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REPORTS OF THE REGIONAL DIRECTORS ON SIGNIFICANT REGIONAL DEVELOPMENTS, INCLUDING REGIONAL COMMITTEE MATTERS

Report by the Regional Director for South-East Asia

The Director-General has the honour to present to the Executive Board a report by the Regional Director for South-East Asia, which highlights significant developments in the Region, including matters arising from discussions at the thirty-eighth session of the Regional Committee. Should members of the Board wish to see the full report of the Regional Committee, it is available in the Executive Board room.

REPORT BY THE REGIONAL DIRECTOR FOR SOUTH-EAST ASIA ON SIGNIFICANT REGIONAL DEVELOPMENTS, INCLUDING REGIONAL COMMITTEE MATTERS

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I. INTRODUCTION

1. During the period under review, which covers the first biennium of the current Seventh General Programme of Work of WHO (1984-1989), an encouraging beginning has been made by the Member States in their march towards the goal of health for all by the year 2000. Wide-ranging implications of a technical, organizational, managerial and financial nature related to the development and implementation of health-for-all strategies are gradually being faced and dealt with through realistic approaches. Thus, the countries are seriously involved in realigning resources, reorganizing infrastructures, remodelling manpower, improving the managerial process, reorienting their research thrust and, above all, stimulating people to participate actively and fully involve themselves in national health development activities. The commitment of the countries in the Region to the principles of primary health care and the goal of health for all is total. This is manifested in an upsurge of health development efforts based on health-for-all strategies in each Member State in both governmental and nongovernmental sectors. However, in spite of the above efforts, the health situation in many countries of the Region remains unsatisfactory. This is rather ironical because most of the technologies to improve health have been known for quite some time, yet their application and availability leave much to be desired. Numerous families in the poorer and developing countries still experience high infant and childhood mortality and morbidity. The minimum health needs of large sections of the population are not met. A high burden of communicable diseases continues to undermine the social and economic productivity of large numbers of people. The vicious circle of disease, poverty, unemployment, malnutrition, and greater vulnerability to disease continues.

2. Against a backdrop of this vicious circle the people and the governments of the Member countries in the Region are making the sincerest efforts to solve health problems, inspired by their total commitment to the goal of health for all. They are doing their best to stretch out the almost inelastic economies to support the development of the health sector, which is usually neglected. There is not an iota of doubt that these developing countries are determined to be true to their words and to overcome all obstacles to achieving an

acceptable level of health for all their people in order to make them socially and economically productive. But in this effort they must receive due support from more fortunate and economically rich countries, which could and should be considered as their legitimate expectation.

II. SIGNIFICANT REGIONAL DEVELOPMENTS

Review of health trends

3. Health facilities have expanded, yet effective access and utilization is beyond the reach of many who are in need of them. Economic, geographical and behavioural barriers to health care continue in spite of an increase in facilities and other resources in both public and private health sectors.

4. Data on mortality and morbidity levels and trends provide important information on a country's health situation. However, for several countries in the Region morbidity data are largely based on hospital and other health facility records. None the less, more and more community-based information is becoming available.

5. In the Region, the decreasing trend in the crude mortality rate is clearly apparent. During the last decade and a half or so, in most countries of the Region infant mortality rates have decreased considerably. The most consistent downward trend can be observed in Burma and in India. In recent years, only four countries - Burma, the Democratic People's Republic of Korea, Sri Lanka and Thailand - have reported rates of less than 50 per thousand, the maximum rate stipulated as the target for health for all by the year 2000. Neonatal deaths make up to 30-60% of all infant deaths in the countries for which information is available. Life expectancy at birth is on the increase in most countries of the Region.

6. Malnutrition and nutritional deficiency disorders, vector-borne diseases (e.g., malaria), tetanus, diphtheria and leprosy are all major causes of death and illness in the Region. Cancer, cardiovascular diseases and other noncommunicable diseases have more recently become a major public health problem in those countries which have achieved higher levels of life expectation.

7. Disasters, both natural and man-made, such as cyclones, floods, landslides, civil disturbance and the movement of refugees due to war and guerilla activities continue to be important problems in the Region.

Response of countries to development

8. In spite of relatively recent industrialization and urbanization, with noticeable environmental changes, the societies in all countries of the Region remain largely traditional and the economies largely agricultural. The social stresses and strains are still limited, but the economic distress has become more pronounced because of the international economic recession and stagnation. Falling commodity prices for export goods and adverse terms of international trade have seriously constrained national income and the ability to generate resources for social and economic development.

9. Although there are important differences among countries in the Region, their approaches to development have a great deal in common. They have sought to achieve and sustain moderate rates of economic growth and diversify their economies as much as possible through industrialization. In most countries the governments are directly responsible for supporting many social development programmes, including health, and the role of the public sector has been steadily expanding.

10. Although there has been a rise in the average income per capita, the benefits of economic growth have failed to reach the majority of the population. Disparities in health status within countries and among different countries have continued to widen. The conventional approach to development, which assumes that aggregate growth is sufficient as an end in itself, is being rejected. In its place, concern for welfare and equity has emerged as a major objective in development strategies. All countries in the Region have now formulated strategies which reflect their concern with non-economic issues, including good health, productive employment, education, shelter and housing, distributive equity of income and development benefits, and personal freedom and dignity. Most important is the interpretation of development also to include the well-being of all people.

11. Given this view, it is easy to see that health and development are virtually inseparable and that health issues extend to the very heart of development. It is evident that the goal of health for all by the year 2000 can be achieved only through overall development, by adopting a development plan that gives as high a priority to social as to economic goals.

Collaboration with other agencies and organizations

12. During the biennium the Regional Office executed 36 country and 12 intercountry UNDP-funded projects with a total financial outlay of about US$ 10.9 million. These projects addressed a wide range of regional health priorities involving the development of both health system infrastructure and technology. As a part of the preparations for mobilization of resources in support of health promotion activities through the UNDP Fourth Intercountry Programme covering the period 1987-1991, the Office, in consultation with the national authorities, prepared and submitted to UNDP 21 project proposals in the area of regional health priorities for possible funding through the Fourth Programme cycle. The Regional Committee at its thirty-eighth session adopted a resolution confirming these proposals as of priority interest to the countries of the Region and endorsing them for UNDP support.

13. The Regional Office also participated actively in the UNDP country programming exercise and closely collaborated with the national health authorities in various preparations in order to help secure maximum possible support for health programmes.

14. During the same period, the Regional Office also implemented 15 UNFPA-funded projects with a total financial input of about $ 1.8 million. The major thrust of these projects was the development and strengthening of the service infrastructure for the integrated delivery of maternal and child care and family planning services, including development of appropriate manpower.

15. Cooperation between the Organization and the South East Asian Medical Information Centre (SEAMIC) in common areas of interest, notably in developing information services in support of the Member countries of the Region, has grown significantly. Active collaboration was maintained with the Asia Pacific Academic Consortium for Public Health in certain fields. A joint effort is being made to develop clearing-house activities to highlight outstanding examples of pilot research projects and studies in primary health care, utilization of appropriate technology, project evaluation, and manpower assessment and development. In addition, the initiative is being taken in activities involving the universities in areas of major public health importance that are common to both the South-East Asia and Western Pacific Regions.

16. Most countries have recognized the importance of the role of nongovernmental organizations and sought their collaboration. The majority of the Member States have also elaborated mechanisms for coordination and complementary action with them. Inventories and directories of these organizations' work have been prepared to facilitate such collaboration.

17. The subjects of international flow of resources and health resources mobilization have regularly been on the agenda of the Regional Committee since resolution WHA34.36 adopting the Global Strategy for Health for All. The Committee has repeatedly urged the Member countries to mobilize all possible resources and the Regional Office to support these efforts in helping to assess the costs and methods of financing health care services. Another important area for WHO support in resource mobilization for health is the strengthening of the advocacy role through feasibility studies and the highlighting of the resource requirements of the health sector in competition with other development needs.

Technical cooperation among developing countries (TCDC)

18. TCDC in the health field has taken stronger roots with the Health Ministers taking a lead, using TCDC as an important process for health development. At their fourth meeting held in New Delhi in September 1984, they had decided that short-term TCDC projects on training, exchange of expertise and information should be implemented. Information on needs of Member States and indicated potentials of Member States to meet these needs have been compiled in the form of a TCDC directory. Using the information collected and disseminated by WHO, bilateral exchanges have been planned between India and Thailand, Nepal and India, Bangladesh and Maldives, Bangladesh and Nepal, and Bangladesh and Sri Lanka. A Memorandum of Understanding covering specific bilateral TCDC activities spread over a three-year period has

been signed between Nepal and Thailand. Sri Lanka has developed a project to provide for training and exchange of expertise in 1985-1986 and proposed to fund the same using both UNDP IPF and national budget. An agreement for Plan of Cooperation in the field of health between Mongolia and the Democratic People's Republic of Korea has been signed.

Developments in WHO programme activities during 1984-1985

19. In general programme development, efforts were made to determine programme priorities and the nature and thrust of activities. Some of the countries have embarked on a joint government/WHO evaluation of one priority programme, which is expected to enable the managerial staff to acquire the technical skill needed to undertake evaluation of all national programmes. The Consultative Committee for Programme Development and Management, which was constituted at the behest of the Regional Committee, has been monitoring the implementation of WHO's collaborative programmes. Significant progress was achieved in implementing the new managerial framework for optimal use of WHO's resources in the countries.

20. In the health systems development programme, the major thrust was to strengthen information support mechanisms at all levels and to train manpower; this included strengthening the infrastructure in epidemiological surveillance, especially at the middle level of health services. Supporting activities were directed towards programme planning, programme budgeting, monitoring and evaluation, promotion of health systems research through national meetings and cooperation in research methodology, and improvement of health levels in support of the implementation of national health policies. The most important element of WHO collaboration was the support provided to Member States in the evaluation of national health-for-all strategies using the common framework and format. All countries provided information generated by this exercise in order to develop country health situation reports, which were the basis for the preparation of regional and world health situation reports.

21. In the organization of health systems based on primary health care, the emphasis of WHO's collaborative programme was on supporting governments to accelerate the implementation of national primary health care (PHC) strategies. Two national institutions were selected as nodal resource institutions for the provision of support in the development of a regional PHC network linking the national PHC points in cooperative efforts for information exchange and training. WHO supported an innovative programme of high priority in Indonesia to deliver at the community level an integrated package of family health care which includes maternal and child health, family planning, nutrition, immunization, and control of diarrhoeal diseases and acute respiratory infections. A district model for PHC development to strengthen the integrated delivery of health services was developed in one district of Bhutan. Several national workshops on PHC to improve the understanding of health service delivery and management at district and subdistrict levels were completed in Bangladesh. A PHC model project was implemented in Mongolia, leading to the improvement of services through an integrated institutional network, management orientation and training, and a referral support system.

22. In the area of health manpower, the countries were supported in their efforts to improve the quality and quantity of manpower, coordination of the different phases of the health manpower development process, such as planning, production and management, and health manpower development research based on the principles of health services research. In Bangladesh, a health manpower review has led to the revision of the targets for the production of health personnel, a limitation in the number of categories of health workers, and a better pattern of distribution of manpower. Burma has consolidated the existing training institutes for the auxiliary and paramedical system of performance and assessment and experimented with a new category of health worker, namely, the "ten household-worker". In Bhutan, the requirements for health manpower have been assessed and rationalized. In the Democratic People's Republic of Korea, major efforts have been directed towards the development of expertise at referral levels. In India, a manpower planning cell has been established in the Ministry of Health to support the manpower planning process based on the concept of integrated development of health services and manpower. In Indonesia, proposals for manpower development during Repelita IV have now crystallized so as to provide manpower support to health-for-all efforts. In Nepal, the undergraduate curricula for medical students and the criteria for admission have been reviewed and improved in close consultation with the health services. In Sri Lanka, the National Institute of Health Sciences has been successfully realigning its training programmes to meet the needs of the services, especially

in respect of paramedical and auxiliary personnel. The Ministry of Higher Education has examined the specific tasks, functions and responsibilities of newly qualified undergraduates so that curricula can be adapted to meet the needs.

23. Significant importance has been attached to the development and improvement of public information and education for health in almost all countries. They have recognized the need for intersectoral coordination between the Ministry of Information (mass media, TV, radio, etc.) and the Ministry of Health in the training of health personnel in communication skills and communications staff in health. Linkages have been established in several countries of the Region to enhance the scope and effectiveness of this programme.

24. With the adoption of the goal of health for all by the Member States, the objective of the regional research promotion and development programme was reoriented towards supporting the much wider aspects of health development in line with the goal. The South-East Asia Advisory Committee for Medical Research has identified and documented the research needs for supporting health-for-all efforts and underlined the importance of health services research in this context by developing a conceptual framework and guidelines for conducting such research.

25. While this programme has collaborated and played a catalytic role in the implementation of actual research projects by providing funds and technical support, its other important activity has been to support the training of research manpower and institutional development with a view to achieving national self-reliance in the field of health research.

26. A multisectoral approach has been adopted by several countries of the Region to strengthen their efforts in solving the problems of malnutrition. WHO's collaborative role has been to examine the trends in various nutritional indicators and situations in the countries with a view to strengthening the national nutrition capabilities and developing the national nutrition programmes for specific deficiency diseases, e.g., iodine deficiency disorders, iron deficiency anaemia, and xerophthalmia.

27. As regards oral health, there has been an increased awareness and concern, which has stimulated action at national level towards the development of preventive dentistry as part of primary health care.

28. Problems of accident have been taken more seriously in most of the Member States. Several epidemiological surveys on accidents were carried out.

29. In the area of family health, the major thrust of WHO's collaboration has been to provide technical support in the planning and management of MCH and FP programmes, training of manpower and the conduct of research especially in defining problems and seeking practical solutions to the problems related to the programme development and management.

30. The workers' health programme covered not only occupational hazards to workers, but also the contribution of the psychosocial and behavioural pattern of workers. The WHO collaborating centre in Indonesia dealt with the prevention of carcinogenic effects of chemicals, occupational safety, and health and ergonomics. National sociocultural aspects were taken into account in developing national programmes for the elderly in the countries.

31. In the area of protection and promotion of mental health, activities in the countries were aimed at determining indicators of mental health. There was an improvement in the technologies for assessing behaviour change for use in immunization programmes and family planning activities and for evaluating the impact of behavioural and mental health interventions as indicators of mental health and of healthy social environments. Countries have felt the need of WHO support for continuous availability of the essential drugs required for the treatment of epileptics and rehabilitation of the mentally and neurologically disabled.

32. In the promotion of environmental health, the Organization has been supporting governments in developing facilities for safe drinking-water and qualitative surveillance systems. As a result of promotional efforts as part of the International Drinking Water Supply and Sanitation Decade, accelerated progress continued to be made in water supply and sanitation, although the achievements to date were considerably short of those called for by

the national targets set for the Decade. WHO inputs for training and institutional strengthening were generally on the increase. The orientation of water supply and sanitation towards the Decade approach also markedly increased.

33. To promote the role of women in the Decade, WHO participated in a UNDP-assisted project by undertaking specific interventions in Indonesia, Nepal, Sri Lanka and Thailand. A new project was prepared for external funding to promote the role of women at home in the application of measures for safe water supply and sanitation in the control of diarrhoeal diseases.

34. The control of environmental health hazards as a programme area gained importance in the Region. Chemical safety attracted much attention in many countries after the tragedy of the leakage of methyl isocyanate gas from a factory in Bhopal, India.

35. In the field of diagnostic, therapeutic and rehabilitative technology, the major thrust of the collaborative programme was on the development of laboratory facilities and technological expertise, establishment of quality control systems and good management practices and self-reliance in reagent preparation and maintenance of equipment, establishment of national drugs policies, strengthening of traditional medicine programmes, and associated research activities. Nine countries have prepared lists of drugs and vaccines in support of their health services.

36. Communicable diseases are still a major problem in the countries of the Region. The main aim of the communicable disease control programme is to cut down morbidity and mortality. Control of communicable diseases with appropriate methodology will help in achieving the objective of health for all by the year 2000. For this, the major emphasis is placed on diarrhoeal disease control and the Expanded Programme on Immunization. The coverage of both these programmes has improved significantly in the last years.

37. There has been an improvement in case-holding case detection in tuberculosis and leprosy. Most countries have accepted multidrug therapy as an essential part of leprosy control programmes and are trying to cover the whole population with multidrug therapy in phases.

38. Although the overall malaria situation continues to cause concern, a declining trend in case incidence has been observed in five out of the nine malarious countries of the Region.

39. There is a declining trend in filariasis in the Region. The status of leishmaniasis and intestinal parasitic infections is static. There is a notable achievement in the guineaworm disease eradication programme in India in that Tamil Nadu State has been declared free from this disease.

40. Sexually transmitted diseases continue to be a major public health problem. The emergence of acquired immune deficiency syndrome (AIDS) in two countries is a cause for concern. There was also a resurgence of endemic treponematosis in a few pockets in Indonesia. Appropriate steps for control were taken by the national authorities. Efforts were under way to assess the magnitude of this health problem in other countries.

41. Dengue haemorrhagic fever still remains a major public health problem in three countries of the Region. Vaccine production efforts have achieved some success. A vaccine will be ready for field trials some time in 1986. Meningococcal meningitis epidemics were reported in India and Bhutan. Viral hepatitis also continues to be an important health problem in some countries.

42. There is a large gap between the resources requirements and the resources available to carry out disease prevention and control programmes in the Member countries and all efforts are being made to bridge this gap through the mobilization of external agencies. Countries need to decide their own priority areas to which the limited available resources should be diverted.

43. WHO support continues for the integration of disease prevention and control programmes into the basic health services using the primary health care approach for achieving the goal of health for all. In Indonesia, an operational research project has been started in order to assess the social, cultural, behavioural, managerial, financial and technical feasibility

of ensuring integrated communicable disease control through the primary health care infrastructure. If successful, the model can be used in other countries for controlling communicable diseases in a more cost-effective manner.

44. Among the noncommunicable diseases, cancer and cardiovascular diseases are notable health problems. WHO continues to assist countries to develop appropriate technology to control the noncommunicable diseases through primary health care. The trend is towards adopting an integrated approach for the prevention and control of noncommunicable diseases through interventions based on common risk factors. A regional programme on smoking and health has been developed, with well-defined action plans for each of the participating countries. A community approach for the early detection and treatment of diabetes has become operational in some countries of the Region, and a community approach for the prevention and control of thalassaemia is being developed.

Overall impact of the WHO programme in the Region, including progress in implementing strategies for health for all

45. A formal and firm commitment to primary health care principles and the health-for-all goals has been made at the highest level in every country of the Region. Many factors have contributed to the progress achieved so far. There is increased emphasis on training health personnel in preventive and promotive aspects. Resources are gradually being reallocated to rural areas and for the urban poor. There is more emphasis on health management systems and training, community medicine, and community participation and involvement. A sharp increase is evident in the development of health personnel in rural areas, and in the development of local manpower and resources for health. Local production of essential drugs is being promoted and the various systems of traditional medicine are receiving attention and support. Immunization and family planning programmes have been intensified and, in many cases, integrated with other health activities. Water and sanitation programmes have been stepped up, and significant gains have been made in food supply and nutrition surveillance. At the national level, the urgent need for more effective monitoring and management of the programmes has been recognized.

46. The evaluation, using the common framework and format, undertaken in 1984 represented the first attempt in measuring progress towards the health-for-all goal.

47. Most countries of the Region have not yet established systematic procedures to assess the level of community satisfaction with the results of the strategy implementation. Conscious efforts will have to be made in the countries to establish systematic processes and to undertake special studies in order to generate the required information for the next evaluation of strategy implementation in 1991.

48. Pre-existing health structures, failure to introduce a dynamic managerial process, and lack of commitment can be said to be the main causes for the insufficient coordination within the health sector. Likewise, lack of committed leaders for health development and, above all, insufficient communication among the various sectors are at the core of ineffective intersectoral action.

49. The capacity for assessment of the quality of health care remains rudimentary at best. An objective assessment of health care delivery will require the establishment of norms and definition of standards of performance for the system as a whole.

50. The evaluation of health-for-all strategies completed early in 1985 by all the Member States of the Region clearly demonstrates the substantial progress made during the past years, though much more has yet to be done at an accelerated pace for the adequate realization of the goal. As an outcome of this evaluation, a number of common issues were critically identified. Among the more important are the need to move more firmly towards better equity, to accelerate reorientation of health systems, to increase community involvement and people's awareness, and to accentuate intersectoral coordination to maximize the impact of national investment.

III. CHANGES IN THE PROGRAMME BUDGET FOR 1986-1987

51. In order to ensure optimal use of WHO's resources at the country level, a constant dialogue was maintained between the Regional Office and the Member States to formulate a detailed programme budget for 1986-1987. Priority activities were identified and suitable allocation of the regular budget resources was made to the different programme areas. There have been some shifts in the resources between different programme areas. Reductions in certain programme areas are offset by an actual or expected increase in the inflow of extrabudgetary resources.

52. The major thrust of WHO's collaboration during the 1986-1987 biennium will be on: (i) further development of the health infrastructure with the objective of providing universal primary health care; (ii) application of the principles of the managerial processes for national health development as applicable to the various levels of health services; (iii) formulation and implementation of health manpower developmet policies and programmes commensurate with the actual needs of the health services; (iv) integration of the processes of health situation and trend analysis on a sound epidemiological base; (v) application of cost-effective and appropriate technology in the control of major communicable diseases; (vi) implementation of need-based programmes in support of the International Drinking Water Supply and Sanitation Decade, balancing the two components; (vii) further development of national research capabilities, particularly health services research, for facilitating the application of known and emerging scientific knowledge for health development; and (viii) interagency cooperation and coordination and mobilization of external resources for health development.

53. Some of the programme areas which registered an increase are: health situation and trend assessment; health systems research; organization of health systems based on primary health care; research promotion and development; oral health; essential drugs and vaccines; drug and vaccine quality, safety and efficacy; traditional medicine; cancer; and health information support.

54. The programme areas which show a decrease in the allocation as compared to the broad programme budget are: managerial process for national health development; health manpower; community water supply and sanitation; clinical, laboratory and radiological technology; tuberculosis; leprosy; and other noncommunicable disease prevention and control activities.

55. The detailed programme budget for 1986-1987 is a reflection of the commitment of Member countries to implement the strategies and plans of action for health for all.

IV. REGIONAL COMMITTEE MATTERS

56. At its thirty-eighth session (24-30 September 1985) the Regional Committee for South-East Asia nominated Dr U Ko Ko to serve for a further period of five years as Regional Director.

57. The Committee noted that the evaluation of the health-for-all strategies carried out by all Member States using the common framework and format had resulted in the generation of useful data that would be valuable in the further improvement of the strategies. The Committee agreed that the time gap in the monitoring cycle should be increased from a period of two years to three, while evaluation could continue on a six-year cycle. The Committee felt that, in order to maximize the benefits of evaluation, each Member State should undertake a total review of the results of the evaluation, involving other sectors.

58. The Committee held technical discussions on "Integrated control of priority communicable diseases using primary health care infrastructure". The Committee endorsed the recommendations made in the report of the technical discussions, the most salient of which was the confirmation that such integrated control was a valid concept and that efforts should be made to promote it. The Committee urged the Member States to take appropriate action for developing and implementing the integrated control of communicable diseases in consonance with national priorities.

59. The Committee took note of the changed procedures for developing the UNDP Intercountry Programme during the fourth cycle, covering the period 1987-1991, and by its resolution SEA/RC38/R12 confirmed that the proposals formulated for UNDP funding were consistent with

the national and regional strategies for attaining the goal of health for all and were of priority interest to the countries. It urged the Member States to ensure that their national external aid coordinating agencies were appropriately briefed regarding these proposals so that necessary support could be provided for them at the appropriate forums during the course of UNDP programme formulation.

60. Endorsing the report of the Sub-Committee on Programme Budget, the Regional Committee noted that the draft of the regional programme budget policy, which was evolved by the Working Group of the Consultative Committee for Programme Development and Management and reviewed by the latter body, was in accordance with the guidelines for preparing a regional programme budget policy as contained in document DGO/85.1. It requested the Regional Director to submit a final draft of the regional programme budget policy to its thirty-ninth session for approval.

61. The Committee also took note of the discussions held in the Sub-Committee on Programme Budget on the issues related to resource allocation for the countries, with particular reference to the country allocation figures, and requested the Regional Director to further intensify the efforts for making some adjustments in this respect.

62. During the discussion on the Regional Director's annual report, the Regional Committee emphasized the importance of maintaining strong links between the Executive Board and the Regional Committee. It was the consensus that, to the extent possible, Regional Committee delegations from Member States should include the persons who were currently serving as members of the Executive Board.

63. The Committee noted that, in order to have an effective managerial system, particularly in view of the scarcity of resources, the governments of the Region had attached a very high priority to the development of a suitable managerial process for national health development. There was an urgent need to strengthen further the national health information system in support of this process.

64. In the field of the organization of health systems based on primary health care, the Committee expressed the view that, although there was adequate political commitment to the goal of health for all by the year 2000 through the primary health care approach, there was still inadequate community involvement in developing primary health care. A number of positive steps had, however, been taken, including the decentralization of appropriate authority to different levels for health development, the inclusion of primary health care activities in minimum needs programmes with a multisectoral perspective, and activities to increase the competence of personnel, both at primary health care and referral levels.

65. With respect to health manpower development, the Committee felt that, despite the advances made in the recent past, shortages of appropriately trained personnel with the correct motivation still constituted one of the major obstacles to the achievement of health-for-all goals. In many countries, there were mismatches between the numbers and types of personnel produced and the needs of the health services; the utilization of trained personnel in service tasks inappropriate to their training aggravated the problem. It was agreed that closer cooperation and coordination between the manpower producers (universities and training institutes) and users (ministries and departments of health) was needed in order to promote the concept of health services and manpower development (HSMD), which could help to solve this problem. The Committee noted that the increasing cost of training programmes conducted by institutions outside the Region and their insistence on high levels of basic education and of proficiency in the English language were major constraints being encountered by the Member States in the full utilization of the Organization's fellowship programme. It was agreed that both the Organization and the countries could explore ways of increasing the number of fellowships held within the country and at regional centres.

66. The Committee stressed the need to strengthen programmes and activities for public information and education for health and highlighted the need to focus these programmes on young people, so as to create an awareness of health in a group whose behaviour was likely to be particularly amenable to change.

67. In the field of research promotion and development, the Committee noted with satisfaction that the South-East Asia Advisory Committee for Medical Research was providing appropriate guidelines for developing research in support of strategies for health for all by

the year 2000. The Committee agreed that health services research should continue to receive high priority; in order to make it effective, however, there was a need for close collaboration between the policy-makers and health administrators on the one hand, and the researcher on the other.

68. Concerning nutrition, the Committee noted the recent advances made in the Member States in the control of iodine deficiency disorders, with WHO's and UNICEF's support, and commended the efforts made in developing a WHO regional strategy and plan of action for the control of such disorders and for bringing out a Regional Office publication on them.

69. The Committee noted that, in several countries, maternal and child health programmes were evolving innovative approaches to encourage the participation of the people by establishing women's groups in the villages. The strengthening of existing infrastructure, training of workers at the grassroots, and construction of facilities were three activities that needed more attention. The Committee stressed that family planning programmes could not achieve success without strong maternal and child health programmes. The importance of integrating immunization, nutrition, oral rehydration, the control of acute respiratory infections and family planning with maternal and child health to provide a package programme was discussed. The Committee emphasized the role of women in health and development and noted that, in several countries, a separate ministry for women's affairs, headed by a female minister, had been established.

70. The Regional Committee noted that while Member States were continuing their efforts to provide safe drinking-water and sanitation to meet International Drinking Water Supply and Sanitation Decade targets, sanitation was still lagging far behind water supply in several countries. A fresh look at the strategies and approaches followed in planning and implementing projects was required in order to provide for basic minimum needs, promote community-organized funding and management, and to develop adequate back-up support from referral levels. Some institutional realignment was necessary in order to develop and deliver water and sanitation programmes in the context of primary health care and so that Decade approaches could have their desired health impact.

71. The Regional Committee stressed the importance of activities being carried out to deal with the problems of chemical safety and environmental pollution control, noting that health hazards were increasingly being experienced in some countries in the wake of gaseous and other pollutants being discharged by traffic, industrial operations, etc. The role of the health authorities in developing a multidisciplinary approach to the control of environmental health hazards needed to be clearly identified and promoted.

72. Noting the progress immunization programmes had made since their inception in many countries, the Committee felt that the most important indicator of their impact was the reduction in morbidity and mortality due to the Expanded Programme on Immunization's target diseases. It felt that the time had come in the Region to set quantified targets for disease reduction for some of these target diseases. The need for integrating immunization with appropriate primary health care interventions, mobilizing voluntary health workers to ensure community motivation and participation, and strengthening the health infrastructure and information systems to improve disease surveillance, was also stressed by the Committee.

73. The Committee felt that though there was a declining trend in malaria incidence in the Region as a whole, there had been no technical break-throughs as yet in regard to the problems of parasite resistance to anti-malarials and vector resistance to insecticides. There was also an acute shortage of drugs and insecticides.

74. The Committee noted that diarrhoeal diseases were among the main contributors to the high rate of infant mortality in the countries of the Region and that efforts were being made to reduce mortality due to these diseases by providing oral rehydration therapy.

75. Noting that acute respiratory infections were a leading cause of morbidity and mortality during childhood in most of the countries, the Committee emphasized the need to develop simple and appropriate technology to combat them and to strengthen the measures currently being employed to reduce their incidence in the Region.

76. The Committee noted with concern that tuberculosis continued to be responsible for a heavy load of morbidity and mortality in several countries of the Region. The tuberculosis control programme was facing problems related to early diagnosis, effective case-holding, adequate treatment, drug resistance, and the availability of sufficient drugs. The role of nongovernmental organizations and voluntary agencies in assisting the national efforts to control the disease was appreciated.

77. Leprosy continued to be a significant public health problem, being endemic in several countries of the Region. Multidrug therapy had been introduced in some of the countries. In a few, evaluation of this therapy showed encouraging results. The involvement of the voluntary agencies and nongovernmental organizations in assisting national efforts to combat the disease were commended. The Committee felt that the early production of a vaccine for the prevention of leprosy would greatly help in reducing the transmission of leprosy, but agreed that much more could still be achieved by the systematic application of available and known technologies.

78. The Committee noted that the activities related to the cancer control programme continued to be geared to the primary and secondary prevention of the commonest cancers in the countries of the Region. The control of tobacco-related disease was a complex subject involving several sectors, such as agriculture, commerce and finance. The Committee was informed that, in accordance with requests made at its thirty-seventh session, a regional workshop on the control of tobacco-related diseases had been held in July 1985.

79. The Committee decided to hold its thirty-ninth session in Thailand in September 1986 and also decided to accept the invitation of the Government of the Democratic People's Republic of Korea to hold the fortieth session of the Regional Committee in 1987 in that country.

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