resources for health development.

Mr Chairman, you will agree that the political climate for development could not have been more conducive than today to evolve national and regional strategies for Health for All by the Year 2000. It has been a long and arduous process starting from the pre-Alma-Ata phase; a distinct logical pattern of collective thinking has been the hallmark of this region. As you are aware, Mr Chairman, there were national-level preparatory activities which culminated in the pre-Alma-Ata Consultation Meeting to assist the Regional Director in preparing his Regional Report for the International Conference on Primary Health Care. In pursuance of the decision of the Thirty-second World Health Assembly on a global timetable, intensive national efforts were made for the formulation of national strategies. They were followed by two joint WHO/UNICEF-sponsored Consultation Meetings - one in December 1979 and the other in June 1980 - to exchange information on the national strategies formulated as well as to evolve collectively a regional strategy. I do not wish to forestall the discussion on this subject, which forms an important item of the agenda (item 15). I would like to say, however, that the internal political climate in this region has, in recent years, been distinctly favourable to health development. During my official visits to our Member States, I have discussed developments in health with the highest political authorities and I came away with the impression that they are fully committed to the social goal of Health for All by the Year 2000, as part
of overall socio-economic development. Towards this end, the countries are taking positive steps for securing multi-sectoral support to health. Establishment of inter-ministerial committees, national health development councils and a network of institutions for health development, are but manifestations of such positive development.

In support of such national strategies to promote the formulation of a rational policy on a regional basis, and also to ensure intersectoral collaboration on a wider front, a number of actions have been initiated at the regional level. These include the establishment of a multi-sectoral Regional Health Development Advisory Group, strengthening of the functional links with ESCAP and other organizations, and inter-agency collaboration in such areas as integrated rural development.

As for planning, a number of strategies were spelt out in the preparatory meeting. In fact, this has been an area where our Region has made praiseworthy progress. Perspective planning for the overall objective of Health for All is a complex and difficult subject. Here, you are venturing out on uncharted seas. Many Member States in this region have already worked out their perspective plans not only in relation to the health sector but also involving their planning commissions to focus on the whole canvas of social development.

As for methodologies, while each country has adopted those most suitable in its national context, certain innovative experiments in this area are worth mentioning. Mr Chairman, in your own country the exercise carried out under your leadership of using the country health programming method for long-term objectives was an extremely worthwhile undertaking, as it not only identified the overall priorities but also the activities and the resources needed to implement them as well.

One of the most important strategies for collective action in this regard relates to the strengthening of managerial processes at the country and regional levels in support of health for all activities. This region has prepared a plan covering the entire gamut of managerial processes, the outline of which has been incorporated in the regional strategies which we will be discussing. To my mind, this is perhaps one of the most crucial areas which deserves very close attention because one of the key factors involved in the process of health development relates to the managerial process.

I do not want to go into the details of the strategies at this time but there are many important areas which need careful thought and concerted action. Some of these include a review of the whole question of community involvement and community participation and a series of actions required to ensure this. Likewise, the question of collective efforts in support of health manpower development and appropriate technologies and the specific question of research support to HFA strategies need to be carefully considered for appropriate collective action.

Commemurate with these commendable national efforts, the Organization itself has been undergoing an intensive process of introspection to examine its own structures, processes and practices critically in the light of its constitutional functions, to reshape itself to respond readily to the call of Member States. Mr Chairman, following the
directive of the Thirty-first World Health Assembly in 1978, the
Director-General initiated a study of WHO's structures in the light of its
functions. As the distinguished representatives are aware, this subject
was considered in May 1980 by the Thirty-third World Health Assembly,
which finally adopted a resolution (WHA33.17) which, together with a
proposed plan of action for its implementation, will be discussed by you
as a separate item on the agenda.

There are a number of major actions which logically have to follow the
Health Assembly resolution. These concern all those involved in the
working of the Organization, the governing bodies, the Member States
and the Secretariat. The World Health Assembly resolution, inter alia,
calls for a more effective role for regional committees in the planning
and implementation of regional programmes and for Member States to take
action in a number of crucial areas, including the strengthening of
health ministries and the narrowing of the gap between policy and
practice, and for the Secretariat to reorient and reform its structures
to be able to respond promptly and adequately to the needs of its Member
States.

Mr Chairman, ladies and gentlemen: As I said in my introduction to this
year's Report, gazing at the crystal ball is a hazardous preoccupation.
Yet, I am inclined to believe that the efforts that our governments have
initiated now will undoubtedly gain greater and greater momentum at both
the national and regional levels and there is no turning back from this
voyage towards health for all.

Speaking of this voyage, the time is short and the task ahead stupendous;
nevertheless, to quote Dr Mahler, "Our philosophies have brought us to
the threshold of universal mass action for health", and I am optimistic
that we will be able to complete this voyage successfully. My optimism
is based on the developments that are taking place in our Region in the
field of health, which, over the course of the past few months I have
had the opportunity to study and review critically. These have been put
together in the publication, "Voyage Towards Health", which has been
formally released by the Director-General this morning.

May I, before I conclude, express my sincere gratitude to all the Member
States for the consideration, kindness and unstinted cooperation extended
to me during my tenure of office. If WHO has been able to contribute in
some way to health development in this region, it has been entirely due
to the will, resolve, cooperation and understanding of our Member States.

Mr Chairman, I would like to pay tribute to Dr Halfdan Mahler for his
imaginative leadership of our Organization at a most crucial juncture in
its history. You have heard his perceptive thoughts and shared his
visions of the Organization in his remarkable key-note address delivered
earlier today. He sketched for us in vivid colours scenarios-in-sequence
for health development indicating how you could wisely use WHO for
achieving our cherished goal of health for all. May I also take this
opportunity to express my gratitude to him for the understanding and kindness, which he so readily extended to me. Let me also felicitate Dr U Ko Ko on his nomination as Regional Director and wish him Godspeed in carrying out his onerous responsibilities! It will now be his task to foster the splendid partnership happily existing between Member States and the Organization, and endeavour to attain new heights in our relentless pursuit of the goal of health for all.
SUMMARY MINUTES*

Third Meeting, 2 September 1980, 9.30 a.m.

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*Originally issued as document SEA/RC33/Min.3, on 2 September 1980.
1 Regional Director's Annual Report (item 7)(cont’d)

DR U KYAW MAUNG (Burma) congratulated Mr Mohamed Musthafa Hussain, Minister of Health of the Republic of Maldives, and Dr Soejoto on their election as Chairman and Vice-Chairman respectively. He also thanked the Director-General for his thought-provoking address and the Regional Director for his untiring efforts over the years in the field of health and on his comprehensive report. He extended greetings from his Government and wished the deliberations success.

PROFESSOR LOEDIN (Indonesia) stated that over the years the Regional Director's report had covered what had been done by the Regional Office, how the resources had been spent, and so on. Since there was now a global and a regional plan of "Health for all by 2000", the report must include some kind of an evaluation to see whether we were moving in the right direction and towards our goal. The report should not only be a reporting process on the resources and outputs but should also indicate the impact of our activities in reaching the goal of "Health for all by 2000". He wanted to know whether the report would include such an evaluation in future years.

DR ZANG YONG PO (DPRK) congratulated the Chairman and the Vice-Chairman on their election. He thanked the Director-General and the Regional Director for their visit to his country in July 1980 and said that great progress had been made in various fields of health. The signing of the Health Charter was an important step in protecting and improving the health of the people. He said that his country had taken a number of steps to promote the health of the people. A Public Health Law had been passed in April for the promotion of prophylactic and therapeutic work. Giving some health statistics, he said that at the end of 1979, his country had a ratio of 23.3 doctors and 120 hospital beds per 10,000 population respectively. The general mortality rate was 4.4 per 1000 and the average life-span was 73 years. To improve further the health of the people, his Government had strengthened cooperation with WHO and was developing relations with many Member States in the health field.

MR ABDUL SATTAR YOOSUF (Maldives) congratulated the Regional Director on his very comprehensive report, which adequately highlighted the health activities in Maldives. His country had launched several energetic programmes this year with greater emphasis on rural health. The report had also underscored his country's efforts in country health programming, the outcome of which was the country health plan. He hoped that, through this programme, Maldives would be able to achieve the goal of health for all by 1990 rather than 2000 A.D.

On behalf of her delegation, MRS NARANTUYA (Mongolia) congratulated Mr Mohamed Musthafa Hussain, Health Minister of Maldives, on his election as Chairman and Dr Soejoto as the Vice-Chairman. She congratulated the Regional Director on his annual report and for his many contributions to health development in the Region, as also for working out strategies for achieving the goal of "Health for all by 2000" for Member countries at the regional
In this context she stressed the importance of the Alma-Ata Conference. During the thirteen years of Dr Gunaratne's association as Regional Director her country had achieved success in fighting infectious diseases. She also recalled the contribution of WHO in the eradication of smallpox. The Member countries of the South-East Asia Region had a great role to play in fulfilling the tasks emanating from the humane principles of the Charter for Health Development which had been adopted during the thirty-first session of the Regional Committee in Ulan Bator. Next year, Mongolia would be celebrating the sixtieth anniversary of its national health services. In these sixty years, the country had achieved great success in providing qualified medical care to the people. For a population of 1.6 million, her country had 4000 doctors and 19 000 hospital beds at the end of 1979, i.e., 22 doctors and 105 hospital beds per 10 000 population.

According to the forecasts of the development of the national economy, there was further scope to increase the material resources and medical services. The difficulties faced by Mongolia were well known to the Regional Director and all Member countries of the Region. To overcome these difficulties, her country relied on bilateral and international cooperation. Mongolia also had close cooperation with COMECON countries, and was making efforts to develop fruitful cooperation in the field of health for all by the year 2000 and the activities related to the International Drinking Water Supply and Sanitation Decade.

DR JESUDASAN (Sri Lanka) congratulated the Regional Director on his very comprehensive report, and agreed with the comments made by the delegate from Indonesia (Professor Loedin) regarding incorporation of the evaluation of primary health care and health for all by the year 2000 in future reports. Supplementing the information on his country's efforts to achieve a balanced development of health services, he said that Sri Lanka had launched a vigorous programme for training field midwives; one midwife would be maintained for a population of three thousand for better coverage of the population. The designation of the field midwife had been changed to family health worker who would now function as a multipurpose worker.

DR POUDAYL (Nepal) thanked the Regional Director for his excellent report and expressed his satisfaction on seeing the accomplishments of the past year. But he was also sad because this would be the last annual report to be presented by Dr Gunaratne.

DR PRAKORB (Thailand) congratulated Mr Mohamed Musthafa Hussain and Dr Soejoto on their election as Chairman and Vice-Chairman respectively. He also congratulated the Regional Director on his excellent report. He said that in Thailand they were convinced of the need to develop health services on a long-term, medium-term and short-term basis in order to serve the human purpose of economic and social development of the country. The Ministry of Public Health, with the consistent support of all other ministries and the National Economic and Social Development Board, would be actively pursuing the programmes which led to the global objective of Health for All by the Year 2000, viz., Primary Health Care, Health Services
Research, Appropriate Technology for Health, Disease Prevention and Control, Health Services and Manpower Development, etc.

Dr Prakorb assured the meeting that they would continuously try to improve and strengthen these programmes through such mechanisms as might be developed gradually. He paid a special tribute to the Regional Director for giving consistent support to his country in all these efforts.

The REGIONAL DIRECTOR thanked the representatives for expressing their satisfaction at the Annual Report and said that their observations and general comments had been noted very carefully both by himself and by Dr Ko Ko. He thanked Mr Vohra (India) for his valuable suggestions regarding the Regional Advisory Committee on Medical Research. He informed the meeting that in the case of environmental health, WHO was using sociologists and health educators, who were non-medical people. Regarding the managerial processes for primary health care, he informed the meeting that on the request of the WHO Director-General, the South-East Asia Regional Office had formulated a draft of the managerial processes which had been included for discussion separately (under Agenda item 15). He agreed that programme development should not be merely theoretical but should also be pragmatic. The Regional Office was already engaged in making country case studies for evaluation purposes.

As for the role of the Regional Committee and the Programme Committee, he assured the delegates that this particular aspect would be included in the report from next year. He fully agreed with Professor Loedin and said that Dr Ko Ko had also noted that there should be a reference in future annual reports regarding the evaluation and impact of the activities and how they could come closer to the goal of Health for All by the Year 2000.

MR VOHRA (India) said he was happy to note that some of his points had been received favourably and requested the Regional Director to see what changes in the mechanisms could be brought about so that whatever resources were available were spent in the right direction.

He made a special reference to the corrigendum (SEA/RC33/2 Corr.1) which referred to the fact that while the external investment had been US$2000 million globally in the environmental health programme in 1979, the South-East Asia Region, where 41% of the world’s population in need of these services lived, did not get its due share.

He also felt that the allocations from the WHO Regular Budget did not go up as it should have been for his country and the Region, and wondered whether the Director-General could clarify this point. The Regional Director’s report brought out amply the activities undertaken by the Regional Office during the year but monitoring and evaluation seemed very essential. With WHO entering into areas too complicated and too inter-connected, he wanted to know the internal mechanisms of the Organization that had been developed for monitoring and evaluation.
He suggested that perhaps a small group of the Regional Committee could review the Annual Report and other allied documents presented to the Committee and report to the Regional Committee. As a consequence, he wondered whether there was a need to review the structure of the Regional Committee.

Referring to the restructuring of the Organization in the light of its functions, he said that a time-frame for the purpose should be borne in mind, and he wanted to know by which date the organizational changes would be effected.

The REGIONAL DIRECTOR reiterated that the comments of the representatives were noted and action would be taken on them. As regards the extra-budgetary resources, he read out the corrigendum and wondered whether the Director-General would like to comment.

The DIRECTOR-GENERAL said that there were few countries in the world which were responsive to meet the needs of developing countries in today's state of the North-South dialogue. WHO had been trying to find a mechanism to mobilize as much resources as possible, but the major constraint was the lack of managerial absorption capacity in recipient countries. Unfortunately, the donor countries cited this as an example for not agreeing to provide sufficient funds. It was for the developing countries to highlight the impact of the assistance from extra-budgetary resources. He cited the example of the World Bank assistance to countries in the field of environmental health being in jeopardy, as the water supply programmes in particular were not able to show their impact on health. As he had emphasized earlier, importance had to be given to people and not pipes. WHO had to demonstrate that the assistance received from all sources had a visible health impact in order that such assistance was sustained. It was also essential that the countries themselves should be able to demonstrate the impact of the assistance and also develop their own managerial absorption capacity. He specifically referred to the setting up of the Health 2000 Resources Group at which both the donor and recipient countries were represented with a view to initiating a dialogue between the two groups. He urged that the countries make use of such forums.

He agreed with Mr Vohra that though this region had the largest proportion of the world's poor, its share of resources was not commensurate with the requirements and as such needed a review. But it should also be kept in mind that it would be difficult to obtain resources commensurate with the requirements, especially because in this region there were comparatively only a few countries, in contrast to other Regions which had a larger number of developing countries. The funding agencies also felt it difficult to support adequately larger countries on account of the sheer magnitude of the prevalent problems.

He further stated that there were intellectual resources and physical infrastructure potential in this region way beyond many other regions, and appealed to the countries of the Region to "lend a hand" to other developing countries. This region was much more advanced in moving forward, and therefore the transfer of resources would be of a different type - primarily in the nature
of soft loans. It was very important that this region should develop its managerial capabilities urgently. He hoped that with the formulation of programmes in this region where the health impact could be clearly demonstrated, more resources could be obtained for water supply and sanitation. The battle lines were well drawn, but they could be fought only by the countries.

Part I - General Review of Activities

Planning and Development of Health Services (pp.1-11)

DR THAN WIN (Burma) said that Burma was in the third year of its first People's Health Plan, launched in 1978. A mid-term evaluation of the Plan had been carried out and it was hoped that the ultimate goal of health for all would be achieved.

DR HAPSARA (Indonesia) referred to the second sentence in Section 1.1, "Planning and Development of Health Services", and suggested that it read: "Governments are continuing to extend the health...".

Referring to sub-section 1.1.2, "Organization of Basic Health Services", he clarified that the mention in the report regarding the primary health care programmes should be understood as the primary health care approach.

Primary Health Care (pp.11-15)

MR VOHRA (India) referred to the very useful meeting WHO had convened on the financing of primary health care in which countries and many international agencies of the Region had participated and at which a number of proposals for programming financial assistance had been stipulated. He wished to know of the results of these efforts.

Family Health (pp.16-20) and Resolutions of Regional Interest Adopted by the World Health Assembly and the Executive Board (WHA33.32) (Agenda item 9)

DR HAPSARA (Indonesia) wondered whether the programme areas of primary health care and family health could be grouped together since the activities under them were closely interlinked.

The REGIONAL DIRECTOR explained that while he agreed with the comments made by the representative from Indonesia, the Regional Office had to follow certain procedures in the preparation of the Annual Report, and it had followed the programme classification structure while reviewing the activities that had taken place under the different programmes.

The DIRECTOR-GENERAL stated that the Member States would get an opportunity to reclassify the programmes during the preparation of the Seventh General Programme of Work. Unfortunately, in the past it had been a case of one or two countries imposing their will in regard to the programme classification, which might not have suited the needs of the developing countries. He therefore made a plea
for the Member States to pay careful and closer attention to the
preparation of the Seventh General Programme of Work so that a more
meaningful programme classification could be drawn up.

MR VOHRA (India), highlighting the importance of the Health Assembly
resolution on infant and young child feeding, said that in a
developing region such as South-East Asia, where the population rate
had been growing, all the aspects relating to the totality of the
problem of controlling population assumed great importance. At the
recent World Health Assembly the developing countries had expressed
their feelings, but because of some vested interests, he did not
think that the battle against this vexing problem could be easily won.
He therefore asked whether the Director-General could press the
claims of developing countries in the global arena so as to arrive
at a formal agreement or understanding between international agencies
and multinational corporations in regard to sub-clause (2) of
operative paragraph 6 of the Health Assembly resolution relating to
intensified coordination with other international and bilateral
agencies in order to mobilize the necessary resources for the
promotion and support of activities related to the preparation of
weaning foods, etc. He also wondered whether the Director-General
could involve UNIDO for concerted action on the licensing and
marketing of breastmilk substitutes and weaning foods. In this
connexion he referred to a newspaper report stating that an inter-
national action group based in Geneva had already detected 24 cases
of default from the code which had been developed by UNICEF and WHO
jointly and endorsed by the Health Assembly last year. In such a
situation he wondered whether the mere endorsement of the Health
Assembly resolution by the Regional Committee would be enough.
This resolution was of crucial importance to this region and he
hoped that it would become a reality in the foreseeable future.

DR ABDUL SAMAD ABDULLA (Maldives), referring to Section 1.1 of the
Regional Director's report, stated that the assistance provided to
the regional hospitals (page 7) had been from UNICEF and UNDP. These
hospitals were being built with direct assistance from UNICEF. These
two agencies had also been actively financing the development of
health manpower in his country.

Referring to the point raised by Mr Vohra, the DIRECTOR-GENERAL said
that the joint WHO/UNICEF meeting had made certain recommendations,
one of which was that UNICEF and WHO should evolve a common code.
However, even if such a code was endorsed by the governing bodies,
it might still not be possible to restrain the multinationals from
undertaking the production of infant food. In this context he
referred to a recent meeting in Geneva in which representatives from
the industry and non-governmental organizations had taken part, in
addition to UNICEF. The major industrialized countries had raised
several objections to the code formulated at this meeting, and these
objections would be referred to the Executive Board and a meaningful
code submitted to the World Health Assembly. This code would make
a big difference only if taken seriously by the Member States. The
World Health Assembly would therefore have to decide whether it
should be a code or a recommendation to Member States and whether
it should be binding on WHO's constitutional provisions and
regulations. He hoped that Member States would give careful thought to this aspect before they came to the next Health Assembly.

The whole crux of the matter lay in the extent to which this would be carried through by legislation at the country level as well as the industrialized countries' feeling responsible in one way or the other to make sure that they did not trespass the limits of marketing practices laid down in the code. The implementation of this code was equally important and therefore there should be some kind of a monitoring machinery. There was a suggestion that a WHO/UNICEF secretariat should be set up to carry out such monitoring, but WHO did not have the resources nor was it equipped to monitor the implementation of the code. It was really for the countries to undertake this task and such monitoring was possible if the code was adopted by the World Health Assembly in its present shape.

Health Education (pp.23-26)

MR VOHRA (India) stated that in the promotion of health for all through PHC, the efforts should be preceded by some kind of orientation or education. There should be appropriate and continuing education before, after and during the implementation of programmes so that the people, who were the beneficiaries of particular efforts, knew how to manage on their own after the completion of the programmes. He cited the example of water supplies, where, in spite of the expenditure of huge amounts, the programmes had not been very successful because there had not been any effort at appropriate orientation or education in water usage, with the result that the people did not know how to dispose of the waste water.

Replying to the point raised by the Indian delegate, the REGIONAL DIRECTOR observed that a World Bank/WHO mission would be visiting Bihar State later this year to assess the impact of water supply, health education and community participation. A study project was also currently in progress in Jhansi. It was gratifying to note that the World Bank had of late been attaching considerable importance to this aspect.

Nutrition (pp.26-28) and Nutritional survey pattern of the South-East Asia Region (supplementary agenda item 4) (document SEA/RC33/22)

DR SAIGAL (India) said that in suggesting the supplementary agenda item on nutrition the main concern of his Government was to emphasize the importance of nutrition while planning for health for all by the year 2000. Nutritional deficiency, about which WHO and UNICEF were very much concerned, was one of the most difficult problems and the health sector alone would not be able to tackle it. In his own country, about 61 per cent of the population lived below the poverty line and no government would be able to provide supplementary food for such a large population. No doubt WHO was seized of the problem and had also organized two meetings on the subject during the past year but much more still remained to be done, and this was the reason for the inclusion of the subject in the agenda.
MINUTES OF THE THIRD MEETING

The REGIONAL DIRECTOR remarked that as far as the South-East Asia Region was concerned, apart from the meetings referred to by Dr Saigal, the Regional Office had developed a separate research-cum-action programme in nutrition in relation to primary health care. A number of countries had already submitted their projects and certain allocations had been made for the research aspects of these projects.

MR DAVID HAXTON (UNICEF) stated that UNICEF was prepared to cooperate with any government to improve the quality of nutritional services. There was the implementation gap—the gap between policy and performance. There were two needs every human being desired—health and nutrition—but attempts at providing health education and nutrition education to the people had not always been successful because they depended on conventional channels. In collaboration with WHO, UNICEF was prepared to support the use of mass media to help non-governmental organizations, village groups and voluntary agencies to transmit the messages of health education and nutrition education to the people effectively.

The DIRECTOR-GENERAL, intervening, said that it was rather odd that there had been failures in such critical areas as health education and nutrition education. Referring to the vociferous deliberations of the recent Copenhagen Conference on Women and Development, he said that most of the ideas in the field of health and nutrition were dominated by the narrowmindedness of man, and that there was a need for a genuine revolution in health so as to understand the key role of women. The present outlook should be changed and women should be accepted as equal partners.

DR PRAKORB (Thailand) said that because of their characteristics nutritional problems varied from country to country and even within the same country, and as such community participation was of vital importance. A holistic approach was necessary for success in this respect.

Drug policies and management (p.37)

MR VOHRA (India) requested the Director-General to provide information about the progress of moves initiated by WHO about two and a half years ago concerning the supply of essential medicines for primary health care programmes.

The DIRECTOR-GENERAL replied that the Organization was doing two very important things: first, it had shown its capacity to stand up and identify a list of essential drugs that could satisfy the needs of even the industrialized countries. Also, as part of its technical functions, WHO was providing Member countries with the technical and moral support to identify national drug policies. An expert committee meeting was being convened next year. Secondly, it was the job of WHO to specify the proper use of these drugs at the primary health care level. Yet another typical function of WHO was the identification of malpractices, setting up safety margins, etc. Referring to the point raised by the representative from India, he said that WHO had been trying to stimulate a number of countries to set up production facilities locally for the most essential drugs.
In this region Indonesia had already embarked on such a project (and WHO would be awaiting the results of this project with interest) as had a number of countries in the African Region. The Organization had also been having a dialogue with the drug industry to bring down the prices of the most essential drugs to a level which every developing country could afford. The argument of the industry had been that the developing countries would not benefit because of the logistic problems. However, a few countries had prepared lists of essential drugs needed by them and these lists were made available to the industry; it remained to be seen what the response from the industry would be. He was genuinely convinced that a concerted effort by the World Bank, UNICEF and WHO to assist in the local production of essential drugs would help to persuade the drug industry to bring down prices.

DR HAPSARA (Indonesia) thanked WHO—both the Regional Office and Headquarters—for their assistance to the project on the establishment and strengthening of comprehensive national drug policies. His country faced a number of problems in the manufacture of drugs, but they had been overcome and now essential drugs were being manufactured within the country.

DR U KYAW MAUNG (Burma) mentioned that his country had already laid down drug policies and identified essential drugs which included those of traditional medicine, which would play a major role in the context of primary health care. However, the main problem of the drug industry was the non-availability of raw material. Since Burma was planning to produce essential drugs locally, he wondered whether WHO could provide assistance in the procurement of raw material.

The REGIONAL DIRECTOR, supplementing the statement of the Director-General, said that the Regional Office had been providing assistance in strengthening the programmes in the field of drug policies and management. Technical discussions on the subject had been held during the thirty-second session of the Regional Committee and these had highlighted the pharmaceutical systems and the strengthening of regional and national programmes. Assistance was being provided from the Regional Director’s Development Fund for the organization of a Consultation on the Role of WHO in Pharmaceuticals, scheduled to be held in October 1980 as a preparatory activity of the global meeting on the subject.

The Asian Development Bank had now come in to support health and development in Burma. In the field of drugs it was collaborating with the Government, and WHO was cooperating in these efforts. A short-term consultant had been assigned to Thailand to develop drug policies and management with greater emphasis on primary health care. The Asian Development Bank was interested in promoting self-reliance in drug management and it was hoped that there would be considerable assistance from the Bank.

Citing an example of genuine cooperation among developing countries, the DIRECTOR-GENERAL said that in the Western Pacific Region, a group of countries on their own were mutually collaborating in
collective purchasing, collective management, collective training, and collective monitoring of programmes in the spirit of TCDC using WHO as a neutral platform. They had been moving forward with this approach in spite of political problems. It would be a good example for other regions to follow.

Disease Prevention and Control - Communicable Diseases (pp. 37-39)

DR JESUDASAN (Sri Lanka) said that his country had launched an expanded programme on immunization. As regards BCG vaccination, the Thirty-third World Health Assembly had decided, after deliberations, that BCG vaccinations should be continued. Recently, however, some press reports on the trials conducted in India had caused some degree of doubt on the efficacy of BCG vaccination. He sought clarification in this regard.

Replying to the delegate from Sri Lanka, the DIRECTOR-GENERAL said that he would first like to congratulate the Government of India for having had the supreme courage to carry out the trial. It was a remarkable one, and by far the best. WHO, in collaboration with the Indian Council of Medical Research, had organized two groups - a scientific group to look into the possible kind of explanation, and the other to decide on the policy inferences to be drawn from the findings of the trial. The net conclusion was that the findings should not alter the basic immunization policy in regard to BCG. There was no question of BCG not having any effect on an uninfected child. The report on the findings was being processed, but he would be glad to make available a copy should any delegate wish to have it.

DR THAN WIN (Burma) said that the Vector-borne Disease Control project in Burma had been in operation since 1978, thanks to the country health programming exercise and external assistance from the Canadian International Development Agency, WHO, UNICEF and the Netherlands. Malaria continued to be a major public health problem and there had been a slight increase in the slide positivity rate in 1980 in those areas under control by residual insecticide spraying and surveillance. Attacks and deaths due to DHF were much higher than during the past year, with Rangoon Division registering the highest number. In April 1980, an external assessment team, consisting of representatives of the Governments of Canada and the Netherlands, together with WHO, had reviewed the programme and made certain recommendations.

The leprosy programme had been extended throughout the country in 1969, though it had been launched in 1952. The number of registered cases under regular treatment had never gone below 85% of all registered cases with regular attendance. Even at this rate of sustained activities, it would take more than twenty years to reduce the proportion of lepromatous cases and child leprosy. Adequate and regular supply of dapsone tablets from UNICEF and other sources would be of great help.
MR ABDUL SATTAR YOOSUF (Maldives) said that malaria had been a problem for a long time, and since 1960 a control programme had been in operation with WHO assistance. Owing to the logistics problem the position had worsened a little, with the annual parasite incidence showing a rise in 1978 and 1979. Malaria had been accorded priority in the country health programme, and it had been decided that Maldives would work for the eradication of malaria by 1985.

Diseases Subject to the International Health Regulations

Smallpox eradication (p.41)

The CHAIRMAN suggested that two World Health Assembly resolutions, WHA33.3 and WHA33.4, on the global eradication of smallpox (document SEA/RC33/17), be also considered along with this item.

DR POUDAYL (Nepal) said that some of the countries in the Region were carrying on with cholera vaccination while some others were not. He suggested that there should be a uniform policy.

As regards the eradication of smallpox, it was a praiseworthy and proud achievement made possible through the gigantic efforts of both WHO and its Member States. Congratulating the Organization for eradicating smallpox from the face of the earth, he said that if the goal of health for all by the year 2000 through the primary health care approach, which covered all priority areas of social and economic development, was to be achieved, then the same approach should be adopted as in the case of smallpox. This meant that there should be an aggressive and realistic mechanism for the implementation of the programme. Both Member States and WHO should develop adequate managerial capability to implement primary health care programmes.

MR VOHRA (India) stated that the Health Assembly resolution on global smallpox eradication brought out a number of issues, particularly the one relating to formulating a uniform policy regarding vaccination. India had collected information from the Regional Office on this matter to find out what was being done both within the Region as well as outside. Agreeing with the comments of the representative from Nepal on the need for a uniform approach, he drew the attention of the Committee to the fact that the available information indicated that in some countries smallpox vaccination continued to be given to defence personnel, while it had been done away with in the case of the civilian population. Perhaps there might be valid reasons for this approach, which needed to be looked into. Also, an internal assessment should be carefully made of what stock of smallpox virus was needed and where this was to be retained. Equally important was the question of setting up an efficient information system for the prompt reporting and registration of cases of rash so that these could be investigated immediately. Finally, he said that the recommendations of the Global Commission should be pursued vigorously to ensure the success of eradication.
Diarrhoeal Diseases including Cholera (pp.41-45)

Mr ABDULLA (Maldives) said that diarrhoeal diseases were a problem in his country. Potable water was obtained from a thin lens of water under the surface, which just provided enough water to the island. To ameliorate the situation, UNICEF and bilateral agencies were assisting in setting up water collection tanks and also for the installation of a piped water system. Diarrhoeal diseases were mostly prevalent among the 1-5 year age group and the infant mortality rate in Maldives was the highest in the Region. Therefore, greater emphasis needed to be laid on the supply of potable water in order to solve the problem.

The REGIONAL DIRECTOR said that as recommended by the Regional Advisory Committee on Medical Research, a working group on diarrhoeal diseases had already been set up, consisting of members from countries of this region and other scientists who would advise on the development and implementation of a service-cum-research programme on the control of diarrhoeal diseases. It was also proposed to hold the first meeting of this working group in November 1980 to review research protocols, specifically on operational research. The Regional Office would take active steps to encourage the development of research protocols and, in fact, the Organization had already designated one institution in Dacca, Bangladesh, and another in Calcutta, India, as WHO Collaborating Centres for the control of diarrhoeal diseases.

Malaria and Other Parasitic Diseases (pp.45-55)

DR POUDAYL (Nepal) said that in Nepal the implementation of the malaria control programme, which originally had the aim of eradicating the disease, had in the beginning been carried out through the National Malaria Eradication Board and the staff members recruited on a semi-permanent basis. However, the situation now was quite different and the eradication of the disease seemed to be a remote possibility in a developing country such as Nepal. Nevertheless, steps were being taken to implement the programme through the establishment of a permanent organization for control, but the main problem was that most of the staff working in the malaria programme had been shifted to other departments, which was one of the reasons for the setback in the malaria control programme. The use of different insecticides such as DDT and malathion also posed a problem and there was no coordination between the ministries of health and agriculture in this regard. As for the development of resistance of the parasite to insecticides, this was a serious problem and research on a regional basis should be conducted on vector resistance to insecticides at a fully equipped centre. It was not possible for Member countries to carry out such research individually.

DR JESUDASAN (Sri Lanka), recounting the experience of his country with regard to the anti-malaria programme, said that this might be of interest to Nepal. To begin with, Sri Lanka had decided on a malaria eradication programme. Subsequently, however, it had been realized that malaria could not be completely eradicated and it was decided to switch over to control strategy. Here, the situation was similar to that in Nepal. In 1964, Sri Lanka had almost achieved
malaria eradication, but owing to certain setbacks there had been an epidemic the same year. Recently, with the assistance of donor agencies a five-year programme for malaria control had been drawn up and steps taken to see that those personnel who had been involved in the anti-malaria programme were now taken on a permanent basis.

As regards insecticides, from 1947 till 1977, Sri Lanka had been using DDT when it switched over to malathion. Soon, however, it had been realized that indiscriminate spraying would cause malaria resistance and thereby lead to a setback to malaria control. It had therefore been decided that only the Ministry of Health would use malathion for malaria control while the Ministry of Agriculture would use other insecticides. So far, no resistance to 4-aminoquinolines had been noted, but they were keeping a watch.

MR VOHRA (India) asked whether, in view of the increase in the incidence of diarrhoeal diseases, this subject should not be included as part of the Tropical Diseases Research Programme (TDR) of WHO.

Replying to Mr Vohra, the DIRECTOR-GENERAL stated that it was felt that TDR would become an unwieldy programme if it included too many subjects. In December this year, a plan would be evolved on a managerial formula for a diarrhoeal diseases training programme. There was a tremendous amount of work to be done and both UNICEF and WHO were actively supporting Member States in this programme, which was expected to yield fruitful results. It was felt that such an important programme should have a separate kind of managerial structure. He also felt that this programme would not have any dearth of resources.

2 Adjournment

The meeting was then adjourned.
SUMMARY MINUTES*

Fourth Meeting, 2 September 1980, 2.00 p.m.

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*Originally issued as document SEA/RC33/Min.4, on 3 September 1980.*
In the absence of the Chairman, the Vice-Chairman presided over the meeting.

1 Annual Report of the Regional Director (item 7) (cont'd)

Poliomyelitis (p.61)

DR POUDAYL (Nepal), referring to polio vaccination as part of the Expanded Programme on Immunization, stated that it was perhaps causing a false sense of security. Some positive action had to be taken in this direction. The cold chain was very expensive and involved difficult technology for adoption by less developed countries such as Nepal. The important questions to be borne in mind in this context were whether the staff was able to reach the population, whether the vaccines were still in a potent condition at the time and whether the immunization actually produced antibodies in a particular group of population in a particular environment.

DR SAIGAL (India) stated that he understood from the report that in spite of administering anti-polio vaccines, the incidence of poliomyelitis had remained the same in Burma between 1966 and 1979. In view of the limitation of resources, the logistic requirements, and the fact that mostly the urban areas only were benefited, it should be seriously considered as to how far polio vaccination should be included in the EPI.

DR KO KO informed the meeting that some controversies had arisen regarding the seroanalysis study in Burma, as in the earlier years of the mass immunization programme polio had not been included.

DR SAIGAL (India) urged that, considering the logistic requirements, WHO should formulate some plans for the countries which had less manpower and financial resources needed to carry out polio immunization as part of the expanded programme on immunization. He stated that in WHO forums even the inclusion of measles had been discussed.

DR JESUDASAN (Sri Lanka) said that each country should make its own decision regarding the immunizations to be included in the expanded programme on immunization keeping in view the availability of manpower, the accessibility of different places, the infrastructure available, etc. He said that in Sri Lanka the EPI programme had started with BCG, polio, triple antigen and smallpox. They did not intend to include measles as the measles vaccine was very unstable. Regarding polio, action had been taken to ensure that the cold chain was effectively maintained.

DR U THAN WIN (Burma) said that the EPI programme in Burma had been started with BCG, DPT and tetanus toxoid vaccinations. Polio immunization would be added in Rangoon in the first instance and extended to other divisions later.
Japanese Encephalitis (p.63)

DR Poudyal (Nepal) said that Japanese encephalitis was a formidable disease with serious complications. WHO should evolve some system for informing Member countries about its outbreak.

DR Ko Ko considered the remarks of Dr Poudyal very valuable but added that this disease came in cycles. Already the Government of India was strengthening its laboratories in order to make epidemiological studies on Japanese encephalitis. The WHO Regional Office was also trying to keep some of the equipment and the insecticide always ready to make them available to Member countries.

Expanded Programme on Immunization (pp.63-67)

DR Saigal (India) urged that tetanus toxoid should cover the entire adult population and not only pregnant mothers. With a predominantly agricultural population, males were equally exposed to tetanus.

Veterinary Public Health (pp.68-69) and Vector Biology and Control (pp.69-71)

DR Ko Ko mentioned that the veterinary public health programme was found to have been much neglected in the past few years and hence the Regional Director had been able to obtain external resources and organize a programme in collaboration with the Government of the Federal Republic of Germany. A post of Regional Adviser had been created in the Regional Office and it was expected that an incumbent would take over the job towards the end of the year. He would be able to draw up a regional programme in the subject and assist the Member countries.

DR Jesudasan (Sri Lanka) stated that rabies was a major public health problem in his country and there were at least 200 deaths annually due to rabies. A programme for the eradication of rabies had been drawn up. It was expected that the eradication of rabies would be achieved during the next 3-5 years. The Government was trying to overcome the problem by immunizing dogs and eliminating stray dogs.

DR Poudyal (Nepal) said that rabies was a major public health problem in his country and he was glad to learn of the eradication programme in Sri Lanka. However, killing of stray dogs was not possible. His country was not able to manufacture rabies vaccine and depended on obtaining vaccine from neighbouring countries. It was not, however, possible to obtain vaccine in time because the demand was higher than the availability. He therefore suggested that the Regional Office should keep sufficient stocks of the vaccine to meet any demands from the countries of the Region.

DR Ko Ko said that with the strengthening of the Regional Office, WHO collaboration in this area would be more effective.
Cancer (pp.72-74)

DR JESUDASAN (Sri Lanka) stated that his country had launched a cancer control project and steps were being taken, with assistance from WHO, to strengthen cancer control activities. The incidence of the disease was rising in his country – this could be as a result of better detection methods or because of an increase in the life span of the population.

DR POU DAYL (Nepal) mentioned that though it was possible to develop a programme for diagnosing cancer in Nepal, treatment was possible only in the cases of early diagnosis. He felt that detection facilities should be developed side by side with treatment facilities.

PROFESSOR LOEDIN (Indonesia) wished to share his country’s experience with others. The people who were really interested in cancer in his country were oncologists who were clinically oriented. Most of the data collected on cancer were hospital-based and as such did not give a true epidemiological picture of the disease: the majority of the patients who came to hospitals were in late stages and were not admitted. The studies carried out by WHO consultants were not of much assistance since they relied upon the hospital-based statistics and showed the incidence of cancer as low, which resulted in cancer receiving a low priority. He therefore wondered whether the time had not come to review the situation to change from a clinical to an epidemiological approach to face the cancer problem in a more realistic way.

He also added that whatever resources that were allocated to cancer went mostly to the purchase of costly equipment which did not benefit all. He also advocated intensifying health education in cancer as well as mental health, degenerative diseases, etc.

DR KO KO said that the representative from Indonesia had set the trend as to what needed to be done. This was the pattern of the approach that would be followed in the Sri Lanka project, which formed part of a global programme. He felt that cancer control programmes would have to be community-based.

DR U KYAW MAUNG (Burma) said that Burma had the same problem of increasing incidence of cancer. They had started a National Cancer Registry and had centralized statistics on the incidence of cancer. Cancer was only confirmed by histology. The problem was how to get the proof of cancer in small hospitals with no histological facilities. Gastro-intestinal cancer was on top. Burma was going ahead with the study of cancer.

DR KO KO said that the first thing was to look into the epidemiology. Based on the epidemiological situation, one should plan the treatment, etc. That was what WHO hoped to demonstrate, including the logistics, coverage, etc., in the Sri Lanka project.
Cardiovascular Diseases (pp.74-75)

DR POUDAVL (Nepal) said that in Nepal smoke produced from cooking was proving to be poisonous and causing cardiovascular problems, especially in the northern parts. Many people in the hills also had cardiovascular problems such as pulmonary hypertension. This was causing great economic loss. He therefore considered this to be an important area which needed WHO's attention.

DR SAIGAL (India) said that there had been reports in the journals recently pointing out that the common method of vasectomy led to heart attacks and cardiovascular diseases. Since family planning was a part of the PHC programme, such reports would be harmful to it. He suggested that WHO should take up this type of research on a priority basis to clarify the position.

Immunology (pp.77-78)

DR U THAN WIN (Burma) said that poisoning by snake-bite was a health problem in Burma as the country's main occupation was agriculture. He suggested that specific attention be paid to technical cooperation to tackle this problem. His country had brought this matter to the attention of the Regional Committee last year also.

DR KO KO assured him that WHO was developing a programme in the Region for some countries such as Burma and Sri Lanka.

Promotion of Environmental Health (pp.82-89) and Resolutions of Regional Interest Adopted by the World Health Assembly (item 9)

MR VOHRA (India) said that, as stated earlier, in all the efforts WHO was making to tap resources available with all United Nations and other agencies, there was a need to get much more than what this region was getting at the moment, and he had especially UNDP in mind.

Secondly, as had been stated by the Director-General earlier, in view of the fact that the World Bank had expressed dissatisfaction with the lack of health impact in the field of water supply and sanitation, what was required was not to attempt to achieve a big target, but to have a compact lower target and try to achieve it, so that the management of wastes was organized simultaneously with water supply and sanitation.

Thirdly, there should be adequate education and involvement of the beneficiaries in the planning and implementation so that the management of water supply and sewerage work could be done more effectively. This was very critically connected with primary health care. If there was adequate participation of the beneficiaries, then the cost of management of water supply and waste disposal could be brought down considerably. There was a very detailed description in this section of the report of what the governments had done. The time had come to undertake a mid-term evaluation of them.
PROFESSOR LOEDIN (Indonesia) felt that the question of social environment should also be included under this chapter, because with the rapid pace of urbanization, by the year 2000 Member countries would be faced with a different pattern of diseases. Urbanization meant development of new towns and movement of people to towns. As the people were living in different social environments, he wondered whether the Regional Office could pay more attention to the change of social environment which the countries were going to face in the year 2000.

MR SATTAR (Maldives), speaking of environmental and social diseases, said that tourism, which was in its infancy in his country, could also be a source of new diseases. He wondered whether a section on environmental protection could also be included in the report.

Referring to the provision of safe drinking water, he said that the declaration of the International Drinking Water Supply and Sanitation Decade had been a step in the right direction for achieving the goal of health for all. His country had already taken steps to prepare a plan of action for the Decade. As regards environmental health, a seminar on rural development had already been held in the atolls recently. Regarding tourism, a sanitation code for tourists had been prepared which, he hoped, would check the emergence of diseases due to tourism.

DR KO KO said that the deliberations on the various facets of the environmental health programme indicated that it was a very complex one. The various points mentioned by the representatives and the Director-General, such as external resources, social environment, community participation, etc., would be kept in mind by the Regional Office. While the importance of financial resources could not be denied, it was equally important to see that the content of the programme was not just piped water supply, but also included human involvement, which was particularly important in view of the International Drinking Water Supply and Sanitation Decade.

Health Information and Statistics (pp.89-92) and Health Indicators for Developing Countries (item 3 of the Supplementary Agenda)

MR VOHRA (India), introducing the item proposed by the Government of India (document SEA/RC33/21), said that the health indicators as set out in the document were not unrelated to the subject of health information and statistics and were evolved to meet the special requirements for the achievement of the goal of health for all. In view of the vast programmes in various fields, it would be essential to have two kinds of indicators, both positive and negative, which could be supplied year-wise, keeping 1980 as the base year. He said that even if there was any particular difficulty in achieving the goal of health for all, it would be useful to collect, compile and analyse such information and he would welcome suggestions from other delegates.

DR HAPSARA (Indonesia), expressing agreement with Mr Vohra's remarks, said that looking into the programmes through the indicators would
help in an effective evaluation of the programmes. Some of the health indicators mentioned in the paper, he said that the one on health impact indices was very important. The specification of each group might need some consideration according to the priority attached by each country to the type of information. The indicators included under group III in the paper, such as physical quality of life indices, needed much more attention. Consideration should also be given to the utilization of these statistics through a feedback mechanism for assisting the decision-making process.

DR JESUDASAN (Sri Lanka) enquired whether it was appropriate to measure a country's quality of life without taking into account such factors as economic development, life expectancy and the literacy rate, as that was what was implied by the quality of life indicators.

MR VOHRA (India) stated that the paper tried to itemize the indices in respect of which information needed to be collected and analysed. As long as there was agreement on these and the methods of collecting this information did not lead to incorrect or imbalanced information, it would serve the purpose.

DR KO KO stated that the Committee would later be discussing the strategy for health for all, when the indicators would be dealt with. He requested the Chairman to permit Dr Mutalik, who was conversant with this subject, to amplify the position.

DR MUTALIK (Director, Comprehensive Health Services) stated that the subject had been discussed earlier by a joint WHO/UNICEF meeting in New Delhi, in group discussions and plenary sessions, and the conclusions arrived at had been incorporated in the Regional Committee document on health strategies (SEA/RC33/19), which would come up for discussion under Agenda item 15.

The Government of India had done exceedingly well in focusing attention on this subject, which had emerged as an important one in the context of health for all by the year 2000. But, once the indicators had been developed, how were the data to be collected? WHO had some time ago prepared a document on health indicators and this, after revision, had been circulated to Member States. As mentioned by the Director-General, as health development picked up pace, the need for indicators would surface increasingly. These indicators would also have to be country specific. At this stage of the evolution of health indicators, it was becoming apparent that the conventional indicators were not enough. It was patently clear that one would have to go far out from the conventional indicators to several others involving inter-sectoral considerations, one of which would be the quality of life indicator referred to by the delegate from Sri Lanka. In this connexion, the Executive Director of UNICEF had done a pioneering work. It was now quite evident that this subject required further collective thinking, and, taking note of the discussions on the subject of health strategies, WHO would actively collaborate with the countries in the further evolution of the health indicators.
Development of Health Manpower (pp.92-106)

DR HAPSARA (Indonesia) stated that after reviewing the document, it appeared that some aspects of health manpower development had not been clearly mentioned. In particular, he referred to the management of health personnel, which included problems connected with career development and other aspects of manpower.

DR U THAN WIN (Burma) suggested that the last paragraph on page 100 of the report needed to be corrected as follows:

"Primary health care was initiated in Burma in 15 townships and has gradually expanded to 70 townships; the aim is to cover 147 townships, i.e. 50% of the population. Community health workers are being trained for the rural areas; the aim was to have 5240 workers at the end of the First People's Health Plan. So far 2780 of them had been trained and posted. A national workshop..."

DR KO KO said that the corrections had been noted and necessary corrigenda would be issued.

MR VOHRA (India) referred to his remarks the previous day on "Distribution of Fellowships", and said that they had not been correctly reflected in the minutes. He had expressed his appreciation of the analysis on page 103 of the fellowships and desired that similar regional analysis of supplies and equipment should be included in the report.

Research Promotion and Development (pp.106-109)

DR POUDAYL (Nepal) stated that in developing countries such as Nepal, the number of technically educated persons was small and most of them were employed in government service. They needed incentives to undertake research. This could be facilitated if the WHO offices at the country level were authorized to handle the financial aspects of the research programme.

DR KO KO said that the point was well taken but observed that the situation varied from country to country. In some countries financial incentives could not be accepted while in others, facilities such as equipment, transport, etc. were needed. He assured the delegates that WHO would certainly respond to specific country circumstances to promote maximum research.

He informed the meeting that this year the Regional Advisory Committee on Medical Research would be completing five years of existence and a committee had been formed under the leadership of Professor Loedin of Indonesia. Based on their report, it would be possible to have new priorities or to redefine the earlier priorities. This would be considered in the next session of the Regional Advisory Committee on Medical Research when research in the Region would be geared more towards meeting the objective of health for all.
MR VOHRA (India), referring to the part on organizational and administrative matters, said that first of all it was to be seen whether the Regional Office itself was equipped to render the kind of services that were required in terms of the WHA resolution on WHO's structures in the light of its functions (resolution WHA33.17), and whether the structure as it stood today was suited to assume such responsibilities. Further, there was a need to keep in mind the new role of the Regional Committee and the Regional Office or the Secretariat to deal with the vast and complex tasks before them. It was also necessary, in this context, to have an overview of the Regional Office's relationship with other agencies. Therefore he proposed that the Regional Committee undertake a broad-based review of the existing regional set-up to see whether any change was needed.

PROFESSOR LOEDIN (Indonesia) suggested that the section on collaboration with other agencies could be more detailed to indicate the degree of relationship of the Regional Office with other agencies. For example, it was mentioned that UNICEF staff took part "in a number of meetings called by WHO" and this could have been elaborated. Perhaps this detail could be introduced in the report from next year.

DR KO KO agreed that the suggestion made by the representative from India was relevant and touched the main problem. Referring to another agenda item, viz., WHO's structures in the light of its functions, he said that the suggestion for studying the regional mechanism could be taken up along with that agenda item. The Annual Report of the Regional Director, which was being discussed, should be seen in retrospect. The proposed discussion suggested by Mr Vohra, if carried out in conjunction with the item on WHO's structures in the light of its functions, would also afford an opportunity for the representative of Bangladesh to participate. In order to obtain a complete picture, it would be necessary also to consider how the whole Organization should be geared to meet the needs and requirements of Member States. Also, the Seventh General Programme of Work should be kept in view.

MR VOHRA (India) pointed out that the structures study was global and required considerable consultations and discussions at different levels. On the other hand, what he had proposed was a quick study of the set-up in this region to bring about the necessary changes needed.

Commenting on the format of this part of the annual report further, Mr Vohra suggested that, instead of the present form of listing the projects that were operational during the year in the countries of the Region, it would be better to indicate in the report the
allocations made for each of the major programme areas. He reiterated his plea for a review of regional programming.

DR HAPSARA (Indonesia) said that each of the countries had their own developmental plans - annual, triennial or quinquennial. Most WHO activities in the countries were inter-related with the programmes that came under the developmental plans and in general followed the priorities allocated under these plans. Therefore, he suggested mentioning the degree of correlation between WHO's activities in a particular area with the objectives of the country's plans, instead of presenting a total regional review. He said that he would be circulating a separate paper on health manpower development in his country.

DR KO KO said that the style and preparation of the Regional Director's Annual Report had been studied and discussed at the Regional Committee meeting held in 1978 in Mongolia when it had been suggested that the usual format be continued. However, if the present Committee suggested changes, he would be glad to incorporate them. Alternatively, a working paper could be prepared giving the complete background information, and an analysis on how the other regions were presenting their reports; such a report could then be studied by the Regional Committee to decide on the future pattern of reporting.

MR VOHRA (India) suggested that instead of merely presenting country and inter-country level activities and listing the number of projects, it would be worthwhile to indicate the main thrust of these activities including their evaluation and the possible impact they had on health development in the Member States. This section might also include a lucid and brief analysis of how the totality of the resources had been expended.

The CHAIRMAN said that the entire Annual Report of the Regional Director had been gone through. He proposed the names of India, Indonesia, Sri Lanka and Thailand to constitute a sub-committee, to draft resolutions on the Annual Report as well as other subjects. This was accepted by the Committee.

2 Adjournment

The meeting was then adjourned.
SUMMARY MINUTES*

Fifth Meeting, 3 September 1980, 7.30 a.m.

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*Originally issued as document SEA/RC33/Min.5, on 4 September 1980.
1 Strategies for Health for All by the Year 2000 (item 15) and Resolutions of Regional Interest adopted by the World Health Assembly and the Executive Board (WHA33.24, EB65.R6)

The REGIONAL DIRECTOR, introducing the document on this subject (SEA/RC33/19), said that the Thirtieth World Health Assembly had affirmed that the main social target of governments and WHO should be the attainment by all citizens of the world by the year 2000, of a level of health that would permit them to lead a socially and economically productive life. This affirmation had been endorsed by the historic declaration at Alma-Ata. Member States had followed up these important developments by pursuing activities for formulating, individually and collectively, national and regional strategies for achieving the goal of health for all, by holding meetings at country and regional levels.

There was growing political commitment in this region, which augured well for health development. This was reflected in the ratification of the Charter for Health Development by most countries, the establishment of high-level inter-ministerial committees under the Prime Minister or a similar decision-making authority, and the high priority accorded to the development of rural health services in the current plans of most countries. To support the national strategies in securing intersectoral collaboration and to strengthen the health sector, a multisectoral Regional Health Development Advisory Council would be established to mobilize collective support and serve as a broad-based advisory group to the Regional Director to facilitate the formulation of more effective and meaningful regional programmes. He stated that he proposed to establish such a council with representation from health as well as health-related sectors for this purpose. Another regional strategy was to mobilize increasing support using global as well as regional resources for promoting and strengthening a network of national health development centres to accelerate the process of health development - a strategy of far-reaching import.

Referring to the number of strategies addressed to various aspects of health development, including TCDC, strengthening of managerial processes at the national level, etc., he said that these strategies would, in the framework of using WHO imaginatively and effectively, which the Director-General had indicated in his keynote address, provide the direction for Member States in their quest for the cherished goal. Stressing the need for mobilizing substantial funds, he was happy to share the optimism expressed by the Director-General that there would be no dearth of resources to support well-planned and realistic national health development activities. The recent decision of the World Bank and the Asian Development Bank to assist social sectors in this region was a very welcome development.

Having crossed the realm of concepts and ideas, Member States and the Organization had now entered the arena of concrete action at the national, regional and global levels in support of the well-worked out national strategies, including the plan of action for implementation, and he hoped that the deliberations on this important item would go a long way in giving a concrete shape to these collective regional actions so that the Member States might derive strength and support from one another and march together towards HFA.
The CHAIRMAN congratulated the Regional Director on his wisdom and foresight in producing a comprehensive document on this important subject.

PROFESSOR LOEDIN (Indonesia) congratulated the Regional Office for producing a very impressive document, which was the outcome of a number of national and regional meetings to formulate the strategies for health for all by the year 2000. As such all the countries had contributed to its preparation, which was only appropriate. He said that any criticism made was not directed against the Regional Office, but was meant only to help improve the paper.

He had observed on the inaugural day that many speakers had voiced concern about the fate of the world and of the human race. This had been discussed for several years and many documents such as the New International Economic Order, the Plan of Action, etc., had all expressed the feeling that this world and the human race could survive only if they joined hands and acted as one.

It was therefore necessary to see health for all by 2000 as a strategic plan. The document should include some ideas that had been expressed in the global context but should be more adapted to the problems and situation in the Region. The document was more in the nature of a collation of what the countries wanted as well as their problems, although certain strategies were spelt out. There was some hesitation to go further, because each country wanted to respect the others' sovereignty, but there should not be too much concern about this since all the Member countries in the Region had agreed to achieve health for all through the primary health care approach. Nearly all of them had also signed the Health Charter. He therefore suggested that the proposed document should include an introduction or a chapter that would make it into a strategic plan for the Region, which could then be used by the Member States in formulating their national plans; in this way, the role of WHO would also become clearly defined.

DR POUDAYL (Nepal) congratulated the Regional Office for having prepared a most worthwhile document. Referring to section 6.1 on page 30, "Intra and Intersectoral Collaboration at the National Level", he stated that in Nepal a Steering Committee for Health for All had been formed under the leadership of the National Planning Commission. The national policy, as reflected in the country's Sixth Plan, called for meeting the basic minimum needs of the people. The Steering Committee was therefore called the "Health for All by 2000/Basic Minimum Needs Steering Committee". He wanted this to be reflected in the proposed document.

While talking of health for all by 2000 through the primary health care approach, it had to be borne in mind that a vast majority of the people in the developing countries lived below the poverty line, and as such unless there was a concrete effort to raise the standard of these people, it would not be possible to apply the primary health care approach, and the vast sums received as aid would end up by being distributed as doles. Such aid would have to be disbursed very carefully among the population so that economic equality could be achieved in the longer run.
DR JESUDASAN (Sri Lanka) stated that all were convinced that the approach to health for all by 2000 should be through primary health care. It had been repeatedly stressed that in order to achieve this there should be political determination and commitment. The authorities in ministries of health were convinced that this was the right approach. It had to be borne in mind, however, that this fact had to be impressed upon members of parliament, who were the real elected representatives of the people. In South-East Asia about 50-60% of the diseases were preventable, but the emphasis laid on prevention had been far from satisfactory. The question therefore was one of shifting the emphasis from the curative services. Even in respect of the curative services, the tendency was to go in for specialized, sophisticated types of medical care which catered to a very small segment of the population. He therefore suggested that it might be useful to have a short seminar for groups of members of parliament from the countries of the Region because they were the persons who knew what the people wanted. He also suggested seminars for technocrats - chiefly medical personnel - so that they changed their attitude and became convinced of the PHC approach to HFA.

Referring to medical education, Dr Jesudasan said that in most of the developing countries the training of personnel did not really suit their needs. A significant proportion of the personnel trained migrated to the developed countries, where their western-oriented education came in useful. There was hardly any emphasis on community medicine. The training should therefore not only be in the cities but should also take place at the peripheral and rural areas so that the trainees were exposed to the actual problems and situations. He also suggested the training of paramedical personnel, particularly midwives and public health nurses. These grassroots workers, posted in remote areas, came in close contact with the families they served and enjoyed the confidence of the communities. In conclusion, he summed up the points made by him during his intervention.

DR SAIGAL (India) said that the document that was being discussed was the result of the joint efforts during the Regional Meeting on Strategies for Health for All by the Year 2000 held in the Regional Office in June 1980. He also felt that the document was useful as guidelines for the Region but concrete strategies needed to be evolved as a continuing effort.

As regards the political commitment, this was there, irrespective of the form of government existing in different countries of the Region; what was needed was action to fulfill this commitment. The real problem in achieving the goals of primary health care, he felt, was to convince everyone that health services were much more than the provision of doctors, drugs and medicines. This concept needed to be changed and the health services should come to mean primary health care. What was required were committed basic health workers who could meet the demands of the community, but the medical profession was not yet ready to assign such work to paramedical workers.

DR ABDULLA (Maldives) commended the Regional Director and his staff on the excellent document prepared by them. The goal of health for all by the year 2000 might seem difficult, but they were moving in the
right direction and he was sure of success. As for political commitment, his country was fully committed to the goal, as stated by the President in his inaugural address, and a further proof was that 9% of the country's budget was allocated to health.

DR POUDAYL (Nepal) agreed that there was political will to achieve the goal, but what was important was to convince the finance ministries, who held the purse strings, of the economic benefits. For example, even though the malaria control programme in Nepal had resulted in considerable economic improvement by way of more land brought under cultivation, agriculture, etc., the Finance Ministry was yet to be convinced of these gains.

Usually health ministries were considered the least influential in any country's bureaucratic system and they were not able to exert any influence at the decision-making level. Perhaps WHO could play a role in upgrading the status of health ministries.

There was a need to retrain two groups of people to ensure the success of HFA: (1) leadership training for medical workers, and (2) training for those at the very grassroots level, i.e., the local people.

MRS NARANTUYA (Mongolia) considered the document a good one and expressed her Government's support.

DR SAMLEE (Thailand), agreeing with the comments made by other speakers, congratulated the Regional Director on his lucid introduction of the document and said that the Thai Government was in agreement with its contents, which resulted from the consultations held in the Regional Office in June 1980. He proposed that a sub-committee of the Regional Committee be formed to work out the details and draw up more specific guidelines for implementation. His delegation would endorse the document placed before the Regional Committee as a guideline for the work to achieve the goal of health for all by the year 2000.

Congratulating the Regional Director on his excellent document, DR U KYAW MAUNG (Burma) said that, as far as health was concerned, his country had, in its own way, been stressing since 1962, in its National Plan for Social and Economic Development, social equity, decentralization of planning, implementation of programmes at local levels, involvement of the community, development of local resources, and promotion of national self-reliance. The country's national policy, strategies and plan of action for health for all were in line with the resolutions of the World Health Assembly and the Alma-Ata Declaration. He seconded the proposal made by Dr Samlee for the establishment of a sub-committee to work out detailed strategies.

MR KWON SUNG YON (DPRK) congratulated the Regional Director on his producing a comprehensive document.

MR VOHRA (India) said that the document was the outcome of collaborative efforts, and the Regional Office had put in a great deal of work in its preparation. There were more than a hundred matters which had been itemized and analysed component-wise on what was required to be
done, but each country should conceive these in terms of its own priority problems. They were a long way from having strategies in respect of each of these items. Time targets should also be fixed for the solution of these problems.

As regards the reference to the question of political commitment among the countries of the Region, he said that the best one could say was that a great deal of awareness had come about at political levels, which had not been the case a few years ago. Thanks to this, India had now reached a stage of having a specific commitment and a specific goal, and the country was now in the process of concretizing action.

There was a need to bring about a radical reorganization in every general area of the programmes, though they might be different from country to country. For example, the medical experts had all along been clinically-oriented or followed a hospital-based approach, and hesitated to make any changes in the approach to the question of health care through the strategy of primary health care. Therefore, if changes were to be brought about, there should be changes in the organizational and structural set up, which should be attached to the kind of service that they were seeking to deliver. There was also a need for a new type of personnel, for primary health care could not be expected to be delivered by those with post-graduate medical qualifications. A fresh look at research priorities was also necessary. While fundamental and basic research should go on, this should not be at the cost of immediate guidelines and the solution of pressing problems.

With regard to problems in inter-sectoral and inter-ministerial coordination, it was not easy to get away from bureaucratic cobwebs. There was a need for strengthening the role of health workers and for decentralizing the health process - in other words, a managerial revolution - while formulating strategies for health for all. This again was not an easy task, as conditions varied from country to country and there were local problems; hence there could not be any regional strategy for this. The exchange of information and ideas amongst the countries would be of great help to each other.

Referring to financial constraints, he said that it was necessary to stick to priorities which were intimately related to primary health care. Making a reference to the World Health Assembly resolution on the restructuring of the Organization, he said that the roles of the Director-General and the Regional Director and the type of advice they should give, had been clearly spelt out in the document. The crux of the situation was that all strategies, regional as well as national, could be built up only with the effective support of the Regional Office. As a short-term measure, the countries could agree to pick up a few crucial items in critical areas and dry to rectify the prevailing lack of performance in those sectors.

Referring to the proposal for setting up a Regional Health Advisory Committee which, in his opinion, should be a small compact body, he said that the committee should not merely give advice but should be entrusted with the specific role of reviewing the whole research structure.
As for TCDC, it had assumed an even greater importance in the context of health for all. It would be necessary to have regional strategies to get a clear idea as to what kind of TCDC was required, and targets should be fixed for this purpose, for example, in the fields of water supply, drugs, training of personnel and so on.

The DIRECTOR-GENERAL explained that for the attainment of health for all the most important strategic element was a moral posture, which could be translated into all kinds of energies - political, cultural, social, emotional, professional and technological. Those who talked about RFA should sincerely believe in what they were advocating. Health for all was a spiritual reality and could be achieved at a cost which was by no means beyond the developmental possibilities of each country. The difficulty was that there seemed to be a tendency to become passive in the face of seemingly insurmountable obstacles.

It was sad to note that most of the documentation provided to statesmen to secure their commitment lacked clarity and incisiveness, with the result that the political support was not forthcoming. Quoting the example of South-East Asia, where political commitment to the basic strategies for achieving the goal of health for all through the primary health care approach had been readily extended, he said that technocrats had made the mistake of not laying proper emphasis on the appropriate technology suited to the local conditions, with the result that the general public had to suffer. There was no understanding between the medical profession and politicians. The medical profession talked about preventive and curative technology while the population, which had its own cultural and social value preferences, wanted something to be done right away. It was therefore not proper for the medical profession to emphasize technologies not suited to the local conditions and fritter away the meagre resources allocated to the health sector.

Referring again to the South-East Asia Region, he said that if the technocrats could adopt the appropriate technology to satisfy the needs of the population, it would help enhance the people's confidence in them. It had been possible to communicate the message of primary health care, which was a well balanced social package, to the population.

Talking of the development of adequate manpower, he said that the Organization had generated systematically a cohesive set of revolutionary doctrines over the past two decades which, he was sorry to note, was not being used in a majority of the medical colleges. Such a lack of ability to use innovative methods would only work to the disadvantage of the large number of doctors being trained by the medical colleges in particular, and the community health workers in general. This kind of problem existed within the Organization also and he was trying to see how to improve the situation.

This region was again in the forefront in ensuring community participation and inter-sectoral collaboration in health matters. This was taking place in many countries and he thought this should form part of the regional strategy. Those countries where there was no such progress should emulate the example set by the other countries.
He emphasized the need for dynamism and stated that WHO could never become better than the collective wisdom of its Member countries. The countries should therefore have the power to change the Organization, if necessary, in order to make use of it the way they wanted. This was again where the regional strategy was linked with WHO's structure study. It was heartening to note that a feeling was emerging that it was not enough to aggregate or itemize some national needs. If the countries wanted to benefit from WHO, it was essential that they felt a moral commitment to a regional kind of strategy. It was not only enough to have a sense of achievement but the question should be asked whether something better could be done in the future. If this kind of an assessment were made, it would become apparent that the countries had not made the best use of WHO. People were not really convinced that health was as important as it was made out to be at meetings and conferences. One of the problems obviously was that the medical profession came from a privileged group of the population. Very few of the persons joining the medical profession had a rural background. Health was one of the most remarkable entry points, but lack of conviction that health was an important and genuine partner in development obviously meant lack of courage or motivation. This region had a vast potential to become a pace setter. The countries had adequate resources to produce all kinds of health personnel, including post-graduates and supporting staff, and it would be unfortunate if these resources were not fully exploited. Additional resources - whether from bilateral or international agencies might be necessary, but in order to be self-reliant each country had to depend on its own resources. Motivation was equally important, and organization, discipline and continuous training were the three qualities needed to provide motivation. There was also a need for quantification in the regional strategy which should contain some kind of indicators. For example, it was possible to quantify the need for health personnel. Indicators should also be set for political commitments. It was precisely this kind of indicators, when they related to the political climate and the cultural heritage, that were going to be very important.

He suggested that the standards as regards the health indicators should be set on the basis of national situations rather than the standards of the developed countries. What was the use of a higher life expectancy rate or a low infant mortality rate, when the quality of life was not of an acceptable standard, e.g., with a higher degree of alcoholism and drug addiction, as found in some developed countries?

He pleaded for making use of WHO for the countries' utmost benefit and bridging the gap between the countries and the Organization. The Organization should be made to subserve the countries' interests instead of the Organization or its secretariat thrusting their own views on the countries. He was fully convinced that, if properly utilized, WHO could be of tremendous assistance to the countries.

The CHAIRMAN mentioned that it was indeed fortunate that the Director-General was present while the Regional Committee was discussing a subject of far-reaching consequence and considerable importance.
Replying to the various comments and suggestions made by the delegates, the REGIONAL DIRECTOR mentioned that the document presented to the Committee was more in the form of a draft to seek the guidance of the Committee. Making reference to the comment of the representative from Sri Lanka regarding national meetings of politicians and national training courses for paramedical workers, he assured WHO's full assistance to such activities. With regard to the convening of a meeting of technocrats, he again proposed activities at the national level, since it was not always certain that people of the right type would be nominated to attend such meetings if sponsored at the regional level. If a national activity were to be held, on the other hand, then the ministry of health could invite those who were actually involved in the implementation of health programmes.

The health ministries themselves should be able to tackle the ministries of finance and planning in the countries. He agreed with the representative from Nepal that the training of paramedical workers was essential and assured him of WHO's assistance.

He agreed with the suggestion of the representative from Thailand to set up a sub-committee to work on further refining strategies as part of a continuing process.

Replying to the points raised by Mr Vohra, the Regional Director said that operational research was very important and he had noted Mr Vohra's suggestion in this connexion. The Regional Office had been in consultation with various Member countries on methods of bringing about technical cooperation among developing countries, and was already in communication with the Government of India on how this could be achieved.

A small summary in respect of each country had been given in the Annex to the document and it also contained information on what action the Regional Office proposed to take. He also accepted the suggestion that a sub-committee should be appointed to go into this question.

2 WHO's structures in the light of its functions
(Agenda item 18) and Resolutions of regional interest adopted by the World Health Assembly and the Executive Board (Agenda item 9)

The REGIONAL DIRECTOR explained the background of the document (SEA/RC33/15) and suggested that this be considered along with document SEA/RC33/16 on the "Meaning of technical cooperation in WHO". He said that when this subject was discussed at the last World Health Assembly, many representatives from this region had actively participated in the discussions, which resulted in resolution WHA33.17. This resolution was reviewed in May 1980 by WHO's Global Programme Committee, which had proposed a plan of action analysing the implications of all the operative clauses of the resolution and indicating possible actions by all concerned. During this session such actions which fell under the purview of the regional committees as well as others which had regional implications would need to be carefully considered by the Committee so as to enable it to provide clear guidelines and plans for future action.
The resolution called for an integrated concept of mutually supportive twin roles for WHO, of direction and coordination in international health and technical cooperation as envisaged in its constitutional mandate. It had been suggested that the Regional Committee should review the document prepared by the Director-General entitled, "The Meaning of Technical Cooperation in WHO" (SEA/RC33/16). It delineated the essential concept of technical cooperation in the entire United Nations, particularly in the World Health Organization. It emphasized three important points - WHO's technical cooperation was fundamentally different from technical assistance; WHO's technical and coordinating functions were mutually supportive, and technical cooperation and coordination together formed an inseparable essence of WHO's unique constitutional role in international health work. A clear perspective of this far-reaching concept was absolutely essential for Member States to make WHO more effective in its crucial role of supporting national health development activities.

He drew special attention to the implications arising out of the resolution of the Thirty-third World Health Assembly on the periodicity of Health Assemblies (WHA33.19), especially in relation to the regional committees. It contained many points which needed to be carefully gone into.

DR SAMLEE (Thailand) said that keeping in view the unanimous expressions of support and commitment from Member countries, and the Alma-Ata declaration on primary health care, WHO had set for itself the most explicit, over-riding and demanding long-term task of attainment of health for all by the year 2000, and it had closely identified its 'raison d'etre' with the support of Member States for achieving this goal at a time of political, social, economic and technological changes. This would necessitate a reassessment of the structure of WHO in the light of this new over-riding task over the next two decades. Although various study groups had found the constitutional establishment and the organizational structure to be substantially sound, yet its complex relationships, processes and procedures seemed to require adjustment for more effective and efficient support of the national, regional and global strategies. He said that Thailand had actively participated in the 1979 SEARO study and endorsed its recommendations regarding WHO operations at the global, regional and country levels. The effectiveness and efficiency of WHO's support to the countries' efforts which was most critical and meaningful, could be brought about by strengthening the role of WHO at country level. The Thai Government/WHO working group had strongly recommended the strengthening of the WHO Programme Coordinator's Office to ensure that the available resources were not dissipated. He pleaded that the number, composition and character of the support staff of the WHO Programme Coordinator's Office should be determined by the size, intensity and complexity of the country's needs and programmes, and it should have the maximum feasible freedom in organizing the available national and WHO resources at the country level. He also made a request that in Thailand, the WHO national level programme should be expanded, and reoriented effectively to align with the Headquarters and Regional Office as well as intersectoral inputs for the national action programmes for health for all.
PROFESSOR LOEDIN (Indonesia) said that his country had opposed the proposal for biennial meetings of the World Health Assembly for many reasons. His Government was concerned that while HFA strategies were just being formulated, the Assembly's role in fact had increased in as much as annual reviews and opportunities for exchange of views and experiences were vital. Furthermore, meeting countries from other regions was equally useful and annual meetings of the Health Assembly provided such an opportunity. Also, health ministers, who normally attended the World Health Assembly, benefited much from meeting and discussing matters of mutual interest with their colleagues in the Region and outside. The move to have the Assembly meet once in two years would negate all these advantages on the dubious consideration of cost, etc.

The CHAIRMAN, agreeing with the views expressed by the delegate from Indonesia, said that they reflected more or less their own feelings also on this subject.

DR POUDAYL (Nepal), referring to the plan of action prepared by the Director-General to implement the Assembly resolution on WHO's structures in the light of its functions, said that it should give top priority to WHO at the country level as regards the various approaches proposed in this plan of action. As the aim of the Organization was to solve or reduce problems that were prevalent in the Member countries, it should extend support at the country level to ministries of health and allied sectors involved in health-for-all activities. The studies and reviews which were proposed to be carried out in this connexion should start at the country level and their objective must be primarily to identify ways and means of strengthening WHO at the country level in order to achieve efficient planning and management capability for implementation, without which it would be difficult to attain the social goal of health for all.

Referring to the realistic and flexible management attitude adopted in smallpox eradication, he said that the Organization at the country level required an increased delegation of authority, financial resources and decision-making authority. Though the management and structure of the Organization at country level may vary from country to country within the Region, he believed decentralization, variety and flexibility in accordance with the basic concepts of primary health care should be seriously considered as guiding principles for the review and study of WHO at the country level. Finally, referring to the recommendation of the Sub-Committee to revert to the title of WHO Representative, he said that if the Organization wanted to strengthen ministries of health, it should not downgrade the seniormost WHO officer at the country level. However, he would welcome the proposal to consider the title of WHO Representative and Programme Coordinator.

DR JESUDASAN (Sri Lanka) endorsed the views expressed by the delegate from Indonesia regarding the periodicity of the World Health Assembly and on the report on WHO's structure. As regards the designation of the WHO Programme Coordinator, he also felt that it should be reverted to the earlier title of WHO Representative, as the title did carry some weight.
MR VOHRA (India), agreeing with the views expressed by the Indonesian delegate, said that if the World Health Assembly met once in two years, it meant that increased authority should be delegated to the Executive Board. With the present membership of the Executive Board, representing one-fifth the population of the world, had only two members, the proposition was not acceptable to his country. Moreover, the Board in such circumstances would have to meet longer and more often. Thus the savings expected by dispensing with one Assembly session might not be real. Another reason in favour of holding the World Health Assembly annually was the target of achieving health for all by the year 2000. As the situation existed today, it was found difficult by Member countries to send representatives to attend the Regional Committee meetings. Stressing the importance of exchange of information between ministers and technocrats, he said that the Health Assembly provided a useful forum for this exchange.

He further stated that his own impression was that document SEA/RC33/15 described only the spadework that had been done by the Global Programme Committee. In the context of the goal that WHO had set for itself it had become essential to review the Organization's structure. The Alma-Ata Conference had laid down the broad framework within which the changes could be brought about. He pleaded with the Director-General and the Regional Director to ensure that the necessary changes were brought about.

He wished to refer to the recent meeting of the sub-committee on inter-country projects, consisting of representatives from Bangladesh, India and Indonesia, because it was relevant here. The meeting had noted that, in the beginning, a fair number of inter-country projects had been initiated when they were relevant to the situation. Over the years, the number of such projects had increased, which, the sub-committee thought, were not all relevant. The sub-committee further noted that as high as 19% of the total budget was being spent on inter-country projects. Similarly, the number of staff as well as group educational activities had increased. In the case of the latter, the increase ranged from 17 in 1973 to 47 in 1979-80. It was good to have such projects only to the extent they were directly or indirectly beneficial to the countries; otherwise the entire concept of inter-country projects, in the context of the limited resources, would imply a waste. There was need for a system of monitoring and evaluation of the projects so that the countries did not make commitments for projects which were not relevant.

There was a need for reviewing and recasting the criteria. The Regional Office and the Regional Committee should be made fit enough to deal with the kinds of problems faced by the countries. There was therefore a need to establish mechanisms for reviewing and monitoring so that the Member countries of this region became more deeply involved in decision-making.

The CHAIRMAN stated that there seemed to exist a consensus on having annual Assemblies. Referring to the observations made by the delegates from India, Indonesia and Nepal, he said that it was important that ministers of health met and monitored what was going on in the Region.
and outside. If the meetings were to be held every two years, a number of subjects would have accumulated and they would mean a longer meeting. The level of representation at these meetings was also important. He suggested that a start could be made by the Regional Committee, which should request governments to ensure ministerial-level representation at these meetings.

At this point, the Vice-Chairman took the chair.

DR THAN WIN (Burma) stated that, being a member of the Sub-Committee on the study of WHO's Structures in the Light of Its Functions, Burma had participated in the study and agreed with the suggestions made in the WHO document and shared the views of the Thai delegation that the practice of holding the World Health Assembly every year should be continued.

The REGIONAL DIRECTOR pointed out that the discussion on the subject had brought out some crucial and important points and considering that all the delegations favoured an annual World Health Assembly, he suggested that the Drafting Sub-Committee be requested to prepare an appropriate resolution for consideration at the plenary session.

The DIRECTOR-GENERAL detailed the background that led to the present proposal to hold the World Health Assembly biennially. No doubt, there was scope to improve the functioning of the Assembly; the duration of three weeks was perhaps long and two weeks could be more productive. But that required the cooperation of all concerned. For example, he suggested that instead of each country from South-East Asia making individual country statements, three of the 10 Member countries could make statements on behalf of the Region. The Regional Committee, as a body, could collectively put forth its views. The Regional Committee might like to consider some such arrangement and incorporate its wishes in an appropriate resolution along with the decision of holding the annual World Health Assembly. In this connexion, he pleaded for more effective participation by the countries of the Region in keeping with the norms of participative democracy in the World Health Assembly.

Concerning the redesignation of WHO Programme Coordinators, he pointed out that this was a matter for the Regional Committee to decide. If an appropriate resolution was passed by the Regional Committee, he would place the matter before the Executive Board and the World Health Assembly for approval indicating to these bodies that this was the political directive from the Regional Committee.

The Director-General emphasized the role of WHO in technical cooperation. Very often there were efforts by various donor agencies to reduce their contributions to WHO. He had to convince them of the Organization's role in technical cooperation and how this was an indispensable ingredient of WHO's functions.

Commenting on the observations made on inter-country projects, he said that those must be identified with the country's needs. He had seen such projects in the past which had no relevance to country priorities and were merely for satisfying the staff. Referring to the importance
of technical cooperation among developing countries, he said that it was important to know how they were going on about TCDC, not only because it was an "in" thing but because of its importance.

The REGIONAL DIRECTOR suggested drafting of a suitable resolution on the periodicity of the Assembly based on the discussions and another resolution on the designation of WHO Programme Coordinators so that these could be referred to the Director-General for consideration.

On the question of restructuring and redefining the functions of the Regional Office, he said that the Director-General had asked the six Regional Directors to make a study on whether their offices were geared to work for the countries in the best way possible, and how the WHO Representatives' Offices should be strengthened. A report on such a study would be submitted to the Director-General by the end of this year. The Director-General had asked the Headquarters Programme Committee also to make a full study. The Regional Director said that he would ask Dr Ko Ko to undertake this study immediately. He also invited representatives of the Member countries to participate as they knew better what their requirements were.

MR VOHRA (India) urged the meeting to come to a definite decision. He agreed with the Regional Director that some kind of spadework was required to specify the role of the countries vis-a-vis the regions and the Headquarters.

PROFESSOR LOEDIN (Indonesia) said that there must be a strategy for the Region based on the HFA/2000 objectives and only then could an evaluation be made using the available resources in the right way. He suggested that only after the objectives were clear, should the study be undertaken.

DR SAMLEE (Thailand) stressed that the main concern was to strengthen the WPC's office. He suggested that a resolution be passed to that effect.

The REGIONAL DIRECTOR clarified that the study to be done would involve both the Regional Office as well as the WPCs' offices.

The VICE-CHAIRMAN remarked that if members agreed, the drafting sub-committee could draft a resolution accordingly.

PROFESSOR LOEDIN (Indonesia) wanted to know specifically what tasks would be assigned to the drafting sub-committee and what kind of resolution the member had in mind.

The REGIONAL DIRECTOR clarified that the drafting sub-committee would be assigned the task of framing resolutions on (1) the question of periodicity of the World Health Assembly and (2) the designation of the WPCs. He also said that keeping in view the comments of the delegates, he would request some of the countries to be associated with this study.
Progress Report on the Preparation of the Seventh General Programme of Work (item 16)

The REGIONAL DIRECTOR, introducing the document (SEA/RC33/10) on the subject, said that during the thirty-second session of the Regional Committee, it had been expected that at least stage one of the preparations, dealing with the health situation, objectives and strategies, would be completed in time for consideration by the thirty-third session, but the detailed guidelines for the preparation of the Seventh General Programme of Work were expected to be approved by the Executive Board in January 1981 and would be made available only early next year. Meanwhile, in January 1980, the Regional Office had distributed to the governments three working papers dealing with the outlines, issues for consideration and programme classification structure of the Seventh General Programme of Work and most of the governments had indicated their general agreement. He invited the delegates to make their comments and suggestions as these would be helpful to the secretariat in the formulation of the Seventh General Programme of Work.

The Regional Director said that a document dealing with pertinent issues and the suggested programme classification structure (document DG/O/80.2) was attached to document SEA/RC33/10 to enable the delegates to give their considered opinion on the various issues.

DR HAPSARA (Indonesia) said that, based on their experience in Indonesia, it was very important to consider thoroughly what the appropriate structure of the programme would be in order to have a long-term health development plan. The design and the systems of the health services must be used as appropriate tools in order to control other programmes. He therefore urged that the Programme would lay stress on the comprehensive health development of the countries.

DR PRAKORB (Thailand) said that the progress made in preparing the Seventh General Programme of Work appeared to be satisfactory and was seen to represent some improvement as well as providing guidelines for programme development based on the principles of the major agreements on the HFA goal, the primary health care strategy and the new international economic order and development strategy. He felt, however, that the emphasis on a high degree of community involvement, as proposed at Alma-Ata, needed to be stressed in the proposed programme classification structure in such a way as to utilize WHO resources to support country policies, strategies and activities in this important area in a truly intersectoral and interdisciplinary spirit. Community involvement being essential in all programmes, some programme classification might be required under comprehensive health systems development to give this element the importance and support it deserved.

MR VOHRA (India), referring to the guidelines given for the preparation of the Seventh General Programme of Work, said that when the Member States and the Organization had already embarked on the objective of health for all by the year 2000, the contents of this programme should be entirely in consonance with the attainment of this goal as manifested in the various regions of the Organization,
and the type of programme classification structure did not warrant much importance. The priorities of the Member countries and the problems faced by them should be reflected in the Programme. He was sorry to note, however, that there was no forceful thrust towards primary health care as was evidenced by the allocation for primary health care in the regular budget. He said that during the next two biennia, a particular plan of approach should be followed to realize the objectives, rather than following the programme classification structure. The general programme of work should be a manifestation of the total picture obtaining in the Member countries and it was imperative that there was a reasonable perspective linkage with the next programme of work in the guidelines which might emanate from Member countries.

The REGIONAL DIRECTOR said that he had noted the observations made by the delegates and after getting the instructions from the WHO Executive Board in 1981, the Regional Office would prepare the regional contribution taking into account the views expressed by the delegates. This regional contribution would be submitted to the thirty-fourth session of the Regional Committee in 1981 before being sent to the Director-General.

4 Arrival of the Representative from Bangladesh

The CHAIRMAN welcomed Professor M.R. Choudhury, who had just arrived, and suggested that, pending the examination of his credentials by the Sub-Committee on Credentials, he be allowed to participate in the discussions; this was agreed to.

(At this point, the Chairman took the Chair.)

5 Preparatory Activities for the International Drinking Water Supply and Sanitation Decade (item 19)

The REGIONAL DIRECTOR, introducing the paper on the subject (document SEA/RC33/9), said that the Water and Sanitation Decade had a special significance for the attainment of the goal of health for all by the year 2000 for two reasons, namely, safe water and sanitary disposal of excreta were vital elements in the package of basic needs in primary health care and the goals of safe water and sanitation for all by 1990 could only be achieved by a broad-based strategy of providing a minimum acceptable service and giving priority to unserved population groups, with the active involvement of the communities. The experience gained from the efforts for the water and sanitation decade would provide important lessons for primary health care and strategies for health for all by the year 2000 as a whole. The Member countries of this region could, individually and collectively, through WHO, take a number of actions to translate the dream of "clean water and sanitation" into reality.

As regards financial resources, though most of the countries in this region were increasing their allocation for water and sanitation, and were preparing realistic plans for the Decade, it was unfortunate that this region had received meagre assistance from external sources, as compared with the other regions. Therefore, the Member countries,
while continuing the increased allocations for water and sanitation, should use WHO and other United Nations agencies not only to allocate more resources themselves for this sector but for generating additional resources. The development of rational plans and programmes and viable projects would be helpful in this regard.

Concerning the development of a rational plan for the Decade, it had to be drafted carefully, and this would involve a number of changes in policies of planning and implementation, if the goals of serving all the less privileged with the meagre resources available in a time-bound programme were to be achieved. Such a plan would serve as the framework not only for national plan allocations, but also for attracting external investments.

Thirdly, political commitment was crucial in a massive undertaking for social change such as the Water and Sanitation Decade. As safe water and sanitation constituted a vital element in the daily life of people, it was important to see that top priority was attached to this endeavour at the highest levels of government. As such, it would be most fitting if a declaration and a commitment to the national goals for the Water and Sanitation Decade were made by the Head of Government or Head of State of each country, preferably prior to the launching of the Decade on 10 November this year. Finally, he stated that WHO and other United Nations organizations, particularly UNDP, UNICEF and the World Bank, needed to consider innovative ways of sharpening the focus of their coordination to provide concerted support to the national programmes of each government and, in the process, enable the planning of the bilateral inputs to the sector in a more rational way. He hoped that by such concrete actions taken boldly, with commitment, it would be possible to provide for the health of all the future generations in the voyage towards health that the Member States had undertaken.

DR PRAKORB (Thailand) mentioned that the Government of Thailand had designated the National Economic and Social Development Board as the focal point for the International Drinking Water Supply and Sanitation Decade. To facilitate action, the UNDP Resident Representative had constituted a technical support team with representatives from WHO, ILO, UNICEF, FAO and the International Bank for Reconstruction and Development. Collaborative work between the concerned government agencies and the technical support team was well under way in preparing programmes for the Decade. However, community involvement in this programme was of the utmost importance. Educating the people in the rural areas about the use of safe water and basic sanitation would be one of the important tasks during the Decade.

The CHAIRMAN, speaking as the representative of Maldives, said that in his country water supply was of vital importance. Provision of safe drinking water to the people was a major problem in the country because it had not been possible to establish a central water supply system. Consequently, the existing water supply was managed exclusively by individual homes which meant that it was almost impossible for the Government to determine the purity of the water. There was no way of ensuring purity as almost all homes had private wells, and it had been observed that underground water was easily susceptible to contamination.
In order to prevent water-borne diseases, it was essential to maintain the required cleanliness and purity.

None of the islands had any arrangement for supplying pure water. In the case of Male, with a population of 29,000, there was a threat of the salinity of the underground water increasing. The Government had worked out a plan for achieving the objectives of IDWSSD and was trying to encourage the people to install private tanks for drinking water, but this was an enormous task and required enormous investments. The Government had also taken steps to put up public water collection systems.

DR Poudyal (Nepal) said that the Government and the people of Nepal were happy to note that a resolution for IDWSSD was being pursued. The main problem in Nepal was one of terrain, because of which it was difficult to provide piped water supply. The Government, however, was doing its best. Sanitation was a more serious problem since it required a behavioural change. This would need a lot of motivation and health education. With the help of agencies such as WHO, it was hoped that the country would be able to build a better future.

Professor Loedin (Indonesia) said that on looking through the various documents it appeared that there was considerable misconception about the basic policies. For instance, many of the reports talked about the goal of achieving health for all by 2000. There was talk of means without an attempt to see of what use these means would be. Referring to water supply, he said that it was viewed as purely an engineering problem.

He felt that in some places in the document the problem had been shown more as an engineering one, rather than a health one, and appropriate changes should be made. Referring to page 4 of the document, he pointed out that the sub-section on health education and community involvement laid stress on proper operation and maintenance of water facilities rather than on the proper use of the water by the people. Health education should concern itself more with water usage.

He proposed deletion of the phrase, on page 11, in section 3.3.4 relating to Indonesia, "the Director-General, Cipta Karya, serves on behalf of", so that the sentence reads as "Instead of a national action committee or equivalent body, the BAPPENAS (National Development Planning Board) is the government focal point for the Decade activities and for inter-sectoral and programme coordination".

Mr Vohra (India) called attention to his earlier remarks that his country and the Region as a whole had not been getting a fair share of international assistance that was being made available for the Decade, and said it was necessary to ensure that the Region got a fair deal. The financial implications of the programme for this region were staggering, as could be seen from Annexes 1 and 2 of the document; 62% of the total population of the Region was unserved by safe water supply, and 70% of this population lived in rural areas. Also, 84% of the total population of the Region was not
covered by sanitary excreta disposal facilities and of this 93% lived in rural areas. It stood to reason that the enormity of the task called for a completely different strategy.

The Director-General had, in his earlier comments, mentioned that the World Bank, for example, wanted evidence of the impact of the programme in order to continue with its assistance. He felt that if a demonstrable evidence of the impact was necessary, then water supply programmes should go side by side with waste disposal programmes. There was little point in expanding water supply programmes without taking up waste disposal programmes as well.

He felt that the terminology of sanitary excreta disposal was not sufficient and proposed changing it to "disposal of waste water" or something similar to that.

He also pleaded for complete community involvement in the planning, implementation and maintenance of services, which would considerably reduce financial outlays in setting up the facilities as well as in maintenance. In addition, the community's interest would have been aroused. He agreed that health education should lay stress on health aspects of water management and should be entirely related to that aspect. It was equally necessary to pay more attention to waste-water disposal schemes, for the incidence of water-borne diseases was in no way less in communities with safe water supply but without waste disposal systems, than in communities without safe water supply and waste disposal systems.

PROFESSOR CHOUDHURY (Bangladesh) mentioned that it had been possible in his country to provide access to safe water supply to 50% of the population in comparison with the regional percentage of 31. As regards the maintenance of the systems, there had been some difficulties and it was proposed that the responsibility for the maintenance of water supply systems be left to the village governments and this would come into effect very soon. Some of the difficulties that were encountered in making the population use the safe water supplied were psychological as well as social - such as hardness of water, different taste, etc., and, in this context, there was considerable scope for health education.

In recent months, his country had been experiencing floods with the consequent unsafe water supply and the danger of pollution of water sources.

He suggested substitution of the word "drinking" by the word "safe" in the title of the document.

DR ABDULLA (Maldives) said that water-borne diseases claimed their own share of mortality and morbidity, especially among children below five years.

In preparation for the International Drinking Water Supply and Sanitation Decade a national plan had been drawn up for the water supply and sanitation project to cover all the islands. A national action committee had been constituted for the International Drinking
Water Supply and Sanitation Decade. It had worked out a plan of action and had circulated copies to the various departments, ministries and to United Nations agencies, and the final report would be ready in the near future. Copies of this report would be sent to UNDP and other organizations for possible financial assistance. They expected to commence the actual execution of the scheme in 1981, if funds became available. The plan envisaged supply of safe water, provision of sanitary facilities and the construction of community latrines to serve 25 to 40 persons in all the islands in Maldives. The schemes were acceptable to the people and would provide at least the minimum sanitation facilities. The West German Government had come forward to provide financial assistance for a drinking water supply and sanitation scheme for Male.

MRS NARANTUYA (Mongolia) said that water sources were not abundant in Mongolia owing to the geographic location and climatic conditions. This called for a rational utilization of the water resources and protection of the environment. International cooperation in the improvement of water supply and sanitation in the country was vital. All water sources belonged to the people by law, and their protection was under State control.

More than 40 per cent of the total State budget was spent on the social and cultural needs of the people. One of the greatest difficulties in solving the problem of water supply and sanitation related to the rural population living in somons and stockbreeders. The unfavourable climatic conditions created difficulties in the construction of water supply and sewerage systems and in their normal functioning. The freezing point on the ground was very deep and the pipes had to be laid five to six metres below the ground level which increased the capital cost. It would therefore be important to study the experience of other countries which had the same difficulty.

The cooperation with WHO and the World Bank in the preparatory period and in the International Drinking Water Supply and Sanitation Decade would help in the realization of the national programme for the development of water supply and sewerage systems in small built-up areas - somon centres. She felt that international cooperation would be most effective in planning and design, supply of equipment, providing technical specialists for the construction of water supply systems for the somon centres, as well as financial assistance for the supply of compact sewage purification plants for the somon centres.

DR JESUDASAN (Sri Lanka) said that in his country a national action committee had been set up. The Finance Ministry had been apprised of the importance of the need for safe drinking water supply and sanitation facilities, and a greater part of the finance was being spent to develop this programme. Emphasis was being given on an aided scheme for the construction of latrines, and a greater amount of money had been allocated for this section. This was being stepped up mainly in the rural areas. Side by side, health education also had been intensified. Similarly, in the water supply scheme
also, the health education component figured. He emphasized the need to have proper maintenance facilities in water supply schemes and control over them, especially in the rural areas by giving an example of a case in which many cases of diarrhoea had been reported because of contamination of water in the reservoir by a person who was a carrier.

The REGIONAL DIRECTOR said that the corrections suggested by Professor Loedin had already been made and a corrigendum would be issued later.

With regard to the observation made by Professor Choudhury on the title of the document, he said that the title had been given by the United Nations. In Bangladesh, the Public Health Engineering Department was responsible for the water supply programmes, and recognizing the need for health education, the Chief of Health Education of this department had been sent by WHO on a fellowship; he had just completed his post-graduate studies in health education and had returned to Bangladesh, where he could now be more useful.

He referred to the difficulties being faced by Mongolia and said that the Regional Office would be happy to provide information from the USSR and Canada where the same conditions prevailed in some areas. Some consultants could also be sent for this purpose from these countries.

6 Second Report of the Sub-Committee on Credentials

MR LASKAR (India), Chairman of the Sub-Committee on Credentials, read out the second report of the Sub-Committee (document SEA/RC33/24 Add.1) recommending recognition of the validity of the credentials presented by the representative of Bangladesh. The report was adopted.

7 Consideration of Resolutions of Regional Interest
Adopted by the World Health Assembly and the Executive Board (item 9)

The REGIONAL DIRECTOR, introducing the document on the subject (SEA/RC33/17), said that the resolutions listed in this document had already been discussed at the 33rd World Health Assembly and the 65th session of the Executive Board. The Regional Committee had also taken up these resolutions along with the appropriate sections on the Regional Director's Annual Report and other relevant agenda items except the resolution on Reimbursement of Travel Costs of Representatives to Regional Committee (EB65.R2), which would be considered under a separate agenda item, viz., item 13.

This was agreed to by the Committee.

8 Reimbursement of Travel Costs of Representatives to Regional Committees (document SEA/RC33/6, Executive Board Resolution EB65.R2 (agenda item 9, para 9)

The REGIONAL DIRECTOR, introducing the documents on the subject (SEA/RC33/6 and the Executive Board's resolution EB65.R2), said
that, in accordance with the decision of the Seventh World Health Assembly, travel expenses of representatives attending regional committees had been borne by the Member States. In 1979 he had enquired from the Director-General about the possibility of reimbursing the travel expenses of representatives who attended the Regional Committee. The Regional Committee for the Western Pacific had also passed a resolution recommending that consideration be given to financing the cost of travel, excluding per diem, in order to enable a representative from each Member State to attend sessions of the Regional Committee. The Executive Board at its sixty-fifth session had discussed the recommendation and decided to invite each regional committee to consider the proposal at its session in 1980 taking into account:

1. the views expressed by members of the Executive Board;
2. the effect that this proposal could have on the total funds available for technical cooperation, and
3. the possibility of limiting the reimbursement to Member States whose contributions were assessed at the minimum rate.

The regional committees were requested to give their comments for consideration at the sixty-seventh session of the Executive Board in January 1981.

The Regional Director referred to Annex 4 of the document and said that the total estimated cost for one return fare (by air) from Mongolia to Jakarta should be corrected to US$ 7295.

DR Poudyal (Nepal) pleaded for the reimbursement of the travel cost and per diem to two representatives attending the regional committees as this would enable the delegates to come fully prepared and participate effectively in the proceedings. He said that by this way representatives from the other ministries and institutions could also be included as their presence would immensely help in deciding important issues.

DR Jesudas (Sri Lanka), endorsing the views expressed by the delegate from Nepal, said that for attendance at the World Health Assembly, the Organization reimbursed the travel costs of one person from each Member country, and no per diem was paid. He wondered, therefore, why reimbursement of travel costs could not be made for attendance at the regional committee meetings also. This would enable the Member countries to send two representatives who could usefully participate in the deliberations of the Regional Committee as well as in the technical discussions and the Subcommittee on Programme Budget.

MR Vohra (India), also agreeing with the views expressed by other delegates on the subject, said that in view of the changing role of the regional committees with various sub-committees being appointed, it should be considered at this stage whether the question of reimbursing the travel costs for attending the meetings of such sub-committees could also be reimbursed.
The REGIONAL DIRECTOR clarified that while a representative from each Member country to the World Health Assembly was reimbursed only travel costs, members of the Executive Board were not only reimbursed the travel cost but were also paid a per diem. It was for the Regional Committee to decide and pass a resolution recommending the payment of travel costs only or per diem as well. As far as attendance at other sub-committee meetings was concerned, he said that the Organization had always reimbursed the travel costs and per diem to the participants.

DR POU DAYL (Nepal) said that in the case of his country, the honourable minister utilized the one ticket provided by the Organization. However, it was not possible for him to be present throughout the Assembly in view of his other pressing engagements, with the result that his country could not take part effectively in the various committee meetings of the Assembly. He therefore suggested that the Organization might consider paying per diem also for two representatives from each Member country.

The DIRECTOR-GENERAL said that it was entirely up to the Regional Committee to set aside whatever amount it considered necessary in order to make it a real forum for TCDC. Of course, when one was dealing with travel costs, the question of frugality came into the picture and also there was the fear of its abuse. However, he felt that the Regional Committee could make its recommendations for consideration by the Executive Board which might leave each Regional Committee to decide on this matter.

9 Real Estate Fund (item 17)

Introducing the document on the subject (SEA/RC33/14), the REGIONAL DIRECTOR mentioned that there was a need for more office space in the Regional Office. Since the last addition to office space in 1971 the activities of the Regional Office had expanded considerably following a marked increase in the Regular Budget and extra-budgetary resources. The number of group educational activities, consultative meetings and documentation had also increased. Additional space was therefore necessary to meet the increased needs and anticipated requirements. After endorsement by the Regional Committee, the proposal would be sent to the Director-General with a request to include it in his report to the sixty-seventh session of the Executive Board in January 1981 and for approval by the World Health Assembly in May 1981.

The Real Estate Fund was financed from casual income appropriated by the World Health Assembly and was not a charge on the Regional allocation. So far this Regional Office had used only a small percentage of it (less than 3%).

MR VOHRA (India) supported the Regional Director's proposal, which was also endorsed by all other representatives.
10 *Health 2000 Resources Group - Nomination of an Additional Member (item 20)*

Introducing the item (document SEA/RC33/8), the REGIONAL DIRECTOR stated that when the idea of an International Health Funding Group was originally conceived, it had only one representative from this region, and Bangladesh had been elected at the thirty-second session of the Regional Committee in September 1979. As a result of the discussions the Director-General had had with experts from donors, developing countries, etc., it had been proposed by the Director-General and accepted by the Executive Board that the Group be designated as "Health 2000 Resources Group". Its membership had also been increased and thus one additional seat became available to the South-East Asia Region. The tenure of the members was two years and they served in their capacity as experts and not as government representatives.

India, proposed by DR Poudayl (Nepal) and seconded by DR Prakorb (Thailand), was elected to nominate a member for this group.

Mr Vohra (India) thanked the representatives from Nepal and Thailand for proposing and seconding his country for this membership. He was also thankful to the Director-General for arranging to secure one more position for this region.

11 *Special Programme for Research and Training in Tropical Diseases (Supplementary Agenda item 1)*

Introducing the subject (document SEA/RC33/12), the REGIONAL DIRECTOR said that on the basis of the criteria established, and keeping in mind the current membership from the Region on the Joint Coordinating Board, the following countries were eligible for membership of the Board: Bangladesh, Maldives, Nepal, Sri Lanka and Thailand.

A representative from Thailand, proposed by Professor Loedin (Indonesia) and seconded by Dr U Than Win (Burma), was then elected for the membership on the Board.

Dr Prakorb (Thailand) thanked the representatives from Indonesia and Burma for proposing and seconding his country's representation on the Board.

12 *Selection of a Subject for Technical Discussions at the Thirty-Fourth Session (item 21)*

Introducing the subject (document SEA/RC33/11), the REGIONAL DIRECTOR invited attention to the resolution of the Thirty-third World Health Assembly (WHA33.17) on the "Study of the Organization's Structures in the Light of Its Functions", which urged the Member States "to review the role of their ministries of health, strengthening them as necessary so that they can fully assume the functions of the directing and coordinating authority on national health work, and to establish or strengthen multisectoral national health councils". This resolution also proposed that all the regional committees take up the subject of
"Role of Ministries of Health as Directing and Coordinating Authorities on National Health Work" for technical discussions in 1981.

MR VOHRA (India) indicated some reservations of his delegation concerning the topic proposed. A theoretical, conceptual document on the subject could emerge as a result of discussions, but it would not be of much use. If one were to discuss it in a practical way, it would lead to an awkward situation and most people would avoid it. On the other hand, it would be advantageous to discuss a subject which could be of practical benefit, such as primary health care, health manpower development planning, etc.

PROFESSOR LOEDIN (Indonesia) stated that, taking into account that the structures of ministries or departments of health varied vastly from one country to another, he supported the viewpoint of the representative from India and felt that no fruitful results would follow the discussions. Instead, he proposed the subject "Inter-sectoral Coordination in National Health Planning", which would cover the same area.

The REGIONAL DIRECTOR pointed out that the Regional Office had only brought the matter to the attention of the Regional Committee in view of the resolution of the Thirty-third World Health Assembly. The Assembly had requested all the six regional committees to discuss the matter, which would again be a subject for technical discussions at the Thirty-fourth World Health Assembly in 1981.

The DIRECTOR-GENERAL voiced his anguish as to how emasculated ministries of health were in the national context. The representatives were fully aware of the reasons behind such a state of affairs. It was for the first time that the United Nations General Assembly had recognized the subject of health as a development area. He felt that a little introspection and a review as to how to make ministries of health more effective could be useful. However, if the representatives felt that the discussion would be of no use, it was for them to decide.

DR POUDAYL (Nepal) said that truth was always bitter and there was no doubting the fact that health ministries in all the countries were functioning in a low key. Perhaps the technical discussions on the subject could be made more useful by inviting persons from other sectors, such as planners and economists. A review of the functioning of health ministries and their role could reveal the failings, the drawbacks and also the possible steps that were needed for improvement.

MR VOHRA (India) withdrew his reservations.

The CHAIRMAN suggested that the Regional Committee might like to agree to the topic proposed by the World Health Assembly since the countries present at the Regional Committee themselves had agreed to review this subject.

PROFESSOR LOEDIN (Indonesia) felt that the technical discussions at the Regional Committee sessions should be precursors to the technical discussions at the Health Assembly and not repetitive.
The REGIONAL DIRECTOR clarified that the topic had been suggested to the regional committees by the Health Assembly, but it was not binding on the Regional Committee to select it. He agreed that inter-sectoral coordination, proposed by the representative from Indonesia, was important, and could be discussed under the title suggested in the proposal. After some discussions, it was agreed that the subject for technical discussions at the thirty-fourth session of the Regional Committee would be "Role of Ministries of Health as Directing and Coordinating Authorities on National Health Work", and the discussions would cover inter-sectoral coordination.

13 Time and Place of the Thirty-fourth Session (item 22)

PROFESSOR LOEDIN (Indonesia) recalled the invitation extended by his Government at the thirty-second session to hold the thirty-fourth session in 1981 in Indonesia, and said his Government had instructed him to renew the invitation.

PROFESSOR CHOUHURY (Bangladesh) said that in view of the invitation already extended by the Government of Indonesia for the thirty-fourth session, his Government would like to host the thirty-fifth session in 1982 in Bangladesh. He had been instructed to convey formally the invitation of his government to hold the session of the Regional Committee in Bangladesh at the earliest opportunity.

The CHAIRMAN thanked the Governments of Indonesia and Bangladesh, on behalf of the Regional Committee and the representatives present, for their invitations, and requested the representatives of Bangladesh and Indonesia to convey the acceptance and appreciation of the Regional Committee to their governments.

The REGIONAL DIRECTOR clarified that the time of the thirty-fourth session would be decided upon - end of August or early September - in consultation with the Government of Indonesia and the Chairman.

14 Adjournment

The meeting was then adjourned.
**SUMMARY MINUTES***

*Sixth Meeting, 6 September 1980, 7.30 a.m.*

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*Originally issued as document SEA/RC33/Min.6, on 6 September 1980.*
1 Consideration of the Report of the Sub-Committee on Programme Budget (item 11.1) and the Organization's inter-country collaborative programmes (documents SEA/RC33/25 and SEA/RC33/7)

DR PRAKORB (Thailand), Chairman of the Sub-Committee on Programme Budget, presenting the report of the Sub-Committee (document SEA/RC33/25), said that the Sub-Committee had reviewed the proposed Programme Budget for 1982-1983, examined the 1979 financial implications, considered the proposals for the UNDP Regional Programme for 1982-1986, reviewed the Organization's inter-country collaboration, and made appropriate recommendations for consideration.

DR SAMLEE (Thailand) said that one of the recommendations of the Sub-Committee was that the Regional Director should establish a small working group to analyse all regular and extra-budgetary programme proposals, and he sought a clarification on whether such a group would be appointed by the Regional Director or the Regional Committee.

PROFESSOR LOEDIN (Indonesia) said that the Sub-committee, in its report, had suggested that detailed activities would be developed subsequently and presented to the Regional Committee in 1981. It had also stated that in this exercise, there would be scope for making justified deviations from the programme allocations now presented. Seeking clarifications on this, he asked whether an evaluation of the use of money was included in the terms of reference of the Sub-Committee. He suggested that apart from reviewing the allocation of resources, the Sub-Committee should be asked to undertake an evaluation to see whether the money was used in the best possible manner.

DR PRAKORB (Thailand), Chairman of the Sub-Committee, clarifying the point raised by Dr Samlee, said that the Sub-Committee had felt that the small group should be established by the Regional Director, and that this group should meet some time before the Regional Committee and submit its report to the Regional Director.

DR KO KO, clarifying the point raised by Professor Loedin, said that the sentence regarding flexibility had been incorporated to enable the Member States and the Regional Office to make some changes to reflect the requirements of the countries while approaching the year of implementation. If the deviations were small, they could be adjusted without difficulty, but if they were of a major nature, then it would be referred to the Director-General and thence to the Executive Board and the World Health Assembly itself, for which justifications were necessary. He agreed with the suggestion of Professor Loedin to incorporate the evaluation aspect in the terms of reference of the Sub-Committee.

Regarding Dr Samlee's point he wished to have the guidance of the Committee since both alternatives were possible.
DR SAMLEE (Thailand) suggested that, in order to avoid contradiction with Rule 15 of the Rules of Procedure, the Regional Director should establish a small working group or a committee but not a sub-committee, and it should submit its report to the Regional Director.

The REGIONAL DIRECTOR said that if the Regional Office knew beforehand the names of the delegates who would be attending the Regional Committee, then three or four of them could be asked to come to the Regional Committee a few days before the start of the session to examine the documents concerning the Programme Budget; they could also go into the evaluation aspect, and submit a report to the Regional Director who would see that appropriate action was taken.

The Regional Committee accepted the Report of the Sub-Committee on Programme Budget.

2 Consideration of the Recommendations arising out of the Technical Discussions (item 12)

DR POUDAYL (Nepal), Chairman of the Technical Discussions group, while presenting the report of the technical discussions on "health manpower planning and community participation for primary health care" (SEA/RC33/26), explained that the report reflected the valuable contributions and suggestions made by the members of the group. The discussions had been extensive and everyone had taken a keen interest to produce a consensus of opinion.

PROFESSOR CHOU DHURY (Bangladesh), referring to recommendation No. 8 on page 6 of the report, suggested that it be reworded as follows:

"Mechanisms to bring about collaboration in manpower planning, training and service in the context of the concept of health services manpower development (HSMD) need to be established in each country."

The report was adopted by the Committee with this change.

3 Consideration of Draft Resolutions

The following resolutions (SEA/RC33/R3-13) were adopted, as drafted and amended by the Committee:

Thirty-second Annual Report of the Regional Director (SEA/RC33/R3)

Formulation of Strategies for Health for All by the Year 2000 (SEA/RC33/R4)

PROFESSOR LOEDIN (Indonesia) asked for a clarification on the regional strategies plan. Secondly, in operative paragraph 1, sub-para (ii), he thought that the national and regional strategies should be updated regularly rather than "from time to time" as worded in the draft resolution. The Committee adopted the resolution.

Study of WHO’s Structures in the Light of Its Functions (SEA/RC33/R5)
Periodicity of the World Health Assembly (SEA/RC33/R6)

The Committee adopted this resolution with some amendments.

Reimbursement of Travel Costs of Representatives to Regional Committees (SEA/RC33/R7)

DR POUdayl (Nepal), noting that the comments he had made earlier during the discussions on this agenda item had not been taken into account in the resolution, said that he considered attendance at the World Health Assembly and the Regional Committee as of utmost importance. He would therefore again like to put forth the suggestion that the Regional Committee should recommend to the Executive Board reimbursement of travel costs and subsistence allowance for two persons for attendance at the Regional Committee as well as the World Health Assembly.

DR SAIGAL (India) said that though he agreed in principle with the suggestion made by the delegate from Nepal, he feared that the recommendation to pay travel costs and subsistence allowance for two persons might be disadvantageous.

DR JESUDASAN (Sri Lanka), referring to the provision made in the Basic Documents of the World Health Organization, said that he would support the suggestion made by the delegate from Nepal.

DR PRAKORB (Thailand) said that the travel costs of only one person for attendance at the World Health Assembly were being reimbursed and that the Regional Committee was now making a recommendation to the Executive Board that one member from each country should be paid travel costs as well as subsistence allowance for attendance at Regional Committee sessions. In the circumstances, he was afraid that if the Regional Committee made a recommendation that reimbursement should be made for two members from each country both to the Regional Committee and the World Health Assembly, it might be counter-productive.

DR THAN WIN (Burma), agreeing with the suggestion made by the delegate from Nepal, said that if the Committee was going to recommend reimbursement of travel costs and subsistence allowance for two persons, he would suggest that this recommendation should be made in respect of the Regional Committee only.

The REGIONAL DIRECTOR, referring to the earlier discussions on the subject in the Executive Board and the World Health Assembly, said that the Committee had now gone to the extent of recommending that travel costs and subsistence allowance for one representative should be paid. He wondered whether, if the Committee made the recommendation for two representatives, it would ensure the attendance of ministers of health.

He suggested, therefore, that the present recommendation for one representative should stand, and if it was approved by the Executive Board, perhaps the Regional Committee might consider the matter again at its next session and move another resolution recommending reimbursement of travel costs and per diem for two persons in view of the importance attached by the Member countries to attendance at Regional Committee sessions.
DR POU DAYL (Nepal) felt that the funds spent on the various meetings could perhaps be used to finance the participation of a second representative. He therefore pleaded for meeting the travel costs of two representatives.

DR SAIGAL (India) said that perhaps the problem could be solved by meeting the travel costs of one representative for the proposed group on the Programme Budget and another as a delegate.

The REGIONAL DIRECTOR stated that this could be done only in the case of those countries which were elected as members of that group.

DR AMORN (Thailand) said that the resolution would have a better chance of being accepted if the case was made out for only one delegate.

PROFESSOR LOEDIN (Indonesia) said that his country had no problem in this regard as their Finance Ministry always took a positive approach towards the subjects of health and education. Nevertheless, he was inclined to support the financing of only one delegate in view of the lobbying of certain groups for holding the World Health Assembly sessions every two years. If the World Health Assembly did not meet every year, it might be possible to increase participation at the Regional Committee meetings. He therefore said that it would be a tactical approach to ask for reimbursement in respect of only one delegate.

DR POU DAYL (Nepal) said that he was convinced of the difficulties. At the same time, some of the countries who wanted to have a fuller participation in the meetings were unable to do so on account of financial constraints. However, since the other Member countries had strongly pleaded for the representation of only one representative, he would not pursue his point further.

The CHAIRMAN said that in view of the observations of the representative from Nepal, it might be taken that he had withdrawn his earlier objections.

PROFESSOR LOEDIN (Indonesia) said that it might be advisable to record in the proceedings that the subject had been discussed at length and that the Regional Committee might keep it open for discussion in the future.

The resolution was adopted without any change.

Real Estate Fund (SEA/RC33/R8)

Safe Water and Sanitation For All By 1990 (SEA/RC33/R9)

Proposed Regional Programme Budget for 1982-1983 (SEA/RC33/R10)

DR KO KO suggested the addition of "and Rev.l" to the document number mentioned in the second line of the introductory paragraph.

DR PRAKORB (Thailand) suggested deletion of the word "sub-" in operative paragraph 4 and substitution of "Regional Director" for the "Sub-Committee on Programme Budget" in the third sub-paragraph of operative paragraph 4.
DR SAIGAL (India) proposed that in view of the suggestions proposed by the representative from Thailand, appropriate changes be made elsewhere, for example, in the Report of the Sub-Committee on Programme Budget. With these changes, the resolution was adopted.

UNDP Regional Programme for 1982–1986 (SEA/RC33/R11)

PROFESSOR LOEDIN (Indonesia) said that he felt that the wording of operative paragraphs 1 and 2 of the draft resolution on the subject appeared to be contradictory, and he suggested appropriate rewording.

DR KO KO explained the background for the existing wording since UNDP would be convening a meeting of the national coordinating authorities in Kuala Lumpur in early 1981 and it was the intention that the representatives of governments at the meeting should be briefed appropriately to enable them to support the priority proposals on the health sector as agreed to by the Regional Committee.

After some discussion, it was agreed that operative paragraph 2 would be reworded to read "URGES Member States that their national coordinating authorities support these proposals, when formulated at the appropriate fora...". The resolution was then adopted.

Time and Place of the Thirty-fourth and Thirty-fifth Sessions of the Regional Committee (SEA/RC33/R12)

Selection of Topic for the Technical Discussions (SEA/RC33/R13)

DR SAIGAL (India) proposed deletion of the word "directing and" from the title of the topic proposed for the technical discussions at the thirty-fourth session.

PROFESSOR LOEDIN (Indonesia) proposed substituting the word "the" for "their" in the second line of the introductory paragraph. He also sought clarification of the phrase "suitable representation" in operative paragraph 3 of the draft resolution.

DR POUDAYL (Nepal) said that he had already pointed out earlier that his country was finding it difficult as it was to send an appropriate delegation. As such, inclusion of a suitable representative to take part in the technical discussions would be a further burden on the Government; he therefore suggested deletion of operative paragraph 3.

The REGIONAL DIRECTOR clarified that the title of the topic proposed was as recommended by the Thirty-third World Health Assembly and, as agreed to earlier in the discussions on the subject, the actual discussions during the thirty-fourth session could be limited to inter-sectoral collaboration in national health planning. He therefore suggested retention of the title as recommended by the World Health Assembly. On the question of suitable representation, he pointed out that this paragraph was being added to the resolution to ensure inclusion of persons who were conversant with the subject of the technical discussions and could contribute to the deliberations. This wording was standard practice and had always figured in this resolution in the past.

After these clarifications, the resolution was adopted.

Adjournment

The meeting was then adjourned.
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*Originally issued as document SEA/RC33/Min.7, on 12 September 1980.*
1 Adoption of the Final Report (item 23)

The Chairman brought to the notice of the meeting a change that had been made in draft resolution SEA/RC33/R4 in accordance with the wishes of the house the previous day. In section 2, item (iv) the word "social" had been deleted so that the item read: "(iv) to take necessary steps to reorient WHO's technical cooperation programme with Member States in consonance with the national and regional strategies to achieve the goal of health for all by the year 2000".

At the suggestion of PROFESSOR M.R. CHOUDHURY (Bangladesh), in the light of the discussions on the relevant resolution the previous day, the Committee decided that the last paragraph on page 23 should be reworded as follows:

"There is a need to establish mechanisms at each country level to bring about collaboration in manpower planning, training and service in the context of the concept of Health Manpower Development."

DR JESUDASAN (Sri Lanka) pointed out a typing error in the heading of section 11 on page 30, viz., "thirty-third session" which should read "Thirty-fourth session".

DR LOEDIN (Indonesia) drew attention to the discussions at the time of adopting resolution SEA/RC33/R13, and suggested that the last sentence on page 30 should read "The Committee gave serious consideration to this suggestion and decided to accept it, but to limit the scope of the discussions to inter-sectoral coordination in national health work".

With these changes, the draft final report was adopted.

Resolution of Thanks (SEA/RC33/R14)

DR SIRAIT (Indonesia) moved the resolution of thanks which was adopted by the Committee.

2 Adjournment (item 24)

MR LASKAR (India), on behalf of the Indian delegation and all who had attended the session, thanked the Chairman and the Vice-Chairman for having so ably conducted the proceedings. He also thanked the Chairmen of the Sub-Committee on Programme Budget and of the technical discussions group for their hard work which had resulted in the smooth and timely functioning and conclusion of the proceedings and for evolving very valuable and relevant recommendations. He also thanked the Drafting Sub-Committee whose deliberations had enabled the Regional Committee to complete its work smoothly and speedily.
Mr Laskar also thanked the Regional Director for his valuable guidance and careful planning of the meeting, but for which the deliberations during the different sessions would never have led to such significant realizations. He added that everyone present would miss him very much since this happened to be his last Regional Committee. He also conveyed his thanks to the Director-General for attending the session and said that the Committee had gained immensely from his wisdom and motivation. He congratulated the silent band of the Organization's functionaries for their excellent work in bringing out the documentation and records so quickly.

He conveyed sincere thanks on behalf of all those present to the Government of the Republic of Maldives, for hosting the session in such beautiful and scenic surroundings and to the people for their warm hospitality. Everyone was deeply touched by the tender warmth and continued affection shown by the Government and the people.

He said the short sojourn in this beautiful island gave an opportunity to everyone to learn a lot and see for oneself how and why "small was beautiful".

DR PRAKORB (Thailand) thanked the Chairman and the Vice-Chairman for their able leadership in conducting the proceedings of the Committee. He also thanked the Chairman of the technical discussions group and said that it was always a pleasure to look back with satisfaction on a task well done. He was confident that in support of the joint decisions and in a spirit of mutual cooperation, Member States would pursue their common goals with determination. The successful implementation of the common goals and policies depended to a large extent on the degree to which these policies would be translated into action at the country level with the collaboration of Member countries, and in this task the leadership of the Regional Director would be indispensable.

Paying a tribute to Dr Gunaratne, who would be laying down his office in February next year, he said that, through his tireless efforts, he had given distinguished service to Member States in the health field. His understanding, leadership and support had enabled them to make remarkable progress in their quest towards better health. He was truly a friend, philosopher and guide to all.

He also expressed his full support to Dr Ko Ko, who had been nominated to succeed Dr Gunaratne, and wished him every success in his new appointment.

Finally, he expressed his grateful thanks to the Government of the Republic of Maldives for hosting the session, and to the Minister of Health and the members of the WHO secretariat for making the work and their stay in the island very fruitful and enjoyable.
PROFESSOR LOEDIN (Indonesia) expressed his gratitude to the Chairman and the Vice Chairman for their able leadership. The deliberations of the Committee had been very effective and, at the same time, conducted in a relaxed atmosphere. He also thanked the Chairman of the Sub-Committee on Programme Budget and the technical discussions group and requested the Chairman to convey his grateful thanks to the Government of Maldives for their kindness in hosting the session. Referring to the change of life and different atmosphere prevailing in the island, he said these brought out the humbleness of the human being and a closeness to nature, which had helped to bring many problems to a satisfactory end. For this he thanked all the delegates, participants and everyone present at the meeting. He also conveyed his thanks to the members of the WHO secretariat, both seen and unseen, for their hard work.

He said that this Regional Committee meeting would be a memorable one for Dr Gunaratne, who could look back with satisfaction on a job well done. He wished him a long and healthy life. He wished Dr Ko Ko strength and extended his support when he took up his new assignment.

Finally, he wished the delegates "Au revoir" till next year when they would be meeting in Indonesia.

DR POUDAYL (Nepal) said that he had been very much impressed by the able and effective conduct of the meeting by the Chairman and the Vice-Chairman and the valuable contributions made by the Regional Director and the WHO secretariat towards the successful conclusion of the session. The Regional Committee would miss Dr Gunaratne, but it was gratifying that an excellent successor to him had been nominated. His country would extend its full support to Dr Ko Ko in his new task as Regional Director. He said he had no words to express his gratitude to the Government and the people of Maldives for all their efforts and the hospitality extended to the delegates.

MR KWON SUNG YON (DPRK) thanked, on behalf of his delegation, the Chairman and the Regional Director for the successful conclusion of the Regional Committee, which had discussed all the items on the agenda as planned. He also thanked the Chairman, the Vice-Chairman and the Chairman of the Sub-Committees and the technical discussions group for the efficient manner in which they had conducted the discussions. On behalf of his delegation and his Government, he expressed appreciation of the efforts of the people and the Government of Maldives and thanked them for their warm hospitality and the excellent arrangements made for the session. He congratulated Dr Ko Ko on his nomination and hoped that all the resolutions adopted by the session would be successfully implemented.

DR JESUDASAN (Sri Lanka) also congratulated the Chairman and the Vice-Chairman for the excellent manner in which they had conducted the session, and stated that under their able guidance the Committee
had been able to arrive at some definite conclusions. He also congratulated the Chairmen of the Programme Budget Sub-Committee and the technical discussions group for the efficient manner in which they had conducted the proceedings. He thanked the Government of Maldives for their warm welcome and generous hospitality. The presence of the Director-General had greatly contributed to the deliberations. This was in a way a sad meeting in that the Regional Committee would no longer have the presence of Dr Gunaratne. During the thirteen years of his tenure, Dr Gunaratne had made an excellent contribution towards improvement of the health of the people of this region. He wished him very good health and happiness in his retired life. He wished Dr Ko Ko strength, courage and wisdom to go ahead with the tasks that lay ahead, with the Organization's aim of health for all by the year 2000 through the primary health care approach. He thanked the staff of WHO for their hard work and their efforts to make the stay of the delegates in Maldives a pleasant one.

MRS NARANTUYA (Mongolia) associated herself and her delegation with the sentiments expressed by the other delegates and expressed her gratitude to the people of the Republic of Maldives, and to the Chairman and the Vice-Chairman for the excellent organization of the session. She paid tributes to the Government of Maldives for their warm hospitality. She also thanked the other delegates for their contribution to the deliberations of the session. She wished success to the workers of the Republic of Maldives and health and prosperity to the people.

DR U KYAW MAUNG (Burma), on behalf of his delegation, conveyed his sincere appreciation and thanks to the Chairman and the Vice-Chairman for the smooth conduct of the deliberations. He also paid rich tributes to the Regional Director, Dr Gunaratne, for his remarkable leadership and excellent work during his thirteen years of association with WHO, and to the staff of WHO for their contribution to the success of the session. He thanked the Government and the people of the Republic of Maldives for their warm and generous hospitality to the delegates.

PROFESSOR CHOWDHURY (Bangladesh) said that he would like to associate himself with the sentiments and observations made by the delegates who had spoken earlier. Although he had arrived late, the few days he had spent in Maldives had impressed him in every respect. He appreciated the Chairman's conducting the meeting most ably and smoothly.

He said that the contributions made by the Regional Director, Dr Gunaratne, for the health development of this region were well-known to all the delegates. His worthy successor, Dr Ko Ko, was also known to all of them; he knew the countries and their problems. Dr Ko Ko had stepped in during a period when the countries of the world and WHO had accepted the challenge of health for all by the year 2000.
He wished him the best of luck in this arduous task and assured him of their help and assistance.

He said that the deliberations and discussions of the Regional Committee meeting and its recommendations would, perhaps, constitute the first step towards health for all by the year 2000.

DR ABDUL SAMAD ABDULLA (Maldives), on behalf of his delegation, thanked the delegates for the kind words expressed about his country, the people and the Government of Maldives. He said that the hosting of the meeting was a big event taking place for the first time in the history of Maldives. All the ministries and departments had been associated with this meeting which was an example of inter-sectoral collaboration. If the delegates felt that the Government had done a good job, they were more than rewarded. He wished the delegates "bon voyage" and for Dr Gunaratne, who had always taken a keen interest in Maldives, he wished a very healthy and long life.

The CHAIRMAN welcomed Mr Kim, Resident Representative, UNDP, Colombo, who could participate in the meeting only that day.

MR KIM (RR UNDP, Colombo) expressed his apologies for not being able to come earlier because of a sudden change in his programme. He expressed his appreciation for the outstanding services rendered by Dr Gunaratne during his term of office. UNDP had had very close cooperation with WHO in areas of common interest.

He congratulated Dr U Ko Ko on his nomination and expressed the hope that the close cooperation already established between UNDP and WHO would continue. He referred to the extensive discussions held between WHO and UNDP both in Manila and SEARO on the UNDP Regional Programme, 1982-86, and said that these discussions had resulted in a large number of proposals which would be incorporated in the draft inter-country programme to be finalized next February. A fact had already emerged from the discussions with the governments that the health sector would receive significantly greater attention than in the past. The programmes relating to health for all and drinking water and sanitation would get priority. Although it was early to commit to individual proposals, yet it was clear that primary health care was a top priority, and as such, would receive corresponding attention from the UNDP inter-country programme. He had been told that WHO would shortly hold a consultation meeting to chalk out a common programme for the whole region and this would be particularly useful to UNDP. He urged the delegates to initiate discussions with their respective national authorities and planning commissions in order to enable them to participate effectively in the forthcoming consultation meeting.

The REGIONAL DIRECTOR said that he was overcome by an overwhelming sense of gratitude in the voyage towards health for all. This had been one of the most crucial and constructive Regional Committee sessions.
The congenial atmosphere, the keen interest and participation by the representatives, the remarkable manner in which the Chairman had steered the meeting and the presence of the Director-General during most of the deliberations on important matters, had contributed to the success of the session. The Committee was also fortunate to hear the thought-provoking key-note address of the Director-General in which he had focused attention on some of the real and basic issues. For Dr Gunaratne, personally, it was the culmination of a gratifying tenure of office of 13 years in the service of the Member States. A number of important issues had been dealt with during this session. Referring to the signing of the Charter for Health Development by the President of the Republic of Maldives, he said that this was yet another significant milestone for this region. The Committee had deliberated on the regional strategies focusing on the purposeful efforts to accelerate further the processes of health development by mobilizing all available resources for a concerted march towards WHO's cherished goal. The Committee also deliberated on the study of WHO's structures, which had vital implications for the strategies for health for all. He felicitated Dr Ko Ko, who had been nominated as Regional Director, and hoped that he would succeed in the task of serving the Member States in health development and in fulfilling the challenging tasks ahead. He was confident that Dr Ko Ko, with his long years of experience in national and international service, would be able to provide appropriate leadership to the Member States. He expressed his sincere appreciation to the Chairman for the exemplary manner in which he had conducted the proceedings. The Committee had been fortunate in having such a dynamic and youthful leader who not only conducted the proceedings very well, but had stimulated, inspired and enriched the discussions. He also complimented the Vice-Chairman for conducting the meetings so ably in the absence of the Chairman.

He thanked all the distinguished delegates for their keen participation and the manner in which they had dealt with crucial issues. He expressed his gratitude to the Government of Maldives for the excellent arrangements and their efforts to make the stay of the participants pleasant as well as for their warm hospitality. He thanked the Government of Maldives on behalf of the secretariat, the delegates, the Director-General, and himself for their magnificent efforts.

He thanked the Resident Representative of UNDP for his attendance and for his speech on the UNDP regional programme for the forthcoming programming cycle.

Finally, he said he was overwhelmed by the kind references made by everyone to his humble services to the Member States. His success in his efforts to assist the governments in their quest towards better health was entirely due to their unstinted cooperation and
their own determination to improve the quality of life of their people. As he was laying down office, he had a sense of gratification for the headway that had been made in the past thirteen years; at the same time, his feeling was one of keen expectation that in the coming years the Member States would be able to achieve a breakthrough as a result of their partnership with WHO. He wished them all success in their efforts. He would like to place on record, though this was not normally done, his sincere appreciation and gratitude to his staff throughout the Region for their unstinted cooperation and loyalty.

The CHAIRMAN said that he was thankful to Almighty Allah for giving them the strength and courage to host this session in Maldives. He thanked the President of the Republic of Maldives for inaugurating the session and addressing it. He referred to the highlights of the session, which included the signing of the Charter for Health Development by the President of Maldives, the presence of the Director-General for five days and his useful interventions and elaborations on a number of issues of importance, and the nomination of a successor to Dr Gunaratne. As regards Dr Gunaratne himself, his country was proud to have been associated with his election in 1967 and to be able to hold the last session which he would be attending.

He thanked the Member countries for sending to the session high-level delegations and the delegates themselves for their cooperation during the deliberations to make the session a successful one.

He pledged his country's support to Dr Ko Ko and to WHO in their endeavours for better health for the world's population. He thanked all those who had worked behind the scene to make available documentation and other facilities to make the session's work smooth and successful.

He craved the indulgence of the delegations and others who had participated in the session for any shortcomings in the arrangements made. Finally, he wished all those present 'bon voyage', and the Regional Director a healthy and happy retired life.

The meeting was then declared closed.