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Report of the Fifty-fifth Session

Jakarta, Indonesia, 11-13 September 2002

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CONTENTS

Page

Annexes

Report of the Regional

[1] Originally issued as Draft Report of the Fifty-fifth session of the Regional Committee for South-East Asia (document SEA/RC55/18 dated 13 September 2003)

Part I

INTRODUCTION

THE FIFTY-FIFTH SESSION of the WHO Regional Committee for South-East Asia was held from 11 to 13 September 2002. It was attended by representatives of all the ten Member Sates of the Region, UN and other agencies, nongovernmental organizations having official relations with WHO, as well as observers.

The session was inaugurated by His Excellency Dr Achmad Sujudi, Minister of Health, Government of the Republic of Indonesia.

The Committee elected Dr Achmad Sujudi (Indonesia) as Chairman and Dr Sangay Thinley (Bhutan) as Vice-Chairman of the session.

The Committee reviewed the report of the Regional Director for the period 1 July 2001 to 30 June 2002 and considered the recommendations arising out of the Technical Discussions on Management of Decentralization of Health Care, held during the 39th meeting of the Consultative Committee for Programme Development and Management.

The Director-General of WHO, Dr Gro Harlem Brundtland, addressed the session.

The Committee decided to hold its fifty-sixth session in the WHO Regional Office in New Delhi in September 2003.

A drafting group on resolutions comprising representatives from Bangladesh, Bhutan, India, Maldives, Nepal, Sri Lanka and Thailand was constituted with Dr Abdul Azeez Yoosuf (Maldives) as Convener. During the session, the Committee adopted four resolutions.

Part II

INAUGURAL SESSION

WELCOME ADDRESS BY THE SECRETARY-GENERAL, MINISTRY OF HEALTH

DR DADI ARGADIREDJA (Secretary-General, Ministry of Health, Government of the Republic of Indonesia) welcomed the representatives from the Member Countries of the SEA Region as well as those of the UN and other specialized agencies. He extended a special welcome to the Ministers of Heath from the Region, who had taken the initiative to attend this meeting, and said that Indonesia was proud to host the Regional Committee session once again. He thanked WHO for its continued support in preparing for this session.

OPENING OF THE SESSION *(Agenda item 1)*

OPENING the fifty-fifth session, DR KYI SOE, Chairman of the fifty-fourth session, extended a warm welcome to the representatives. He said that the countries of the SEA Region, despite their own complexities and characteristics, were striving to improve the health of the people in the context of their own health systems. WHO was playing a crucial role in making this possible. Most countries faced daunting health challenges and financial constraints. The double burden of diseases was being compounded by new, emerging and re-emerging problems. The situation was further aggravated by widespread poverty, population growth, low status of women as well as environmental degradation. The need of the hour was equity, solidarity and a spirit of understanding to help in rolling back diseases like malaria. In spite of the constraints, Member Countries had made remarkable progress in the field of health. In this context, he stressed the need for vigorous efforts to

mobilize resources, both within the countries and from international sources. At the same time, it was imperative to use the available resources efficiently and effectively.

ADDRESS BY THE REGIONAL DIRECTOR, WHO

DR UTON MUCHTAR RAFEI, Regional Director, said that the presence of Health Ministers from the countries of the South-East Asia Region at the session added considerable stature to the Regional Committee. Their presence reflected their strong commitment to health development in the Region. Welcoming the representatives from the Democratic Republic of East Timor, he said that WHO had extended full support to the country in setting up and strengthening its health systems.

Dr Uton appreciated the dynamic leadership of Her Excellency President Sukarnoputri Megawati. He said that Indonesia had made significant progress in health development through a series of strategic policy directions and reform actions, especially in health systems development. He pledged WHO's continued support to the country in its march towards better health for its people.

Dr Uton said that the South-East Asia Region faced the most formidable health challenges posed by the double burden of communicable diseases and noncommunicable diseases, and called for increased efforts to effectively tackle these problems.

The Region was making commendable progress in eradicating poliomyelitis and eliminating lymphatic filariasis and leprosy. Much had been done in controlling tuberculosis through expansion of the coverage of the DOTS strategy. High priority was being accorded to combat HIV/AIDS as well as malaria, which had re-emerged in some areas. Member Countries were still experiencing frequent outbreaks of dengue/dengue haemorrhagic fever. However, with concerted efforts, the case-fatality rate had been dramatically reduced to less than 1%.

Though the gains had been significant, much more remained to be accomplished in order to bring health and prosperity to the population inhabiting the Region. There was a need to focus on the

marginalized and those without access to essential health care, particularly women and children.

WHO's Corporate Strategy and the Country Cooperation Strategy now formed the cornerstone of its collaborative activities. This collaboration had recently led to the approval of several proposals from countries in the Region by the Global Fund to fight AIDS, TB and Malaria.

Another noteworthy development was the increasing availability of extrabudgetary resources for the Region. The fact that donors were now willing to invest in the South-East Asia Region reflected their confidence that resources were spent effectively and efficiently (for full text of the address, see Annex 4).

ADDRESS BY THE DIRECTOR-GENERAL, WHO

DR GRO HARLEM BRUNDTLAND, Director-General, WHO, extended a warm welcome to the delegation from East Timor. She recalled the terrible events in the United States last year and said since then global interdependence had become even clearer. The countries had become more conscious of the potential for disease and other threats to health posed by terrorists. WHO had recognized more fully the links between health and human security.

The Director-General stated that not enough had been done to tackle poverty that affected three billion people across the globe. The world's poorest communities were not sharing the benefits of globalization, as was highlighted recently at the World Summit on Sustainable Development. The evidence that investment in health had an important role in alleviating poverty was clearer than before. Increased health actions could transform the lives of poor populations. She said that the rich countries needed to take responsibility for meeting their share of this investment.

Referring to the fact that over 1.5 billion people lived in the SEA Region which comprised developing or least developed countries, she stressed that unless efforts were successful in this Region, the global goals would not be achieved. The issues on the health agenda for the Region were broad and included infant, child

and maternal morality as well as polio, HIV/AIDS, essential medicines, controlling the tobacco epidemic and unhealthy environments.

The Director-General referred to the discussions with Ministers wherein it had become clear that there was a seriousness of purpose in pursuing the health agenda. The Region had a long history of mutual cooperation and of sharing experiences which could help in seeking solutions. She assured all possible support to the countries in their efforts to take the health agenda forward.

ADDRESS BY THE MINISTER OF HEALTH, GOVERNMENT OF THE REPUBLIC OF INDONESIA

H.E. DR ACHMAD SUJUDI welcomed the representatives of the Member Countries, especially the representatives of East Timor, who were attending the Regional Committee session for the first time.

Emphasizing the importance of decentralization in the health sector, he stated that it would have a profound influence on the efficiency and equity of public health programmes. Its implementation would bring health services closer to the people. However, decentralization was a complex issue. It would take a long time and strong commitment to increase human resources at the local level to manage the process. His government was attempting to make 'decentralization' health-friendly. The process would definitely increase the accountability of government officials, he added.

Dr Sujudi emphasized that a shared purpose and common aims were essential for working together. The international community, major donors and governments had accepted the Millennium Development Goals as benchmarks to measure the progress of development. The goals were ambitious, but achievable. Innovations were essential to develop the infrastructure and health systems. Greater emphasis was needed on research focusing on the health of the poor. Since there would always be a shortage of resources to meet the planned goals and targets, it was

essential to establish stronger alliances and partnerships for achieving common goals (for full text of the address, see Annex 5).

Part III

BUSINESS SESSION

SUB-COMMITTEE ON CREDENTIALS *(Agenda Item 2, document SEA/RC55/17)*

A SUB-COMMITTEE on Credentials, consisting of representatives from Bhutan, Democratic People's Republic of Korea and India was appointed. The Sub-committee met under the chairmanship of the representative of Bhutan and examined the credentials submitted by Bangladesh, Bhutan, DPR Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand. The credentials were found to be in order, thus entitling all representatives to take part in the work of the Regional Committee.

ELECTION OF CHAIRMAN AND VICE-CHAIRMAN *(Agenda item 3)*

DR ACHMAD SUJUDI (Indonesia) was elected Chairman and Dr Sangay Thinley (Bhutan) as Vice-Chairman.

Dr Sujudi thanked the representatives for electing him Chairman, which he considered an honour for himself and his country. He was confident that with the cooperation and support of all concerned, the Committee would successfully cover the agenda in the next two days.

ADOPTION OF AGENDA AND SUPPLEMENTARY AGENDA, IF ANY *(Agenda item 4, document SEA/RC55/1 Rev 1)*

THE COMMITTEE adopted the Agenda as contained in document SEA/RC55/1 Rev 1 (Annex 1).

LIST OF PARTICIPANTS

The List of Participants is at Annex 2.

LIST OF OFFICIAL DOCUMENTS

The List of Official Documents is at Annex 3.

ADDRESS BY THE DIRECTOR-GENERAL, WHO *(Agenda item 6)*

DR GRO HARLEM BRUNDTLAND, Director-General, WHO, said that the Organization's regional structure gave it a unique place in the United Nations system. Paying rich tributes to the staff in the regional offices and in the countries, she said that it was encouraging to see that shared experience among countries had led to the development of regional solidarity and solutions. The presence of Ministers of Health was a clear reflection of this solidarity and commitment.

Recalling the Country Focus Initiative announced by her at the Fifty-fifth World Health Assembly, she said it would ensure a sharper focus on the needs of countries, supporting effective action through better standard setting and technical cooperation.

The Director-General said the draft Proposed Programme Budget 2004-2005 was on the agenda of all Regional Committees. It included Health and the Environment as an additional priority. The existing priority of health systems had been expanded to include essential medicines while children's health was proposed to be added to the priority area of Making Pregnancy Safer. For the first time, the proposals indicated the extrabudgetary resources proposed to be spent in countries and at the regional level. These proposals would strengthen WHO's presence in countries. Referring to the reallocation of the Regular budget between regions in accordance with the formula decided by the Assembly in 1998, Dr Brundtland said that SEAR was amongst the regions where the formula called for a reduction. In the first biennium, the full 3 per cent was applied but for the current biennium the reduction was limited to 2 per cent per year and she was proposing 1.5 per cent per year globally for 2004-2005. The actual reduction for the SEA Region, which had a number of least developed countries, amounted to 1 per cent per year.

Dr Brundtland welcomed the delegation from East Timor which would soon be joining the Organization. She proposed to increase

the Regular budget allocation to the SEA Region so that an appropriate country budget could be established.

The Director-General said that investment in health paid more dividends in terms of economic development, poverty reduction and environmental protection. Many of the Millennium Development Goals (MDGs) set two years ago, were concerned with health. She strongly believed that MDGs should be a key rallying point for action.

Last year, the Report of the Commission on Macroeconomics and Health was launched. WHO was now ready to work with Member States in taking this initiative forward.

The focus of World Health Report 2002 would be on risks to health. It would show the importance of widening the focus to include major risks to health, and to work within and outside the health system to reduce these risks and prevent disease. The report would also highlight chronic diseases such as diabetes, obesity, cardiovascular diseases and cancer. The accelerating death rate was fuelled by widespread tobacco use, diets rich in salt, sugar and fat, reduced physical activity and increased alcohol consumption. She said that simple changes in diet and physical activity could play a critical role in reversing the trend. In response to the resolution adopted by the World Health Assembly in May 2002, WHO was planning a broad and inclusive public consultation that would lead to a global strategy to improve diet and physical activity.

Dr Brundtland said a year ago, a sharp reduction in the price of several life-saving medicines raised the hopes of millions. It was necessary to ensure that those who needed life-saving care were not kept waiting any longer.

By setting in motion the Framework Convention on Tobacco Control (FCTC), WHO could make public health history. The FCTC negotiation process had been a catalyst for Member States to take policy decisions for strong national tobacco control. She informed the Regional Committee that the draft FCTC was ready for the next negotiating session in October. It detailed points of potential agreement on such issues as tobacco advertising, promotion,

sponsorship, illicit trade in tobacco products, taxes, and international cooperation in such areas as agriculture diversification. In this context, she highlighted the need for political commitment.

The World Report on Violence and Health would be launched in Brussels on 3 October 2002. It would be the first report of its kind to address violence as a global public health problem. The report was intended to raise awareness of violence as a public health issue and provide Member States with the tools to address its causes and consequences.

Referring to the Healthy Environments for Children Alliance, Dr Brundtland said that in 2000, over 4.7 million children had died of illnesses aggravated by unhealthy environments. Acute respiratory infection and diarrhoeal deaths were the largest components responsible for these deaths.

In conclusion, the Director-General said that WHO had a well-balanced and comprehensive approach to improving world health which reflected the Organization's corporate strategy. It was a challenging agenda, no doubt, but could be tackled with mutual cooperation (for full text of the address, see Annex 6).

* * *

Congratulating the Director-General on her thought-provoking and inspiring address, delegates lauded her dynamic leadership in placing health firmly on the international development agenda. Her bold initiatives and guidance had helped Member Countries realize impressive gains in important health areas such as the Framework Convention on Tobacco Control, Roll Back Malaria, Stop TB, Making Pregnancy Safer, Safe Motherhood, and Sustainable Development.

The importance given to restructuring and strengthening of WHO country offices to meet the changing needs of health care services was appreciated. This would help national health systems to improve their capacity and to tackle the changing pattern of emerging and new diseases in the Region.

The Committee expressed satisfaction that all Member Countries of the Region were actively involved in the FCTC process, and in implementing tobacco control measures. Member Countries were at various stages in the formulation of legislation to control tobacco use.

Noting the Director-General's initiative in promoting intersectoral coordination and integration, the Committee congratulated her for establishing the Commission on Macroeconomics and Health. It also thanked the Director-General for allocating additional resources to the Region, to accommodate the health needs of the Democratic Republic of East Timor.

Thanking the Committee for its observations, the Director-General expressed the hope that through sharing of experiences and concerns, Member Countries and WHO would move forward on global health issues.

STATEMENTS BY REPRESENTATIVES OF UN AGENCIES

MR SADIQ RASHEED (Regional Director for South Asia, United Nations Childrens Fund), in a written statement, referred to the General Assembly's Special Session on Children which had strongly reaffirmed the 1990 commitments to children. The Assembly had put forward a strong action-oriented agenda, "A World Fit for Children", that called for major improvements in child survival, health, education and protection by 2015.

The challenge now was whether the solemn promises of the Special Session could be translated into strategies and substantive investments in children. Ministers of Health and multilateral agencies like WHO and UNICEF could work together to make tangible lasting improvements in the health status of children and women.

UNICEF, WHO and the governments in South Asia should ensure that the fruits of higher economic growth were used in education and health, and that children everywhere in the Region were protected and had universal access to basic essential health services. To achieve this objective, the two agencies must re-

commit themselves to working closely with national governments to: (1) revitalize routine immunization, (2) eradicate poliomyelitis, (3) reduce the unacceptably high burden of maternal mortality, and (4) improve the nutritional status of children, women and adolescent girls.

THE WORK OF WHO IN THE SOUTH-EAST ASIA REGION: REPORT OF THE REGIONAL DIRECTOR – 1 JULY 2001 – 30 JUNE 2002

(Agenda item 5, documents SEA/RC55/2 and Cor. 1, and Inf 1, Inf 2 and Inf 3)

INTRODUCING his report for the period 1 July 2001 – 30 June 2002, the Regional Director referred to the steady progress made by the Region during the period under review. Outbreaks of diseases like cholera, dengue/dengue haemorrhagic fever, malaria and Japanese encephalitis had been controlled effectively through prompt action. There was marked improvement in the control of tuberculosis. The spread of HIV/AIDS, including cross-border spread of the infection, was being tackled in an integrated and coordinated manner. In view of the spread of multidrug-resistant malaria, WHO had established a surveillance network for drug resistance monitoring in the Mekong countries and in the South-East Asia Region. The introduction of a new oral drug recently was expected to help efforts to eliminate the spread of kala-azar. WHO had assisted Member Countries to develop national plans for the elimination of lymphatic filariasis in order to reach the target by 2020.

In regard to rabies, the focus was on improved surveillance and reporting mechanisms, advocacy and developing strategic plans of action. Increasing attention was being paid to phasing out nerve tissue vaccines and replacing them with more cost-effective tissue culture vaccines. WHO was also assisting in effective surveillance and response to hepatitis B and Japanese encephalitis, which were emerging as problems in many countries.

With a view to effectively preventing and controlling noncommunicable diseases, WHO had initiated the development of sustainable surveillance systems in all Member Countries. A regional strategy for integrated disease surveillance for both communicable and noncommunicable diseases was being developed. A number of studies covering various aspects of

hazards due to tobacco use had been initiated. These included sentinel prevalence studies on tobacco use, the implications of chewing tobacco on reproductive health etc.

In order to improve adolescent health, several activities had been implemented through health promoting schools, health jamborees and life skills education. Injury prevention had been selected as a priority area for intercountry collaboration. Prevention of blindness and deafness also was receiving increased attention. The health of the elderly was being viewed more comprehensively, with the focus on community and home-based health care. In the area of mental health, strategies for community neuropsychiatric services had been developed.

Child and adolescent health had been identified as one of the 14 priority areas for intercountry collaboration. Gender, newborn health, growth and development, nutrition and child rights were taken up as integrated activities. Progress was achieved in the implementation of the IMCI (integrated management of childhood illness) approach. Enhancing primary health care through the district health system, quality assurance in health care delivery and hospital accreditation were some of the activities in health system development that received attention. Given the importance of nursing and midwifery in health care, a multi-disciplinary advisory group was constituted to carry out in-depth country assessments.

In the area of human resources for health, the focus was on the quality of training in public health and continuing education of health workers. Guidelines were developed for accreditation of health professional training institutes and networking of public health institutes in the Region.

The issue of safe water supply and sanitation, poison control and hazardous waste disposal were addressed as priority areas. The occupational health programme helped to assess the status of environmental impact assessment capacity in the countries and supported arsenic mitigation action by developing a case definition and management protocol.

The nutrition for health and development programme focused attention on addressing concerns of micronutrient deficiencies

through vitamin A, iron and iodine supplementation. Food safety was also strengthened by promoting the implementation of the ten-point regional strategy, developed in 1988.

With the Region being prone to natural disasters, the focus of the emergency preparedness and response programme was on promoting preparedness.

In order to ensure the quality, safety and adequacy of blood, guidelines for formulating country-specific blood safety policies were finalized. WHO continued to support Member Countries in making quality essential medicines available at affordable prices to all, particularly the poor and disadvantaged.

In the area of evidence and information for policy, the focus was on promoting the use of information for evidence-based decision-making, development of an information culture and disseminating evidence-based information on health situation and trends.

Member Countries used the regional health research strategy to strengthen their health research. Support was continued in the areas of priority setting in health research and promotion of health research culture.

In view of the growing importance and need for external resources for health development in the Region, a resource mobilization strategy was developed, which provided the national authorities and the WHO country offices with the necessary tools and information to mobilize external resources. WHO continued to strengthen collaboration and coordination with other UN agencies, intergovernmental and nongovernmental organizations as well as with regional organizations.

The Regional Director's Development Fund was used to provide technical assistance to East Timor as well as for organizing workshops on subjects such as community health care, management of anthrax, prevention and control of hospital-associated infections and a community deafness survey. Emergency relief operations during the floods in DPR Korea, India and Myanmar, and the drought in Sri Lanka were also supported.

The Committee reviewed and discussed the report. The following points emerged:

The Committee was concerned at the threat posed by indiscriminate advertisement campaigns carried out by multinational companies promoting tobacco use, unhealthy foods and unhealthy lifestyles. Calling for suitable measures to curb such practices, particularly among vulnerable adolescents, the Committee suggested the organization of a Ministerial meeting including the health, education and information sectors.

The Committee noted that the health problems arising from global warming and rapid urbanization required urgent attention and baseline data. It was important to gather and share adequate surveillance data to focus interventions.

In regard to arsenic poisoning and the support required in case definition and management, the Committee noted that this subject had been discussed at the 27th session of the WHO South-East Asia Advisory Committee for Health Research. In addition, it was planned to address all aspects relating to epidemiological evidence, regional perspective and programme activities for case definition at a regional consultation scheduled to be held in November 2002. Control of arsenic poisoning had also been included as one of the 14 regional priority health issues. The Committee was also informed that a large project supported by the UN Foundation was being implemented in Bangladesh.

The Committee expressed satisfaction over the availability of a generic training module for quality assurance in primary health care and the assistance provided by WHO in this regard. It cautioned against losing the main focus of primary health care in the face of competing priorities. It urged WHO to review the present status of primary health care.

The Committee commended the technical support provided by WHO in obtaining resources from the Global Fund for AIDS, Tuberculosis and Malaria (GF). Expressing the hope that more funds could be obtained during the second round in the future, the Committee requested that the regional task force, which was

already facilitating country efforts to obtain such funds be kept active.

Noting with satisfaction the progress of collaborative activities carried out in the Member Countries, the Committee called for proper focusing of activities on a few strategic areas. It also noted that the Country Cooperation Strategy and the WHO Corporate Strategy adequately addressed this issue. In addition, the Country Focus Initiative, recently launched by the Director-General, was also expected to address this issue.

In the area of HIV/AIDS, the priority was on research to prevent mother-to-child transmission and the development of vaccines. Local production of anti-retroviral drugs at affordable prices were equally important. The Committee urged WHO to extend technical support to the countries in preventing HIV/AIDS through injected drug usage. Many countries had undertaken activities to control communicable diseases in border areas through cross-border collaboration. A more coordinated approach was required in the area of control of dengue and dengue haemorrhagic fever.

The Committee called for cost-effective drugs without side effects for kala-azar as well as human resource development for prevention of blindness.

The Committee appreciated WHO's support on rapid response to health emergencies. However, national disaster preparedness and emergency programmes needed to be further developed and strengthened.

In regard to environment and health problems caused by air pollution from indoor cooking and vehicular emissions, the Committee noted that this required a multisectoral approach and that WHO was working with the relevant agencies such as the UN Environment Programme.

Many countries of the Region were facing problems in the areas of health care financing due to the high cost of technology, increasing elderly populations and ineffecient systems. It urged WHO to assist countries to assess the cost-effectiveness of health care delivery as well as to sustain health systems development.

Noting that many countries in the Region were facing problems related to health sector reforms, the Committee urged WHO to support the countries in overcoming these problems through a coordinated regional approach by addressing issues such as cost-effectiveness and quality of health care.

In regard to multi-disease surveillance for both communicable and noncommunicable diseases, the Committee was apprised that by the end of the biennium, most countries would have integrated surveillance systems. With the availability of adequate resources, leprosy was expected to be eliminated by 2005, and filariasis by 2015. The Committee noted that considerable progress had also been achieved in polio eradication. It called for accelerated implementation of DOTS for effective control of tuberculosis.

Appreciating the successful interregional collaboration in malaria control in the Mekong basin area, the Committee urged that this collaboration also be extended to HIV/AIDS prevention and control. The Committee noted the availability of a regional strategic plan for the control of DF/DHF. Vaccine cost and their questionable quality were impediments in the control of Japanese encephalitis.

The Committee felt that in regard to human resources development, the issues relating to quality, accreditation, and relevant training programmes in management needed to be addressed.

Noting the initiatives by the countries in the areas of promoting school health, adolescent health, the Committee stressed the need to develop new strategies to combat other lifestyle-related diseases. It appreciated this year's World Health Day theme of 'Move for Health' which had triggered innovative activities like sponsored walks to create awareness and promote health. Substance abuse and prevention of alcoholism also needed continued attention.

The Committee **noted** with satisfaction the progress made during the period under review in the implementation of WHO's collaborative programmes and activities in the Region and

congratulated the Regional Director and his staff on presenting a succinct and comprehensive report highlighting the work of WHO.

ADDRESS BY THE CHAIRMAN, SEA-ACHR

PROF. N.K. GANGULY (Chairman, SEA-ACHR) presented the conclusions and recommendations of the 27th session of the South-East Asia Advisory Committee on Health Research, held in Dhaka in April 2002. He said that, among other subjects, SEA-ACHR discussed: WHO's collaborative research policy and promotion programme; the update on the national ethical review mechanism; overview of the national health research systems; health impact assessment, health research related to prevention and control of cardiovascular diseases and collaborative programmes with the global partners. It recommended (a) the establishment of an expert group to develop a strategic research framework for Member Countries to better organize, manage and disseminate existing knowledge, (b) the development by Member Countries of their national ethical guidelines in collaboration with the Regional Office; (c) the updating by the Member Countries of their national health research systems profiles, and (d) the promotion by Member Countries of health research related to arsenic poisoning. The meeting also recommended that WHO, in partnership with the regional and national networks of institutions, promote operational and community-based health research on prevention and control of cardiovascular diseases.

STATEMENTS BY INTERGOVERNMENTAL AND NONGOVERNMENTAL ORGANIZATIONS

MR CHO KAH SIN (Association of South-East Asian Nations - ASEAN) stated that his organization greatly valued its collaboration with WHO. ASEAN's regional meetings provided unparalleled opportunities to address "mainstream" health concerns over a wide range of sectors. The Association was actively engaged in setting up a regional disease surveillance network, strengthening food and drug safety and articulating common positions on a variety of issues such as FCTC. While many plans of action have been formulated, the operationalization of these plans into concrete

activities continue to be a challenge. In order to move forward with the implementation of these plans, ASEAN proposed that (a) WHO keep the ASEAN Secretariat informed of WHO activities in the Region so that activities addressing ASEAN regional priorities could be opened to all ASEAN member countries for participation (with the collaboration of SEARO and WPRO); and (b) WHO and the ASEAN secretariat explore the possible utilization of the WHO intercountry programmes and extrabudgetary resources for ASEAN regional activities.

He observed that with WHO and ASEAN attending each other's annual meetings, there would be more opportunities to exchange information and to reduce duplication. The extension of the ASEAN-WHO MoU, which had just been extended for five years (through to 2007) would provide an opportunity to undertake a systematic review of the existing cooperation.

DR T. FUJITA (Regional Representative, Office International des Epizooties (OIE)/World Organization of Animal Health) said that his organization worked towards providing animal health standards and technical expertise, besides advising on prevention and control of animal diseases, including zoonoses and aquatic animal diseases. It also coordinated research on animal disease surveillance and control, and examined regulations on international trade in animals and animal products with a view to their harmonization between Member Countries. OIE emphasized closer coordination with other relevant international organizations including WHO, FAO and the Codex Alimentarius Committee for effective implementation of its activities. As the supply and demand of animal products had increased rapidly in Asia in the past decades, public health actions related to animal health needed to be improved by a well-organized mechanism to reduce foodborne illness, and strengthened through an approach based on risk analysis, with the collaboration of national authorities and relevant international organizations. As such, he felt that WHO and OIE could work more closely for their mutual interest, thus assisting Member Countries in the Region.

MR ALAIN AUMONIER (International Federation of Pharmaceutical Manufacturers Associations - IFPMA) said that ensuring people's

access to health was a primary condition for economic development and a responsibility shared by a number of stakeholders. With regard to accessibility of essential medicines, he said that the pharmaceutical industry welcomed the creation of the GF, which represented an important step in building solidarity between developed and developing countries. In keeping with the World Health Assembly resolution that health is a responsibility shared by all stakeholders, the research-based pharmaceutical industry was already engaged in public-private partnerships In research and development (R&D) in malaria, TB, vaccines etc. IFPMA and its various national associations were extremely concerned with the development of counterfeit drugs in many markets, which was becoming a growing public health threat in many countries. Closer collaboration at the national level between public health authorities and the local pharmaceutical associations to effectively detect counterfeit products could make a real contribution to promoting the quality of care and patient safety.

MS ANGELA SMITH (International Lactation Consultant Association - ICLA) said that ICLA had taken note of the adoption of the new global strategy on infant and young child feeding by the Fifty-fifth World Health Assembly. Breast-feeding had a unique way of providing ideal food for the healthy growth and development of infants. As a global public health recommendation, infants should be exclusively breastfed for the first six months of life. The implementation of this new strategy could reduce morbidity and mortality among mothers and babies. ICLA provided practical, clinical and evidence-based technical support for the implementation of the new strategy and was ready to assist in efforts to improve the health and nutrition of infants and young children. She urged the governments to define national goals and objectives with a realistic framework for their achievement.

MR J.B. MUNRO (Inclusion International) said that his organization was an NGO of voluntary societies which advocated for and supported children and adults with intellectual disability, and their families. There was an increasing challenge posed by the post-polio syndrome which affected 25 per cent of polio survivors. However, few public health professionals were aware of this syndrome. He urged WHO to issue educational information to

health professionals about post-polio syndrome and on how to help the sufferers. He also called for improved midwifery services in remote, as well as densely populated areas as too many accidents at birth caused intellectual and long-term disability.

DR INA S. TIMAN (International Society of Haematology-International Council for Standardization in Haematology – ISH-ICHS) said that anaemia was still one of the major problems in many of the developing countries including Indonesia. Good and reliable laboratory diagnostics were essential for appropriate diagnosis of anaemia. Around 60-70 per cent of the laboratories in Indonesia still used the manual photometric method as a tool to measure haemoglobin while many primary health care units still did not have the basic equipment. WHO was urged to give more attention to standardization of haematology procedures, including haemoglobin measurement, and the need to use WHO colour scale for Hb determination for primary health care units and blood donor screening.

DR JYOTI H. TRIVEDI (The Medical Women's International Association) said that her organization was concerned with women's status, rights, education and empowerment and mainstreaming gender in health. The functioning of centrally planned and controlled management had many lacunae such as bureaucratic delays, non-availability or transport, finances etc., but most importantly, failure of community participation, both in planning and utilization. Decentralized planning would ensure accountability, responsibility and efficient and effective functioning of the health centres.

DR ACHIR YANI S. HAMID (International Council of Nurses – ICN), in a written statement, said that ICN was aware that the health sector was undergoing dramatic change and reform. It believed that an efficient and well-managed health system required broad consultations with health professional associations and other stakeholders. As the reform of the health sector was an ongoing process, nurses and other health professionals needed to be involved in managing the change. It was regretted that this nursing potential was still largely untapped in many countries because nurses were not fully involved in policy development, implementation and evaluation at all levels of health care. Nurses,

by their numbers and diversity of skills, could be the backbone to improving health system performance and health outcomes. ICN called on WHO and governments to involve associations of health professions, such as national nurses associations, and their leaders be part of national dialogue for health reform. It assured its continued commitment to partnership with WHO and to strengthening nursing's contribution for better management of health systems and better outcomes for all people.

MS DWI NASTITI ISWARAWANTI (Industry Council for Development – ICD), in a written statement, said that ICD was a non-profit organization based in the United Kingdom with an international membership of companies in the food and allied industries. Its mission was to improve public health through partnership projects aimed at meeting food safety and nutrition goals worldwide. It focused its activities on improving food safety, water quality and nutrition in developing countries by providing technical expertise for training programmes and logistical and financial support. In collaboration with RCCN, SEAMEO (Regional Centre for Community Nutrition, South-East Asian Ministers of Education Organization), ICD was currently supporting training activities in food safety throughout South-East Asia.

REVIEW OF PROPOSED PROGRAMME BUDGET 2004-2005

(Agenda items 7.1and 7.2, documents Draft PPB 2004-2005 and SEA/RC55/10)

THE COMMITTEE noted that, as had been the case in the 2002-2003 biennium, the Proposed Programme Budget 2004-2005 had been presented in two parts. Part I comprised the strategic budget for the whole Organization, building on the experiences and lessons learnt from the 2002-2003 biennium. The Committee appreciated the improvements introduced in PB 2004-2005. The principles of results-based budgeting had been taken a step further with the definition of strategic approaches and indicators at the WHO operative level for all areas of work. The Committee noted with satisfaction that the global Programme Budget now also included Health and Environment as a global priority; and that Child Health, and Essential Medicines had been added to existing priorities.

Part II of the Proposed Programme Budget 2004–2005 focused on the regional health situation, as well as lessons learnt from the previous biennium. It provided a summary of health developments in the Region, and on that basis outlined regional strategies and priority areas for action over the next biennium.

The Committee welcomed the Director-General's proposal to limit the reduction of the Regular budget for the South-East Asia Region to 1 per cent per year for the 2004–2005 biennium. It also welcomed the Regional Director's proposal to maintain the 75:25 percent allocation between country and RO/ICP funds respectively, with the ratio unchanged from 2002–2003.

The Committee noted the significant increase in extrabudgetary resources projected by the Director-General for 2004–2005. Based on criteria such as populations at risk and burden of diseases, it was felt that the Region should logically receive an increasing share of those resources. Even where national priorities did not fully coincide with those of WHO, the country offices should be supportive in resource mobilization efforts vis-à-vis other development partners.

Echoing the concerns of CCPDM, the Committee pointed out the potential conflict between programmatic priorities being set by donors and the constitutional role of WHO's governing bodies. While this problem could not be entirely eliminated, the Director-General was continuously reminding donors that extrabudgetary resources should be applied within the strategic framework of the programme budget.

It was noted that due priority had been accorded in the region-specific Part II to the prevention and control of dengue, Japanese encephalitis and kala-azar, arsenic contamination, health education, health promotion and physical activities.

The Committee was of the view that in order to tackle the double burden of diseases and to meet the challenge of increased incidence of diabetes, hypertension and mental health, substantial resources would be required.

While WHO should address the issue of bridging the gaps in technologies, there had been difficulty in introducing existing

technologies. Appropriate ways and means to utilize existing and emerging technologies should therefore be given due attention.

The Committee urged the Member Countries to carefully prepare for the in-depth evaluation of resolution WHA51.31 governing regional allocations, to be reported to the World Health Assembly in 2004, with a view to protecting the SEA Region's share of the global WHO budget.

Member Countries were urged to implement the collaborative programmes efficiently in order to reduce as much as possible the surrender of funds. This would strengthen the case for increased regional allocations.

The Committee reviewed and endorsed the observations, conclusions and recommendations relating to the Proposed Programme Budget 2004-2005, as contained in the report of the CCPDM (document SEA/PDM/ Meet.39/13).

A resolution on the subject was adopted (SEA/RC55/R2).

REVIEW OF THE INTERCOUNTRY PROGRAMME *(Agenda item 8.1, document SEA/RC55/14 and Cor.1)* and SELECTION OF AN INTERCOUNTRY PROGRAMME OR CONTENT AREA FOR EVALUATION AND REPORTING TO THE FIFTY-SIXTH SESSION OF THE REGIONAL COMMITTEE IN 2003 *(Agenda item 8.2, document SEA/RC55/11)*

THE COMMITTEE was informed that in accordance with the recommendation of the High Level Task Force for Intercountry Collaboration (HLTF), the supplementary intercountry programme had been evaluated by joint teams comprising country representatives and staff from the WHO country and Regional Offices. The teams visited Indonesia, Sri Lanka and Thailand and met concerned officials involved in programme implementation. The teams identified lessons learnt and made recommendations on (a) the need for thorough briefing of national officials and WHO staff on the purpose and objectives of the intercountry programme; (b) the involvement of national officials at the technical and operational levels in the formal high-level task force mechanism

for the development of products and activities, and (c) the adequacy and complementarity of the intercountry programme.

The Committee urged WHO to address the weaknesses in the HLTF mechanism, as noted in the joint evaluation, while formulating the intercountry programme for 2004–2005. In this context, the Committee was informed that the HLTF would comprise members from both policy and operational levels. The first meeting would deal with policy aspects and the outcomes while the second would finalize details of the work plans such as products and activities.

The Committee felt that Member Countries should continue to be involved in future evaluations in order to enhance their capacity. It noted the suggestion that intergovernmental organizations such as ASEAN and SAARC could be involved in the evaluation of the supplementary intercountry programme (ICP–II) within the WHO evaluation framework and Memorandum of Understanding with the respective organizations.

The Committee recognized the importance of other ICP–II programme areas such as control of kala azar, promotion of community–based mental health programmes and child and adolescent health, including IMCI. It noted the excessive reliance on regional workshops and meetings in the implementation of the intercountry programme and urged WHO to identify other suitable mechanisms to help achieve programme objectives.

The Committee noted with appreciation the work of the joint evaluation teams and endorsed their findings and recommendations. It also endorsed the recommendations of the 39th meeting of the CCPDM on the "Selection of an intercountry programme or content area for evaluation and reporting to the 56th session of the Regional Committee in 2003" (document SEA/PDM/Meet.39/13) and selected for evaluation and reporting to the 56th session of the Regional Committee the intercountry programme "Multi–disease surveillance and response, including health hazards, risk behaviour surveillance, through intercountry and interregional collaboration and use of regional mechanisms like ASEAN, SAARC, Mekong Basin Project, and Intercountry Cooperation in Health Development".

CONSIDERATION OF THE RECOMMENDATIONS ARISING OUT OF THE TECHNICAL DISCUSSIONS ON MANAGEMENT OF DECENTRALIZATION OF HEALTH CARE *(Agenda item 9.1, document SEA/RC55/16)*

THE COMMITTEE was informed that Technical Discussions were held on "Management of decentralization of health care" during the 39th meeting of the CCPDM.

DR DEDDY RUSWENDI (Indonesia) Rapporteur, presented the recommendations arising out of the Technical Discussions, as contained in document SEA/RC55/16. He said that every country was practising some form of decentralization and had different experiences, successes and constraints in the process. The question was not whether or not to decentralize health care services, but how to design and implement the process in keeping with the prevailing country situation.

Decentralization in different forms was not a new political, administrative or managerial process and was being practised in all sectors. It was an ongoing process, extending to all sectors of the government. Communities at the local level should be actively involved in planning, implementation and monitoring. Advocacy to increase awareness among people of their rights in demanding quality health care services should be a priority. Partnerships with nongovernmental organizations and civil society should be promoted. Human resource development was a critical issue for the success of decentralization and should be matched with resource allocation and managerial capacity. Appropriate financial and administrative mechanisms should be in place before decentralization was undertaken.

In implementing decentralization, WHO's assistance was sought for providing evidence-based information and technical support in coordination with other partners. WHO's support was also sought in facilitating and promoting coordination among research institutions in Member Countries through WHO collaborating centres.

The Committee noted that decentralization should be done in the overall socio-political context prevailing in the respective

countries. An in-depth analysis of the existing system should be undertaken to identify successes, problems and constraints to further improve and strengthen the decentralization process. The Committee sought WHO's assistance in this regard.

The Committee felt that the interests of the poor and other vulnerable sections of the community needed to be taken into account in the process of decentralization. It was important to ensure that the role of the government in health care delivery was not undermined in implementing decentralization.

The Committee took note of the various efforts made by the Regional Office and the study carried by WHO headquarters to have evidence-based information in supporting country-led initiatives. To take the process forward, an intercountry consultation would be organized to share country experiences as well as to formulate necessary guidelines. The subject would also be included as an agenda item at the meeting of the Health Ministers. The Regional Office would give an update in this regard to the Regional Committee.

A resolution on the subject was adopted (SEA/RC55/R3).

SELECTION OF A SUBJECT FOR THE TECHNICAL DISCUSSIONS TO BE HELD PRIOR TO THE FIFTY-SIXTH SESSION OF THE REGIONAL COMMITTEE *(Agenda item 9.2, document SEA/RC55/9)*

RECOGNIZING the significance of high proportion of out-of-pocket expenditure and scarce availability of public funding for health care, the Committee selected the topic of "Social Health Insurance" and **decided** to hold Technical Discussions on the subject in conjunction with the 40th meeting of the CCPDM (SEA/RC55/(1)). It urged the Member States to participate fully in the Technical Discussions and requested the Regional Director to take steps for the preparation and conduct of the Discussions.

REGIONAL MECHANISM FOR BULK PURCHASE OF SELECTED QUALITY ESSENTIAL DRUGS *(Agenda item 10.1, document SEA/RC55/12)*

THE COMMITTEE noted that the subject of regional mechanism of bulk purchase of selected quality essential drugs was extensively discussed and deliberated at the 39th meeting of the CCPDM, as well as at the 20th meeting of the Health Ministers, held prior to the current session of the Regional Committee, and endorsed the recommendations arising out of the above meetings for appropriate action by Member Countries and by WHO.

A resolution on the subject was adopted (SEA/RC55/R4).

PREVENTION AND CONTROL OF DENGUE, JAPANESE ENCEPHALITIS AND KALA-AZAR *(Agenda item 10.2, document SEA/RC55/7)*

THE COMMITTEE observed that some environmental issues, including solid waste management, were critical to the prevention and control of vector-borne diseases and called for appropriate awareness and education campaigns at the community level to tackle them. Noting that the availability of good laboratory facilities for diagnosis and proper clinical management were essential for the prevention and control of communicable diseases, the Committee stressed that efforts be focused on promoting further research, especially on behavioural aspects as well as vaccine development. In this regard, networking of national centres of excellence in the Region as well as designating some of these as WHO collaborating centres would prove helpful. The importance of multisectoral partnerships in prevention activities was also emphasized.

Noting that rapid urbanization often led to vector breeding, the Committee suggested that Member Countries formulate necessary legislative measures. In view of the restrictions on the use of DDT spraying as well as the prohibitive cost of drugs for kala-azar, the Committee called for appropriate strategies for controlling the disease.

With regard to Japanese encephalitis, even though some recombinant vaccines were now available, awareness and education programmes still formed the mainstay of prevention and control activities. The Committee, therefore, called for increased WHO

support to intensify vaccine development and production. The need to provide teaching and training materials for trainers and health personnel at the community level was also highlighted.

The Committee suggested that appropriate action be taken to ensure timely availability of WHO guidelines for DHF management so that these could be appropriately disseminated to facilitate preventive action.

The Committee was informed that WHO was promoting the networking of public health and veterinary public health offices towards the strengthening of national rabies control programmes, as well as in the formulation of a 5-year plan for rabies control and immunization, in collaboration with other regions of WHO. An interministerial conference on rabies control was also proposed to be organized in 2003.

The Committee was apprised that WHO was promoting the concept of healthy public policy in the prevention and control of dengue, dengue haemhorrhagic fever, Japanese encephalitis and rabies, and that relevant advocacy materials would soon be finalized and distributed to the Member Countries.

DELIBERATE USE OF BIOLOGICAL AND CHEMICAL AGENTS TO CAUSE HARM *(Agenda item 10.3, document SEA/RC55/6)*

THE COMMITTEE'S attention was drawn to the increasing threat of the deliberate use of biological and chemical agents, and radionuclear (BCR) material. The public health implications of BCR material as a result of natural occurrence and accidents could not be underestimated. Anthrax was recognized as an important potential biological weapon that could cause significant panic. Though appropriate public health tools for epidemiological investigation and laboratory diagnosis of anthrax were available, there was a need to enhance national capability for their effective use.

The Committee appreciated the work of the Regional Working Group on Emergency Response to address the issue and be fully

prepared to respond swiftly to requests for assistance, including training, provision of literature and evaluation of diagnostic tools.

The Committee expressed concern that stocks of smallpox virus in some laboratories were being maintained. Considering the potential danger arising from this situation, WHO needed to provide Member Countries with guidelines on the storage and use of smallpox vaccines.

The Committee noted with satisfaction that a workshop was conducted in Thailand last year which produced guidelines on anthrax control. The need to share expertise to deal with the problem of anthrax was highlighted. The Committee was informed that WHO was planning to conduct a workshop on the subject at the end of 2002.

WHO STRATEGY FOR TRADITIONAL MEDICINE 2002-2005

(Agenda item 10.4, document SEA/RC55/13)

THE COMMITTEE noted that traditional medicine, which was well established and widespread in the Region, was a resource that could be integrated into the national health care system. It acknowledged that the WHO Traditional Medicine Strategy 2002-2005 provided, for the first time, a "road map" for the countries in organizing, developing and incorporating traditional medicine into their national health care systems. A policy on traditional medicine on which to base legislation, regulation and other activities was essential. A few countries had drafted policies providing a clear identification of priorities while others were still at the initial stage.

The Committee appreciated the working paper containing the summary of the WHO strategy for traditional medicines in the regional context.

The Committee was informed that there was a vast potential for commercialization of herbal medicines. WHO, therefore, should support Member Countries in protecting their interests. Knowledge and information in this regard should be shared among countries. The Committee also noted the problems relating to patenting, high prevalence of spurious medicines, unskilled traditional medicine practitioners, unregulated sale of products without quality control

mechanisms and lack of standardization. The Committee highlighted the need for regional collaboration in this area and appreciated WHO's efforts and looked forward to continued support. It noted the efforts of the Regional Office to designate additional collaborating centres in this area.

REGIONAL IMPLICATIONS OF THE DECISIONS AND RESOLUTIONS OF THE FIFTY-FIFTH WORLD HEALTH ASSEMBLY AND THE 109TH AND 110TH SESSIONS OF THE EXECUTIVE BOARD AND REVIEW OF THE DRAFT PROVISIONAL AGENDA OF THE 111TH SESSION OF THE EXECUTIVE BOARD *(Agenda item 11, document SEA/RC55/8 and Add.1)*

THE COMMITTEE, while endorsing the recommendations of the 39th meeting of the CCPDM, requested that appropriate follow-up actions be taken as contained in the working paper.

The Committee reviewed the draft provisional agenda of the 111th session of the Executive Board and endorsed the observations of the 39th meeting of the CCPDM. The Committee noted the provisional agenda of the 111th session of the Executive Board.

UNDP/WORLD BANK/WHO SPECIAL PROGRAMME FOR RESEARCH AND TRAINING IN TROPICAL DISEASES: JOINT COORDINATING BOARD (JCB) - REPORT ON ATTENDANCE AT 2002 JCB

(Agenda item 12.1, document SEA/RC55/3)

THE COMMITTEE was informed that the representatives of Bangladesh, India and Thailand attended the deliberations of the 25th session of JCB, held on 24-25 June 2002, and reported to the 39th meeting of the CCPDM.

The Committee **noted** the observations and recommendations of the 39th meeting of the CCPDM on this subject.

WHO SPECIAL PROGRAMME FOR RESEARCH, DEVELOPMENT AND RESEARCH TRAINING IN HUMAN REPRODUCTION: POLICY AND COORDINATION COMMITTEE (PCC): REPORT ON ATTENDANCE AT 2002 PCC AND NOMINATION OF A MEMBER IN PLACE OF

BANGLADESH WHOSE TERM EXPIRES ON 31 DECEMBER 2002 *(Agenda item 12.2, SEA/RC55/4)*

THE COMMITTEE was informed that the representatives from Bangladesh, India and Indonesia attended the deliberations of the 15th meeting of PCC, held on 26-27 June 2002, and reported to the 39th meeting of the CCPDM.

The Committee **noted** the observations and recommendations of the 39th meeting of the CCPDM on this subject.

The Committee **nominated** Thailand as a member of PCC (category 2) for a period of three years with effect from 1 January 2003 and requested the Regional Director to inform WHO headquarters accordingly (SEA/RC55/(2)).

TIME AND PLACE OF FORTHCOMING SESSIONS OF THE REGIONAL COMMITTEE *(Agenda item 13, document SEA/RC55/5)*

THE COMMITTEE **confirmed** its earlier decision to hold the fifty-sixth session of the Regional Committee in 2003 at the WHO Regional Office for South-East Asia in New Delhi, India (SEA/RC55/(3)). The Committee noted the invitation of the Government of India to host the meeting of the Health Ministers in conjunction with the Regional Committee.

The Committee **accepted** the confirmation by the Government of the Republic of Maldives to host the fifty-seventh session in 2004, in conjunction with the meeting of the Health Ministers. The exact venue and dates of the session would be decided at the next session.

The Committee also **noted** the invitations of the Governments of Bangladesh, Bhutan and Nepal to host the fifty-eighth session of the Regional Committee in 2005. The final decision in this regard would be taken at its next session.

ADOPTION OF RESOLUTIONS

THE COMMITTEE adopted the following resolutions:

1. Resolution of Thanks
2. Proposed Programme Budget 2004-2005
3. Management of Decentralization of Health Care

4. Accessibility to Essential Medicines

ADOPTION OF THE REPORT OF THE FIFTY-FIFTH SESSION OF THE WHO REGIONAL COMMITTEE FOR SOUTH-EAST ASIA

(Agenda item 14, document SEA/RC55/18)

THE COMMITTEE adopted the draft report of the fifty-fifth session, as contained in document SEA/RC55/18, with certain modifications.

CLOSURE OF THE SESSION *(Agenda item 15)*

THE REPRESENTATIVES from the Member Countries congratulated the Chairman and the Vice-Chairman for their smooth conduct of the session. They expressed their appreciation to the National Organizing Committee for the excellent arrangements made not only for the Regional Committee session but also for the 39th meeting of the CCPDM and the 20th Meeting of Ministers of Health. The representatives expressed their gratitude to the Government of Indonesia for its warm hospitality and kindness and thanked H.E. Dr Achmad Sujudi, Minister of Health, for inaugurating the session and his thought-provoking speech. They also expressed their appreciation to the Director-General of WHO, Dr Gro Harlem Brundtland, for attending the session and for her inspiring address and dynamic leadership in placing health firmly on the international development agenda. The representatives said that the current session of the Committee was made unique by the presence of Health Ministers from the Member Countries, which also enriched the discussions at the meeting. The session provided an excellent opportunity for renewing the friendship between Member Countries and further strengthening the collaboration between them, which was demonstrated by the consensus reached on all issues debated. They expressed their appreciation to the WHO Secretariat, including the staff from WHO headquarters, the Regional Office and the country office in Indonesia, for their excellent support. It was suggested that in order to have more meaningful and detailed discussions at the Regional Committee meetings, its duration be appropriately extended and the agendas of the Regional Committee, the CCPDM, and the Health Ministers Meeting suitably formulated so as to avoid overlap.

The Regional Director, in his closing remarks, thanked the Ministers of Health for their cooperation and guidance in various health development matters, which would help improve the health status of the people in the SEA Region. He said that the valuable suggestions made by the representatives during the session would guide WHO in strengthening the collaborative activities in the Region. The cohesiveness and shared vision would enable Member Countries and WHO to work harmoniously towards meeting the many challenges that faced them in health development. Dr Uton also thanked the officials of the Ministry of Health and members of the National Organizing Committee for their untiring efforts, and the management of Gran Melia Hotel for their hospitality and excellent arrangements which brought the session to a successful conclusion.

The Chairman thanked the representatives for their active participation, constant support and consideration, which made his task easier. He wished to place on record his deep appreciation for the Director-General of WHO for her stimulating and thought-provoking address, which would effectively guide the work of the Organization and its collaboration with Member States. The current session of the Regional Committee had discussed various issues relating to health development in the Region and adopted important resolutions. The valuable suggestions made by the Committee would guide the Member States and WHO in their joint endeavours to achieve the best possible level of health for the people of the Region. He thanked Dr Uton and his dedicated staff for their hard and untiring work to make the session successful. He also thanked the representative from Maldives for confirming the invitation of his government to host the fifty-seventh session of the Regional Committee in Maldives in 2004. In conclusion, he expressed the hope that the representatives would be returning to their countries with greater determination to improve the health of their people.

The Chairman then declared the session closed.

Part IV

RESOLUTIONS

SEA/RC55/R1 RESOLUTION OF THANKS

The Regional Committee,

Having brought its fifty-fifth session to a successful conclusion,

1. CONVEYS its gratitude to the Government of the Republic of Indonesia for hosting the session and thanks the members of the National Organizing Committee, the staff of the Ministries of Health and Foreign Affairs and other national authorities for making the session a success;

2. THANKS H.E. Dr Achmad Sujudi, Minister for Health, Government of the Republic of Indonesia, for inaugurating the session and for his thought-provoking speech;

3. THANKS the WHO Director-General, Dr Gro Harlem Brundtland, for her inspiring address and for her dynamic leadership in placing health firmly on the international development agenda, and

4. CONGRATULATES the Regional Director and his staff on their dedicated efforts towards the successful and smooth conduct of the session.

Fifth Meeting, 13 September 2002

SEA/RC55/R2 PROPOSED PROGRAMME BUDGET 2004-2005

The Regional Committee,

Having considered the draft Proposed Programme Budget 2004-2005, Part I (document Draft PPB 2004-2005) providing the

strategic framework for the Organization for the next biennium, and the Region-specific Part II thereof (document SEA/RC55/10),

Noting with appreciation the Director-General's proposal to limit to 1 per cent per annum the reduction in the Regular Budget for 2004-2005 imposed on the South-East Asia Region through resolution WHA51.31,

Welcoming the continuous focus on results-based budgeting in WHO which facilitates transparency and accountability of the Secretariat vis-a-vis Member States,

Welcoming further the Director-General's proposals to strengthen WHO's country programmes, reflected in the draft Proposed Programme Budget 2004-2005, providing indicative estimates of extrabudgetary resources at this level for all areas of work, and

Noting the report of the 39th Meeting of the Consultative Committee for Programme Development and Management (CCPDM) on the subject (document SEA/PDM/Meet.39/13),

1. ENDORSES the recommendations of the 39th meeting of the CCPDM,

2. URGES Member States:

   (a) to ensure efficient and timely implementation of programmes to avoid surrendering unspent Regular Budget funds, and

   (b) to actively consult between themselves and with countries in other regions similarly affected with a view to formulating a common position in the forthcoming in-depth evaluation of resolution WHA51.31, to be reported to the Fifty-seventh World Health Assembly in 2004;

3. THANKS the Director-General for her intention to propose an appropriate budget for the Democratic Republic of East Timor for 2004-2005, without impacting the allocation of other countries in the Region, and

4. REQUESTS the Regional Director to convey to the Director-General the need for increases in extrabudgetary resources for the South-East Asia Region in 2004-2005, in view of the Region's high burden of disease and to take this need into consideration when finalizing the programme budget for submission to the World Health Assembly.

Fifth Meeting, 13 September 2002

SEA/RC55/R3 MANAGEMENT OF DECENTRALIZATION OF HEALTH CARE

The Regional Committee,

Recalling its own resolutions SEA/RC41/R8 and SEA/RC53/R3 on the development of district health systems and equity in health and access to health care,

Recognizing the need to have effective management of decenralization of health care within the context of national health sector reforms and ensuring equity in access to health care, and

Having considered the report and recommendations of the Technical Discussions on "Management of decentralization of health care" (SEA/RC55/16),

1. ENDORSES the recommendations contained in the report;

2. URGES Member States to ensure equity in access and efficiency of quality health care while implementing national policies, strategies and plans for decentralization of health care and strengthening their district health systems, and

3. REQUESTS the Regional Director to share evidence-based information and country experiences on the process and products of management of decentralization of health care.

Fifth Meeting, 13 September 2002

SEA/RC55/R4 ACCESSIBILITY TO ESSENTIAL MEDICINES

The Regional Committee,

Recalling World Health Assembly resolutions WHA54.11 and WHA55.14 as well as its own resolutions SEA/RC2/R27 and SEA/RC21/R6 on ensuring accessibility to quality essential medicines in the Region,

Recognizing that accessibility to essential medicines for all citizens in the Region requires national commitment for specific regulations and actions designed to promote a policy for, and access to, quality essential medicines as well as their rational use within national health systems, and

Considering possible ways to strengthen regional, country, and intercountry mechanisms to ensure increasing accessibility to quality essential medicines, including bulk purchase schemes,

1. URGES Member States:

   (a) to strengthen national mechanisms for the use of essential medicines lists in health care and to consider prequalification in drug procurement systems as a means of ensuring quality;

   (b) to strengthen Drug Regulatory Authorities in their efforts to ensure safe and effective quality medicines, and

   (c) to promote the regional bulk purchase scheme for selected quality essential medicines, and

2. REQUESTS the Regional Director to provide technical assistance to Member Countries to strengthen their Drug Regulatory Authorities and to further facilitate the development of the regional bulk purchase scheme for selected quality essential medicines.

Fifth Meeting, 13 September 2002

Annexes

Annex 1

AGENDA[1]

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	SEA/RC55/17
3.	Election of Chairman and Vice-Chairman	–
4.	Adoption of Agenda and Supplementary Agenda, if any	SEA/RC55/1 Rev.1
5.	The Work of WHO in the South-East Asia Region: Report of the Regional Director – 1 July 2001 – 30 June 2002	SEA/RC55/2 & Cor.1 and Inf.1, Inf.2 & Inf.3
6.	Address by the Director-General, WHO	–
7.	Programme Budget:	
	7.1 Review of Proposed Programme Budget 2004-2005	Draft PPB 2004-2005
	7.2 Review of region-specific (Part-II) Proposed Programme Budget 2004-2005	SEA/RC55/10
8.	Programme Evaluation:	
	8.1 Review of the Intercountry Programme	SEA/RC55/14 & Cor.1
	8.2 Selection of an intercountry programme or content area for evaluation and reporting to the 56th session of the Regional Committee in 2003	SEA/RC55/11

[1] Originally issued as document SEA/RC55/1 Rev.1 dated 28 August 2002

9.	Technical Discussions:	
	9.1 Consideration of the recommendations arising out of the Technical Discussions on "Management of Decentralization of Health Care"	SEA/RC55/16
	9.2 Selection of a subject for the Technical Discussions to be held prior to the 56th session of the Regional Committee	SEA/RC55/9
10.	Technical Updates:	
	10.1 Regional mechanism for bulk purchase of selected quality essential drugs	SEA/RC55/12
	10.2 Prevention and control of dengue, Japanese encephalitis and kala-azar	SEA/RC55/7
	10.3 Deliberate use of biological and chemical agents to cause harm	SEA/RC55/6
	10.4 WHO strategy for traditional medicine – 2002-2005	SEA/RC55/13
11.	Regional implications of the decisions and resolutions of the Fifty-fifth World Health Assembly and the 109th and 110th sessions of the Executive Board *and* review of the Draft Provisional Agenda of the 111th session of the Executive Board	SEA/RC55/8 & Add.1
12.	Special Programmes*:*	
	12.1 UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases: Joint Coordinating Board (JCB) – Report on attendance at 2002 JCB	SEA/RC55/3
	12.2 WHO Special Programme for Research, Development and Research Training in Human Reproduction: Policy and Coordination Committee (PCC) – Report on attendance at 2002 PCC and nomination of a member in place of Bangladesh whose term expires on 31 December 2002	SEA/RC55/4

13.	Time and place of forthcoming sessions of the Regional Committee	SEA/RC55/5
14.	Adoption of the report of the fifty-fifth session of the Regional Committee	SEA/RC55/18
15.	Closure of the Session	-

Annex 2

LIST OF PARTICIPANTS[1]

1. Representatives, Alternates and Advisers

Bangladesh

Representative

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[1] Originally issued as document SEA/RC55/15 dated 10 September 2002

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Prof Dr Umar Fahmi
Director-General of
Communicable Disease Control and Environmental Health
Ministry of Health
Jakarta

Drs Holid Djahari MM
Director-General of
Pharmaceutical Services
Ministry of Health
Jakarta

Prof Dr HM Achmad Djojosugito MHA
Director-General of Medical Services
Ministry of Health
Jakarta

Dr I Gusti Agung Wesaka Puja
Director of Human Rights, Social and Cultural
Ministry of Foreign Affairs
Jakarta

Dr Irhamsyah Ratu Bagus
SKM Head of HRH Development Board
Jakarta

Dr Sri Astuti S. Suparmanto Msc
Head
National Institute of Health Research and Development
Jakarta

	Drs Sampurno MBA Head National Agency for Drug and Food Control Jakarta
	Dr Setiawan Soeparan MPH Chief Bureau of Planning and Budgeting Ministry of Health Jakarta
	Mr M Primanto Hendrasmore Official Ministry of Foreign Affairs Jakarta
	Mr Bonanza P. Taihitu Official Ministry of Foreign Affairs Jakarta
Observers	Dr Anhari Achadi Senior Adviser to the Minister of Health Services Jakarta
	Drs Richard Panjaitan SKM Senior Adviser to the Minister of Pharmaceuticals Jakarta
	Dr Nyoman Kandun MPH Senior Adviser to the Minister of Environment and Epidemiology Jakarta
	Dr Dini K.S. Latief Msc Senior Adviser to the Minister of Institutions Capacity and Decentralization Jakarta
	Dr Muharso Senior Adviser to the Minister of Health Financing Jakarta

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Dr Syafii Achmad
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Annex 3

LIST OF OFFICIAL DOCUMENTS[1]

SEA/RC55/1 Rev.1 and Add.1 Rev.1	Provisional Agenda and Annotated Provisional Agenda
SEA/RC55/2	The Work of WHO in the South-East Asia Region: Report of the Regional Director, 1 July 2001 – 30 June 2002
SEA/RC55/3	UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases: Joint Coordinating Board (JCB) – Report on attendance at 2002 JCB
SEA/RC55/4	WHO Special Programme for Research, Development and Research Training in Human Reproduction: Policy and Coordination Committee (PCC) – Report on attendance at 2002 PCC and nomination of a member in place of Bangladesh whose term expires on 31 December 2002
SEA/RC55/5	Time and place of forthcoming sessions of the Regional Committee
SEA/RC55/6	Deliberate use of biological and chemical agents to cause harm
SEA/RC55/7	Prevention and control of dengue, Japanese encephalitis and kala-azar in the SEA Region
SEA/RC55/8 and Add.1	Regional implications of the decisions and resolutions of the Fifty-fifth World Health Assembly and the 109th and 110th sessions of the Executive Board, *and* Review of the draft provisional agenda of the 111th session of the Executive Board
SEA/RC55/9	Selection of a subject for the Technical Discussions to be held prior to the Fifty-sixth session of the Regional Committee

[1] Originally issued as document SEA/RC55/20 dated 23 September 2002

SEA/RC55/10	Review of Region-specific (Part II) Proposed Programme Budget 2004-2005
SEA/RC55/11	Selection of an intercountry programme or content area for evaluation and reporting to the fifty-sixth session of the Regional Committee in 2003
SEA/RC55/12 and Cor.1	Regional mechanism for bulk purchase of selected quality essential drugs
SEA/RC55/13	WHO strategy for traditional medicine 2002-2005
SEA/RC55/14 and Cor.1	Review of the Intercountry Programme
SEA/RC55/15	List of participants
SEA/RC55/16	Consideration of the recommendations arising out of the Technical Discussions on "Management of Decentralization of Health Care"
SEA/RC55/17	Report of the Sub-committee on credentials
SEA/RC55/18	Draft report of the fifty-fifth session of the WHO Regional Committee for South-East Asia
SEA/RC55/19	Decisions and list of resolutions
SEA/RC55/20	List of official documents
SEA/RC55/21	Report of the fifty-fifth session of the WHO Regional Committee for South-East Asia

Information Documents

SEA/RC55/Inf.1	List of technical reports and advocacy material issued and meetings and courses organized during 1 July 2001 – 30 June 2002
SEA/RC55/Inf.2	List of plans of action in operation during 2002-2003 (Regular Budget)
SEA/RC55/Inf.3	Rabies in the South-East Asia Region

Resolutions

SEA/RC55/R1	Resolution of Thanks
SEA/RC55/R2	Proposed Programme Budget 2004-2005
SEA/RC55/R3	Management of Decentralization of Health Care\
SEA/RC55/R4	Accessibility To Essential Medicines

Annex 4

TEXT OF ADDRESS BY THE REGIONAL DIRECTOR

It is with great pleasure that I welcome you all to the 55th session of the WHO Regional Committee for South-East Asia. I am particularly happy to be in this august gathering as Indonesia is the country I know best. Your Excellency, Dr Achmad Sujudi, Minister for Health, we wish to convey our heartfelt thanks to the Government of Indonesia for hosting this meeting in Jakarta. I would also like to express my deep appreciation to the WHO Director-General, Dr Gro Harlem Brundtland, who has travelled half way across the world to attend this session.

This session of the WHO Regional Committee is truly special as the Health Ministers from our Region are also present here with us. At the last meeting of Health Ministers, the Honourable Ministers decided to hold their future meetings, back to back with the Regional Committee. Excellencies, your presence adds to the stature of the Regional Committee. It also reflects your Excellencies' strong commitment to health development in the Region.

It is in this spirit that we would like to welcome, in particular, the representatives from the Democratic Republic of East Timor, who are attending this session as observers. WHO has extended its full support to the newly independent nation of East Timor, in setting up and strengthening their health systems. We assure them of our continued support.

Cooperation and solidarity, equity and justice, efficiency and effectiveness – all vital elements of health development – have long been promoted by the health leaders of Indonesia. These elements are duly enshrined in the principles of Panca Shila, first enunciated in Bandung, in 1955. Under the dynamic leadership of Her Excellency President Megawati Sukarnoputri, Indonesia is making significant progress in health development. A series of

strategic policy directions and reform actions are taking place to provide a smooth transition for decentralization, especially in health systems development. We, in WHO, pledge our continued support to Indonesia in its march towards better health for all its people.

The South-East Asia Region faces some of the most formidable health challenges known to humankind. Our countries still have high maternal and child mortality rates and the largest burden of communicable diseases. In addition, there is a growing incidence of noncommunicable diseases. Thus, we face the daunting challenges posed by this double burden. What we need to do is to considerably increase our efforts to effectively tackle these problems. We possess the knowledge, technology and the means, to help lift this burden. We must use these resources to set our people free from the vicious cycle of poverty and disease.

In the past year, since we met at Yangon, there have been some significant developments in health in the Region. We have seen commendable progress in eradicating poliomyelitis and eliminating lymphatic filariasis. We are also close to eliminating leprosy. Much has been done in controlling tuberculosis, using the DOTS strategy. High priority is being accorded to combat HIV/AIDS as well as malaria, which has re-emerged in some areas.

Member Countries are still experiencing frequent outbreaks of dengue/dengue haemorrhagic fever. However, with concerted efforts, the case-fatality rate has been dramatically reduced to less than 1 per cent.

Though the gains are significant, much more remains to be accomplished if we are to bring health and prosperity to a fourth of the global population inhabiting our Region. We need to focus more sharply on the marginalized, those without access to essential health care, particularly women and children.

Keeping these factors in mind, WHO is according priority to the needs of Member Countries. WHO's Corporate Strategy and the Country Cooperation Strategy are now well integrated into WHO's work. These form the cornerstone of our collaborative activities.

This collaboration recently led to the approval of several proposals by the Global Fund to fight AIDS, TB and Malaria. Sizeable resources were thereby mobilized to fight these diseases. However, we need more resources for health development, as recommended by the Commission on Macroeconomics and Health in its report.

Another noteworthy development has been the increasing availability of extrabudgetary resources for the Region. These amounted to 114 million US dollars during the biennium 2000–2001. We expect a similar level of extrabudgetary resources during the current and the next biennia. This is particularly gratifying since our Region does not have any donor countries.

International NGOs and bilateral and multilateral financial agencies are pledging more resources to our Region. The Nippon Foundation recently pledged sustained support for the elimination of leprosy from the Region. This is a welcome development because our Region accounts for 75 per cent of the global burden of leprosy.

The fact that donors are now willing to invest in the South-East Asia Region reflects their confidence that resources are spent effectively and efficiently.

What we need to do and what we must do is to ensure that health is not seen as a miracle but as a fundamental human right. Only then can we truly claim our place as keepers of the people's health. I know this is difficult but, Your Excellencies, with your continued commitment, it is certainly possible.

I am sure this session of the Regional Committee, already a pace-setter in many ways, will help to accelerate the momentum to achieve our cherished goal of health for all.

Annex 5

TEXT OF ADDRESS BY H.E. DR ACHMAD SUJUDI, MINISTER OF HEALTH, GOVERNMENT OF THE REPUBLIC OF INDONESIA

Welcome to all the delegates of the 55th Regional Committee Meeting.

I would like to express my sincere gratitude and appreciation to you all for coming to Jakarta and making a contribution to this 55th meeting.

While there are a number of topics on the agenda during the next few days, one of the most important topics that cross many technical programmes is decentralization.

Indonesia, like many other countries in the Region, is undergoing a process of decentralization. The administrative and fiscal functions of the central government are being transferred to provincial and district governments.

Decentralization will have a profound impact. It will influence, among other things, governance, efficiency and equity, and the public health programmes. But it is also an opportunity for revitalizing the health sector.

Within each of our countries, the populations are very diverse. We have learned that no one method of implementation will be appropriate everywhere. By giving resources directly to local communities, they can adapt services to their own needs and cultures. Decentralization can bring health services closer to the people.

As many of us know, however, decentralization is a very complex process. It will take many years and a strong commitment

to increase the human resources at local levels to manage the process.

It will also require a stronger central level to accept the new roles and responsibilities and to manage these changes.

At the central government, we are still struggling to change our role from "rowing the boat to steering it;" from directly implementing projects to establishing ourselves as leaders in influencing policies and making decentralization "health-friendly."

Forging a real change is never easy. You have to confront established ways *of* thinking and working. But I am convinced that change is essential for our shared purpose.

There will also be a good amount of trial and error. But we can learn from our mistakes.

An important lesson that we have learned in Indonesia is the value of partnerships. We have worked with many international and non-governmental organizations that support decentralization and good governance. Under the right circumstances - where government actions are transparent and civil society is permitted to operate freely - decentralization will increase the accountability of government officials. An active and involved civil society is a healthy society.

Having a shared purpose and common aims is essential to working together.

The Millennium Development Goals, for example, have been accepted by the international community, major donors, and governments as benchmarks to measure development progress.

Three of the Millennium Development Goals focus on health, emphasizing the importance of health interventions in poverty alleviation and economic development.

These Goals are ambitious but they are also achievable.

They are achievable because they comprise conditions that account for most of the illnesses and deaths among the vast majority of our populations. More importantly, the technology exists. Each can be effectively addressed via specific policy, behavioural, or health interventions. We do need to mobilize a much higher level of resources from international and domestic budgets in line with commitments for poverty reduction.

But money alone is not the whole story. We have to innovate. Systemic problems require systemic approaches. We have to strengthen - and in many cases build - the infrastructure and health systems necessary to implement proven interventions.

And we have to scale up research and development that is focused on the health of poor people.

The goals and targets that we set for ourselves are ambitious, and there are never enough resources. All of us committed to change, however, must work together, establish ever stronger alliances and partnerships, and focus our collective resources on common goals. Working together, we can place people at the centre of sustainable development.

Annex 6

TEXT OF ADDRESS BY THE DIRECTOR-GENERAL, WHO

It is a great pleasure to join you here in Jakarta on the occasion of the Regional Committee for the South-East Asia Region of WHO.

This year the first of the six annual Regional Committee meetings is in this Region. The African Region will be the last in a month's time. It is a busy schedule.

As many of you will know, these will be the last Regional Committees I shall be attending as Director-General. WHO's regional structure gives it a unique place in the United Nations system. I want to pay tribute to our dedicated staff in the Regional Offices and to the host governments of those Offices. I also would like to express my appreciation to the hard-working staff in our country offices. It has been particularly encouraging to see the way in which shared experience among countries has led to the development of regional solidarity and solutions. The presence of Ministers of Health here today is a clear reflection of this solidarity and commitment.

At present, the Regional Directors and I have been looking especially at improving our country operations. WHO is present in 147 countries around the world. That now includes all the countries of this Region. I was delighted to visit the Democratic People's Republic of Korea at the end of last year to open the new WHO Office there.

At this year's World Health Assembly, I announced a Country Focus Initiative. Its purpose is to ensure that WHO focuses better on the needs of countries, supporting effective health action through both standard setting and technical cooperation.

Our initiative draws on the work now being undertaken by

WHO and countries to establish Strategies for Cooperation. It involves the organization as a whole in responding to the strategic agenda for health for each country. It will improve the core competencies of country teams so that they are better able to pursue the agreed strategy, and to enhance the way in which regional and Geneva-based WHO programmes support country action. It will transform WHO's administrative systems so that they enable more effective operations of WHO country offices. And it will improve the sharing of information between WHO and countries, and increase the ability of WHO to work with the UN system, World Bank and other development partners.

We are consulting with Member States and development partners to establish options for taking this initiative forward. We will then present the key elements to the Executive Board.

The outline of our **Proposed Programme Budget 2004-2005** is on the agenda of all Regional Committees this year. Following the debate on priority setting in the Executive Board, health and the environment is now proposed as an additional priority. And two existing priorities have been expanded. Health systems will include work on essential medicines, and I am suggesting that children's health be added to the priority of making pregnancy safer.

The new budget has expected results and indicators that integrate activities at all levels of WHO, and it relates to all sources of funds. In response to requests from many Member States, the budget proposals also show, for the first time, how much of our extrabudgetary resources we estimate will be spent in countries and at the regional level.

I have made proposals for investing in **strengthening WHO's presence in countries**. This is vital if we are to deliver the goals of the Country Focus Initiative. It is needed if we are to administer effectively what we expect to be a growing role for country offices to deal with extrabudgetary resources and with donors. I mentioned yesterday to Ministers our intention to build up expertise on health systems in our country offices. There is also a need to collect and collate relevant health information, in conjunction with national health authorities.

The forthcoming biennium will be the third in which we have had to consider the question of the reallocation of the regular budget between regions, in accordance with the decision by the Health Assembly in 1998. As you know, that resolution set a maximum of 3% per year for the reduction in the Regular Budget in any region. SEAR is amongst the regions where the formula called for a reduction. In the first biennium, the full 3% was applied. For this current biennium, I decided to limit the reduction to 2% per year, and I am proposing 1.5% per year for 2004-2005. However, given that there are several Least Developed Countries in this Region, the reduction in fact amounts to only 1% per year. You will recall, of course, that a review of the resolution is scheduled for 2004.

I should like to take this opportunity to recognize and welcome the presence here of the delegation from East Timor, which I expect will soon be joining WHO. As a new Member State joins this Region, I intend to propose an addition to the current allocation for the Region, so that the new country budget will not be at the expense of other country allocations.

When I spoke yesterday to the Ministers of the Region, I referred to some of the important global challenges in health.

I have come to Jakarta from the **World Summit on Sustainable Development** in Johannesburg. We can demonstrate with confidence that investment in health pays major dividends: both as a precious asset in itself, and in terms of economic development, poverty reduction and environmental protection.

Acting on this understanding is our challenge. We have to address new issues, and adopt new ways of working.

Let me remind you of some **key elements of our agenda**:

- Two years ago, world leaders agreed on a set of development goals for the millennium. Many of them are concerned with health. The Millennium Development Goals show us the benefits of having a limited list of objectives, a careful definition of indicators and a rigorous analysis of

costs. I strongly believe that the MDGs can become a key rallying point for action, not just internationally, but at country level too.

- Last year, the Report of the Commission on Macroeconomics and Health was launched. As you know, it has already had a major impact internationally. I was excited to hear the recommendations from the Health Ministers Meeting, and to know that several countries in this Region are actively pursuing some of the report's recommendations. We are ready to work with you to take these initiatives forward.
- Both the CMH and World Health Report for 2000 showed us that it is difficult to provide a minimum package of essential health care for less than about $30-40 per capita. Today, most of the countries in this Region still have to work with much less. You know that it will take some years before you can reach the necessary level of expenditure. We need to find ways to strengthen existing health systems so that they can make effective use of additional resources to fight the diseases associated with poverty.
- But there are positive signs of change. A year ago, the Global Fund to fight AIDS, TB and Malaria was a promising idea. Today, it is a reality. This region has been a trailblazer in showing how WHO and countries can work together to prepare good proposals and to ensure that the Fund can be successful.
- A year ago, a sharp reduction in the price of several life-saving medicines raised the hopes of millions. Today, there are very many still waiting. We need to do what it takes to ensure that those who need access to life-saving care are not kept waiting much longer.
- Three years ago, we began to negotiate the Framework Convention on Tobacco Control. The Health Assembly next year is expecting to adopt the Convention and we will need to ensure that it comes into force and is implemented with all speed.

- This year's World Health Report will focus on risks to health. It will show that we need to widen our focus to include the major risks to health, and to work within and outside the health system to reduce these risks and prevent disease.

Underpinning this whole agenda is one constant theme: **the need to drastically scale up what we are doing to improve health outcomes** – particularly for poor people.

When I spoke to Ministers yesterday, I focused on particular aspects of this agenda. I outlined some of our plans to strengthen our health systems work, particularly in relation to human resources. I also reviewed in some detail the progress that has been made in increasing access to essential and life-saving medicines, and in establishing the Global Fund to fight AIDS, TB and Malaria.

Today, I will concentrate on a different part of the agenda.

Four years ago, we dared to dream. Together, we decided to walk down the uncharted path of writing global rules and regulations for the promotion, production and sale of a product that kills half of its regular users. The verdict of the medical community has been unequivocal for several decades: each of the four million annual deaths worldwide, caused by **tobacco** consumption, is preventable. Likewise, the policy options are clear: tobacco deaths can be reduced through tax increases, advertising bans and clean indoor air regulations.

I remember my discussions with health ministers and officials. We agreed that, if we did not act decisively, our grandchildren and their children would look back and seriously question how people claiming to be committed to public health and social justice had allowed the tobacco epidemic to continue unchecked.

The search for solutions took us to Article 19 of WHO's Constitution, which empowers Member States to negotiate global rules and standards. If we were to use the Organization's treaty-making power as a means of preventing tobacco-related diseases,

by setting in motion the Framework Convention on Tobacco Control (or FCTC) negotiations, WHO could make public health history. The more I shared those ideas, the more I was reassured that the time to act had come. The FCTC was the way forward.

Our ambitious initiative has paid off. The FCTC will benefit countries in many ways. Most significantly, the Convention will ensure that public health policies, tailored to national needs, can advance without the risk of being undermined.

In the last four years we have learnt a great deal about building partnerships. But what the FCTC negotiations have shown us, in sharp focus, is the critical role of the state in advancing a public health agenda, and in setting norms and standards.

Our efforts, of course, do not go unopposed. In all regions, in all countries, the vector of the tobacco epidemic is present and, in most cases, still thriving. The tobacco industry continues to act and react solely in its own interests – safeguarding profits and market share. Highly-engineered advertising, promotion and products continue to lure and ensnare young women and men. Flawed science and propaganda flood the stage. Companies court the public with demonstrations of apparent corporate citizenship.

We now have the first complete draft of the FCTC ready for the next negotiating session in October. It represents a consolidation of work to date. It details points of potential agreement on such key issues as tobacco advertising, promotion, sponsorship, illicit trade in tobacco products, taxes, and international cooperation in such areas as agricultural diversification and financial resources.

The most important ingredient needed to make the FCTC a reality is political commitment. The elements are in place and we are in the final, crucial stages that will determine how strong WHO's first international treaty will be. News of progress comes from all parts of the world, as countries prepare for the final lap of this marathon. We have to ensure that the end-product properly reflects the hard work that has gone into preparing it.

We are less than a year away from adopting WHO's first treaty.

And I am committed to seeing that the FCTC negotiations reach their successful conclusion by the target date of May 2003. In preparation for this momentous occasion, I urge you in each of your countries to lay the foundations now, so that the adoption of the Framework Convention on Tobacco Control will proceed smoothly when we meet for the 56th World Health Assembly in May 2003.

I am very pleased to announce that on 3 October 2002 I will go to Brussels to launch the World Report on Violence and Health. This is the first report of its kind to address violence as a global health problem. In launching this report, we intend to raise awareness about the problem of violence as a public health issue and provide Member States with the tools to address its causes and consequences.

Worldwide, an estimated 1.6 million people lost their lives to violence in 2000. About half were suicides, almost one-third were homicides, and about one-fifth were war-related. Millions more survive acts of violence but remain affected for the rest of their lives.

The report strongly makes the case for a much more active role for public health in the prevention of violence. Earlier this year, the Executive Board endorsed this role, focusing on strengthening services for victims, improving understanding through data collection and research, and the planning and evaluation of primary prevention programmes.

The launch of the World Report on Violence and Health will be followed by a year-long Global Campaign on Violence Prevention, involving activities with Member States and civil society to implement the recommendations. I invite you to join me and the Organization in making this campaign a success.

As I mentioned in my overview just now, the World Health Report this year will focus on risks to health. The risks that are analysed in detail include some familiar enemies of health and allies of poverty, such as malnutrition, unsafe water, poor

sanitation and hygiene, unsafe sex (particularly related to HIV/AIDS), iron deficiency and indoor smoke from solid fuels.

But the report also highlights the risks which lead to chronic diseases such as diabetes, obesity, cardiovascular diseases and cancer. The accelerating death rate from these causes is fuelled globally by rapidly changing patterns of consumption. Those changes include widespread tobacco use, diets rich in salt, sugar and fat, reduced physical activity and increased alcohol consumption. But these trends are *not* inevitable. They can be prevented in cost-effective ways. To succeed, however, will require rapid and robust interventions.

Simple changes in **diet and physical activity** play a critical role in reversing the trend.

We have come a long way in developing new recommendations for healthy eating. An expert technical report is being finalized, following review and comments from various sources. This inclusive and transparent process has resulted in our receiving more than 130 comments, which are being considered by our panel of experts. The technical report will be published early next year and will make an important contribution to improving diet and physical activity patterns globally.

In response to the resolution adopted by the World Health Assembly in May, WHO is planning a broad and inclusive public consultation process that will lead to a global strategy to improve diet and physical activity. This process involves, first and foremost, our Member States. Six regional consultations are planned for next year. I ask for your full participation.

Continuing the theme of risks to health, in Johannesburg last week, I launched the **Healthy Environments for Children Alliance.** In 2000, over 4.7 million children died from illnesses aggravated by unhealthy environments. Acute respiratory infection and diarrhoeal deaths are the largest components of this.

We know how unsafe environments make children sick. Human waste finds its way into water, into food. Water is further

contaminated with germs and chemicals. The air is polluted with smoke from indoor cooking or tobacco use. Other toxins get into air and soil. Insects that carry diseases bite children. Children are injured by accidents at home or on the road.

We laid the foundations in Johannesburg for an alliance between groups who share a common commitment. We will build agreements on risks, interventions, strategies and indicators. It will build a platform from which to intensify our work.

As I started my term in 1998, I committed WHO to making a difference. Our analysis of the Global Burden of Disease dictated that we had to set clear priorities, and we have done so. WHO now has a well-balanced and focused approach to improving world health that reflects our corporate strategy: scaling up action to address the health conditions that drive and are driven by poverty. Making sure that the health sector plays a central role in curbing the pandemic of HIV/AIDS, that is a key challenge in this country and this Region. Helping to establish health systems that are effective, fair and responsive to people's needs. Addressing the risks that contribute to ill health worldwide. And, to underpin all these efforts, doing everything we can to put health at the very centre of political attention.

It is a challenging agenda, and one which we can only tackle together.

Annex 7

REPORT OF THE THIRTY-NINTH MEETING OF THE CONSULTATIVE COMMITTEE FOR PROGRAMME DEVELOPMENT AND MANAGEMENT TO THE REGIONAL DIRECTOR[1]

1. INTRODUCTION

The Thirty-ninth meeting of the Consultative Committee for Programme Development and Management (CCPDM) was held at the Gran Melia Hotel, Jakarta, Indonesia, from 5 to 7 September 2002. Representatives from all Member Countries and an observer from East Timor participated.

2. INAUGURAL SESSION

Welcoming the participants and the observer from the Democratic Republic of East Timor participating in the CCPDM for the first time, the Regional Director, Dr Uton Muchtar Rafei, stated that the CCPDM would review the implementation of the WHO collaborative programmes carried out during the 2000-2001 biennium and the first six months of 2002-2003. He commended the achievement of 100 per cent implementation by the SEA Member Countries, which had resulted in fewer reserves at the end of 2000-2001 than in the previous bienniums. This should reduce the amount surrendered as unspent funds at the end of 2002.

Referring to the current biennium, the Regional Director stated that, while the rate of implementation had improved from the previous biennium, there was a need to accelerate efforts to achieve the target at both the country level and in the intercountry programme areas.

[1] Originnaly issued as document SEA/PDM/Meet. 39/13

The Regional Director drew attention to the joint evaluation of the supplementary intercountry programme (ICP-II) undertaken in accordance with the recommendation of the 53rd session of the Regional Committee. He requested the CCPDM to recommend one specific programme supported from ICP-II for evaluation and reporting to the 56th session of the Regional Committee in 2003. Referring to the Proposed Programme Budget 2004–2005, Dr. Uton said that the CCPDM's observations and recommendations would be forwarded to the Regional Committee.

In addition to the Technical Discussions on "Management of Decentralization of Health Care," he requested the CCPDM to give its views on the "Regional Mechanism for Bulk Purchase of Selected Quality Essential Drugs" and the "Technical Update on Global Fund to Fight AIDS, Tuberculosis and Malaria."

3. ELECTION OF CHAIRMAN AND RAPPORTEUR

Dr Dadi S. Argadiredja (Indonesia) was elected Chairman, and Dr Gado Tshering (Bhutan) as Rapporteur.

Dr Kyi Soe (Myanmar) was elected Chairman of the Technical Discussions and Dr Deddy Ruswendi (Indonesia) as Rapporteur.

4. ESTABLISHMENT OF THE DRAFTING GROUP *(Agenda item 2)*

A Drafting Group, consisting of Dr Ranjit Kumar Dey of Bangladesh, Dr Pak Jong Min of DPR Korea and Mr Anil Kumar Jha of India was established to prepare the report of the meeting.

5. PROGRAMME BUDGET: REVIEW OF WHO COLLABORATIVE PROGRAMMES IMPLEMENTED DURING THE 2000-2001 BIENNIUM (A*genda item 3.1*) AND REVIEW OF WHO COLLABORATIVE PROGRAMMES IMPLEMENTED DURING THE FIRST SIX MONTHS OF 2002-2003 BIENNIUM *(Agenda item 3.2)*

Ms Poonam Khetrapal Singh, Deputy Regional Director, stated that the background documents on these agenda items provided

information on the implementation of the WHO collaborative programmes at the country and intercountry/regional levels during 2000-2001 and the first six months of 2002-2003 biennium. During the current biennium, the most significant change in monitoring and reporting related to the achievement of the Global Expected Results. She hoped that by incorporating the lessons learnt the quality of WHO programmes would continue to improve and the pace of implementation accelerate. This would enable the countries and the Regional Office to achieve the target of 85% implementation by the end of December 2002.

Mr Helge Larsen, Director, Administration and Finance, presented the financial aspects of implementation of PB 2000-2001 and 20002-2003. The highlights of his presentation were:

- During the past several bienniums, the South-East Asia Region had surrendered reserves ranging from US$3 million to US$5 million. These were by far the highest among all WHO regions. During the 1998-1999 biennium, the SEA Region surrendered US$3.76 million to Casual Income, which was 44% of the total surrendered from all regions and HQ.
- Poor financial performance severely constrained the Region's ability to argue convincingly against the adverse effects of resolution WHA51.31. It also weakened the Region's case for additional extrabudgetary resources.
- The financial implementation during the 2000-2001 biennium had improved significantly with reserves reduced from US$16 million in 1998-1999 to US$ 12.7 million.
- Of the US$ 12.7 million, US$ 7.3 million has been liquidated and US$ 0.5 million surrendered as of 20 August 2002, leaving US$ 4.9 million for activities to be completed before the end of December 2002.
- Incentives and disincentives during the 2000-2001 biennium encouraged early implementation and reduction in reserves.

- As far as the current biennium was concerned, implementation of the intercountry programmes as of 20 August 2002 was better (54%) than the country programme (46%). Nevertheless, accelerated efforts are needed in both areas to meet the target of 85% by 31 December 2002.

Dr Than Sein, Director, Evidence and Information for Policy, summarized the technical aspects and highlighted the major lessons derived from the implementation of the WHO programme during the 2000–2001 biennium and the first six months of 2002–2003, as below:

- High-level health advocacy is necessary for supporting the development of sound national policies and strategies.
- Partnerships with regional organizations such as ASEAN and SAARC can strengthen intercountry health development efforts, especially in combating major endemic diseases, provide access to essential medicines and facilitate human resource development. WHO can effectively support Member Countries in mobilizing bilateral and multilateral funding for national health development.
- Enhanced partnerships with nongovernmental, community-based organizations and the private sector can effectively move the national health development agenda forward.
- Continuity in programme direction is essential for addressing health development issues in an effective and sustainable manner.
- Joint planning and management of WHO collaborative programmes by the Member Countries and the WHO Secretariat, through mechanisms such as the High Level Task Force can significantly improve programme implementation.
- The availability and strengthening of government/WHO coordination mechanisms at country level play a key role in guiding the planning, implementation and evaluation of

WHO programmes. These mechanisms can effectively enhance the complementarity of WHO collaborative programmes with programmes supported by other development partners.

Discussion Points

- It was noted that some of the common denominators for delayed implementation often were: (i) late approval of work plans, (ii) low quality APWs, (iii) terms of fellowships as well as lack of facilities for in-country fellowships, and (iv) frequent turnover/reorganization in Ministries of Health.
- While the Ministries of Health were doing their best to achieve effective implementation, it is often difficult to monitor or influence implementation by other sectors e.g. Water and Sanitation, Environment, etc.
- Joint WHO/Government coordinating mechanisms in most countries greatly facilitated effective programme implementation. Such mechanisms needed to be further strengthened.
- Pooled funds should be channelled not only to countries which have additional absorptive capacity, but also to those lacking resources to achieve regional priorities.
- Common constraints faced by the countries as well as the lessons learnt should be compiled to facilitate programme implementation and discussed in-depth with senior government officials so that effective joint action could be initiated to avoid surrender of RB funds.
- The management of carry-overs of unliquidated obligations/reserves from the previous biennium represented a major preoccupation during the first year of the next biennium, which affected timely implementation.
- It was noted that APWs by far constitute the largest proportion (78%) of unliquidated reserves. Contracts must be monitored closely to ensure timely delivery of final products.

- Countries expressed concern with regard to changes in the terminology used in the work plans which made their preparation difficult. It was clarified that these emanated from resolutions and decisions of the Executive Board and the World Health Assembly.
- The biennial work plans, while conforming to Organization-wide norms, should be simplified to facilitate effective and timely implementation.
- WHO should help in mobilizing additional resources through bilateral and multilateral mechanisms to address country-specific needs.
- In response to a suggestion that the role of paramedics in health care delivery should be a subject for technical discussions, it was clarified that this issue could be addressed when the Regional Committee takes up the agenda item on the selection of subjects for Technical Discussions.
- The strong relationship among the partners in health care management, such as universities and NGOs was noted.

Recommendations

(1) Work plans should be completed and approved well before the beginning of the biennium. All efforts should be made to formulate realistic plans and to strictly adhere to the established schedules.

(2) WHO and national counterparts should continue to exercise vigilance in ensuring liquidation of outstanding obligations from 2000-2001, and in timely implementation of the work plans for the current biennium.

(3) WHO should prepare a regional summary report of common lessons learnt and constraints to effective and timely implementation to be presented in future meetings of the CCPDM.

6. REVIEW OF EVALUATION OF THE SUPPLEMENTARY INTER-

COUNTRY PROGRAMME CONDUCTED DURING 2002, AND SELECTION OF AN INTERCOUNTRY PROGRAMME OR CONTENT AREA FOR EVALUATION AND REPORTING TO THE 56TH SESSION OF THE REGIONAL COMMITTEE IN 2003

(Agenda item 3.3)

Ms Poonam Khetrapal Singh, Deputy Regional Director, stated that the 53rd session of the Regional Committee had recommended that an evaluation of the supplementary intercountry programme (ICP-II) be conducted. Accordingly, an evaluation was carried out during 2002 by joint teams comprising representatives from Member Countries and the Regional Office. She requested the CCPDM to review the findings of the evaluation for reporting to the 55th session of the Regional Committee.

The Deputy Regional Director added that the 54th session of the Regional Committee had requested the CCPDM to select one specific programme for evaluation in 2003 from the supplementary intercountry programmes. The CCPDM's recommendations would be considered by the 55th session of the Regional Committee.

Dr Harry Feirman, Planning Officer, further elaborated the process, findings and recommendations of the evaluation of ICP-II. The highlights were:

- ICP-II was often perceived as additional resources to meet country-specific needs, rather than as a means of addressing priority issues affecting two or more countries that can best be dealt with on a multi-country basis.
- The national officials at the policy and technical-/implementation levels as well as WHO staff at all levels should be thoroughly briefed on the purpose and objectives of ICP-II.
- While the High Level Task Force for Intercountry Collaboration (HLTF) mechanism ensured meaningful participation of policy-level officials in planning 2002-2003 PB, it generally was felt that there should be greater involvement of national officials at the technical and operational levels within the formal HLTF mechanism. This

was particularly important with regard to the development of the products and activities.

- National officials at the operational level should receive the relevant sections of the ICP-II work plans that relate to their areas of responsibility. Information on subsequent programme changes in those areas should be shared with them.
- Despite being effective, there was over-reliance on regional consultations/meetings for achieving programme outcomes. Their extensive use placed excessive demands on the national officials and adversely affected programme implementation.
- With regard to the selection of an intercountry programme area for evaluation, based on criteria established by the Regional Committee, it was suggested that the CCPDM consider one of the following: (i) Multi-disease surveillance; (ii) Mental health problems and substance abuse; (iii) Cross-border disease control; and (iv) Regional networks for human resources in public health.

Discussion Points

- It was noted that the apparent lack of understanding of the purpose and objectives of the supplementary intercountry programme could be due to the bias in the questions addressed to the programme managers at the country level.
- In the evaluation of intercountry programmes, participation of experts from countries of the Region should be encouraged.
- On the question of excessive reliance on regional workshops/meetings, it was clarified that the use of such mechanisms is necessary to fulfil specific programme needs.
- In view of the importance of the evaluation exercise, it was felt that the duration and the terms of reference be expanded to cover an in-depth analysis.

- While it was not possible to include additional areas such as macroeconomics and health under ICP-II in the current biennium, revisions could be considered for 2004-2005.
- The Committee appreciated the work of the evaluation team and endorsed its findings and recommendations.
- The Committee, after a thorough debate, proposed that the ICP-II programme – "Multi-disease surveillance and response, including health hazards, risk behaviour surveillance, through intercountry and interregional collaboration, and use of regional mechanisms like ASEAN, SAARC, Mekong Basin Project, and Intercountry Cooperation in Health Development (ICP CSR 001)" be evaluated in 2003.

Recommendation

The Committee recommended that the ICP-II programme – "Multi-disease surveillance and response, including health hazards, risk behaviour surveillance, through intercountry and interregional collaboration, and use of regional mechanisms like ASEAN, SAARC, Mekong Basin Project, and Intercountry Cooperation in Health Development (ICP CSR 001)" be evaluated in-depth in 2003 and reported to the 56th session of the Regional Committee.

7. REVIEW OF PROPOSED PROGRAMME BUDGET 2004-2005 AND REVIEW OF REGION-SPECIFIC PART-II OF PROPOSED PROGRAMME BUDGET 2004 *(Agenda items 3.4 and 3.5)*

Ms Poonam Khetrapal Singh, Deputy Regional Director, stated that the Proposed Programme Budget for 2004-2005 (PB 2004-2005) was prepared jointly by WHO headquarters and the Regional Offices. The supplementary region-specific Part II of the Programme Budget was prepared outlining the regional situation in terms of issues and challenges and the broad regional strategies. The Deputy Regional Director requested the CCPDM to review these documents and make its comments, observations and recommendations to be forwarded through the Regional Director to the 55th session of the Regional Committee, for its consideration.

The Deputy Regional Director then highlighted the salient features of PB 2004–2005:

- PB 2004–2005 presented a uniform strategic framework for the Organization, using 35 areas of work. It applies principles of results-based budgeting and focuses on expected results and indicators in order to ensure full transparency and accountability as to how the Secretariat manages the resources entrusted to it.
- PB 2004–2005 addresses 11 global priorities jointly identified by HQ as well as regions.
- Clearer formulations and definitions of expected results and indicators are provided. Indicative estimates of expenditures at country, regional and global levels also are included.
- The PB document projects a significant increase of 37% in extrabudgetary resources.
- The region-specific Part II of PB 2004–2005 providing the regional perspective would enable the Region to contribute effectively to the global goals, objectives and expected results while, at the same time, addressing the issues and challenges unique to the Region.
- The Director-General has taken steps to limit the reduction to the Region's regular budget allocations for 2004–2005 to 1.99% for the biennium, compared to 2002–2003. Had the World Health Assembly resolution WHA51.31 been implemented fully, the cumulative reduction over the last four bienniums would have been 16.7%, rather than the actual reduction of 8.2%.
- With regard to the distribution of the regional allocation, it is proposed to maintain the 75:25 ratios between the allocation to countries and RO/ICP respectively.

Discussion Points

- While there was no increase in the global RB allocation, there was considerable increase in the extrabudgetary resources. The potential conflict which existed between programmatic

priorities being set by donors and the constitutional role of WHO's governing bodies was pointed out. While this problem could not be entirely eliminated, the Director-General was continuously reminding donors that extra-budgetary resources should be applied within the strategic framework of the programme budget.

- Though the Region accounts for a quarter of the world's population and to more than 40 per cent of the global disease burden, the Regular budget allocation for the Region continues to decline. During the forthcoming global evaluation of the implementation of World Health Assembly resolution WHA51.31, to be reported to the Assembly in May 2004, the SEA Region needs to work with other regions affected similarly.
- Any reduction in country programme allocations needs to be done in consultation with the governments.
- The Director-General will provide indicative country allocations following the January 2003 meeting of the Executive Board.
- It was noted that while HRH is not a separate area of work, human resources development is included within Organization of Health Services, and spread across other areas of work.

Recommendations

(1) Member States of the SEA Region need to work with other countries which also were experiencing reduced regular budget allocations as a result of resolution WHA51.31. It was recommended that the forthcoming meetings of the governing bodies be used to develop a joint position on this subject, as an important input into the evaluation which could be reported to the World Health Assembly in 2004.

(2) CCPDM recommends the endorsement of the Proposed Programme Budget 2004-2005 as contained in Parts I and II.

8. REGIONAL IMPLICATIONS OF THE DECISIONS AND RESOLUTIONS OF THE FIFTY-FIFTH WORLD HEALTH

ASSEMBLY AND THE 109TH AND 110TH SESSIONS OF THE EXECUTIVE BOARD AND REVIEW OF THE DRAFT PROVISIONAL AGENDA OF THE 111TH SESSION OF THE EXECUTIVE BOARD

(Agenda item 4)

Ms Poonam Khetrapal Singh, Deputy Regional Director, noted that in accordance with a recommendation of the 37th meeting of CCPDM and endorsed by the Regional Committee, all the decisions taken and resolutions adopted by the World Health Assembly and the Executive Board were being placed before the CCPDM for its review. The working paper on the subject provided in a matrix salient information from the operative paragraphs of the decisions and resolutions as well as actions proposed for the Member States and WHO. CCPDM's observations and recommendations would be submitted to the Regional Committee for consideration and endorsement.

Discussion Point

The subjects relating to deliberate use of biological and chemical agents (WHA55.16), and control of dengue and dengue haemorrhagic fever (WHA55.17) would be taken up at the 55th session of the Regional Committee as substantive agenda items.

Recommendation

The CCPDM recommends that the Regional Committee take note of the actions taken and proposed, as contained in the working paper SEA/PDM/Meet.39/9 and SEA/RC55/8.

9. REPORTS BY COUNTRY REPRESENTATIVES ON THEIR ATTENDANCE AT THE MEETING OF THE COORDINATING BODIES OF WHO'S GLOBAL PROGRAMMES *(Agenda item 5)*

9.1 UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases: Joint Coordinating Board

(Agenda item 5.1)

Ms Poonam Khetrapal Singh, Deputy Regional Director, in her introductory remarks, said that the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, known as TDR, had been functioning under the aegis of WHO. A Joint Coordinating Board (JCB) had been established to coordinate the interests and responsibilities of the parties cooperating in this Special Programme. From the SEA Region, representatives from Bangladesh, India and Thailand attended the 24th session of JCB, held in Geneva on 25-26 June 2002.

The representatives who attended the session reported on the JCB meeting. Among the issues debated, the JCB endorsed the Research Capacity Strengthening (RCS) strategies for 2000-2005 and recommended that continued attention be directed to the RCS needs of high-disease burden and least developed countries, exploring opportunities for enhanced support through a regional or sub-regional level. The Board was particularly impressed with the collaboration between Indian researchers, the pharmaceutical companies and WHO/TDR, which had led to the successful registration of Miltefosine for the treatment of kala-azar.

The CCPDM noted the report.

9.2 WHO Special Programme for Research, Development and Research Training in Human Reproduction: Policy and Coordination Committee (PCC) *(Agenda item 5.2)*

Ms Poonam Khetrapal Singh, Deputy Regional Director, said that the Policy and Coordination Committee (PCC) of the Special Programme of Research, Development and Research Training in Human Reproduction (HRP) acted as a governing body and was responsible for HRP's overall policy and strategy. To coordinate the interests and responsibilities of the collaborating partners, the PCC reviewed and decided upon the planning and execution of the Special Programme, including the budget. At present Bangladesh, India, Indonesia and Nepal are members of the PCC from the Region. Representatives from Bangladesh and India participated in the 15th PCC meeting held in Geneva in June 2002.

The representatives who attended the session reported on the proceedings of the meeting. Highlighting the salient deliberations, he said that the meeting noted the report of the Executive Director, Family and Community Health Cluster of WHO/HQ on developments within the cluster and recent and future challenges to reproductive health. It urged that advocacy efforts in reproductive health at the international fora should be continued. It also recommended that the Programme should (a) assist in exploring ways for RH programmes to best address HIV/AIDS; (b) facilitate the implementation of best practices and research evidence; (c) address the need of couples and individuals who wish to have children while, at the same time, protecting themselves against HIV infection; (d) give due attention to STIs and social science research; and (e) facilitate actions for increasing the visibility of sexual and reproductive health issues.

The CCPDM noted the report.

10. REGIONAL MECHANISM FOR BULK PURCHASE OF SELECTED QUALITY ESSENTIAL DRUGS *(Agenda item 6)*

Ms Poonam Khetrapal Singh, Deputy Regional Director, said that the Health Ministers from Member Countries of WHO's South-East Asia Region, at their meeting in August 2001, requested WHO to assess whether a Bulk Purchasing Scheme for generic essential drugs of assured quality would be practical. The Ministers requested the Regional Office to prepare a position paper and present it to the Regional Committee in September 2002. The paper has been placed before the CCPDM for its review and comments, which would then be submitted to the Regional Committee.

Dr K. Weerasuriya, Regional Adviser, Essential Drugs and Medicines Policy, highlighted the salient points as follows:

- Experience on bulk purchase schemes in other regions have shown that each scheme needed some impetus generated from the Region itself, expertise from within the Region and decisions at a high political level.
- WHO/HQ had developed a scheme for the UN system in which manufacturers with acceptable quality of drugs for

HIV/AIDS and its complications were identified, and prequalified. Pre-qualifying manufacturers rather than including all registered manufacturers as suppliers is increasingly being used to assure quality.

- The criteria proposed for pre-qualification were (i) inspection and approval of a pharmaceutical manufacturing facility by an internationally recognized drug regulatory authority (DRA), (ii) the ability of the manufacturers to maintain the standard pharmacopoeial specifications, and (iii) export performance of at least three years.
- Pre-qualification has been used with great success in vaccines for childhood immunization and also in supplies such as condoms. However, countries need to consider the scheme in the context of the limited resources available for health. Pre-qualification criteria could be modified according to the needs of individual countries.
- While manufacturers in some countries had shown interest in the scheme, they preferred to follow their routine manufacturing norms, rather than specially producing for the bulk purchase scheme. Other countries in the Region do not have manufacturers that have been inspected and approved by the international DRAs and therefore do not qualify to be suppliers.
- WHO would provide information on this scheme and bring pre-qualified suppliers and countries together to negotiate the quantities and the prices of essential drugs. The Regional Office would also provide technical support to countries and act as an "honest broker" in bringing the two parties together.
- SEARO could provide the technical support needed for the development of pre-qualification criteria with the participation of the Drug Regulatory Authorities in those countries as well as the supply divisions in the respective ministries of health.
- Different countries would have different interests in the scheme. While some countries would be interested as

buyers, others would be interested in supplying the drugs. The scheme should be limited to a few selected drugs.

- If countries could agree on common specifications for purchasing essential drugs, the Regional Office would facilitate the joint purchase by the countries.

Discussion Points

- Criteria for prequalification used internationally recognized authorities from outside the Region. It was suggested that the WHO GMP scheme administered by the national authorities in the individual countries could be used instead.
- It was suggested that due recognition be given to manufacturers whose products are being purchased by UN agencies using appropriate quality criteria. Those manufacturers could be considered for inclusion in the prequalified list.
- It was recognized that quality assurance was a continuing process and needed sustained efforts by concerned authorities to ensure that standards are maintained after prequalification.
- Since financial implications of the Bulk Purchase Scheme were not clear, it would be worthwhile on a trial basis to do dual tendering with separate quotations from the regular suppliers as well as the prequalified ones and to compare prices.
- In the context of decentralization, some countries did not purchase at a central level. In such a situation, it might be appropriate for sub-national authorities to be involved in this scheme.
- Some countries are purchasing some drugs from outside the Region as they have insufficient information on suppliers in the Region. Through BPS, appropriate information could be provided enabling them to purchase from within the Region.

Recommendations

(1) WHO should continue to provide technical assistance to

countries to enable them to further strengthen their Drug Regulatory Authorities.

(2) Prequalification criteria for the Bulk Purchase Scheme for Selected Quality Essential Drugs should include companies whose products have been purchased by UN agencies using appropriate quality criteria.

(3) Member Countries and WHO should work together to make the "WHO Good Manufacturing Practices (GMP) Certification Scheme" more effective.

11. TECHNICAL UPDATE ON GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA *(Agenda item 6)*

Ms Poonam Khetrapal Singh, Deputy Regional Director, in her introductory remarks, drew the attention of the CCPDM to the working paper which provided the background on the Fund, and the developments that took place in the Region and WHO's role in providing necessary technical backstopping to the Member Countries. In response to the first call for applications, nine of the 10 Member Countries of the Region submitted proposals for which approval had been received for five countries amounting to US$ 283 million in April 2002. A meeting was organized in Dhaka in July 2002 to share experiences among Member Countries relating to the first round and the lessons learnt for preparation of proposals for the second round in September 2002. Technical support missions to specific countries had also been organized to assist them in preparing quality and sound proposals.

In his presentation, Dr Jai Narain, Coordinator, HIV/AIDS, TB and Other Diseases, explained the background and the principles of the Global Fund to fight AIDS, TB and Malaria (GFATM), which became operational in January 2002. Following the first call for applications on 4 February 2002, nine of the 10 Member Countries of our Region had prepared and submitted country and multi-country proposals for the "quick start" funding before the deadline of 10 March. SEARO provided technical support in the preparation of applications on-site or through a rapid response team from the Regional Office. WHO also has assisted the Fund in the composition of the Technical Review Panel by forwarding names of experts from the Region and had kept countries informed of the developments

relating to the Fund. Notably, five out of the seven country proposals from our Region on TB were approved for funding – the highest among all the regions.

While countries worked hard in preparing proposals at short notice against a tight deadline, strong concerns were expressed on why certain proposals from countries were not approved for funding. The second call for applications has been made and the proposals are due to be submitted by 27 September 2002. Technical support is being provided by WHO in preparation of good quality proposals. Technical support missions to specific countries as needed were finalized.

Discussion Points

- Articulation of high-level political commitment, vulnerability at country level and presence of risk behaviour are important components of the country proposals. The countries were preparing proposals in order to meet the 2nd round deadline of 27 September 2002.
- For proposals already recommended for funding in the 1st round, there is still no clarity on the mechanism for financial management including disbursement through principal recipient and the role to be played by the Local Fund Agent (LFA) at country level. In addition, the issues relating to the procedures for technical monitoring and evaluation of GF-supported activities should be addressed.
- Countries need, on a continuing basis, technical support in preparation of country proposals and in implementation as well as in monitoring and evaluation. While the role of WHO in financial management was rather limited, it has, however, a critical role in advising on the establishment of a national coordination mechanism, in keeping countries informed of the development relating to the GF, and in using the GF mechanism to strengthen national health capacity.
- WHO's support in the preparation of proposals which resulted in obtaining funds from the GF for the SEAR countries was appreciated.

Recommendation

WHO should continue to provide information to the Member Countries on new developments relating to the Global Fund. Technical support in the preparation of the proposals, implementation, technical monitoring and evaluation of GF-supported activities should also be continued.

12. TECHNICAL DISCUSSIONS ON MANAGEMENT OF DECENTRALIZATION OF HEALTH CARE *(Agenda item 8)*

Technical Discussions on Management of Decentralization of Health Care were held on 6 September 2002. Dr Kyi Soe, Director-General, Department of Health Planning, Myanmar, was elected Chairman and Dr Deddy Ruswendi, Head, Centre of Health Policy Analysis, Ministry of Health, Indonesia, was elected as Rapporteur. The report and recommendations arising out of the Technical Discussions will be submitted to the Regional Committee.

13. ADOPTION OF REPORT

The CCPDM reviewed the draft report of its thirty-ninth meeting and adopted it with minor modifications.

14. CLOSURE

Ms Poonam Khetrapal Singh, Deputy Regional Director and Director, Programme Management, speaking on behalf of the Regional Director, congratulated the members of the CCPDM for a very productive meeting and lively discussions. The recommendations of the CCPDM would now be submitted to the Regional Director and to the Regional Committee as appropriate. She congratulated the Chairman for not only conducting the meeting effectively with his skillful handling of the discussions but also for ensuring a cordial environment that helped fruitful deliberations. She expressed her appreciation for the excellent arrangements and hospitality of the national authorities.

Members of the CCPDM thanked the Chairman for the smooth conduct of the meeting and the Secretariat for the clarifications provided and the timely preparation of the report and other

working papers. They also conveyed their appreciation to the national authorities for their generous hospitality.

The Chairman, in his concluding remarks, congratulated the Rapporteur and the drafting group for preparing a report that truly reflected the discussions. He also appreciated the support provided by the WHO Secretariat.

He then declared the meeting closed.

Annex 8

CONSIDERATION OF THE RECOMMENDATIONS ARISING OUT OF THE TECHNICAL DISCUSSIONS ON "MANAGEMENT OF DECENTRALIZATION OF HEALTH CARE"[1]

1. INTRODUCTION

TECHNICAL DISCUSSIONS on "Management of Decentralization of Health Care" were held on 6 September 2002. Dr Kyi Soe, Director-General, Department of Health Planning, Ministry of Health, Myanmar, was elected Chairperson and Dr Deddy Ruswendi, Head, Centre of Health Policy Analysis, Ministry of Health, Indonesia, as Rapporteur. The Agenda and Annotated Agenda (SEA/PDM/Meet.39/TD/1.1 and 1.2 respectively) and the working paper for the Technical Discussions (SEA/PDM/Meet.39/TD/1.3) formed the basis for the discussion.

1.1 Introductory Remarks by the Chairperson

WELCOMING the participants and representatives of nongovernmental organizations, the Chairperson highlighted the further need for evidence-based information and practical experiences from the countries in order to understand the process and implementation of decentralization of health care and to provide appropriate support to countries. He stressed that the primary intention of decentralization of health care is to improve efficiency, quality and equity. Therefore, every effort should be made to ensure that the above objectives are achieved to improve the health status of people, particularly the poor and marginalized sections of the population. However, he said that the experiences so far are mixed. He urged the participants to carefully analyse the prevailing situation in the countries and provide suggestions for future improvements.

1.2 Introduction of the Working Paper on Management of Decentralization of Health Care

[1] Originally issued as document SEA/RC55/16 dated 11 September 2002

DR MONIR ISLAM, Director, Family and Community Health, WHO/SEARO, presented a summary of the working paper. He highlighted the rationale for countries adopting the process of decentralization of health care services. He elaborated on the various forms of decentralization, emphasizing that in the Region countries are at different stages and levels of the decentralization process. Dr Islam explained that for successful implementation, countries need to fulfil some basic conditions like political commitment to fiscal decentralization, development of appropriate and adequate human resources, and establishment of an in-built system of monitoring and evaluation. During the implementation process, countries must maintain or further improve efficiency and quality, ensuring equitable access to health care services. He explained that a step-wise implementation may be more appropriate as lessons learnt and capacity built from such implementation can help improve services in other districts or regions of the same country. The central government, particularly the Ministry of Health, needs to play a crucial role to ensure the success of decentralization. Significant achievements were made and lessons were learnt during the decentralization of health care in the Region. However, a lot needs to be achieved in sustaining political commitment and leadership, building appropriate capacity for fiscal responsibility and management, adequate human resource development and deployment for health care delivery, adequate supervision, monitoring and evaluation. The Member Countries in the Region, considering the prevailing socio-cultural, political and economic situation, may need to consider an appropriate mix of approaches in implementing decentralization. The Regional Office will be ready to provide evidence-based information and technical support to achieve the objectives of decentralization to improve the health of the people, particularly the poor and vulnerable section of the population.

2. DISCUSSIONS

DURING the general discussion, it was clear that some form of decentralization was practised in every country. Different countries had different experiences, successes and constraints in this process. It was clear that the question was not whether or not to decentralize health care services but how to design and implement the process taking into consideration the prevailing situations in each country to achieve set goals and objectives of the national

health policies. The participants were divided into three groups to further discuss the critical issues related to decentralization. The group discussions covered the following issues:

- Experiences in Member Countries
  - Policy formulation
  - Implementation – maintaining equity, quality and efficiency
  - Monitoring and evaluation
  - Lessons learnt
- Mechanisms for technical cooperation and exchange of expertise among Member Countries to improve management of health care in decentralized settings
- Identification of needs for evidence-based information and areas for future research needs
- Role of WHO/SEAR

The following are the highlights of the group discussion:

- The groups emphasized that decentralization is not a new political, administrative or management process which many other sectors had experienced. In some countries, even constitutional changes were made to achieve decentralization of health care within a given period of time. The decentralization process in the health sector is fairly new and ministries of health need to learn from other sectors where decentralization is either in place and functioning successfully or has been completed.
- Decentralization should take place at the centre and percolate to the periphery, within the overall governmental system across all sectors, rather than in the health sector in isolation.
- It was also felt that different forms of decentralization may be necessary in different countries.
- People at the local level should be actively involved in planning, implementation and monitoring. Advocacy was

needed to put health on the local priority list and increase awareness among people to demand for their rights.

- Partnerships with NGOs and civil society should be promoted. In the process the Ministry of Health needs to play a very important role in defining policies, setting guidelines (financial and technical), maintaining quality and ensuring equity. The ministry will need to adopt various mechanisms to deliver at least essential health care services to all sections of the population, particularly the poor and marginalized.
- There should be central control in regulating profit and non-profit-making organizations including NGOs. Support from donors and other partners should be coordinated by the ministry.
- The health ministry should be responsible for specialized health care services and medical supplies in order to make sure the population has equitable access to necessary and quality care services.
- Human resource development is a critical issue for the success of decentralization and needs to go hand-in-hand with adequate resource allocations and retention of some income generated in local settings.
- The centre should also play an important role in basic education and training, with the local authorities taking the responsibility for in-service training or retaining the existing pool of human resources.
- An efficient division of responsibility among different levels is necessary but the responsibilities, particularly at the lower level, must match its capability in respect of necessary and appropriate expertise and human resources.
- Health sector spending at the local level was gradually decreasing because of a lack of understanding, information and advocacy regarding the importance of investment in health. It was felt that the proportion of public sector spending allocated to the health sector under decentralization needs to be determined, particularly at the level of self-governing local authorities.

- The centre, in consultation with local governments may need to make appropriate legislative and/or administrative arrangements for the level and distribution of health spending and local discretion in expenditure decisions. In a few countries, such initiatives are already in progress.
- Implementation of decentralization should be a step-wise process where WHO can play an important role in providing evidence-based information and technical support in coordination with other partners. WHO may also facilitate the identification of technical deficiencies and assist in human resource development.
- WHO needs to facilitate and promote coordination among research institutions in Member Countries through the use of WHO collaborating centres and sharing of experience and information, acting as a clearing house of information.

3. CONCLUSIONS AND RECOMMENDATIONS

DECENTRALIZATION is not a new process in countries. Health sector decentralization, although new, needs to take into account ongoing processes of decentralization in other sectors.

Health problems are not the same across societies and cultures; health and social services are organized differently; the democratic process and socioeconomic conditions are different; public versus private providers, including NGOs and community-based organizations (CBOs), are playing different roles; and countries or even different states within a large country are at different stages of development. Therefore, the most appropriate form of decentralization will depend on individual country situations.

- WHO should assist Member Countries in reviewing and analysing ongoing implementation of decentralization of health care services. Evidence-based information and lessons learnt should be documented and disseminated to Member Countries.
- Advocacy to policy makers should be intensified to increase adoption of appropriate public health policies and increased and sustained political, financial, administrative and management support. The central government, particularly

the Ministry of Health, should play an important role in defining the roles and responsibilities of different levels and work in close collaboration with local governments.

- Similarly, efforts should be intensified at the community level to promote better understanding of the rationale and process of decentralization and to increase their active participation.
- Assessment of human resources needed for effective implementation of decentralization should be carried out and human resource development and deployment should be enhanced accordingly.
- An in-built system of monitoring and evaluation needs to be established at all levels of the health care system to ensure efficiency, quality, equity and accountability.
- WHO should provide necessary technical support to the Member Countries in coordination with respective governments and other partners.
- Adequate support should be provided to carry out appropriate research and to strengthen dissemination of research findings.

Annex 9

PRESENTATION ON HEALTH AND SUSTAINABLE DEVELOPMENT

Professor Emil Salim, Professor, Faculty of Economics, University of Indonesia and Chairman of the Commission on Sustainable Development and of the Preparatory Committee for the World Summit on sustainable development, made a presentation on "Health and Sustainable Development" on 12 September 2002.