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Report of the Fifty-third
Session

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Report of the Regional

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Part I

INTRODUCTION

THE FIFTY-THIRD SESSION of the WHO Regional Committee for South-East Asia was held in New Delhi, India, from 4 to 7 September 2000. It was attended by representatives of all the ten Member States 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 C.P. Thakur, Union Minister for Health and Family Welfare, Government of India.

The Committee elected Mr Javid A. Chowdhury (India) as Chairman and Dr U Kyi Soe (Myanmar) as Vice-Chairman of the session.

The Committee reviewed the report of the Regional Director for the period 1 July 1999 to 30 June 2000, and considered the recommendations arising out of the Technical Discussions on (1) Equity in Access to Public Health, and (2) Healthy Settings, held during the 37th meeting of the Consultative Committee on Programme Development and Management.

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

The Committee accepted the confirmation by the Government of the Union of Myanmar to host its fifty-fourth session from 3-6 September 2001.

A drafting group, consisting of representatives from Bangladesh, India, Indonesia, Myanmar, Sri Lanka and Thailand, was formed to draft resolutions for consideration by the Regional Committee. Ms Sujatha Rao was elected Chairperson of the group. During the session, the Committee adopted 13 resolutions.

Part II

INAUGURAL SESSION

WELCOME ADDRESS BY THE SECRETARY, MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA

MR JAVID A. CHOWDHURY, Secretary, Ministry of Health and Family Welfare, welcoming the distinguished delegates and guests stated that he was honoured that India was hosting the fifty-third session of the Regional Committee after a gap of 25 years. Recalling India's association with WHO since its inception, he commended the support provided by WHO in eradicating smallpox, containing malaria and in formulating policies for addressing inequity in health. Despite considerable constraints, India had made excellent progress in reducing the level of infant mortality and in reducing fertility rates, expanding health facilities in the remotest areas, and providing access to polio drops for all infants.

WHO's technical collaboration had facilitated mobilization of funds for India from the World Bank for the control of malaria, TB, HIV/AIDS, leprosy and blindness as well as in developing capacity and intensifying many other disease control programmes. Besides, India also benefited from WHO's technical cooperation in combating HIV/AIDS, TB, leprosy and polio. He hoped that polio

would be eradicated and leprosy eliminated from India in the near future.

ADDRESS BY THE REGIONAL DIRECTOR

DR UTON MUCHTAR RAFEI, Regional Director, WHO South-East Asia Region, recalled some of the significant health developments achieved by India during the last decade. Guinea-worm disease had been eradicated and polio was expected to be eliminated by 2005. India also hoped to eradicate leprosy by 2001. Other countries in the Region had also made remarkable progress towards achieving the goal of Health for All.

Dr Uton emphasized the need for the Regional Committee to deliberate and decide upon certain crucial issues emanating from the discussions of the recent meetings of the Health Ministers of SEAR and of the Consultative Committee for Programme Development and Management (CCPDM).

In order to meet the increased expectations of the health sector, the Organization had recently accelerated the reform process initiated in 1992. A fresh impetus for WHO to make a difference had been provided by Dr Gro Harlem Brundtland since she took over as Director-General in July 1998. Like any other corporate entity, WHO too would now focus on the business that it does best and, in partnership with countries, identify areas where it has a comparative advantage.

Dr Uton informed the Committee that WHO country cooperation strategies (CCS), being jointly developed by WHO and the Member States, would form the basis for preparing the

respective collaborative programmes for the 2002 -2003 biennium. This would be within the framework of the four strategic directions and six core functions of WHO, and the targets set out in the Regional Health Declaration. For achieving these targets, it was imperative to rationalize the use of scarce resources, as well as to ensure a better balance between resources for the country and intercountry programmes. He urged the Committee to consider seriously the observations and recommendations of the 18th Health Ministers' Meeting and 37th CCPDM in this regard.

The Regional Director underlined the need for enhancing regional and intercountry programmes through various mechanisms. This would help sustain the several priority programmes, such as polio eradication, International Cooperation in Health Development (ICHHD), and cross-border disease control activities. He concluded by stressing the importance of enhancing partnership in health development (for full text, see Annex 4).

ADDRESS BY THE DIRECTOR-GENERAL, WHO

DR GRO HARLEM BRUNDTLAND, Director-General, WHO, thanked the Government of India for hosting the Regional Committee meeting. She underscored the direct correlation between improved health and poverty alleviation and hoped that difficult challenges would be addressed successfully with collaborative and concerted efforts.

It was as a result of working together that the target of achieving polio eradication and elimination of leprosy seemed to be within sight. Political commitment was promising in India, Indonesia, Myanmar and Nepal, which were among the 12

countries carrying 90 per cent of the global leprosy disease burden. Tobacco control has now almost become a movement in some countries of the Region, with Thailand standing out as a role model. The support for the Framework Convention on Tobacco Control was strong and encouraging. Despite the relatively low infection rate of HIV/AIDS in this Region, the countries needed to guard against complacency in order to prevent the future spread of HIV and thereby avoid a devastating economic, social and human disaster.

The regional structure of WHO facilitated establishing regional priorities like elimination of leishmaniasis and control of Japanese encephalitis as well as focusing on regional aspects of global problems such as tuberculosis, food safety and safe water supply.

Dr Brundtland was happy with the spirit of 'One WHO' permeating the work of the Regional Office and headquarters teams who were working together with countries, to strengthen the intercountry mechanism. The Director-General hoped that the joint efforts of Member Countries and WHO would succeed in achieving dramatic improvements in people's health, and in tackling global health priorities, promoting equity and reducing poverty.

ADDRESS BY THE UNION MINISTER FOR HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA

DR C.P. THAKUR, Union Minister for Health and Family Welfare, in his inaugural address highlighted his long association with WHO as a physician and researcher.

He said that equitable access to health care services was given high priority in India. In view of the scarce resources available for

public health spending, the private sector was fast emerging as a major provider of health care services. Ensuring an equitable system of health care remained the responsibility of governments.

The World Health Report on Health Systems provided interesting and innovative indicators to define health systems. While agreeing with the broad principles of measurement of health systems, he felt that the exercise of ranking countries could have been avoided. Health promotion through healthy settings, prevention of diseases through health education and information dissemination were also very important areas of concern, he added. In view of the vital importance of intersectoral collaboration in achieving the goal of health for all, the formulation and implementation of the National Population Policy as well as the National Health Policy must involve other relevant sectors as well.

Dr Thakur praised Dr Brundtland for lending direction and focus to WHO as well as to the global health agenda. He urged WHO to play a leading role in matters related to global trade agreements, especially with regard to their adverse implications on the health of the people. He also urged WHO to support developing countries in setting achievable standards under Codex Alimentarius, and in developing capacity and knowledge. WHO support was also needed for codification and standard-setting with regard to alternative systems of medicine which were becoming more popular in view of the high costs of modern drugs and medicines.

VOTE OF THANKS

DR S.P. AGARWAL, Director-General of Health Services, Government of India, proposed the vote of thanks.

Part III

BUSINESS SESSION

OPENING OF THE SESSION (*Agenda Item 1*)

IN THE ABSENCE of the Chairman of the fifty-second session, Prof. Dr Azrul Azwar, Vice-Chairman, opened the fifty-third session of the Regional Committee, which was attended by the Director-General of WHO, representatives of Member Countries and UN and other agencies as well as nongovernmental organizations in official relations with WHO.

SUB-COMMITTEE ON CREDENTIALS (*Agenda Item 2*)

A SUB-COMMITTEE on Credentials, consisting of representatives from Indonesia, Myanmar and Thailand was appointed. The Subcommittee met under the chairmanship of Dr (Ms) Sumarjati Arjoso (Indonesia) and examined the credentials submitted by Bangladesh, Bhutan, DPR Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand. The credentials were all found to be in order, thus entitling all representatives to take part in the work of the Regional Committee.

The report of the Sub-committee (SEA/RC53/20) was approved by the Regional Committee.

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

MR JAVID A. CHOWDHURY (India) was elected Chairman of the fifty-third session of the Regional Committee. Dr U Kyi Soe (Myanmar) was elected Vice-Chairman.

Mr Chowdhury thanked the representatives for electing him as Chairman and said he looked forward to their support and cooperation in the smooth conduct of the session.

He observed that Member Countries highly valued the quality of WHO's technical inputs. He urged the Director-General to allow flexibility to countries in drawing up the priorities for the budget. While appreciating WHO's efforts to attract extrabudgetary resources, he urged that mechanisms be established within WHO to appropriately manage these resources in line with the priorities of the Region.

Identification of national centres of excellence/expertise for training of health professionals was central to utilizing resources within the Region, thereby considerably reducing the cost of extraregional fellowships. A directory of training institutions in India had been compiled, which might be useful for other Member Countries while sending their health professionals for training.

Reiterating the recommendations of the 18th Meeting of the Health Ministers in Kathmandu, he sought support in drawing up an intercountry programme for prevention of cross-border transmission of communicable diseases such as malaria and kala-azar.

ADOPTION OF AGENDA (*Agenda Item 4, documents SEA/RC53/1 (Rev. 2 & 3)*)

THE COMMITTEE adopted the Agenda as in document SEA/RC53/1(Rev.3).

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

DR GRO HARLEM BRUNDTLAND, Director-General, WHO, highlighted the importance of the meeting, the first in the new millennium, convened at a time when great opportunities and challenges faced the world. The period in retrospect would be seen as a turning point for improvements in health for all the world's people, she said. In order to bring about real changes in society, economic dimensions of issues affecting the people should be viewed carefully.

Health was a central factor in economic and social development, and improvement in health a key in breaking the debilitating cycles of poverty. The 13th International AIDS Conference, held in Durban, in July this year, had stressed that all people living with HIV/AIDS world-wide should have access to adequate care, and that everyone should be in a position to protect themselves from HIV infection. Subsequently, leaders of the G8 nations agreed on specific targets to reduce the death toll from malaria, HIV/AIDS, TB and children's diseases by 2010.

Referring to several important achievements, the Director-General said that a few years ago polio was one of the leading causes of disability. Today, polio is on the verge of eradication. The political courage displayed by the leaders of some countries in the Region to eliminate leprosy was commendable, she added.

The Global Alliance for Vaccines and Immunization (GAVI) was a prime example of a new model for partnerships in international health, remarked Dr Brundtland. Proposals to the Global Fund for Children's Vaccines from eligible countries are being accorded priority as the GAVI partners are fully committed to the effort to eradicate polio, she said.

Similar partnerships are being forged in the Roll Back Malaria, Stop TB and Make Pregnancy Safer programmes. The process of implementing country-level partnerships was leading to a more collaborative and sustainable approach to building more effective health systems. This new approach to international health action was setting the stage for a reform in development funding. It had encouraged WHO to tackle the infectious diseases affecting the world's poorest people: HIV/AIDS, malaria, TB, diarrhoea and other diseases of childhood.

Dr Brundtland pointed out that infectious diseases were responsible for around 45% of mortality in developing countries and HIV/AIDS, TB and malaria contributed half of these; the lifesaving measures for these diseases were either unavailable, unaffordable, or improperly used. WHO would be focusing on the need to increase access to essential drugs and prevention methods such as bed nets and condoms.

Dr Brundtland reiterated that the management of any health system involved coping with competing demands, matching resources to needs, and attempting to ensure that all have access to the care necessary for good health. Improving health outcomes, responding to the people, and fairness of financing, were the three purposes through which the performance of health systems could

be assessed. In the *World Health Report 2000*, WHO had attempted such an assessment, using the limited data available. However, the report had raised some controversy as far as the views on the means to assess health systems and what makes a good health system were concerned. At the same time, the debate generated by the Report would give an opportunity to many Member States to assess their health systems, and efforts that could be made to improve performance.

The Director-General reassured the delegates that WHO will be working closely with Member States in an initiative to enhance the performance of Health Systems to apply the new WHO assessment framework at national as well as sub-national levels; to use this analysis as an aid to national policy formulation, and to work together to facilitate positive change. Four SEAR countries are already participating in this initiative.

Dr Brundtland visualized the rapid shift of the burden of disease from infectious to noncommunicable diseases, which would seriously challenge the health care system in the near future and necessitate hard decisions. Global tobacco control was a key priority area and WHO would also look at a vastly neglected area of public health – mental health. Mental health will be the focus of World Health Day, the World Health Assembly and the World Health Report in 2001.

The Director-General remarked that the success of the Framework Convention on Tobacco Control (FCTC) would depend on the ability to link compelling data to robust decisions. For the first time, the public health community would lead treaty negotiations on FCTC. Countries as well as tobacco companies

would be thinking about their actions from a public health perspective, she said.

The South-East Asia Region was unfortunately no exception to the fact that all of the WHO regions had over the past year, been heavily affected by disasters and crises, both natural and man-made. WHO had an important role to play before, during and after emergencies and to make sure that long-term health perspectives are built into the emergency relief so that money spent on any emergency can benefit long-term development needs.

Dr Brundtland said that the Programme Budget 2002-2003, which marked a significant departure from previous bienniums, would be a key instrument for advancing the process of change and reform in WHO. The programme budget for each area of work had been worked out through an Organization-wide process, jointly between regional offices and headquarters. In order to prevent the priority areas from being diluted and the quality of programmes from suffering, the Director-General suggested that the Regional Office and intercountry programmes be strengthened in order to enable more effective and timely technical support to be extended to countries. The increased Regional Office and intercountry allocations could then be spent on increased collaborative activities in established WHO priority areas at the country level.

In conclusion, Dr Brundtland exhorted everyone to work together to grasp the opportunity and make this decade the decade that spread the health revolution to all (for full text, see Annex 5).

* * *

Responding to the Director-General's address, some delegates expressed concern over the assessment and ranking with respect to their respective countries in the *World Health Report 2000*. It was stated that the data and statistical figures used were incomplete, old or incorrect. The establishment of a high-level task force by the Regional Director to review the findings of the *World Health Report 2000* was appreciated. The Framework Convention on Tobacco Control was identified as a crucial priority area. Aspects relating to international agreements on trade were referred to and implications of TRIPS for the health of people in developing countries highlighted. It was suggested that countries be asked to identify and decide on the use of WHO resources for dealing with national priority areas.

The Director-General was requested to mobilize additional technical and extrabudgetary resources to better address the health problems in the Region. Particular focus was requested in three priority areas: HIV/AIDS; Stop TB, and Roll Back Malaria.

The Committee expressed concern about the availability and affordability of HIV/AIDS drugs. Issues of illiteracy, poverty, and the disease burden suffered by women in the Region were raised. Health and environmental problems arising out of issues like climate change, global warming etc. were highlighted. The importance of tele-health and tele-medicine as part of health development in the 21st century was underscored. The grave threat posed by dengue and dengue haemorrhagic fever in various countries of the Region was also highlighted. Drug trafficking and drug abuse were other areas which needed WHO technical assistance and collaboration.

It was pointed out that resources could be mobilized for health sector reform by involving the society and the private sector. Adequate attention should be paid to the area of disaster management. The area of efficiency savings and their reallocation to priority areas should be strengthened and decisions taken judiciously.

Responding, the Director-General said that the *World Health Report 2000* had generated enormous response and interest. The ranking of countries had drawn the welcome attention of heads of states towards health development. In this sense, it had served as a curtain-raiser for certain countries and had succeeded in enhancing political awareness. The weaknesses in the Report would be rectified with the help and assistance of countries.

Dr Brundtland said that women's health and gender issues are important and seen as aspects permeating many programmes. She highlighted the importance of the role of WHO Representatives in obtaining assistance from GAVI for Member Countries. Efforts would continue to increase the affordability and availability of drugs. Regarding climate changes, which affect the health of people, WHO was working with other UN agencies for possible preventive actions. WHO is improving its efforts and analysing the problems of dengue and dengue haemorrhagic fever alongwith malaria and kala-azar. Regarding extrabudgetary resources, the Director-General stated that WHO would continue efforts at impressing and convincing donors that their money was being put to good use for health development programmes.

**STATEMENT BY REPRESENTATIVE OF UNICEF,
REGIONAL OFFICE FOR SOUTH ASIA**

DR MONICA SHARMA, Deputy Regional Director, appreciated WHO's efforts in initiating technical discussions on major health issues such as equity in access to public health and healthy settings. Reconfirming UNICEF's commitment to support WHO's efforts on major health issues of infant mortality and morbidity, immunization, polio eradication, neonatal tetanus elimination, health of the poor and marginalized population, nutrition etc., she stressed the need for working together for improvement of children's health.

UNICEF placed emphasis on different components of early child development such as nutrition, reduction of vitamin A and iodine deficiency disorders, low birth weight, neonatal care, promotion of breast-feeding and integrated management of childhood illness.

Further collaboration was sought on health issues such as HIV/AIDS, Roll Back Malaria, technology management and human resource development as an integrated force for change to drive strategic options for sustainable development for health.

Attempts to mobilize partnerships within UN and other developmental agencies, civil societies and the private sector to develop sustainable mechanisms were major thrust areas of UNICEF'S future activities.

HIGHLIGHTS OF THE WORK OF WHO IN THE SOUTH-EAST ASIA REGION – REPORT OF THE REGIONAL DIRECTOR FOR THE PERIOD 1 JULY 1999 TO 30 JUNE 2000

(Agenda Item 5, document SEA/RC53/2)

INTRODUCING his report, for the period 1 July 1999 to 30 June 2000, the Regional Director said that it was a rather unique report as it reflected the health situation at the turn of the century. The South-East Asia Region continued to face the formidable challenge of ensuring equitable access to health care, with the scarce resources available, to one-fourth of the global population. The Member Countries were making admirable progress in the prevention and control of communicable and noncommunicable diseases as well as in strengthening health systems. With the increasing role of the private sector, the concerned national health authorities needed to ensure that it did not result in exploitation of the poor.

Recounting the progress made on several fronts during the year under review, the Regional Director underscored a few examples such as the Roll Back Malaria and Stop TB initiatives and the synchronized national immunization days. He stressed the need to further increase and maintain the high immunization coverage by improving the routine immunization programmes. WHO's continued support in strengthening the immunization programmes in Member Countries was assured.

Intercountry cooperation was further strengthened through regular cross-border meetings of concerned national and local health officials and administrators with the focus on control of

priority communicable diseases, such as malaria, HIV/AIDS and tuberculosis.

The Region had earned the distinction of becoming the first WHO Region to have been certified as guinea-worm free by the International Commission in February 2000. With 5.5 million people estimated to be infected with HIV, the Region was on the verge of becoming the centre of a global epidemic. It was therefore necessary to create public awareness to prevent and control STDs and ensure blood safety with greater emphasis on surveillance and research, he said.

Member Countries were adopting an integrated preventive approach to control noncommunicable diseases through appropriate efforts to promote healthy lifestyles among youth with the help of mass media. The South-East Asia Anti Tobacco (SEAAT) Flame was launched to create awareness on tobacco hazards.

Referring to the *World Health Report 2000*, Dr Uton informed the Committee that a high-level task force meeting had been convened in July 2000 to identify the gaps and weaknesses in the concepts, principles and methods used in the Report, and to suggest refinements for future reports in order that these could serve as more useful tools for health planners and decision-makers.

WHO continued to take a lead in encouraging international debate on priority issues by organizing several international conferences in the Region in the areas of tobacco control, prevention of blindness and public health in the 21st century. Furthermore, annual meetings of Ministers of Health and Health

Secretaries from countries of the Region as well as medical parliamentarians were organized. All of these provided fora to exchange views, experiences and possible solutions to problems of common concern, such as malaria, use of tobacco, polio eradication, tuberculosis control and poverty alleviation, as also cost-effective solutions such as use of traditional medicine in the health care systems of Member Countries.

Dr Uton informed the Committee that the 18th meeting of Health Ministers recently concluded in Kathmandu endorsed the intercountry approach to health development, and recommended development of an action plan including the criteria and indicators to utilize intercountry funds in consultation with the Member Countries. It also recommended preparation of regional action plans for eradication of leishmaniasis within a specific time frame and for health promotion, prevention and control of Japanese encephalitis, malaria, HIV/AIDS, dengue and arsenic contamination of drinking water.

WHO continued to support the Intercountry Cooperation for Health Development (ICHHD) initiative through adoption of the Manila Declaration and formulation of an Action Plan for seven priority areas. However, the commitment of the participating countries to ICHHD at the highest political and administrative levels was essential for its sustainability.

During the period under review, considerable extrabudgetary funds received by the Region were utilized for polio eradication, leprosy elimination, children's health, reproductive health, prevention and control of HIV/AIDS and tobacco control. However, ensuring the optimal utilization of WHO's resources by Member

Countries was an essential prerequisite to the attainment of better health for their populations.

The Regional Director recalled the various measures set in motion by the Director-General, including the formulation of the WHO Corporate Strategy, in order to improve the Organization's efficiency and to make its work more meaningful while addressing the priority needs of countries. At the Regional Office level too, similar measures were initiated, such as the Country Cooperation Strategy (CCS), aimed at improving WHO's collaborative activities at the country level.

In conclusion, the Regional Director stressed the need for improvement in efficiency, expansion of partnerships and broadening of horizons in view of the increasing budgetary constraints. The difficult task of WHO's mandate to protect, promote and improve people's health could be made easier by further strengthening collaborative efforts in the spirit of regional solidarity to achieve the cherished goal of health for all.

* * *

The Committee noted that countries of the Region faced varying degrees of economic crisis, which, to some extent, affected the health programmes. In addition to disease-specific intercountry programmes, technical support was needed for strengthening countries' capability in disease surveillance in order to detect new emerging diseases. In this direction, countries needed development and strengthening of necessary infrastructure, particularly establishment of laboratory facilities. Countries needed to understand the shift in the nature of

infectious agents and develop the capability for early identification of new agents such as Nipah virus causing encephalitis.

Referring to the scanty information on noncommunicable diseases in the Regional Director's Report, the Committee noted that countries were in the process of improving their health information systems, despite the increased financial implications, in order to make available quality data to facilitate better reporting. Prevention of deaths and injuries due to accidents, especially traffic accidents, was another priority in the countries, and its control required strong multisectoral action. In certain countries, deaths caused by accidents exceeded those caused by HIV/AIDS. WHO was requested to accord high priority to accident and injury prevention.

Concerned that violence against women was a major public health problem, the Committee sought WHO support in helping the countries to assess the determinants and consequences of violence against women. Help was also sought in developing effective policies and interventions to deal with this problem.

A Mega-Country Health Promotion Network covering the ten most populous countries with approximately 60% of the world's population was created by WHO. Bangladesh, India and Indonesia formed part of this network. WHO had prepared an Action Plan on Health Promotion in which seven areas had been identified for intercountry cooperation. Resources had been mobilized to support this initiative. Several important projects, such as Healthy Cities and health promoting schools, had been initiated and required continued support of WHO.

The Committee called for quantification of achievements by Member Countries during the period under review and suggested a modified format of the report with country-wise analysis. Specific information by country on various health activities was also suggested for inclusion to enable Member Countries to know about the activities undertaken by each of them. A chapter on mobilization of extrabudgetary resources by the Regional Office was also sought to be included in the report.

The Committee noted that health sector reform was one of the important priority areas for WHO support. In this context, it was essential to identify strengths and weaknesses in the health system in order to meet health challenges. In addition to technical aspects, management aspects also needed to be adequately addressed.

The Committee recognized the need to strengthen the national health surveillance systems for the control of both communicable and noncommunicable diseases (NCDs). A good and reliable laboratory infrastructure coupled with clinical research facilities would go a long way in improving and strengthening national health surveillance systems. The Committee noted that the global strategy for integrated NCDs had been developed by WHO/HQ and approved by the World Health Assembly in May 2000. The strategy focused on integrated surveillance and control of risk factors at both family and community levels.

The issue of family and community health, including adolescent health, was discussed and the need to ensure safe abortions stressed. The regional strategy on reproductive health, with special focus on reducing maternal mortality was supported. In addition, occupational and environmental health were sought to

be given priority in order to protect labour in the informal sector. Environmental issues had become important as a result of urbanization, industrialization and rapid development in the Region.

The Committee noted that the need to strengthen intercountry programmes was emphasized at the recently concluded Health Ministers Meeting in Kathmandu. Mutual cooperation between and among Member Countries and the Regional Office should be strengthened for the success of the programme. WHO's technical and financial support for intercountry cooperation for health development was also noted.

The Committee expressed its concern over the slow pace of research and development efforts for production of vaccines by Member Countries and agreed to accord high priority to the regular supply of quality drugs as well as to the production of anti-TB and essential drugs. The need to support cost-containment measures in the production of drugs and vaccines was emphasized. A multisectoral approach involving the pharmaceutical industry and all relevant partners was called for.

The Committee was informed that a small task force had been set up to study the details of the vaccine policy. The policy development process would continue to involve the countries very closely towards improving and strengthening EPI services, and ensuring the quality of vaccines.

The Committee noted that priority was being accorded to the Tobacco Free Initiative in countries of the Region.

The Committee also noted the coordinating role played by WHO in activities involving multiple donors. Emergency medical services needed to be taken up within the Emergency and Humanitarian Action and Social Change and Noncommunicable Diseases programmes. NGOs should also be actively involved in programme implementation.

The Committee noted that considerable progress had been made in cross-border collaboration, especially among countries belonging to the Western Pacific and South-East Asia regions.

The Committee was apprised that traditional medicine had been receiving increased attention for the past few years. It had been one of the priority areas for WHO collaboration. The Regional Office was developing a monograph, which would include information on current trends and practices and the status of traditional medicine in countries of the Region.

A resolution on the Regional Director's report was adopted (SEA/RC53/R1).

ADDRESS BY THE CHAIRMAN, 25TH SEA-ACHR

PROF. N.K. GANGULY, Director-General, Indian Council of Medical Research and Chairperson of SEA-ACHR, presented the conclusions and recommendations of the 25th session of the South-East Asia Advisory Committee on Health Research held in Bali, Indonesia in April 2000. He said that the SEA-ACHR had since been reconstituted to amalgamate both the important research bodies of ACHR and Medical Research Councils of Member Countries with expanded membership to reorient its work within the framework of

WHO's Corporate Strategy. ACHR now had new terms of reference and was poised to improve collaboration and coordination in health research in the Region. While remaining an advisory body to the Regional Director, it would also endeavour to function as a rapid response team to give appropriate advice to the Regional Director on emerging global, regional and national health research issues. This year's ACHR session emphasized the need for creating databases in the countries so that the information could be better managed.

The Global Forum on Health Research, COHRED and the WHO Kobe Centre as well as TDR and RPC/HQ also participated in the deliberations of the ACHR with a view to enhance and strengthen its involvement in the arena of international health research collaboration.

The ACHR made several recommendations in vital areas of health research management. These included management and coordination of health research, criteria for setting health research priorities, formulation of national health research policies and strategies, management of health research information, and also some specific important subjects such as HIV/AIDS research, operational research in reproductive health, strengthening ethical review and developing a regional vaccine policy.

In conclusion, Prof. Ganguly informed the Committee that the Regional Office was developing a web site on health research.

STATEMENTS BY THE REPRESENTATIVES OF UNICEF AND NONGOVERNMENTAL ORGANISATIONS

DR STEVE ATWOOD (Head of the Health Section, UNICEF, India Country Office) referred to the GAVI initiative in which UNICEF was an active partner. Raising the issue of safe disposal of syringes and development of new vaccines, he stressed the need for developing a suitable system for disposal of used syringes. UNICEF was actively involved with WHO in the development of guidelines and policy recommendations.

DR DELLA DAVIS and DR STEVE ATWOOD (UNICEF) commended WHO for the strategy for reduction of maternal mortality and said that UNICEF joined hands with WHO in addressing the challenge to reduce the maternal mortality rate. UNICEF promoted the cause of women's health by strengthening accountability in the provision of health care to all women.

The Committee was informed that the Women's Right to Life project had been set up with US \$12 million from the Gates Foundation for promoting the cause of child survival and safe motherhood. UNICEF was committed to holistically address issues of women's right to life; women's education and violence against women. Maternal deaths due to unsafe abortion needed to be prevented.

DR M.C. MAHESHWARI (International League against Epilepsy) said that epilepsy was the most common neurological illness globally. It was estimated that there were 40 million people suffering from epilepsy the world over—nearly 75 per cent of patients did not either seek or get medical treatment. Very few governments or departments of health had any plans for dealing

with the problem of epilepsy, which remained universally neglected. A recent study conducted jointly by WHO and the World Bank had revealed epilepsy to be a significant global health and economic burden.

DR S.K. KABRA (International Cystic Fibrosis (Mucoviscidosis) Association) drew the attention of the Committee to the incidence of *Cystic fibrosis* in South-East Asian countries, particularly India, leading to early deaths among affected children. He said that early detection of this disease would make a significant difference to the quality of life and the life expectancy of children, and called for creating awareness of this disease by incorporating it in the medical curriculum.

MS KIRAN KUKREJA (International Council of Women) said that although public health services were accessible to women in urban areas, their utilization was significantly low. Women, particularly those suffering from STDs/RTIs/HIV-AIDS were unable to avail of these facilities due to the insensitive attitude of the staff, and were forced to visit private clinics. Staffing of STD/RTI clinics with female doctors, nurses and paramedics would go a long way in addressing the situation and improving accessibility of services in a largely patriarchal society.

DR TULSI BASU (Medical Women's Association) highlighted the immunization activities covering polio, hepatitis B, DPT, BCG and measles, undertaken by her organization. She said that a group of self-sufficient committed women doctors had proved that they could make a difference to the community, without any external financial aid.

DR JAGJIT S. CHOPRA (World Federation of Neurology) stated that the mission of the Federation (WFN) was to improve human health globally through promoting the care of persons with disorders of the nervous system, by fostering the best standards of neurological education, and in promoting research. He highlighted areas of WFN's significant collaboration with WHO as well as with national and regional bodies. He underscored the importance of giving adequate attention to the diseases of the whole nervous system, and urged WHO to enhance its collaboration with countries in the prevention of neurological disorders.

DR ASHOK PATIL (International Association of Agricultural Medicine and Rural Health) was happy that the topic of healthy settings was being discussed at the Regional Committee. He stated that this area accordingly deserved more appropriate resource allocation as well. The social, economic and religious aspects also needed to be taken into consideration while addressing the issues related to healthy settings in order to ensure equitable access to health care for all – rural people in particular.

DR DIPAK SHUKLA (International Hospital Federation) mentioned that although hospitals were an important part of healthy settings, they suffered from shortcomings in the area of insect control, sanitation, ventilation and power supply. The resultant ailments acquired by patients prolonged their stay, causing additional financial burden on their families. As such, hospital infrastructure development was an area of serious concern. Better coordination between the public provider and the user would ensure a more cost-effective utilization of resources. Referring to blood safety, he urged countries to ensure that national transfusion policies clearly spelt out uniform standardized

testing procedures, thereby ensuring availability of safe blood to all sections of the community. Labelling of blood and blood products clearly listing the tests conducted would help consumers to be aware of the risks associated with incompletely tested blood. He also proposed setting up regional councils of professional experts in Member Countries with regulatory authority for evaluation, improvement and monitoring of blood transfusion service infrastructure and training.

DR S. NATH (Sulabh International Social Service) stated that though lack of hygiene and sanitation caused 70 per cent of diseases, this area did not receive its due share of resources. He urged WHO to facilitate setting up of a model in this Region to be followed by all Member Countries. School sanitation and hospital waste management were other critical areas that deserved greater attention.

MR ALAIN AUMONIER (International Federation of Pharmaceutical Manufacturers Associations) referred to the achievements mentioned in the *World Health Report 2000* with particular reference to Health Systems. He termed illness as a health crisis and felt that health insurance system or pre-paid health care services was the most effective and efficient mechanism in solving the crucial problem of equitable access to health. The pharmaceutical industry was involved in major research efforts in the battle against HIV/AIDS. He emphasized the significance of intellectual property rights for developing countries. He further stated that access to medicines was a matter of public and private partnership. Lowering the prices of anti-HIV/AIDS products in least developed countries by some companies was a recent initiative in this direction.

DR ARUN GUPTA (Consumer International) informed the Committee that Consumer International was a network of 150 citizens' groups. Referring to infant and young child nutrition, he highlighted the significance of breast-feeding as a priority area and mentioned the recent regulation in many countries regarding the minimum period of exclusive breast-feeding for six months. He requested that consideration be given to formulating a resolution on this subject.

DR M. NURUL ISLAM (World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians) informed the Committee that his organization had conducted a workshop as a follow-up to Resolution WHA48.8. Participants from WHO South-East Asia and Eastern Mediterranean Regions deliberated on ways of making medical education and practice more relevant to people's needs. The workshop recommended identification of needs and priorities of the community through surveys and reports; strengthening basic medical education; continuing medical education and coordination with related sectors, creating awareness through mass media and provision of cost effective drugs.

MR MANINDRA CHOUDHRI (International Association of Medical Laboratory Technologists - IAMLT) informed the Committee that the IAMLT was engaged in all fields of medical laboratory sciences supporting primary health care, hospitals, environmental and research facilities. IAMLT considered education in medical laboratory science as the cornerstone of ensuring quality of performance and health services.

PROFESSOR S.N. MUKHERJEE (International Association for Maternal and Neonatal Health) drew the attention of the Committee to the increasing number of preventable maternal deaths occurring worldwide, directly attributable to socioeconomic factors. He stressed that maternal morbidity was as important an issue as maternal mortality. The priority areas of concern for reducing maternal mortality were obstetric emergencies, reproductive pattern and spacing of pregnancies, unsafe abortions and inadequate contraceptive usage. He commended WHO on the Regional Strategy for Maternal Mortality Reduction.

DR ARVIND MATHUR (Aga Khan Foundation), complimented WHO for developing comprehensive regional strategies for reduction of maternal mortality in the South-East Asia Region, and said that the strategies seemed to be provider-oriented and system-focussed. The Foundation considered the mother to be the first level of the health system as the primary care provider as well as beneficiary. As such, mothers as well as future mothers (adolescents) play a vital and active role in decision-making, thus ensuring appropriate delivery of services by the health care provider. Appropriate public-private partnerships need to be developed in order to bridge the existing gaps and deliver an affordable and acceptable package of services. Quality of services and management were central to providing better health care to women.

DR RAJ KUMAR (ORBIS International) said that Vision 2020 had raised great hopes and expectations among eye professionals in the Region. Acknowledging the progress made in the prevention of blindness, he emphasized that there was a need to translate regional strategies into definite action plans. Commitment of

resources including WHO was, important for the success of the strategy.

MR R.D. TULSIRAJ (International Agency for the Prevention of Blindness), congratulating WHO on launching Vision 2020, appreciated the opportunity to work in partnership with WHO. He recommended enhancement of intercountry collaboration to reduce the disparity between Member Countries in terms of human resources and infrastructure. He said that WHO should assist in the development of appropriate mechanisms for sharing the strengths of Member Countries. He stressed the need for training of paramedical personnel to assist ophthalmologists in the countries, and sought the approval of the governments to pursue this.

PROPOSED PROGRAMME BUDGET 2002- 2003

(Agenda Item 7, documents PPB/2002 -2003, SEA/RC53/13 (Rev.1) and Corr.1)

THE COMMITTEE'S attention was drawn to the WHO Corporate Strategy addressing the challenges of the rapid evolution of international health. The Proposed Programme Budget for 2002-2003 (PPB 2002-2003) incorporated the new strategy as a policy framework.

The Committee was informed of certain remedial actions undertaken by WHO to overcome the budgetary constraints with respect to the 2000-2001 budget. These included Mutually Agreed Separations of staff, abolition and freezing of some Professional and General Service posts and the closure of the WHO Liaison Office at UN ESCAP, Bangkok. Intercountry activities and co-operation among Member Countries had also been strengthened.

The trend to further strengthen collaborative activities would continue during 2002-2003.

It was noted that the PPB 2002-2003 had been presented in two parts. Part I comprised a single strategic global budget based on the philosophy of 'One WHO'. The PPB 2002-2003 encompassed 35 priority programme areas, highlighted issues and challenges – supported by relevant technical information. It indicated overall goals to be achieved, as well as WHO's specific objectives in respect of these goals. It also enumerated expected results and their indicators, and gave an overview of the evaluation of results achieved. The Committee appreciated that a more analytical and informative approach had been adopted. Quantifiable targets had been indicated under each priority programme in the new PPB, which was a welcome change. The Committee noted that the PPB document was more programme-based and result-oriented. One important step in its formulation was to find the right balance between continuity and increased focus on the new priority areas.

Part II of the PPB 2002-2003 encompassed the regional situation within its ambit, and focused on region-specific strategies and priority actions. Intercountry health activities had been accorded appropriate emphasis. The recently-concluded 18th Meeting of Health Ministers of the Region, held in Kathmandu, had recommended an enhanced intercountry approach to health development in the Region to facilitate national capacity-building.

The Committee noted that the Regular budget at the regional level was guided by resolution WHA51.31, which proposed that up to 3% per year should be redistributed to Regions in greatest need.

The Committee further noted that the reduction of approximately 2.7% in the SEA Regional Budget allocation for the biennium was relatively lower than originally anticipated and thanked the Director-General for her consideration.

It was reiterated that funds from other sources would be mobilized to achieve WHO's global, as well as regional and national health goals. It was estimated that extrabudgetary funds for the Region would be equal to or higher than the Regular budget funds; the target was to raise around US\$ 100 million during 2002-2003.

The Committee observed that the PPB 2002-2003, as presented by the Director-General, is a global budget based on the philosophy of 'One WHO'. It further noted that the views of the Regional Committee would serve as an important input in finalizing the Budget. The Regular budget was described as a "finite budget", which could not be stretched beyond a certain limit. The budget formulation process had to respond to global change by setting a strategic direction for the Organization as a whole. The document outlined WHO's core functions and reflected how regional priorities could be addressed within global priorities.

The Committee endorsed broadly the observations and recommendations of the recently-concluded meeting of the 37th Consultative Committee for Programme Development and Management.

The Committee expressed concern over the non-inclusion of detailed programme-wise and country-wise information, in respect of allocations of extrabudgetary resources and the criteria adopted in such allocations. It was stated that Regional Office and country

offices had not been able to adequately convince the donors to mobilize extrabudgetary resources. The Regional Office should strengthen its capacity to support resource mobilization at regional and country levels. In order to ensure an equitable allocation globally of Regular budget and extrabudgetary resources to Member Countries, key aspects such as population, poverty, disease burden and national capacity etc. should be taken into consideration.

The Committee expressed its concern over the shifting of the budget allocation away from countries to the Regional Office/ICP. The Committee recommended that there should be a return to the same ratio of distribution of funds between country and RO/ICP as contained in the approved SEA Regional Programme Budget for 2000-2001.

The Committee emphasized that, in order to achieve the global targets of polio eradication and leprosy elimination by the established deadlines, enhanced allocations were needed. The Committee reaffirmed its commitment to protect the budget allocations of the Least Developed Countries of the Region in line with the terms of resolution WHA51.31. The Committee highlighted that SEAR carried about 40% of the total global disease burden and, therefore, needed additional support in terms of increased allocations for country-specific and intercountry activities. It was noted that since the Director-General was required to prepare the Programme Budget in accordance with WHA51.31, some redistribution of Regular budget funds from the Region was inevitable. Therefore, more extrabudgetary resources should be earmarked for SEAR.

The Committee further emphasized the need for greater participation between and among countries of the Region. The existing intercountry mechanisms which aimed at strengthening the participatory approach had proven effective. The Committee recommended proactive involvement and participation of Member Countries in all stages, from planning to programme evaluation, of the intercountry programme. Effective and efficient utilization of funds should be given priority. The Committee stressed the need for better monitoring. The Committee was informed that the team constituted by the Regional Director to carry out efficiency studies had analysed the working of country offices as well as the Regional Office. Their recommendations on improved monitoring and follow-up had already been received and would be implemented.

The Committee noted the improved flow of information from the Regional Office to the country offices in the form of monthly reports containing useful budgetary information on collaborative activities. It was emphasized that better information exchange is crucial.

The Committee expressed concern at the increased allocation for the Regional Director's Office, especially against the backdrop of a decreasing regional budget. It was, however, clarified that there was no overall increase in the number of staff posts, and that the higher allocation resulted from a redistribution of existing staff posts following the restructuring of the Regional Office in line with HQ clusters. The issue was under review at present and it was likely that the allocation would be revised.

The Committee agreed that human resources development, and the malaria, TB and HIV/AIDS programmes were priority areas

for the Region and merited higher allocations. Other important programmes/areas, such as cancer, tobacco, maternal health, food safety, mental health, blood safety, health systems and investing in change, should also be accorded greater priority. Mental health was not receiving due attention as a significant health problem. Other areas of priority for the Region included dengue, Japanese encephalitis and contamination of ground water. However, this was not a comprehensive list and more areas could be identified and added. The need for a higher allocation of funds for the prevention and control of noncommunicable diseases was also stressed.

The Committee was informed of the current trend of donor agencies to be more inclined to invest in health. The Director-General had been continuously negotiating with donor agencies to mobilize funds resulting in increased availability of extrabudgetary funds for WHO for the coming bienniums. Polio eradication, research in human reproductive health and tropical diseases research, including malaria and child health were some of the priority areas which appealed to the donors. So far, donors had not come forward to support proposals for advocacy on health issues, which was the reason why in the last two bienniums intercountry funds had been allocated for this purpose. The Committee noted that an extensive exercise at the country level was needed to identify country resources, prioritize health programmes and match common areas of health concerns with the donor countries. The WHO country offices could take a lead in this regard.

It was clarified that the role of Regional Committees is to comment and make recommendations on the budget allocations. The recommendations of the Regional Committees are then

submitted to the Executive Board for comments, which are forwarded to the World Health Assembly for final approval.

The Committee appreciated the Regional Director's initiative to immediately establish a high-level task force to advise on the preparation of a comprehensive intercountry programme.

A resolution on the subject was adopted (SEA/RC53/R2).

CONSIDERATION OF THE RECOMMENDATIONS ARISING OUT OF THE TECHNICAL DISCUSSIONS ON: (1) "EQUITY IN ACCESS TO PUBLIC HEALTH", AND (2) "HEALTHY SETTINGS"

(Agenda Item 8.1)

THE COMMITTEE was informed that Technical Discussions on the two subjects had been held in conjunction with the 37th meeting of CCPDM, in accordance with the decision of the Regional Committee (SEA/RC51/R4). Reports of the Technical Discussions on both subjects had been placed before the Committee for deliberation.

Technical Discussions on "Equity in Access to Public Health"

(document SEA/RC53/18)

DR KYI SOE (Myanmar), Chairman of the Technical Discussions, presented the report and recommendations contained in document SEA/RC53/18. He said that *Equity in health* denoted minimizing unfair or unjust disparities in health. Norms or standards regarding what is considered fair or just vary from country to country, person to person and time to time. It is for this reason that the notion of equality is becoming more frequently used. This calls for intersectoral collaboration, political commitment and refinement of the conceptual framework to measure the level of equity in health

and health care. Adherence to ethical practices and standards of health care including certification of health institutions, preventive and promotive health services in the private sector, and people's access to health information should be ensured. Concerted efforts should be made at the political and policymaking levels to redress the disparities in health and its determinants and to follow the standards of good health practices. Collection, analysis and utilization of disaggregated data was part of total health sector reform. Provision of essential quality health care services to all should be governed by needs rather than people's purchasing power.

The difficulties in setting norms leading to different perceptions about the terms 'equity' and 'equality' were acknowledged. The Committee was informed that equity was mainly concerned with reducing the gaps between the rich and the poor by setting up specific, unambiguous targets regarding health and access to health care. This could be ensured by strengthening existing health information systems to provide data disaggregated by sex, income, etc. to enable the formulation of specific interventions to address inequities. Resources also needed to be allocated in a cost-effective manner.

Reviewing the recommendations emanating from the Technical Discussions, the Committee noted that distribution and use of new, high-cost technologies resulted in increasing the gulf between the rich and the poor. Mechanisms needed to be developed to reduce this gap and make health care freely accessible to the poor and marginalized population.

The Committee observed that, though the role of the health care providers was emphasized, the role of the community was equally important in ensuring equity. The Committee recognized that equity in access to public health was a basic right of the community.

The necessity to institute a health insurance mechanism to reduce the inequities in access to health care caused by other determinants besides poverty was recognized. WHO assistance was sought in the establishment of a social security system including health care to benefit the poorest segments of society. The Committee noted the report and endorsed the recommendations of the Technical Discussions.

A resolution on the subject was adopted (SEA/RC53/R3).

Technical Discussions on "Healthy Settings" (*document SEA/RC53/19*)

DR B.D. CHATAUT (Nepal), Chairman of the Technical Discussions, presented the recommendations as contained in document SEA/RC53/19. The Committee noted that identification of pilot districts and establishment of necessary infrastructure by Member Countries for undertaking healthy district projects; strengthening human resources for managing their implementation, monitoring and evaluation; active involvement of communities, NGOs and the private sector were critical to the success of the healthy settings approach.

Noting that the concept and practice of healthy settings had already been demonstrated in several Member Countries, the Committee suggested that a healthy district could be the umbrella

for various healthy settings. The Committee agreed that political will, sustained efforts, active involvement of the community, partnerships with NGOs, intersectoral coordination, and building supportive social environments would help to achieve the goals of healthy settings projects. Action plans for capacity building at country level should be developed for sharing experiences of the healthy settings approach among SEAR countries. The Committee felt that this approach was also useful to villages and marginalized populations in remote areas, as it provided scope for a coordinated effort from NGOs and local groups. It would also help in prevention and early treatment of diseases such as cancer, hepatitis, etc. through appropriate screening of people.

The Committee appreciated the efforts of Myanmar in launching a "National Sanitation Week". Decentralized planning and political commitment to the programme at the highest level had resulted in substantial increase in coverage of both the rich and poor in urban and rural areas during the last two years. "Self-help" by the community was the key to the success of this approach. The Committee noted that simple, low cost techniques in providing good sanitation facilities to the people prevented the incidence of faecal-borne diseases, leading to reduction in mortality and morbidity in the long run.

The Committee also observed that while the healthy settings approach was important as a process, what was significant were the outcomes and the managerial mechanism to achieve these outcomes.

The Committee agreed with the need to ensure safe disposal of syringes and other materials. It was, however, felt that the magnitude of the immunization programme had to be taken into consideration.

In view of the exhaustive discussions as well as valuable recommendations made on the subject by the CCPDM as noted from its report, no further comments were made by any of the country representatives.

The Regional Director commended the Member Countries for the initiatives taken by governments in the area of healthy settings and assured them of WHO's support to supplement their efforts. However, he emphasized the need for greater political commitment. He also acknowledged the significant contributions made by some nongovernmental organizations in this area.

A resolution on the subject was adopted (SEA/RC53/R4).

REGIONAL IMPLICATIONS OF THE DECISIONS AND RESOLUTIONS OF THE FIFTY-THIRD WORLD HEALTH ASSEMBLY AND THE 105TH AND 106TH SESSIONS OF THE EXECUTIVE BOARD AND REVIEW OF THE DRAFT PROVISIONAL AGENDAS OF THE 107TH SESSION OF THE EXECUTIVE BOARD AND FIFTY-FOURTH WORLD HEALTH ASSEMBLY
(Agenda Item 9, documents SEA/RC53/12 and Inf.1)

Part 1

THE COMMITTEE was informed that in accordance with the decision of the forty-seventh session of the Regional Committee, a document containing important decisions and resolutions passed

by the World Health Assembly and the Executive Board had been reviewed by the CCPDM. The purpose of presenting the document to the Committee was to seek its response on the important resolutions which had regional implications. Of the eight selected resolutions, the Committee focused on two specific resolutions: (1) Global Alliance for Vaccines and Immunization (GAVI) (WHA53.12), and (2) Framework Convention on Tobacco Control (WHA53.16).

GAVI, a global network of governments, bilateral agencies, WHO, UNICEF, the World Bank, the pharmaceutical industry, the Bill and Melinda Gates Foundation and the Rockefeller Foundation, was aimed at improving immunization services including the introduction of new vaccines and expanded use of vaccines. The Committee noted the recommendation of the CCPDM for Member Countries to play a proactive role to enhance resources for immunization.

The Committee took note of the need for Member Countries to implement tobacco control measures, including development of legislative frameworks and the plan to establish an intergovernmental negotiating body to negotiate specific public health issues and to prepare a draft framework convention on tobacco control.

The Committee also noted that the other areas to be accorded priority were: the prevention aspects of HIV/AIDS (WHA53.14); technical assistance to develop/update rules/regulations for controlling allowable claims regarding marketing and labelling of food products including health foods; the need for WHO to provide technical support to country representatives for their active involvement in the regional and global Codex Committees (WHA53.15)

Part 2

THE COMMITTEE was informed that in view of the correlation of the work of the Regional Committees with that of the Executive Board and the World Health Assembly, it was customary to review the agendas of the forthcoming sessions of these two bodies. However, only the draft provisional agenda for the 107th session of the Executive Board to be held in January 2001 was available. The Agenda included the topics of global strategy for infant and young child feeding, health promotion, health surveillance and risk; international health regulations, strengthening of health services and the Proposed Programme Budget for 2002-2003.

The Committee noted the recommendations of the CCPDM to organize comprehensive briefing for all EB members and WHA delegates from the Region well before the sessions; and that important issues pertaining to arsenic contamination in ground water affecting some countries of the Region which had been discussed at the EB/WHA be included in the next session of the Regional Committee.

UNDP/WORLD BANK/WHO SPECIAL PROGRAMME FOR RESEARCH AND TRAINING IN TROPICAL DISEASES: JOINT COORDINATING BOARD (JCB) – REPORT ON 2000 JCB AND NOMINATION OF A MEMBER IN PLACE OF INDIA WHOSE TERM EXPIRES ON 31 DECEMBER 2000 (*Agenda Item 10.1, document SEA/RC53/5 (Rev.1)*)

THE COMMITTEE was informed that on behalf of India, Sri Lanka and Indonesia, the representative from Indonesia had reported on the deliberations of the 23rd session of the JCB, held in Geneva in June 2000 to the 37th Meeting of CCPDM. Considerable progress

had been made in tropical diseases research through the partnership approach and with greater involvement of the private sector. JCB accorded high priority to dengue, tuberculosis and malaria, research in diagnostics and the need for information network.

The Committee nominated Bangladesh as a member of JCB for three years from 1 January 2001 to 31 December 2003.

**WHO SPECIAL PROGRAMME FOR RESEARCH DEVELOPMENT
AND RESEARCH TRAINING IN HUMAN REPRODUCTION,
POLICY AND COORDINATION COMMITTEE (PCC) – REPORT
ON 2000 PCC AND NOMINATION OF A MEMBER IN PLACE OF
INDONESIA WHOSE TERM EXPIRES ON 31 DECEMBER 2000**

(Agenda Item 10.2, document SEA/RC53/9 (Rev. 1))

THE COMMITTEE noted that, on behalf of Bangladesh and Indonesia, the representative from Bangladesh reported on the deliberations of the 13th session of the PCC, held in Geneva in June 2000 to the 37th meeting of CCPDM. The PCC deliberated on integrated management of pregnancy and child-birth, research related to HIV/AIDS, making pregnancy safer initiative and progress of the human reproduction programme.

The Committee renominated Indonesia to the PCC for a further period of three years from 1 January 2001 to December 2003.

**HEALTH TECHNOLOGY AND PHARMACEUTICALS: REPORT OF
THE MEETING OF INTERESTED PARTNERS (MIP)**

(Agenda Item 10.3, document SEA/RC53/8 (Rev. 1))

THE COMMITTEE was informed that following a reorganization of related clusters in WHO/HQ the Meeting of Interested Partners (MIP) of all cosponsored programmes of all the clusters would be held together, in a composite manner, in future. The participation of Member States in such a meeting will be pursued according to the need.

The Committee noted the observations by the 37th meeting of the CCPDM on the report of a representative from Myanmar on the MIP held in April 2000.

**REGIONAL STRATEGY ON PROMOTION OF BLOOD SAFETY
IN MEMBER STATES** (*Agenda Item 11, document SEA/RC53/7*)

THE COMMITTEE noted the proposed regional strategy for development of national blood safety programmes to ensure safety, quality and adequacy of blood and blood products. There was a general shortage of blood, with 80 per cent of the global population in developing countries having access to only 20 per cent of the global supply of safe blood. WHO proposed a five-pronged strategy through establishment of well organized national coordinated blood transfusion services, careful selection of safe blood donors, screening and testing of donated blood, quality assurance and appropriate clinical use of blood.

Though some progress had been made with regard to the provision of safe blood, yet the safety and adequacy of blood was far from satisfactory in most Member Countries. With the advancement in medical and surgical specialities, resulting in a higher demand for blood and blood products, the demand-supply ratio was likely to further worsen, making it difficult for countries

to sustain national transfusion programmes. The Committee noted WHO's five key strategies for strengthening blood transfusion services which could be considered as a checklist for improving safe supply of blood in Member Countries. The strategies which were crucial in the context of the prevailing systems of blood supply and health care delivery in Member Countries should be prioritized and implemented.

The Committee noted the progress of blood safety measures introduced by several Member Countries.

The Committee was informed that the Indonesian Red Cross Society had blood transfusion units in every big city, which functioned in accordance with the Society's standards. However, accessibility to safe blood was low in the rural areas, resulting in higher maternal mortality on account of postpartum haemorrhage. WHO technical support was requested for setting up reliable blood testing facilities in the rural areas.

DPR Korea endorsed the need for a regional strategy for promotion of blood safety. WHO support was sought in ensuring implementation of strict measures for blood testing, thereby guaranteeing availability of safe blood in medical institutions; rational use of blood and blood products, appropriate transfusion; and designing programmes to motivate voluntary blood donors for periodic donation.

A resolution on the subject was adopted (SEA/RC53/R6).

REGIONAL STRATEGY ON PROMOTION OF FOOD SAFETY IN

MEMBER STATES *(Agenda Item 12, documents SEA/RC53/6 (Rev.1) and Add.1)*

REFERRING to the World Health Assembly resolution WHA53.15, the Committee recalled the request of the countries to the Director-General to proactively pursue the development of international standards, regulations and guidelines appropriate for developing countries. It should be ensured that international food regulations and guidelines protected developing countries and did not impose unrealistic requirements due to conceptual differences in the perception of what constituted risk.

The Committee noted that food safety issues in most countries of the Region were very fundamental. Absence of programmes incorporating good manufacturing practices and standard sanitary operating procedures necessitated that basic food hygiene interventions be accorded the highest priority. The most pressing food safety risks in the Region were lack of personal hygiene, contaminated raw materials, high-risk street foods and local foodstuffs.

Intersectoral involvement in the food chain was necessary for the successful implementation of food safety programmes. The agricultural sector should also be included in the regional strategy, as it was concerned with the use of antibiotics and pesticides.

The Committee observed that there was wide variation in food safety programmes in the Region. The control of genetically modified organisms could be achieved by the development of legislation appropriate to the country situation.

Concerning the appropriateness of Codex Alimentarius standards in the regional context, the Committee appreciated that WHO was supporting full participation of Member Countries in the work of the Codex. The Committee suggested that countries must ensure the active participation of concerned health professionals at the Asian Codex meeting in September 2001.

The Committee lauded the efforts of the Regional Office for its plans to hold a regional workshop to address the incorporation of the Hazard Analysis Critical Control Point (HACCP) system in food inspection programmes, and its use as a means of controlling food safety.

A resolution on the subject was adopted (SEA/R53/R7).

REGIONAL STRATEGY ON VISION 2020: THE RIGHT TO SIGHT

(Agenda Item 13, document SEA/RC53/3 (Rev.1))

THE COMMITTEE agreed that there was an acute shortage of adequately trained ophthalmic manpower in the Region. The human resources programmes in the countries needed to be strengthened and made more comprehensive to attract greater participation of paramedical personnel.

The Committee noted that the Regional Strategy on Vision 2020 would be implemented in a phased manner. Most countries accorded high priority to the prevention of blindness, as evidenced by the increase in the number of cataract surgery cases. The Committee suggested that the Regional Coordination Group recently constituted by WHO should also include eminent ophthalmologists.

WHO support was sought to train general practitioners to perform cataract surgery, in countries which had a severe shortage of ophthalmologists. This required close monitoring by ophthalmologists to ensure the quality and safety aspects. The Committee observed that intercountry technical cooperation for the local production of high quality intraocular lenses needed strengthening to make them more affordable to the poor and marginalized population.

The Committee took note that the existing PHC infrastructure had been utilized to successfully introduce the blindness prevention programme in some countries. It lauded the key role played by local and international NGOs, coupled with promotional and educational campaigns.

The Committee recognized that accidents and cataract contributed to the increasing number of blind. The commitment of professionals, paramedical personnel and community participation were essential to meet the challenge.

A resolution on the subject was adopted (SEA/RC53/R8).

REGIONAL STRATEGY FOR REDUCTION OF MATERNAL MORTALITY IN THE SOUTH-EAST ASIA REGION

(Agenda Item 14, document SEA/RC53/11)

THE COMMITTEE noted that the South-East Asia Region accounts for 40 per cent of the global maternal mortality rate. The major causes of maternal deaths were haemorrhage, infection, hypertension, obstructed labour, unsafe abortion and a range of diseases aggravated during pregnancy, such as malaria, hepatitis, rheumatic heart disease and diabetes, all of which could be

prevented or treated cost-effectively at community or district hospitals.

The Committee appreciated the concerted efforts of Member Countries on the Safe Motherhood Initiative since 1987 to address the extremely serious public health problem of maternal death and disability. The International Conference on Population and Development in Cairo in 1994, and the Fourth World Conference on Women in Beijing in 1995 had called for greater efforts to achieve a rapid and substantial reduction in maternal mortality and morbidity caused by childbirth and unsafe abortion. The UN General Assembly Special Session on Population and Development emphasized the need to intensify efforts at all levels for reducing the prevailing high levels of maternal mortality. Further, WHO launched the Making Pregnancy Safer Initiative in early 2000, promoting trained attendance at childbirth, strengthening the health system and building partnerships at various levels including families, communities, donors and civil societies. However, efforts to reduce avoidable deaths of women during childbirth needed to be intensified.

The Committee suggested that in their efforts to expand and improve the coverage of essential health care services and infrastructure, the countries of the Region should train and utilize appropriate personnel in midwifery skills so that they could cope with emergency obstetric complications. Hospital services should be further strengthened to manage postpartum haemorrhage.

The Committee recommended the adoption of a unified approach in the regional strategy for reduction of maternal

mortality, particularly to address the issue of unwanted pregnancies leading to maternal deaths.

The Committee appreciated the extensive measures taken by several Member Countries for improving coverage of antenatal care, attendance by trained personnel at birth and postpartum care. A large number of first referral units were also set up to provide essential obstetric care including post-abortion care. The Committee noted the use of voluntary health workers consisting largely of village women in providing care to the pregnant mother and appropriate health education. It was also noted that a few countries have conducted studies on maternal mortality and had requested WHO to provide technical and financial support to expand such studies, in some cases, on a nationwide basis.

A resolution on the subject was adopted (SEA/RC53/R9).

**FOLLOW-UP ACTIONS TAKEN ON THE RESOLUTIONS OF THE
PREVIOUS FIVE SESSIONS OF THE REGIONAL COMMITTEE,
MEETINGS OF THE HEALTH MINISTERS AND HEALTH SECRETARIES**

(Agenda Item 15, documents SEA/RC53/16 and (Add.1))

THE COMMITTEE noted that a wide range of issues of vital importance were covered in the meetings of the Health Ministers and Health Secretaries as well as in Regional Committee sessions. Inclusion of follow-up actions emanating from the meetings as an agenda item helped in critically analyzing the actions taken by countries as well as by the Regional Office.

The Committee suggested that taking up a particular resolution, instead of all, would facilitate closer examination and evaluation of the actions taken by Member Countries and the

Regional Office, and pave the way for further follow-up by providing remedial measures for any barriers identified in implementation. The Committee agreed that evaluation of the implementation of one priority programme area at intercountry level, selected from the previous resolutions, in consultation with the countries, would be a more effective method of follow-up.

THE FRAMEWORK CONVENTION ON TOBACCO CONTROL IN THE SOUTH-EAST ASIA REGION (*Agenda Item 16, document SEA/RC53/14*)

THE COMMITTEE noted the extensive tobacco control measures taken by the countries of the Region during the past two years. Legislation to ban smoking and spitting in public places, declaration of smoke-free public places and imposition of a special levy on tobacco use were some of the preventive measures promoted by WHO. Various studies testified to the fact that tobacco companies in some countries resorted to dubious marketing strategies such as smuggling and sponsoring health programmes to systematically derail the tobacco control measures.

The Committee, recalling resolution WHA52.18 related to the development of an International Framework Convention for Tobacco Control (FCTC) in accordance with Article 19 of the WHO Constitution, appreciated the efforts of WHO in initiating the negotiation process. Since the negotiations on the Framework Convention on Tobacco Control (FCTC) were to begin soon, Member Countries needed to take up this matter at the highest political level.

The Committee took note of the preparations for the draft framework convention and related protocols in dealing with tobacco control measures. It called for active participation by

Member Countries in the negotiations at the meeting proposed to be held from 16–21 October 2000, which might involve major political decisions.

The Committee observed that there may be some limitations among Member Countries in implementing the FCTC and related protocols due to various political and socioeconomic constraints.

A resolution was adopted on the subject (SEA/RC53/R10).

**CROSS-BORDER COLLABORATION ON CONTROL OF
COMMUNICABLE DISEASES** (*Agenda Item 17, document SEA/RC/53/15*)

THE COMMITTEE expressed satisfaction at the inclusion of this subject as an agenda item as well as at the very succinct working document. It was noted that HIV/AIDS, TB, malaria, visceral leishmaniasis (kala-azar) and emerging diseases such as Japanese encephalitis and Nipah viral epidemics were among the areas meriting mutual cross-border collaboration. The Committee commended the WHO initiative in developing a regional framework, facilitating investigation and organizing several cross-border intercountry meetings and related activities. The Committee called for appropriate local coordination mechanisms to ensure the implementation of recommendations made at these meetings.

Apart from cross-border intercountry meetings, the Committee suggested the need for interregional meetings as some Member Countries shared borders with countries of other regions such as the Western Pacific (WPR) and the Eastern Mediterranean (EMR). The Committee acknowledged the need for a strong surveillance system, evaluation of outcomes of cross-border

meetings as well as a synchronized and coordinated approach to tackle diseases common to both sides of a border.

The Committee requested WHO to establish a task force for developing a coordinated and coherent policy on cross-border control of priority diseases. The interregional coordination mechanism would facilitate translation of policy decisions into action at district level in border areas. The Committee also urged WHO to focus on intercountry and interregional cooperation and resource mobilization.

The Roll Back Malaria project was cited as an example of successful interregional collaboration involving the Regions of South-East Asia and the Western Pacific. Separate Memoranda of Understanding had also been signed by some Member Countries with international bodies such as ASEAN and SAARC for conducting joint activities in cross-border control of priority diseases.

A resolution was adopted on the subject (SEA/RC53/R11).

**SELECTION OF A SUBJECT FOR THE TECHNICAL DISCUSSIONS
TO BE HELD PRIOR TO THE FIFTY-FOURTH SESSION OF THE
REGIONAL COMMITTEE** (*Agerda item 8.2, document SEA/RC53/10*)

THE COMMITTEE selected "Mental Health and Substance Abuse, including Alcohol" for the Technical Discussions to be held during the meeting of the CCPDM prior to the Regional Committee Meeting in 2001.

A resolution was adopted on the subject (SEA/RC53/R5).

TIME AND PLACE OF FORTHCOMING SESSIONS OF THE REGIONAL COMMITTEE (*Agenda item 18, document SEA/RC53/4*)

THE COMMITTEE accepted the confirmation by the Government of the Union of Myanmar to host its fifty-fourth session in early September 2001 (the exact venue to be confirmed in due course).

The Committee accepted the invitation of the Government of the Republic of Indonesia to host its fifty-fifth session in Indonesia in 2002. In accordance with relevant resolutions of previous sessions of the Regional Committee, it decided to hold its fifty-sixth session in 2003 at the WHO Regional Office for South-East Asia in New Delhi, India.

A resolution was adopted on the subject (SEA/RC53/R12).

CONSIDERATION OF DRAFT RESOLUTIONS

THE COMMITTEE adopted 13 resolutions.

ADOPTION OF THE FINAL REPORT OF THE FIFTY-THIRD SESSION OF THE REGIONAL COMMITTEE (*Agenda Item 19*)

The Committee adopted the draft final report of its fifty-third session, as contained in document SEA/RC53/21.

CLOSURE OF THE SESSION (*Agenda Item 20*)

THE REPRESENTATIVES from Member Countries congratulated the Chairman and the Vice-Chairman for their wisdom and skill in conducting the session smoothly. They were unanimous in expressing their appreciation and gratitude for the generous

hospitality and courtesies extended to them by the Government of India. They expressed gratitude to H.E. Dr C.P. Thakur, Minister for Health and Family Welfare, Government of India, for inaugurating the fifty-third session of the Regional Committee and for his inspiring address. They also thanked the Director-General, WHO, Dr Gro Harlem Brundtland for attending the session and for her thought-provoking and stimulating address during the business session. They expressed satisfaction with the deliberations, which would help in finding solutions to a variety of health-related problems facing the countries of the Region. Most of the representatives hoped that with collective efforts and continued collaboration between Member Countries and WHO, many health problems affecting the poor in particular, would be tackled effectively.

The Regional Director in his closing remarks said that the deliberations and resolutions adopted by the fifty-third session of the Regional Committee would set the tone for the work of WHO in the Region in the coming years. Referring to some important areas such as blood safety, food safety, prevention of avoidable blindness, FCTC, cross-border collaboration in the control of communicable diseases; equity in access to public health and healthy settings, he expressed the need for a stronger intercountry mechanism to help the Member Countries to tackle their common health problems more effectively. The Regional Director reiterated that a high-level task force would be constituted at the earliest for this purpose. He thanked H.E. Dr C.P. Thakur, Minister for Health and Family Welfare, Government of India, for gracing the inaugural session and for his stimulating address. He also thanked the officials of the Ministry of Health and Family Welfare, Government

of India, and members of the organizing committee for making the meeting a success. He commended the Chairman and Vice-Chairman for the excellent manner in which they conducted the proceedings. Valuable contributions made by the distinguished delegates, which would go a long way in strengthening the collaborative activities in the Region, were appreciated.

The Chairman acknowledged that it was an honour and privilege for him to be elected to the office, and thanked the representatives for their cooperation and understanding during the course of the meetings. He expressed his abiding faith in international organizations and remarked that the world was one big global family. Active participation by all countries at forums such as the Regional Committee sessions always helped in arriving at workable solutions to specific problems, he added. He was happy that the candid discussions had helped in harmonizing even conflicting viewpoints and in bringing out the shared commonality of the health problems facing the Region. He applauded WHO's role in providing high-quality technical know-how and in fostering a feeling of brotherhood among Member Countries. He also praised the WHO Director-General as a great supporter of the poor and the underprivileged and as a dynamic and outstanding personality, who had given life and momentum to the Organization.

In conclusion, the Chairman thanked the Director-General, WHO, for her inspiring address, and the Regional Director and his team for their useful contribution in making the Regional Committee session a success. He also expressed his gratitude to members of the Organizing Committee, for their tireless efforts in ensuring the success of the event. The contributions made by

NGOs were acknowledged, as through them, millions of people got access to reasonable public health care. He conveyed his special thanks to the Vice-Chairman for effectively conducting the session in his absence.

He then declared the meeting closed.

Part IV

RESOLUTIONS

SEA/RC53/R1 REPORT OF THE REGIONAL DIRECTOR

The Regional Committee,

Having reviewed and discussed the report of the Regional Director containing highlights of the work of WHO in the South-East Asia Region for the period 1 July 1999 to 30 June 2000 (SEA/RC53/2), and

Recalling its own resolution SEA/RC52/R2, relating to preparation of annual and biennial reports on the Work of WHO,

1. NOTES with satisfaction the progress made during this period in the implementation of WHO's collaborative programmes and activities in the Region;
2. CONGRATULATES the Regional Director and his staff for bringing out a clear and comprehensive report, and
3. REQUESTS the Regional Director, that future reports should:
 - (a) highlight the results achieved and provide details of related financial expenditure, and

- (b) provide more detailed information on flow of funds from both regular and extrabudgetary sources, country-wise and programme-wise.

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SEA/RC53/R2 PROPOSED PROGRAMME BUDGET 2002-2003

The Regional Committee,

Noting with appreciation the Director-General's emphasis on WHO's Corporate Strategy for improving the effectiveness of the Organization, and her proposed approach to the implementation of resolution WHA51.31 in the South-East Asia Region,

Having considered the Proposed Programme Budget for 2002-2003 (Part-I) (document PPB/2002-2003) and Part-II (document SEA/RC53/13 (Rev.1) and Corr.1), and the report of the 37th meeting of the Consultative Committee for Programme Development and Management (CCPDM) (document SEA/PDM/Meet.37/8),

Taking note of the recommendations of the 18th Meeting of Health Ministers on rationalizing WHO resources to strengthen intercountry collaboration, and

Recognizing that the Proposed Programme Budget for 2002-2003 provides the strategic framework and objectives for the work of "One WHO",

1. ENDORSES broadly the recommendations of the 37th Meeting of the CCPDM, subject to the qualifications stated below;

2. EXPRESSES concern at the reduced regional Regular Budget allocation compared to certain other regions and at the proposed shift of funds from the country to the regional office/intercountry programme;

3. APPRECIATES the Regional Director's initiative to establish a high-level task force with members from all countries of the Region, to advise him on the preparation of an enhanced intercountry programme, and

4. REQUESTS the Regional Director to convey the following points to the Director-General for her consideration while finalizing the Proposed Programme Budget for 2002-2003:

(a) to maintain the same budgetary allocation ratio between the country and regional levels and among countries as in the approved budget for 2000-2001, and

(b) to consider ways and means in consultation with international development partners for increasing the overall allocation of extrabudgetary resources to the South-East Asia Region for country and intercountry programmes.

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SEA/RC53/R3 EQUITY IN HEALTH AND ACCESS TO HEALTH CARE

The Regional Committee,

Recalling World Health Assembly resolution WHA51.7, adopting the World Health Declaration on Health for All Policy for

the 21st Century; and also its own resolution SEA/RC50/R4 on the Declaration on Health Development in the South-East Asia Region in the 21st century,

Recognizing the need for ensuring equity in access to health and health care, particularly for women, the poor and other vulnerable groups,

Emphasizing the provision of essential health care for all, through appropriate health sector reform, and

Having considered the report and recommendations of the Technical Discussions on "Equity in access to Public Health" (SEA/RC53/18),

1. ENDORSES the recommendations contained in the report;
2. URGES Member States:
 - (a) to develop and/or refine the conceptual framework, indicators, methodologies and tools for measuring inequity in health and access to health care;
 - (b) to strengthen the national health information systems in collection and analysis of disaggregated data, particularly covering women, the poor and vulnerable groups, to enable formulation of policy options for enhancing equity in access to health care;
 - (c) to enhance accessibility and affordability of health care for the poor and vulnerable groups, and
 - (d) to intensify health sector reform efforts that contribute to reduction of inequity in access to health care, and

3. REQUESTS the Regional Director:

- (a) to intensify cooperation and exchange of experiences with Member States and relevant health development partners in strengthening the national health information systems, with special emphasis on disaggregated data related to women, the poor and other vulnerable groups to help minimize inequity in health and access to health care, and
- (b) to support Member States in research studies to help improve equity in health and access to health care particularly for women, the poor and other vulnerable groups.

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SEA/RC53/R4 HEALTHY SETTINGS

The Regional Committee,

Recalling the World Health Assembly resolutions WHA51.12 and WHA51.28 relating to health promotion and environmental health, and its own resolutions SEA/RC40/R5 and SEA/RC41/R8 relating to development of comprehensive district health systems,

Recognizing the need for intersectoral action for sustainable health development and its relevance in the "healthy settings" approach,

Emphasizing that the healthy settings can be initiated within the various national health promotion and health development

programmes, such as healthy cities and islands, health promoting schools, healthy workplaces, and healthy districts, and

Having considered the report and recommendations of the Technical Discussions on "Healthy Settings" (SEA/RC53/19),

1. ENDORSES the recommendations contained in the report;
2. URGES Member States:
 - (a) to identify by the end of 2001, at least one district to pilot a "healthy setting" programme, with active involvement of local communities, other sectors and NGOs, and
 - (b) to evaluate the existing technical and managerial capabilities for promoting various "healthy settings" programmes, and enhance these where necessary, and
3. REQUESTS the Regional Director:
 - (a) to provide necessary technical support, including guidelines and indicators to Member States for formulating plans to establish "Healthy District" projects, and
 - (b) to promote exchange of experiences among Member States and WHO on various "healthy settings" approaches and strengthen networking among countries.

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SEA/RC53/R5 SELECTION OF TOPIC FOR TECHNICAL DISCUSSIONS

The Regional Committee,

Recognizing the increasing magnitude of drug and alcohol abuse and also the problem of mental health in the Region,

1. DECIDES to hold Technical Discussions in 2001 on the subject of Mental Health and Substance Abuse, including Alcohol;
2. URGES the Member States to participate fully in these Technical Discussions, and
3. REQUESTS the Regional Director:
 - (a) to take steps for the preparation and conduct of these discussions during the meeting of the Consultative Committee for Programme Development and Management, prior to the Regional Committee in the year 2001, and
 - (b) to submit its recommendations to the Regional Committee.

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SEA/RC53/R6 BLOOD SAFETY

The Regional Committee,

Recalling World Health Assembly resolution WHA28.72, the Executive Board resolution EB79.R1 and its own resolution SEA/RC39/R6 on national policies on safety of blood and blood products,

Realizing the grave danger posed to health as a result of using unsafe blood and/or blood products, particularly those contaminated with transmissible organisms, and recognizing the

need for ensuring safety of blood and blood products in provision of quality health care,

Appreciating the laudable role of voluntary non-remunerated donors in augmenting the supply of safe blood and blood products, and

Noting the progress made in most Member States in implementing national blood safety programmes and strengthening blood transfusion services in collaboration with NGOs,

1. URGES Member States:

- (a) to ensure political commitment towards national blood safety programmes, supported by effective legislation;
- (b) to promote recruitment of carefully screened, voluntary non-remunerated blood donors selected from low-risk population;
- (c) to support efficient screening of donated blood to prevent transfusion of transmissible infections and strengthen quality assurance programmes in collection, processing, distribution and use of blood and blood products;
- (d) to enhance necessary budgetary allocation for assuring access to safe blood and blood products and their effective use, and
- (e) to promote appropriate and rational use of blood in clinical settings, and

2. REQUESTS the Regional Director:

- (a) to intensify collaboration with Member States and relevant partners in strengthening national blood transfusion programmes;
- (b) to promote quality assurance in blood transfusion services, both in the public and private sectors, and
- (c) to mobilize resources for ensuring safe blood in Member States in the Region.

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SEA/RC53/R7 FOOD SAFETY

The Regional Committee,

Recalling World Health Assembly resolution WHA53.15, relating to food safety,

Recognizing that foodborne illnesses associated with microbial pathogens, biotoxins and chemical contamination represent a serious threat to public health in the Region,

Aware of the need for improved surveillance systems to evaluate the burden of foodborne diseases and to develop evidence-based regional control strategies,

Realizing that Member States in the Region primarily rely for their food supply on traditional agriculture and small to medium-sized food industry, and that the food safety systems in most countries need strengthening,

Highlighting the need to make the largest possible use of information from the developing countries in risk assessment for setting reasonable international standards, and

Emphasizing the need for technical and institutional strengthening and capacity building in the countries of the Region,

1. URGES Member States:
 - (a) to adopt the 10-Point Regional Strategy for Food Safety as a framework for development of national food safety programmes, and
 - (b) to provide adequate resources to establish and strengthen food safety programmes in close collaboration with appropriate national food authorities, nutrition and epidemiological surveillance programmes, and
2. REQUESTS the Regional Director:
 - (a) to support Member States in the implementation of the 10-Point Regional Strategy for Food Safety;
 - (b) to pro -actively pursue action on behalf of the countries of this region so that the level of technological development in the countries of this region is taken into account in the adoption and application of international standards of food safety;
 - (c) to provide necessary technical assistance and promote research in formulating evidence-based strategies for the control of foodborne diseases, particularly risk factors and simple methods for management and control of these health risks;
 - (d) to facilitate the collection of data and and risk assessment studies through research centres in the countries of the Region;

- (e) to support capacity-building in Member States and facilitate the involvement of the concerned national health authorities in the work of the Codex Alimentarius Commission, and
- (f) to hold a regional consultation to review food safety issues in the Region.

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SEA/RC53/R8 VISION 2020: THE RIGHT TO SIGHT

The Regional Committee,

Noting that one-third of the world's 45 million blind live in the Region, that a majority of them are poor, and that most blindness is caused by preventable conditions such as cataract, trachoma infections and Vitamin A deficiency, and

Acknowledging that the global and regional strategies for "Vision 2020: The Right to Sight" were successfully developed by WHO, Member States and other national and international partners with the aim of eliminating avoidable blindness by the year 2020,

1. URGES Member States:

- (a) to expedite the adoption of the "Vision 2020 Strategy" in all Member States in the Region;
- (b) to clear the backlog of, and cater to, current cases of cataract by adopting various interventions, including development, in a time-bound manner, of appropriate human resources depending on the country needs;

- (c) to promote awareness on the causes, prevention and treatment of various eye disorders, and
 - (d) to promote expansion of primary eye care, and transfer of appropriate technology through partnerships, and
2. REQUESTS the Regional Director:
- (a) to provide necessary support to enhance and expand national programmes for prevention of blindness in Member States to increase coverage of primary eye care services, and
 - (b) to share and exchange experiences on successful strategies to prevent blindness.

Seventh Meeting, 7 September 2000

SEA/RC53/R9 MATERNAL MORTALITY

The Regional Committee,

Recalling World Health Assembly Resolutions WHA40.27, WHA42.42, WHA46.18, WHA47.9 and WHA48.10, and its own resolution SEA/RC39/R5 relating to maternal health and quality of care, as well as the recent WHO initiative on Making Pregnancy Safer,

Noting with concern that 40 per cent of the global maternal deaths occur in the South-East Asia Region and that a majority of the Member States had a maternal mortality rate of more than 100 per 100 000 live births in the late-1990s, and

Recognizing that despite affordable technologies to prevent such deaths, a large majority of women, particularly the poor and the marginalized, do not always have effective access to such life-saving technologies,

1. ENDORSES the proposed Regional Strategy for Reduction of Maternal Mortality in the South-East Asia Region;

2. URGES Member States:

(a) to review and/or update national policy for maternal health to ensure women's access to quality care, with an emphasis on facilitating skilled attendance at birth and enhancing accessibility to essential obstetrics and post-abortion care;

(b) to incorporate the national strategy for reduction of maternal mortality and morbidity as an important element of health sector reform, and

(c) to undertake regular reviews and monitoring, including research studies towards improving the coverage and quality of maternal health care, particularly for the poor and the marginalized, and

3. REQUESTS the Regional Director:

(a) to intensify technical collaboration with Member States and relevant partners in order to accelerate the implementation of interventions for making pregnancy safer, including the provision of skilled birth attendants, and

(b) to promote and support national efforts in undertaking regular reviews and monitoring, including research studies

towards improving the coverage and quality of maternal health care.

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SEA/RC53/R10WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

The Regional Committee,

Recalling World Health Assembly resolutions WHA52.18 and WHA53.16 and its own resolution SEA/RC52/7, and

Noting the global urgency and the importance of the development, negotiation and adoption of the Framework Convention on Tobacco Control,

1. URGES Member States:
 - (a) to promote mechanisms in support of the negotiation and adoption of the FCTC and tobacco control in general, and
 - (b) to actively promote the FCTC and tobacco control using the platform of regional mechanisms and associations such as SAARC and ASEAN, and
2. REQUESTS the Regional Director:
 - (a) to provide continued technical support to Member States towards the negotiation, adoption and implementation of the FCTC, and

- (b) to provide technical assistance to established subregional and national fora on the FCTC process.

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**SEA/RC53/R11 CROSS-BORDER COLLABORATION ON CONTROL OF
COMMUNICABLE DISEASES**

The Regional Committee,

Expressing satisfaction at the progress in cross-border collaboration on control of communicable diseases, and

Noting with concern the threat posed by Kala Azar, HIV/AIDS, Japanese Encephalitis and Malaria,

1. URGES Member States:

- (a) to enhance cross-border collaboration to include priority communicable diseases, and evaluate outcome of meetings;
- (b) to develop strong surveillance systems, and
- (c) to enhance synchronized and coordinated activities, especially at the district level on both sides of the border, and

2. REQUESTS the Regional Director:

- (a) to establish a task force to develop a coordinated and coherent policy for control of priority communicable diseases, and

(b) to enhance intercountry and inter-regional collaboration with regional mechanisms like SAARC, ASEAN and other international organizations to address cross-border health problems.

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SEA/RC53/R12 TIME AND PLACE OF FIFTY-FOURTH, FIFTY-FIFTH AND FIFTY-SIXTH SESSIONS

The Regional Committee,

1. CONFIRMS its previous decision (SEA/RC52/R4) to hold the fifty-fourth session of the Regional Committee in Myanmar from 3rd to 6th September 2001;
2. THANKS the Government of the Republic of Indonesia for its invitation to host the fifty-fifth session of the Regional Committee in 2002, and
3. DECIDES to hold the fifty-sixth session of the Regional Committee in the Regional Office in New Delhi in 2003.

Seventh Meeting, 7 September 2000

SEA/RC53/R13 RESOLUTION OF THANKS

The Regional Committee,

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

1. CONVEYS its gratitude to the Government of India for hosting the session, and thanks the members of the National Organizing Committee, the staff of the Ministries of Health and Family Welfare and External Affairs and other national authorities for making the session a success;
2. THANKS H.E. Dr C.P. Thakur, Union Minister for Health and Family Welfare, Government of India, 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
4. CONGRATULATES the Regional Director and his staff on their dedicated efforts towards the successful and smooth conduct of the session.

Seventh Meeting, 7 September 2000

Annexes

Annex 1

AGENDA¹

1. Opening of the Session
2. Sub-committee on Credentials SEA/RC53/20
 - 2.1 Appointment of the Sub-committee
 - 2.2 Approval of the report of the Sub-committee
3. Election of Chairman and Vice-Chairman
4. Adoption of Agenda and Supplementary Agenda, SEA/RC53/1 (Rev. 2)
if any
5. Highlights of the work of WHO in the South -East SEA/RC53/2 and
Asia Region – Report of the Regional Director for Inf.1
the period 1 July 1999 – 30 June 2000
6. Address by the Director-General, WHO
7. Proposed Programme Budget 2002 -2003 PPB/2002-2003
SEA/RC53/13
(Rev.1)
and Corr.1
8. Technical Discussions:

¹ Originally issued as document SEA/RC53/1 (Rev.3) dated 4 September 2000

- 8.1 Consideration of the recommendations arising out of the Technical Discussions on:
- (1) Equity in access to public health, and SEA/RC53/18
 - (2) Healthy settings SEA/RC53/19
- 8.2 Selection of a subject for the Technical Discussions to be held prior to the fifty-fourth session of the Regional Committee SEA/RC53/10
9. Regional implications of the decisions and resolutions of the Fifty-third World Health Assembly and the 105th and 106th sessions of the Executive Board, and SEA/RC53/12, Add.1 and Inf.1
- Review of the draft provisional agendas of the 107th session of the Executive Board and the Fifty-fourth World Health Assembly
10. Special Programmes/HQ Cluster Meetings:
- 10.1 UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases: Joint Coordinating Board (JCB) – Report on 2000 JCB and nomination of a member in place of India whose term expires on 31 December 2000. SEA/RC53/5 (Rev.1)

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|---|------------------------------|
| 10.2 WHO Special Programme for Research, Development and Research Training in Human Reproduction: Policy and Coordination Committee (PCC) – Report on 2000 PCC and nomination of a member in place of Indonesia whose term expires on 31 December 2000. | SEA/RC53/9 (Rev.1) |
| 10.3 Health Technology and Pharmaceuticals: Report of the Meeting of Interested Partners (MIP) | SEA/RC53/8 (Rev.1) |
| 11. Regional strategy on promotion of blood safety in Member States | SEA/RC53/7 |
| 12. Regional strategy on promotion of food safety in Member States | SEA/RC53/6 (Rev.1) and Add.1 |
| 13. Regional strategy on Vision 2020: The Right to Sight | SEA/RC53/3 (Rev.1) |
| 14. Regional strategy for reduction of maternal mortality in the South -East Asia Region | SEA/RC53/11 |
| 15. Follow-up actions taken on the resolutions of the previous five sessions of the Regional Committee, Meetings of the Health Ministers and Health Secretaries (item proposed by the Royal Thai Government) | SEA/RC53/16 and Add.1 |
| 16. The Framework Convention on Tobacco Control in the South-East Asia Region (item proposed by the Royal Thai Government) | SEA/RC53/14 |

17. Cross-border collaboration on control of communicable diseases (item proposed by His Majesty's Government of Nepal) SEA/RC53/15
18. Time and place of forthcoming sessions of the Regional Committee SEA/RC53/4
19. Adoption of the final report of the fifty-third session of the Regional Committee
20. Closure of the session.

Annex 2

LIST OF PARTICIPANTS¹

1. Representatives, Alternates and Advisers

BANGLADESH

Representative Mr Mir Shahabuddin Mohammad
Joint Secretary (Public Health and WHO)
Ministry of Health and Family Welfare
Dhaka

BHUTAN

Representative Dr Sangay Thinley
Secretary
Ministry of Health and Education
Thimphu

Alternate Dr Pem Namgyal
Deputy Secretary
Policy and Planning Division
Ministry of Health and Education
Thimphu

¹ Originally issued as document SEA/RC53/17 dated 1 September 2000

DPR KOREA

Representative Dr Pak Jong Min
Director
Department of External Affairs
Ministry of Public Health
Pyongyang

INDIA

Representative Mr Javid A. Chowdhury
Secretary (Health)
Ministry of Health and Family Welfare
New Delhi

Alternates Mr S.P. Agarwal
Director-General of Health Services
Ministry of Health and Family Welfare
New Delhi

Ms K. Sujatha Rao
Joint Secretary (SR)
Ministry of Health and Family Welfare
New Delhi

INDONESIA

Representative Prof Dr Azrul Azwar, MPH
Director-General of Community Health
Ministry of Health
Jakarta

Alternates

Dr (Ms) Sumarjati Arjoso
Adviser to the Minister of Health on
Environment
and Diseases Control
Ministry of Health
Jakarta

Dr Setiawan Soeparan, MPH
Chief, Bureau of Planning
Ministry of Health
Jakarta

MALDIVES

Representative

Mr Ibrahim Shaheem
Director, Disease Control and Prevention
Department of Public Health
Malé

Alternate

Ms Shehenaz Fahmy
Assistant Director
Ministry of Health
Malé

MYANMAR

Representative

Dr Kyi Soe
Director-General
Department of Health Planning
Ministry of Health
Yangon

Alternate(s)

Dr Hla Pe
Deputy Director-General
Department of Health
Ministry of Health
Yangon

Dr Ohn Kyaw
Chief/Director, International Health Division
Ministry of Health
Yangon

NEPAL

Representative

Dr B.D. Chataut
Director-General and Chief
Policy, Planning, Foreign Aid
and Monitoring Division
Department of Health Services
Ministry of Health
Kathmandu

Alternate

Dr Chhatra Amatya
Director
Planning & Foreign Aid Division
Department of Health Services
Ministry of Health
Kathmandu

SRI LANKA

Representative

Dr H.A.P. Kahandaliyanage
Senior Assistant Secretary (Medical Services)
Ministry of Health and Indigenous Medicine
Colombo

THAILAND

Representative

Dr Supachai Kunaratanapruk
Deputy Permanent Secretary
Ministry of Public Health
Bangkok

Alternates

Dr Somsak Chunharas
Director
Bureau of Health Policy and Planning
Office of the Permanent Secretary
Ministry of Public Health
Bangkok

Associate Prof. Wiwat Arkaravichien
Faculty of Pharmacy
Khon Kaen University
Khon Kaen

Associate Prof. Jongjit Angkatavanich
Faculty of Pharmacy
Mahidol University
Bangkok

Mrs Saichai Limtrakool
Foreign Relations Officer
International Health Division
Office of the Permanent Secretary
Ministry of Public health
Bangkok

***2. South-East Asia Advisory Committee on Health Research
(SEA-ACHR)***

*Chairman, 25th Session of
SEA-ACHR* Prof. N.K. Ganguly
Director-General
Indian Council of Medical Research
New Delhi

3. Representatives from United Nations/Other Agencies in SEAR

<i>Delegation of European Commission, The</i>	Mr P. Bardhan Adviser (Development) 65 Golf Links New Delhi
<i>Department for International Development</i>	Mr Bob Fryatt Health Adviser Health Sector Group (DFID India) British High Commission Plot 5, Block 50F Nyaya Marg, Chanakyapuri New Delhi 110 021
<i>International Committee of the Red Cross</i>	Dr Mark Steinbeck Regional Medical Adviser 47, Sunder Nagar New Delhi 110 003
<i>International Labour Organisation</i>	Mr John Woodall Senior Specialist on Social Security South Asian Multidisciplinary Advisory Team Theatre Court, 3rd Floor India Habitat Centre, Lodi Road New Delhi 110 003
<i>United Nations Children's Fund</i>	Dr Monica Sharma Deputy Regional Director Regional Office for South Asia P.O. Box 5815 Lekhath Marg Kathmandu, Nepal Dr Steve Atwood Head of the Health Section

India Country Office
73 Lodi Estate
New Delhi 110 003

Dr Dale Davis
Coordinator
Regional Women's Health and Right to
Life Project
Regional Office for South Asia
P.O Box 5815, Lekhnath Marg
Kathmandu, Nepal

Dr Erma Manoncourt
Deputy Director/Programme
India Country Office
73, Lodi Estate
New Delhi – 110 003

4. Representatives from Nongovernmental Organizations

<i>Aga Khan Foundation</i>	Dr Arvind Mathur Programme Officer (Health) Sarojini House, 2nd Floor 6, Bhagwan Dass Road New Delhi 110 001
<i>Consumer International</i>	Dr Arun Gupta Breastfeeding Promotion Network of India BP-33 Pitampura Delhi 110 034

<i>FDI World Dental Federation</i>	Prof. Hari Parkash Head of Dental Department All India Institute of Medical Sciences New Delhi 110 029
<i>Inclusion International</i>	Mr J.B. Munro 120 Factory Road Mosgiel 9007 Otago, NZ
<i>International Agency for the Prevention of Blindness</i>	Mr R.D. Thulasiraj Lions Aravind Institute of Community Ophthalmology 1, Annanagar Madurai 625 020
<i>International Association for Maternal and Neonatal Health</i>	Dr S.N. Mukherjee President – National Section in India 204 Tower Block Swasthya Vihar New Delhi 110 092
<i>International Association of Agricultural Medicine and Rural Health</i>	Dr Ashok Patil President Pravara Medical Trust Loni – 413 736 Dist Ahmednagar Maharashtra

<i>International Association of Medical Laboratory Technologists</i>	Mr Manindra Chaudhri President All India Institute of Medical Technologists CD-84 Salt Lake City Calcutta 700 064
<i>International Council of Women</i>	Dr Kiran Kukreja 99 Bharat Nagar New Friends Colony New Delhi 110065
<i>International Cystic Fibrosis (Mucoviscidosis) Association</i>	Dr S.K. Kabra Associate Professor Department of Pediatrics All India Institute of Medical Sciences New Delhi 110 029
<i>International Federation of Ageing</i>	Major Gen R.S. Pannu Acting President Dr S.D. Gokhale Past President Guru Trayi Building 1779-1784 Sadashiv Peth Bharat Scout Ground Compound Pune 411 030
<i>International Federation of Pharmaceutical Manufacturers Associations</i>	Mr Alain Aumonier Director, International Affairs Corporate Public Policy Aventis Pharma International 20 avenue Raymond Aron F- 92165 Antony Cedex

*International Hospital
Federation*

Dr Dipak Shukla
Medical Superintendent
Pushpawati Singhanian Research Institute
for Liver, Renal & Digestive Diseases
Press Enclave Marg
Sheikh Sarai-II
New Delhi 110 017

*International League
against Epilepsy*

Dr M.C. Maheshwari
Professor and Head
Chief, Neuro-Sciences Centre & Dean, AIIMS
Department of Neurology
Neuro -Sciences Centre
All India Institute of Medical Sciences
Ansari Nagar
New Delhi 110 029

*International Life
Sciences Institute*

Mrs Rekha Sinha
ILSI-India
Y 40B, 1st Floor
Hauz Khas
New Delhi 110 016

*International
Pharmaceutical
Federation*

Mr Pankaj R. Patel
Cadila Healthcare Limited
Zydus Tower, Satellite Cross Road
Sarkhej
Ahmedabad 380 015

*International Society of
Chemotherapy* Prof K.B. Sharma
Centre for Infectious Disease Education
and Research
B-7 Swasthya Vihar
Delhi 110 092

*International Society of
Surgery* Dr Natesan Rangabashyam
Sree Ramana Surgical Clinic
38 Venkatanarayanan Road
T Nagar
Chennai 600 017

*International Special
Dietary Foods Industries* Mr Krishna Chidambi
(Representative)
Ms Deepali Darira Hariharan
(Observer)
Nestle India Ltd
DLF Centre, Sansad Marg
New Delhi – 110 001

*Japanese International
Cooperation Agency* Mr Hidekaya Kumano
DLF Building, 2nd Floor
Parliament Street
New Delhi – 110 001

*Medical Women's
International Association* Dr Tulsi Basu
10 Protapaditya Road
Calcutta 700 026

<i>Project ORBIS International Inc.</i>	Dr Raj Kumar ORBIS India Country Director C-10, IInd Floor Gulmohar Park New Delhi 110 016
<i>Rotary International</i>	Mr Hemant Ahuja 14, Sunder Nagar New Delhi – 110 003
<i>Royal Commonwealth Society for the Blind</i>	Mrs Alice Crasto Regional Director for India Sight Savers International A3, Shiv Dham, Plot No.62 New Link Road, Malad Mumbai 400 064
<i>Thalassaemia International Federation</i>	Mrs Shobha Tuli 1st Vice-President D-110 Panchsheel Enclave New Delhi 110 017
<i>World Confederation for Physical Therapy</i>	Prof. D.H. Dastoor President Indian Association of Physiotherapists Mazda Chaman, 12, Dattatreya Road Santa Cruz (West) Mumbai 400 054
<i>World Federation for Medical Education and International Diabetes Federation</i>	Prof Ravinder Madan 37 A/C, Gandhi Nagar Jammu 180 012 (J&K)

<i>World Federation of Neurology</i>	Dr Jagjit S. Chopra House # 532, Sector 33-B Chandigarh 160 047
<i>World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians</i>	Dr Nurul Islam Regional Vice -President 3 DIT Market, 1st Floor Narayanganj 1400 Bangladesh
<i>World Psychiatric Association</i>	Prof Gopal Chandra Kar President Indian Psychiatric Society Parighat Road Cuttack – 753009, Orissa
<i>World Veterans Federation</i>	Brig. Mohinder Singh (Retd) President Indian Ex-Services League 9 Nyaya Marg Chanakyapuri New Delhi 110 021

5. Observers

*Sulabh International
Social Service*

Dr Shambhu Nath
Chairman- cum -Director
Sulabh International Institute of Health
and Hygiene
Sulabh Bhawan
Mahavir Enclave
Palam-Dabri Marg
New Delhi 110 057

*Voluntary Health
Association of India*

Dr Mira Shiva
Tong Swasthya Bhawan
40 Institutional Area
Near Outab Hotel
New Delhi 110 016

Annex 3

LIST OF OFFICIAL DOCUMENTS

SEA/RC53/1 (Rev. 3)	Agenda
SEA/RC53/2	Highlights of the work of WHO in the South -East Asia Region – Report of the Regional Director for the period 1 July 1999 – 30 June 2000
SEA/RC53/2 Inf.1	List of Plans of Action and Extrabudgetary Allotments in operation during 2000-2001
SEA/RC53/3 (Rev.1)	Regional strategy on Vision 2020: The Right to Sight
SEA/RC53/4	Time and place of forthcoming sessions of the Regional Committee
SEA/RC53/5 (Rev.1)	UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases: Joint Coordinating Board (JCB) – Report on 2000 JCB and nomination of a member in place of India whose term expires on 31 December 2000.
SEA/RC53/6 (Rev.1)	Regional strategy on promotion of food safety in Member States
SEA/RC53/6 (Rev.1) Add.1	Implementation of initiatives to manage Food Safety

SEA/RC53/7	Regional strategy on promotion of blood safety in Member States
SEA/RC53/8 (Rev.1)	Health Technology and Pharmaceuticals: Report of the Meeting of Interested Partners (MIP)
SEA/RC53/9 (Rev.1)	WHO Special Programme for Research, Development and Research Training in Human Reproduction: Policy and Coordination Committee (PCC) – Report on 2000 PCC and nomination of a member in place of Indonesia whose term expires on 31 December 2000.
SEA/RC53/10	Selection of a subject for the Technical Discussions to be held prior to the fifty-fourth session of the Regional Committee
SEA/RC53/11	Regional strategy for reduction of maternal mortality in the South-East Asia Region
SEA/RC53/12	Regional implications of the decisions and resolutions of the Fifty-third World Health Assembly and the 105 th and 106 th sessions of the Executive Board and Review of the draft provisional agendas of the 107 th session of the Executive Board and the Fifty-fourth World Health Assembly
SEA/RC53/12 Add.1	Review of the Draft Provisional Agendas of the 107 th Session of the Executive Board and the fifty-fourth World Health Assembly
SEA/RC53/12 Inf.1	Global Strategy for infant and young child feeding

SEA/RC53/13 (Rev.1)	Proposed Programme Budget 2002 -2003 – Part II
SEA/RC53/13 (Rev.1) Corr.1	Proposed Programme Budget 2002 -2003 – Part II – Corrigendum
SEA/RC53/14	The Framework Convention on Tobacco Control in the South -East Asia Region (item proposed by the Royal Thai Government)
SEA/RC53/15	Cross-border collaboration on control of communicable diseases
SEA/RC53/16	Follow-up actions taken on the resolutions of the previous five sessions of the Regional Committee, Meetings of the Health Ministers and Health Secretaries
SEA/RC53/16 Add.1	Details of Follow-up actions taken on the Resolutions of the previous five sessions of the Regional Committee, Meetings of the Health Ministers and Health Secretaries
SEA/RC53/17	List of Participants
SEA/RC53/18	Recommendations arising out of the Technical Discussions on Equity in Access to Public Health
SEA/RC53/19	Recommendations arising out of the Technical Discussions on Healthy Settings
SEA/RC53/20	Report of the Sub-committee on credentials
SEA/RC53/21	Draft Report of the fifty-third session of the Regional Committee for South -East Asia

Resolutions

SEA/RC53/R1	Report of the Regional Director
SEA/RC53/R2	Proposed Programme Budget 2002- 2003
SEA/RC53/R3	Equity in Health and Access to Health Care
SEA/RC53/R4	Healthy Settings
SEA/RC53/R5	Selection of Topic for Technical Discussions
SEA/RC53/R6	Blood Safety
SEA/RC53/R7	Food Safety
SEA/RC53/R8	Vision 2020: The Right to Sight
SEA/RC53/R9	Maternal Mortality
SEA/RC53/R10	WHO Framework Convention on Tobacco Control
SEA/RC53/R11	Cross-Border Collaboration on Control of Communicable Diseases
SEA/RC53/R12	Time and Place of Fifty-fourth, Fifty-fifth and Fifty-sixth Sessions
SEA/RC53/R13	Resolution of Thanks

Annex 4

TEXT OF ADDRESS BY THE REGIONAL DIRECTOR

ON BEHALF OF the World Health Organization, South-East Asia Region and on my own behalf, I extend a warm welcome to you all to this fifty-third session of the WHO Regional Committee for South-East Asia.

Established as early as the 11th century, historic Delhi presents a colourful pageant of Indian history. Even though your stay is short and many of you have been here before, I am sure you will still find something new and interesting in the capital of this great country.

Ladies and gentlemen, the pace of health development in India has accelerated significantly in the past decade, with the country recording some remarkable achievements.

I will recall a few of them. Guinea-worm disease has been eradicated and it is expected that India will eradicate polio in 2005. This has been made possible by the cooperative efforts of many stakeholders. I particularly wish to commend the intensified National Immunization Days where millions of children were immunized. WHO is proud to have been associated with the Government and other partners in this historic public health effort.

The sustained efforts towards eliminating leprosy are also paying rich dividends. India hopes to achieve the goal in 2001.

I am confident that these remarkable achievements will generate stronger commitment to address the many challenges that remain in the new century.

Distinguished representatives of the Regional Committee, this session of the Committee is the first to be held in the 21st century. In that sense, it is both unique and symbolic. Above all, the Regional Committee will, this year, deliberate and decide upon certain crucial issues which will have an important bearing on WHO's work in the Region in the new millennium.

Many of these issues were discussed a few days ago, at the 37th meeting of the Consultative Committee for Programme Development and Management (CCPDM). I will elaborate when I present the Report of the CCPDM to the distinguished representatives later in the business session.

Since we met in Dhaka last year, Member Countries have continued to progress steadily towards achieving the goal of Health for All, despite many challenges and obstacles. These achievements are described in my Report on the Highlights of the Work of WHO in the South-East Asia Region. The report clearly shows that our Member Countries, in partnership with WHO and other stakeholders, have addressed the daunting challenges to health development in a spirit of solidarity.

Ladies and gentlemen, the 1990s saw rapid globalization, privatization, and economic liberalization. Together with the explosive expansion in information technology, this raised

people's expectations of, and demands from, the health sector. This, I believe, will be the foremost challenge to WHO and other stakeholders in health development in the coming years.

Fully aware of this challenge, the Executive Board in 1992 called upon the Director-General to initiate work on WHO's response to global change. As we are well aware, this reform process accelerated rapidly after July 1998, when Dr Brundtland took over as Director-General. Now, like any other corporate entity, responsible to its shareholders, in this instance the Member States, WHO too will focus on the business that it does best. In partnership with the countries, we will identify areas where the Organization has a clear comparative advantage.

I am pleased to inform the Regional Committee that the countries and WHO are jointly developing country cooperation strategies. These strategies will be the basis for developing the respective collaborative programmes for 2002-2003 within the framework of the four strategic directions and six core functions of WHO and the targets set out in the Regional Health Declaration.

Distinguished representatives of the Regional Committee, we must now decide together on the best way to utilize the resources of WHO for achieving these targets. For this purpose, I believe that we must first rationalize the use of our scarce resources. We must ensure a better balance between the resources for the country programmes and those of the intercountry programmes starting from the biennium 2002-2003 and beyond.

The High-level Policy Advisory Panel which met in July 2000, agreed with WHO's approach for doing so. We will discuss these

issues in detail during the substantive discussions on recommendations of the CCPDM on the proposed programme budget for 2002-2003. I am confident that the Regional Committee will agree with the recommendations of the CCPDM on this issue.

Ladies and gentlemen, it is my fervent desire to ensure that the technical and financial support of the regional and intercountry programmes will enable us to consolidate and build upon the many innovative programmes we embarked upon in the previous and current bienniums. These include, among others, the programme on International Cooperation in Health Development (ICHHD), the final push for eradicating poliomyelitis from the Region, Roll Back Malaria, Safe Blood, Food Safety and Control of Noncommunicable Diseases.

I see another role for WHO in these efforts. That of a catalyst to help our countries achieve their full potential. The *World Health Report 2000* provides us with information for doing so. I believe that this report shows us where we are and where we can be. This makes it easier for us to make the correct choices for reaching our goals.

Excellencies, distinguished representatives, ladies and gentlemen, as the new century begins, let us rededicate ourselves to bring better health to all the people of this Region. Let us resolve to bring together all stakeholders and players in health development to achieve our goal of Health for All.

In conclusion, let me once again express my sincere gratitude to the Government of India and to Your Excellency for hosting this

session of the Regional Committee. I look forward to a fruitful session and wish you all success in your deliberations.

Thank you.

Annex 5

TEXT OF ADDRESS BY THE DIRECTOR-GENERAL, WHO

This is an important meeting – the first in the new millennium and one held at a time when there are both great opportunities and great challenges in front of us.

Most often, turning points in world history are only reported in retrospect. Events that may seem important at the time quickly fade into oblivion. Momentous achievements may be inconspicuous at the start. Only years later can one see a pattern and identify the starting point for fundamental change.

I begin today's address to you by explaining why – for me – this year will be seen as a turning point for improvements in health for all the world's people.

I have always believed that it is difficult to make real changes in society unless decision makers fully appreciate the economic dimensions of the issues affecting their people. This is how thinking about the environment has shifted. It used to be a cause for convinced and marginalised greens: it now commands the attention by all the major players within national and international society.

When we last met, in Geneva in May, there were already several promising signs that the world's decision makers saw a new

and important linkage. They recognised that health is a central factor in economic and social development. Improving health is key in breaking the debilitating cycles of poverty .

Since then, we have seen signs that the world is willing and eager to act. In July, the 13th International AIDS conference in Durban established new norms: that all people living with HIV/AIDS world-wide should have access to adequate care, and that everyone everywhere should be in a position to prevent themselves from HIV infection.

Also in Durban, the European Commission announced renewed support for the fight against HIV/AIDS, malaria and tuberculosis. Later the same month in Okinawa, I joined leaders of the G8 nations as they met with leaders of key G77 countries, including the Prime Minister of Thailand.

Subsequently the G8 called for a step change in international health outcomes. They agreed to specific targets to reduce the tolls from malaria, HIV/AIDS, TB and children's diseases by 2010.

These announcements are fruits of the hard work carried out by you, your political leaders, and thousands of other health workers in this region. You also took part in a range of national, regional and international conferences – on conditions that disproportionately affect the world's poorest people such as malaria, tuberculosis, HIV.

While health problems have dominated the headlines, we are also on the brink of several important achievements.

I speak first about Polio and Leprosy. A few years ago, Polio was one of the leading causes of disability. We are now very close

to eradicating this disease. World-wide, polio transmission now only occurs in 30 countries. In this region you have made extraordinary progress. Still, the closer we are to success, the harder we need to work. We can achieve full eradication if we work together. We need to ensure that immunisation days are of the highest possible quality, and that we reach every child. We also need to maintain and improve the capacity and quality of surveillance.

Within the next year or two, we expect that the global target of eliminating leprosy as a public health problem will be achieved. 12 countries in the world now carry 90% of the disease burden: these include India, Nepal, Myanmar and Indonesia. The leaders of these countries have shown political courage in backing intensive efforts to eliminate this disease. I encourage them to maintain this commitment and ensure everyone concerned does what is necessary to ensure successful elimination of the disease.

HIV/AIDS is a global pandemic. Recently, the focus has been on the tragedy unfolding in Africa, as countries there are devastated by HIV infection rates of up to 30%. Yet, lower infection rates in this region should lead no-one to complacency. Many of the elements that have led to the disastrous infections levels in part of Africa also apply in parts of Southeast Asia. Unless we act wisely and forcefully to prevent spread of HIV, we could face a economic, social and human disaster of enormous proportions.

On the issue of HIV/AIDS care, there has been change. Over the past few months, governments and other partners have worked together to enable many more people living with HIV to access the care they need. Rhetoric is becoming reality.

Following the World Health Assembly in May, WHO – together with UNAIDS, and other UN agencies – has pursued its mandate and progressed in a dialogue with the pharmaceutical industry. A contact group, due to hold its first meeting next month, will bring together Member States, UN agencies and representatives of the industry and NGOs, in what we hope will be a fruitful exchange of information and views.

The initiative is being harmonized with other global and regional partnerships against AIDS. Efforts are initially being taken forward in Africa, but they will move elsewhere soon afterwards, and swiftly lead to some real change.

Several other priority health problems are now being addressed by partners working together in new and effective ways. In my speech to the World Health Assembly in May, I presented the Global Alliance for Vaccines and Immunization – GAVI – as a prime example of a new model for partnerships in international health. During the Assembly, delegates from the 74 eligible countries received guidelines for the submission of proposals to the Global Fund for Children’s Vaccines, and I encouraged a quick response so that support could start to flow to countries by the end of this year.

This urge for expediency was heeded .. and how! Twenty four countries submitted proposals to the GAVI Secretariat in the very tight timeframe required. Of those proposals, an independent review committee found that 13 countries were ready to receive vaccines and/or direct financial support, with disbursements starting already in September. The rest will be submitting additional information for the next round so that they too can receive support as soon as possible. And another 20 or so

countries are expected to submit proposals during the next review in October.

The Global Fund supports programmes that are designed by countries. It contributes to the sustainability of national health systems, and to synergy between immunisation services and other health system components. For example, with the polio eradication initiative. GAVI partners are fully committed to the effort to eradicate polio.

Similar principles are being applied as we join forces to roll back malaria, stop TB and make pregnancy safer. Countries are at the hub of each partnership, with partners reflecting shared goals, strategies and values. We try to respond to people's needs in ways that reflect the best available evidence. Resources are used and accounted for with care, so that those who provide funds are confident that they are used to best effect. The process of implementing country-level partnerships provides an opportunity to assess the current situation. It leads to more collaborative and sustainable approaches to building more effective health systems. It gives partners an opportunity to re-engage and re-activate their financial and technical contributions to countries' health services.

This new approach to international health action is setting the stage for a reform in development funding. A reform that puts countries clearly in charge and in control of health programs and future opportunities for funding and support.

It has encouraged WHO to search for new roads to scale up the global effort to tackle the infectious diseases particularly affecting the world's poorest people: HIV/AIDS, malaria, TB, diarrhoea and other diseases of childhood.

The point of departure is clear: Infectious diseases are today responsible for around 45% of the mortality in developing countries. Approximately half of infectious disease mortality can be attributed to just three diseases – HIV/AIDS, TB and malaria. They cause over 300 million illnesses and nearly 5 million deaths each year – and for none of them is there an effective vaccine to prevent infection in children and adults.

They penalise poor communities, as they perpetuate poverty through work loss, school drop-out, decreased financial investment and increased social instability – at staggering social and economic costs. For example, a recent study has shown that Africa’s annual GDP would be up to \$100 billion greater today if malaria had been eliminated 30 years ago.

We have drugs that can cure malaria, TB and the opportunistic infections associated with HIV. We have bed nets and condoms that can prevent malaria and HIV infection. Yet for far too many people – especially poor people – these lifesaving measures are unavailable, unaffordable, or improperly used.

At the same time, some of the drugs we have are losing their effectiveness – slowly but surely – because of the relentless development of antimicrobial resistance. Windows of opportunity to cure these infections are therefore closing. The research and development pipeline has not kept up with needs, and new drugs and vaccines have been slow to appear on the market.

WHO will be focussing on the need to increase access to essential drugs and prevention methods such as bed nets and condoms. We remain committed to working with governments and with our development partners to explore all possible mechanisms

to expand financing, ensure affordability, and promote effective use of essential drugs and preventive health technologies.

An immediate and large scale action is urgently required. There are differences in the strategies and approaches for HIV, TB and malaria. However, for each the locus of prevention and care is most often at the home – not in established health services. Governments have a central role to play in setting the environment and providing leadership. But action to turn back these three diseases will also require the efforts and innovation of a wider range of partners.

To achieve the global targets of cutting TB and HIV/AIDS mortality by 50%, and HIV infection rates by 25%, we need a new mechanism to take proven, effective interventions to scale.

It is an immense challenge for all of us, but the rewards are also promising. It means we all will have to think new – make new alliances and improve our performance. We must also build on the best achievements of GAVI and the work in Stop TB, Roll Back Malaria, as well as from the successes against polio, onchocerciasis, leprosy, guinea worm and lymphatic filariasis.

The G8 have embraced the overall targets and the concept of a massive effort against infectious diseases. The European Commission will convene a roundtable at the end of September and the G8 are planning a meeting in early December to discuss how to move further towards such new mechanisms.

If our joint efforts are to succeed, we must have channels through which resources for health reach those who need them,

and systems for ensuring that resources are used effectively and equitably, and that there is accountability.

A renewed effort to address diseases associated with poverty should contribute to the development of health systems.

The management of any health system is a balancing act: coping with competing demands, matching resources to need, and attempting to ensure that all have access to the care necessary for good health. The balancing act is particularly difficult for those countries whose per capita spending on people's health is less than, say, \$100 per person per year. It is even more difficult in settings where the institutions of government are undermined – or even paralysed – by conflict.

We need to find better ways to assess the performance of health systems that reflect the three purposes: improving health outcomes, responding to the people and fairness of financing. As you know, this year, WHO attempted such a first assessment, using the limited data available, in the *World Health Report 2000*.

Not surprisingly, the Report proved controversial. Its publication led to wide-spread discussions both in national and international media and among health professionals about how to assess health systems, as well as a more fundamental debate about what makes a good health system.

This debate is good. Discussion about the concepts and analyses in the World Health Report has given us all new insights. To continue the global dialogue on how to get the most out of health systems, we will work closely with Member States to make better uses of existing data sources and where necessary to collect

new information so that the annual assessments of health systems performance are based on the best available evidence.

Even more importantly, this wave of interest in improving performance offers a unique opportunity for many Member States to assess the future of their health systems, and efforts that could be made to improve performance.

WHO is aware that there are no quick and easy answers. And we know that even when there are some agreed basic policy directions, for example expanding pre-payment, it can mean hard work to put them into practice.

In response to numerous requests, WHO will be working closely with a number of Member States in an Initiative to Enhance the Performance of Health Systems to apply the new WHO assessment framework at national and also sub-national levels; to use this analysis as an aid to national policy formulation; and to work together to facilitate positive change. Within SEARO, four countries are already participating in the Initiative.

In many countries, the focus of our attention is clearly on HIV/AIDS, malaria and on other infectious diseases. Yet, the rapid shift of the burden of disease from infectious to non-communicable diseases will seriously challenge health care systems in the near future and difficult decisions will have to be taken.

For most conditions, there is a lag between exposure to risk and visible outcomes, but policy decisions to deal with this shifting burden of disease is required now. Based on the evidence, global tobacco control is a key priority area. During the next 12 months

we will also be looking at a vastly neglected area of public health. I am talking about mental health.

Next year, mental health will be the focus of World Health Day on April 7. No country and no community is immune to mental disorders and their impact in psychological, social and economic terms is huge. Yet, societies raise barriers to both care and the reintegration of people with mental disorders. What makes our task doubly urgent is that there is no reason for inaction – much less exclusion. World Health Day, the World Health Assembly in May 2001 and the World Health Report 2001 – all will focus on mental health. Together, we will find solutions and strive to make the necessary change.

As I saw in Bangkok earlier this year, you are making it happen when it comes to tobacco. WHO is at the front of this global public health struggle. We are not interested in tobacco wars. We want tobacco solutions.

In October, we will begin the negotiations on the Framework Convention on Tobacco Control; this will be the first time that the public health community has led treaty negotiations. The process we set in motion has already fostered a global debate and pushed countries as well as tobacco companies to think about their actions from a public health perspective. The success of the FCTC will depend on our ability to link compelling data to robust decisions.

First, there will be two days of public hearings in Geneva. We will listen to the views of all interested parties, including the tobacco producers and the industry as we prepare to write global rules for tobacco control. This is an occasion for everyone interested to contribute to a global tool for public health.

The South East Asia Region is unfortunately no exception to the fact that all of the WHO regions have over the past year been heavily affected by disasters and crises, both natural and man-made.

Cyclone Orissa has had a devastating impact in India. Bangladesh faces regular disruption from cyclones and floods. Sri Lanka is continuing to experience armed conflict in the North. The Democratic People's Republic of Korea is the subject of United Nations System Inter-Agency Consolidated Appeal. Indonesia is seeking to cope with sectarian violence in some parts. And we are all working to achieve a successful transition in East Timor.

What lessons can we draw? The first is that in situations of sustained conflict, health can serve as one of the bridges to peace. As we saw in the course on this subject held in Sri Lanka earlier this year, health professionals can make a contribution to peace building and conflict reduction. I hope that health can be one element in taking forward the discussions between North and South Korea.

The second is that there is no short cut to dealing with emergencies. Spending on preparedness for disaster may seem like resources not being fully used, but the lesson is always that each of our countries will be affected one day in one way or another. There needs to be focus on training, hospital and health services planning, and stockpiling of supplies .

WHO has an important function to perform before, during and after emergencies. Our role is to assist nations with accurate assessments of damage and needs. It is to ensure the best possible coordination of agencies involved, and to make sure that long-

term health perspectives are built into the emergency relief, so that money spent on an emergency can benefit long-term development needs. And afterwards, we in WHO need to help countries share their experiences.

Given the major challenges that face us all – governments and technical agencies – how will we respond, and what can you, our Member States, now expect from WHO?

WHO continues to have a unique role. At all times we pursue the best interests of our constituency – the optimum health of all the people within our 191 Member States.

At all times we try to ensure that we are guided by the best available evidence – based on the careful analysis of experience, on the results of relevant research.

The clearest reflection of how WHO is changing to serve Member States better is the upcoming budget, which you will discuss later this week. The Programme Budget 2002-2003 is a key instrument for advancing the process of change and reform in WHO. Both in its content and in the way it is being prepared, it marks a significant departure from previous biennia.

The budget is a manifestation of the new corporate strategy, which sets out the ways in which WHO's Secretariat intends to address the challenges of rapid evolution in international health. The programme and budget for each area of work has been worked out through an Organization-wide process, jointly between staff from Regional Offices and from Headquarters.

Thirty-five areas of work have been identified for the whole Organization and constitute our common building blocks. In the

process, we clearly identify the 11 priorities endorsed by the Executive Board and have moved additional resources to those priorities.

The proposals for 2002-2003 also follow the decision of the Health Assembly in 1998 to reallocate some regular budget resources between regions. In line with the flexibility given by the Health Assembly, I have however proposed a somewhat lower level of reallocation in the next biennium. This will benefit those regions, like SEARO, which are contributing considerably to the transfers.

There are also some changes in the balance of regular budget funding within the Region. As most delegates would be aware, over the past few biennia, the programme budget implementation rate in the South-East Asia Region has been the slowest compared to other Regions. In keeping with the budget reform process underway in WHO, we need to look at this issue objectively.

The facts are that some countries in the Region are not able to fully absorb their budgetary allocations in time. Often, towards the end of the biennium, this leads to activities that are not really of priority interest, either to the countries or to WHO. In the process, the quality of programmes also suffers. What we need to ensure is that priority concerns are addressed seriously.

This can be done by strengthening the Regional Office and inter-country programme to enable more effective and timely technical support being extended to the countries. This needs a rationalization of the regional budget to provide for an increase in the Regional Office and intercountry programme allocation. Not for extra staff. Not for extra travel. Not for more meetings. But to

increase collaborative activities in the established WHO priority areas at the country level.

All of this will also give greater importance to the need to focus on a strategic approach to our work in countries. You have made great progress in developing a strategic approach within SEARO. Defining clear priorities helps to ensure that there is a better match between country needs and globally agreed strategies.

Mr Chairman, We are seeing a change in perceptions. Health is big news. Health is accepted as a central and necessary element in reducing poverty and ensuring economic growth and social progress. There is movement among donors to allocate more money towards interventions that will fight diseases. There is a growing realization that we need international agreements and co-operation to fight threats to health, such as from tobacco. In short – health has been placed at the centre of the development agenda.

The first decade of this century can become the one in which the world's two billion poorest can share in the health revolution.

But there is nothing irreversible in this process. We need to continue our hard work to maintain the momentum. The tiniest sense of complacency may turn health's central role in development from a permanent paradigm shift to little more than this year's fashionable theory.

We are on the brink of seeing real and substantial gains for the health of the poorest, but to do so we need to have realistic

perceptions of what we can all achieve and what will be necessary for us to succeed.

First of all, we need to see increases in development assistance from bilaterals and development banks and complemented by resources from other donors such as the foundations. Their contribution should add to and not replace existing financial commitments.

Secondly, the demand for improved results and measurable outcomes will be relentless. Funding will dry up unless it can be shown that increased activities have led to improved indicators within a relatively short period of time.

Thirdly, of course, the challenge is more than anything for developing countries themselves. A new focus on health will put increasing demands on countries' own funding, on absorption capacity, and on governance. To make substantial and lasting improvements to health, people themselves and their governments will always be the main driving force.

Let us work together to grasp this opportunity. Let us make this decade the decade that spread the health revolution to all.

Thank you.

Annex 6

REPORT OF THE 37TH MEETING OF THE CONSULTATIVE COMMITTEE FOR PROGRAMME DEVELOPMENT AND MANAGEMENT TO THE REGIONAL DIRECTOR

1. INTRODUCTION

Dr Uton Muchtar Rafei, Regional Director of WHO South-East Asia convened the 37th meeting of the Consultative Committee for Programme Development and Management (CCPDM) in the Regional Office from 30 August to 2 September 2000.

2. INAUGURAL SESSION

Dr Uton Muchtar Rafei, in his inaugural address, while welcoming the participants to this first meeting in the new century, stated that many important events had taken place related to WHO's programme development and management. A series of joint planning exercises had been initiated during the last few years to ensure more active involvement of Member countries, including in the formulation of operational plans for the 2000-2001 ICP II programme. The World Health Assembly (WHA) had requested shifting of funds from casual income to certain priority areas

identified for 2000-2001 and beyond. The first instalment of 250,000 dollars had been disbursed among these priority programmes and a similar amount would be disbursed later.

A working group was also established to study the efficiency of the WHO South-East Asia Regional Office and Country Offices. A review of the implementation of the 1998-1999-programme budget indicated that some Member countries had faced constraints in absorbing the quantum of resources made available for respective country programmes. He stated that the biennium 2002-2003 presented great challenges and opportunities and urged the need for more effective and efficient discharge of WHO's responsibilities towards Member Countries. The country programmes should be in line with WHO priorities, and the funding requested should be within the absorptive capacity of the countries. He urged the CCPDM to review the proposed programme budget for 2002-2003 in that context. In pursuance of the "One WHO" concept, the Director-General had prepared a single Programme Budget document in consultation with the six regional offices and headquarters, underpinned by a corporate strategy, inclusive of strategic directions and a set of core functions. Part II of the proposed programme budget sets out the regional perspective and areas for priority action in the Region. Intercountry programmes had been strengthened so that WHO was better equipped to address the daunting challenges in the new millennium in the South-East Asia Region.

* * *

Dr Gado Tshering (Bhutan) was elected Chairperson, and Mr Anil Kumar Jha (India) as Rapporteur. A Drafting Group, consisting

of Dr H.A.P. Kahandaliyanage of Sri Lanka, Mr Mir Shahabuddin Mohammed from Bangladesh, and Dr B.D. Chataut from Nepal, was constituted to prepare the draft report of the meeting.

3. REMARKS BY THE DEPUTY REGIONAL DIRECTOR

Ms Poonam Khetrupal Singh, the Deputy Regional Director and Director, Programme Management, gave a historical perspective to the evolution of the CCPDM. She outlined its establishment as a small committee in 1980, in pursuance of resolution SEA/RC32/R10 of the thirty-second session of the Regional Committee and its subsequent expansion in 1982 as CCPDM by the Regional Director.

Ms Singh added that the Regional Director had entrusted to the CCPDM from time to time other functions related to WHO programme development and management. The terms of reference of the CCPDM had been amended in 1998 as decided by RC51. Consequently, the CCPDM had now taken over the functions of the erstwhile Sub-committee on Programme Budget of the Regional Committee. Further, the Technical Discussions were now conducted during the meeting of the CCPDM. As an advisory body, the CCPDM makes its recommendations to the Regional Director who has the prerogative to submit them to the Regional Committee.

4. REVIEW OF WHO COLLABORATIVE PROGRAMMES IMPLEMENTED DURING THE 1998-1999 BIENNIUM

Introducing the Agenda Item, Ms Poonam Khetrupal Singh, Deputy Regional Director and Director, Programme Management said that the background document on this important agenda item provided information on the implementation of the WHO collaborative programmes at the country and intercountry/regional levels during the biennium 1998-1999. The document had been prepared under 15 major programme headings in line with the area of work as in the Programme Budget 1998-1999. The report indicated an improvement in the implementation of technical programmes.

Presenting the subject, Dr M. Khalilullah, Acting Programme Development Officer, stated that the report on implementation of the WHO collaborative programme in the Member Countries of the Region during 1998-1999 was prepared on the basis of the programme classification for the biennium. The most important accomplishment was the eradication of guineaworm from the Region. Other achievements included significant progress made towards control of leprosy, poliomyelitis and tuberculosis.

Discussion Points

- © There was improvement in the implementation of WHO collaborative programmes in the countries of the Region compared to the previous two biennia and with other regions, as a result of a collective effort. This led to 63% overall obligation by the end of the first year of the biennium and 100% by the end of its second year.
- © WHO financial rules allow a period of one calendar year for the carryover of funds from the previous biennium. Funds for planned activities are kept in reserve. However, exchange rate fluctuations and conservative cost estimations had an impact

on actual obligation of funds. As per current estimates, an amount of nearly US\$ 2.5 million out of the regional RB reserves for 1998-99 are likely to be surrendered to casual income at the end of this year. The successful joint efforts of the WHO Country Offices (WCOs), SEARO and national authorities in liquidating obligations were noted. The need for realistic planning and early start of activities was stressed.

- © The new WHO human resources policy will be proposed to the Executive Board in January 2001, and an important aspect of this new policy is related to staff appraisal. This would include recommendations to improve the assessment of staff at all levels on all types of contracts.
- © HIV/AIDS was a flagship project of the Regional Office. Behaviour surveillance was an essential element of HIV/AIDS control and needed greater emphasis in order to undertake appropriate measures to control this epidemic. A communication/counselling strategy, including "social vaccination", was being drafted and expertise available in the countries in this field would be utilized.
- © There is a need to strengthen collaborative mechanisms between WHO and Member Countries for monitoring and evaluation of WHO activities, including workshops, seminars, fellowships and study tours, in terms of achievement of their objectives. WHO should develop guidelines and time frames for submission and approval of proposals for activities as well as for timely liquidation of obligated funds.
- © Emerging issues like food safety and obesity, its relation with diabetes, cardiovascular and other diseases as well as use of

junk food by the younger generation were of great concern for some countries.

- © Steps should be taken to accelerate the implementation of fellowships and study tours. Similarly, requests for procurement of supplies and equipment should be processed promptly.
- © One-fourth of the surrendered budget of nearly \$4 million from the previous biennium was due to currency fluctuation. WHO should find a mechanism so that the Region does not lose on account of economic problems.

Recommendations

- (1) Future reports should provide information on achievements of goals, objectives and expected results as planned under each area of work.
- (2) Emerging issues like food safety, obesity and ineffective health foods should also receive due attention by WHO and Member Countries.
- (3) WHO and Member Countries should implement the effective "social vaccines" (e.g. targeted intensive health and behaviour education, building of life skills among youth and 100% condom use among commercial sex workers) for prevention and control of HIV/AIDS, within the context of regional and national HIV/AIDS programmes.
- (4) Member Countries and WHO should make concrete efforts to complete activities carried over from the last biennium (1998-

1999), in order to avoid surrendering of Regular Budget reserves by December 2000.

- (5) WHO should strengthen its staff appraisal mechanism. Indicators should be developed to monitor their performance.
- (6) WHO-government collaborative mechanisms should be strengthened for monitoring and evaluation at country and regional levels, for timely submission and approval of proposals as well as liquidation of obligated funds.

5. PROGRAMME BUDGET FOR 2000 -2001

5.1 Review of WHO Collaborative Programmes Implemented During the First Six Months, i.e. 1 January to 30 June 2000

In her introduction, Ms Poonam Khetrpal Singh, Deputy Regional Director and Director, Programme Management said that the six-monthly review report provided an elaboration of activities implemented in terms of expected results planned for the first six-months of the biennium 2000-2001. Though it indicated an improvement in performance, there had been a slow take-off during the first months of the biennium. It was essential that the countries and WHO complete the planned activities within the agreed timeframe, and ensure obligation of the allotted budget by December 2000.

Dr M. Khalilullah, Ag Programme Development Officer, made a brief presentation on the review of WHO collaborative programmes implemented during the first six months of the biennium 2000-2001. The report on the implementation of WHO collaborative

programmes covering the period 1 January to 30 June 2000 was based on the achievement of expected results.

Discussion Points

- © During the period under review, the budget obligation both in respect of extrabudgetary and regular budget resources was 34%. Of this, regular budget obligation was 23% and extrabudgetary was 48%. By late August, RB obligation had reached 34% and EB obligation 49%.
- © The reasons for slow programme implementation in the beginning included shortage of health resources, changes among national programme managers and implementing the carry-over activities from the previous biennium.
- © Development of new training programmes, structured study tours, workshops, meetings, and operational programmes addressing emerging and cross-border issues should be given priority, with enhanced allocation.
- © The improvement of implementation of WHO collaborative programmes at country level in most countries was noted and concern expressed about the drop in implementation rate of supplementary ICP programmes (ICP II) compared to the last biennium. WHO-SEARO was requested to accelerate the implementation so that meetings, training workshops, structured study tours and research studies could be implemented by the last quarter of the first year.

Recommendations

- (1) Implementation, monitoring and evaluation mechanisms, both technical and financial, in the Regional Office and Country offices should be strengthened through development of appropriate modules and guidelines.
- (2) Member Countries and WHO should enhance budgetary allocations for cross-border health development activities.

5.2 Efficiency Savings in SEAR

Ms Poonam Khetrupal Singh, Deputy Regional Director and Director, Programme Management said that while adopting the appropriation resolution for the financial period 2000-2001, the World Health Assembly in May 1999 had approved the Programme Budget without any compensation for 'cost increases' or 'exchange rate movements'. In response to this resolution, the Director-General (DG) of WHO had set up a task force to identify areas of potential efficiency savings in the Regular Budget allocations of WHO headquarters and the regions. The DG had requested the World Health Assembly in 1999 for an increase of 3% in the global WHO budget for the biennium 2000-2001, for adjustment of cost increases as well as exchange rate movement. However, the Assembly approved the budget at the 1998-1999 level and asked the DG to absorb the estimated cost increases and currency adjustments. In addition, the DG was also requested to identify 2-3% additional efficiency savings within the budget itself for reallocation to priority programmes. Efforts are thus under way to generate savings to cover cost increases and currency fluctuations and also to provide additional funds for priority areas. DG then requested the respective Regional Offices to generate savings

based on 1998-1999 expenditure on travel, study tours, fellowships and procurement. Expenditure data was to be reported every six months during the biennium.

Mr David Nolan, Director, Administration and Finance, made a brief presentation on the progress made in effecting efficiency savings. For SEAR, an initial allocation of \$500,000 was identified for specific priority programme areas. An additional \$750,000 was expected to be received from WHO/HQ by January 2001, making a total of \$1.25 million from efficiency savings for priority areas. Out of the already allocated initial amount, a high level of implementation had been achieved. The areas from where funds were shifted were travel, study tour, fellowships and procurement. Expenditure ceilings were set for these areas during the 2000-2001 biennium.

Mr Helge Larsen, Director, Budget and Management Reform, WHO headquarters, stated that the task force set up to study the implementation of efficiency savings had set a target of \$5.2 million for SEAR. Of this, \$4.7 million was set aside for covering cost increases and the remaining \$0.5 million for shifting to priority programme areas. The Director-General had agreed to monitor the utilization of efficiency savings and report to the Executive Board periodically throughout the biennium. The Regional Offices, therefore, had to report the progress to the Director-General every six months. Mr Larsen highlighted SEAR's commendable performance in this regard as compared to other regions.

Discussion Points

- © Efficiency savings were to be used for priority areas identified by WHO Governing Bodies. These included mental health, food safety, strengthening of health systems, noncommunicable diseases, blood safety and making pregnancy safer. Information on the latest status of allotments issued for \$250,000 out of efficiency savings to these priority areas in SEAR, was presented and its implementation noted.
- © While noting the decision of the World Health Assembly on selection of priority programmes for using efficiency savings, it was suggested that such prioritization should be more flexible in order to reflect the needs of the Member Countries of the Region.
- © Efficiency savings and cost cutting were implemented simultaneously. Allocation of funds to training programmes, fellowships, study tours and group educational activities should not be decreased, as these activities are crucial for national institutional capacity building and for promotion and protection of health.
- © It was noted that during the first six months of the current biennium, SEAR had made the most significant overall progress in achieving and utilizing efficiency savings compared to other Regions and Headquarters.

Recommendation

Taking into consideration the specific needs of the Member Countries, a more participatory approach should be adopted in the

planning of activities and allocation of funds from efficiency savings.

6. REVIEW OF THE PROPOSED PROGRAMME BUDGET FOR 2002 - 2003

Ms Poonam Khetrpal Singh, Deputy Regional Director and Director, Programme Management, said that the Proposed Programme Budget for 2002-2003 is a key instrument in the reform process towards achieving 'One WHO'. As a strategic programme budget for the Organization, it represents a significant departure from previous biennia, both in content and in the manner in which it had been prepared. It provides a balance between continuity and an increased focus on new priority areas identified by the Executive Board at its 106th session in May 2000. The proposed budget reflects 35 areas of work that best illustrate the thrust of One WHO. Part I of the proposed programme budget was a joint effort of Regional Offices and the WHO headquarters, and would be the basis of discussions at all Regional Committees, the Executive Board and the World Health Assembly.

The Deputy Regional Director further said that Part II of the Proposed Programme Budget was prepared in consultation with the national authorities and the WHO country offices and would also be presented to the forthcoming Regional Committee. The regional part (Part II) reflects, in addition to the global priorities, priority areas identified by the individual countries. Thus, within the global strategic framework for 2002-2003, this part contained the regional perspective and outlines, the issues and challenges facing

the Region in the coming biennium and the broad regional strategies to address them.

Ms Singh added that the Ministers of Health of the Region, at their meeting held recently in Kathmandu, agreed to enhance support for intercountry collaboration with Member Countries. This was seen as a means of strengthening regional solidarity and as a response to the globalization of public health problems and issues. The Ministers reaffirmed the need for strengthening the intercountry approach and ensuring efficient and effective implementation of recommendations and resolutions of the WHO Governing Bodies.

Mr Helge Larsen, Director, Budget and Management Reform, WHO headquarters, stated that the Proposed Programme Budget for 2002-2003 was a key instrument in the ongoing reform process. The preparation of the document had been significantly different from the previous biennia. This was the first programme budget which was prepared with the Director-General's close involvement. The past practice was to present the submissions received from the Regional Offices to the World Health Assembly *in toto*, for approval without appropriate scrutiny of the programme content and the resources in an integrated manner. The present document was prepared through extensive consultations between Headquarters and the Regional Offices. In this process, it was ensured that some continuity was maintained from the 2000-2001 biennium. In the result-based budgeting process, the programme formulation revolved around a set of objectives and expected results. These results provide the basis for resource requirements. Achievements of the expected results are measured by performance indicators that ensure accountability.

In his presentation, Mr David Nolan, Director, Administration and Finance, outlined the timetable and processes involved in the preparation of the Strategic Programme Budget for 2002-2003. Part II of the Budget reflecting the regional perspective was prepared within the overall strategic global framework of WHO. This regional framework reflects the aspirations of Member Countries as contained in various declarations. The regional priorities proposed were a combination of global, regional and national health issues and were the outcome of a series of consultations with the Member Countries through questionnaires and also through the formulation of WHO Country Cooperation Strategy. Part II thus provided clear, well-defined regional priorities, which would ensure a better match between country and regional needs and global and regional strategies.

Discussion Points

- © It was noted that the preparation of the proposed programme budget 2002-2003 has been significantly different from 2000-2001. It is a result-based budget where programme formulation is based on objectives and expected results. The expected results justify resource requirements and performance indicators measure achievements.
- © The 18th Health Ministers' meeting in Kathmandu decided that the intercountry programmes should be further enhanced as a means of strengthening regional solidarity and as a response to the globalization of public health problems and issues.
- © The criteria used to identify the priority areas at the global, regional and national levels were discussed. It was noted that

health promotion and cross-border disease control should be among the regional priority areas.

- © The budget reduction based on WHA51.31 (i.e. a maximum of 3% budget cut per annum) should be evenly spread between the Regional Office/ICP budget and the budget allocated for countries. It was noted that the Director-General had proposed a programme budget for SEAR with a reduction of only 2.7% for 2002 -2003.
- © The Member Countries and WHO have called for a strong commitment and joint endeavours to meet the target of financial obligation of at least 75% by the end of December in the first year of the biennium and 100% by the end of September in the next year.
- © Some members suggested that there should be a high-level task force meeting to review and make recommendations on regional/intercountry and country priorities and also on the detailed indicative country-planning figure for each country. It is expected that the Director-General will decide the detailed tentative country-planning figures after the Executive Board meeting.
- © Member Countries and WHO will prepare detailed plans of action for WHO collaborative programmes within 35 programme areas of work, between February and May 2001. The detailed Plans of Action will be submitted to the Regional Committee in September 2001.
- © A concern was expressed at the increasing allocation to the Regional Director's office over the years, in the context of the decreasing regional budget. It was clarified that there was no

overall increase in staff posts, but this was mainly due to the redistribution of staff in the Regional Office in early 2000. The matter is under review.

- © Supplementary ICP funds should not be used for recruiting additional long-term staff or for supplies and equipment at the Regional Office.
- © Some concerns were expressed regarding the tendency to depend on extrabudgetary sources, which are not subject to the scrutiny of the Governing Bodies. With the WHO movement towards an integrated 'One WHO' budget, these concerns would be addressed.

Recommendations

- (1) The CCPDM taking note of Part I of the Strategic Budget for 2002 -2003 and Part II dealing with the regional components, recommends to the Regional Committee, through the Regional Director, to adopt an appropriate resolution requesting the Director-General to take into consideration the following points while finalizing the programme budget for 2002 -2003:
 - The reduction in the regional budget for 2002-2003, mandated by resolution WHA51.31, should be shared proportionately, in relation to their current budget, between the non-least developed countries and the Regional/Intercountry Programmes (ICP).
 - The pro-rata pooled resources for supplementary intercountry mechanisms (ICP II), being implemented for the last three biennia, should continue in 2002 -2003 and also in the future biennia, using the principle of full

participation of Member Countries in the planning and management of these resources.

- As recommended by the Health Ministers and also by the earlier sessions of the South-East Asia Regional Committee, the enhancement of intercountry programmes with appropriate resource allocations could also be initiated, taking into account the progress of implementation by the countries.
 - The indicative country planning figures for 2002-2003 should be made available to the Member Countries as early as possible in order to facilitate preparation of detailed plans of action by the joint WHO/government coordination mechanisms.
 - There should be flexibility in prioritisation of the WHO collaborative programmes to accommodate regional and country priorities.
- (2) The intercountry programmes for 2002-2003 in the context of regional solidarity and cooperation, should be developed jointly by Member Countries and WHO. A high-level task force should be established to ensure that the priority needs of the Member Countries are accommodated.

7. WORKING GROUP STUDY ON EFFICIENCY OF WHO SOUTH-EAST ASIA REGIONAL OFFICE AND COUNTRY OFFICES

Ms Poonam Khetrpal Singh, Deputy Regional Director and Director, Programme Management said that, in pursuance of a decision of the fifty-first session of the Regional Committee in 1998, the Regional Director had established a Working Group to study the efficiency of the WHO Regional Office and the Country

Offices. The group was to submit a report to the Regional Director for submission to the CCPDM in September 1999. However, owing to heavy commitments in their countries the Working Group members had to postpone their scheduled visits to country offices, and thus they completed the study only in April 2000, and the report was submitted by end-July.

Dr Kan Tun, Liaison Officer with Country Offices, presented in detail the findings and recommendations of the members of the Working Group. In particular, he highlighted the weaknesses in WHO programme development and management identified by the Working Group as well as the remedial measures initiated by the Regional Director to improve the efficiency and effectiveness of WHO's collaboration with Member Countries.

During the discussions, the CCPDM appreciated the efforts of the Working Group. The CCPDM also thanked the Regional Director and his staff, including those in country offices, for extending excellent cooperation and support to the Working Group in undertaking the study. While noting with satisfaction the actions taken by the Regional Director to implement recommendations of the Working Group, the Committee noted that the Country Cooperation Strategy mechanism should be effectively utilized to strengthen the WHO country offices.

The CCPDM felt that the efficiency study was a very useful exercise in that it had afforded an opportunity to senior national health officials to get well acquainted with the various facets of managerial process for WHO programme development and management. At the same time, the study had also enabled the Working Group to identify the strengths and weaknesses in programme development and management at the country and

Regional Office levels, and make suitable recommendations to the Regional Director. The CCPDM felt that WHO should strive to maintain its technical leadership in the health sector.

Recommendation

WHO should carry out similar studies at periodic intervals to further improve and enhance the efficiency and effectiveness of the WHO country offices and the Regional Office. The reports of such studies should be made available to Member Countries.

8. REPORT ON THE MEETING OF THE COORDINATING BODIES OF WHO GLOBAL PROGRAMMES

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

Ms Poonam Khetrupal Singh, Deputy Regional Director and Director, Programme Management 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. The 23rd session of the JCB was held in Geneva on 26 -27 June 2000. Participants from India, Indonesia and Sri Lanka attended.

Dr Sumarjati Arjoso, representative from Indonesia, made a presentation on the meeting of the Joint Coordination Board. She mentioned the progress of work in tropical diseases research and the successful work through partnerships (including the private

sector). Dengue, tuberculosis and malaria, research in diagnostics, and the need for an information network were among the priority areas.

The CCPDM noted the report.

8.2 Research, Development and Research Training in Human Reproduction Policy and Coordination Committee (PCC)

Ms Poonam Khetrupal Singh, Deputy Regional Director and Director, Programme Management 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 its overall policy and strategy. To coordinate the interests and responsibilities of the parties cooperating in the Special Programme, 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 Indonesia participated in the 13th PCC meeting held from 22 -23 June 2000 in Geneva.

Mr Mir Shahabuddin Mohammed, representative from Bangladesh, reported on the proceedings of the 13th PCC meeting. The concept of integrated management of pregnancy and child-birth, research related to HIV/AIDS, making pregnancy safer initiative and progress of the human reproduction programme were some of the highlights.

The CCPDM noted the report.

8.3 Health Technology and Pharmaceuticals Cluster: Meeting of Interested Partners

Ms Poonam Khetrpal Singh, Deputy Regional Director and Director, Programme Management said that for many years WHO had held annual or biennial meetings to discuss the work of particular programmes. The establishment, two years ago, of clusters organized to bring together related areas of work had enabled recent Meetings of Interested Partners (MIP) to be organized along cluster lines. This also ensured that meetings required as part of a cosponsored programme were held within this arrangement. WHO would continue to hold MIP in addition to the formal meetings of the cosponsored programmes. The latter would be held in accordance with the memoranda of agreement on which the programmes were based. In the case of MIP, provisional guidelines had been drawn to allow flexibility in the way of working, to meet the individual needs of each cluster.

At the second Meeting of Interested Partners of the Health Technology and Pharmaceuticals cluster, held in April 2000, Bangladesh and Myanmar were invited from the Region to attend. Myanmar attended the meeting.

Dr Ohn Kyaw, representative from Myanmar, reported on the meeting. Some of the issues discussed were –WHO Corporate Strategic Agenda and HTP strategic direction, access to essential drugs with emphasis on priority health problems and the poor, immunization with emphasis on polio eradication, blood safety including injection safety, global collaboration for blood safety, safe injection global network (SIGN), inter-cluster vaccine research initiative including HIV Vaccine Initiative and the Global Alliance for Vaccines and Immunization (GAVI).

The CCPDM discussed and took note of the report, and made the following observations.

- There was a strong need for WHO's close collaboration with WTO with regard to negotiation and implementation of the international multilateral trade agreements such as TRIPS and GATS, which have implications for the health sector, particularly for more vulnerable developing countries.
- Support was needed by countries for facilitating the availability and accessibility of essential drugs. WHO's proactive role was urged to promote the capabilities of Member Countries for controlling prices of essential drugs particularly for treatment of HIV and cancer.
- The licensing process, parallel imports, regulated and unregulated markets, and trading of drugs on the internet were areas of concern for Member Countries of this Region.
- Efforts had to be initiated through the concerned ministries (Commerce, Trade, External Affairs, etc.) in the respective countries regarding compulsory licensing and other measures to improve the affordability and accessibility of drugs.
- International and regional technical collaboration was needed in the provision and manufacture of essential drugs in the countries keeping in view their financing capability to ensure sustainability, affordability and accessibility.

- Some multinational pharmaceutical companies were providing free drugs for leprosy and filariasis elimination.
- WHO has secured Observer status with WTO and it would endeavour to safeguard the interests of the health sector. WHO/WTO collaboration had already been enhanced with WHO's participation in WTO meetings.
- It was noted that DG/WHO had decided to convene the meetings of interested partners (MIPs) for all WHO clusters at the same time.

Recommendations

- (1) WHO should enhance its dialogue with WTO and other multilateral trade agreement bodies at global and regional levels. It should be proactively engaged in negotiations of Member Countries with these bodies.
- (2) WHO/SEARO should regularly provide the Member Countries with relevant information and case studies on the procedures, implications and experiences on various aspects of trade negotiations.

9. REGIONAL IMPLICATIONS OF THE DECISIONS AND RESOLUTIONS OF THE FIFTY-THIRD WORLD HEALTH ASSEMBLY AND THE 105TH AND 106TH SESSIONS OF THE EXECUTIVE BOARD, AND REVIEW OF THE DRAFT PROVISIONAL AGENDAS OF THE 107TH SESSION OF THE EXECUTIVE BOARD AND THE FIFTY-FOURTH WORLD HEALTH ASSEMBLY

Introducing the agenda item, Ms Poonam Khetrapal Singh, Deputy Regional Director, and Director Programme Management, said that

the resolutions and decisions adopted by the WHO governing bodies were brought to the attention of the Member States as they had significant regional implications. Accordingly, eight resolutions and one decision relevant to our Region had been identified from the decisions and resolutions of the fifty-third World Health Assembly and 105th and 106th sessions of the Executive Board for discussions and noting by the fifty-third session of the Regional Committee.

In his presentation, Dr M. Khaliullah, Acting Programme Development Officer, said that 17 resolutions of the fifty-third World Health Assembly and 31 resolutions/ decisions of the 105th and 106th EB were reviewed. Out of these eight resolutions and one decision, which had regional implications were considered. He highlighted the salient features of each of the selected resolutions.

The CCPDM then took up the resolutions/decisions for consideration and made the following observations and recommendations:

(1) *Stop Tuberculosis Initiative (WHA53.1 and EB105.R11)*

The CCPDM noted that tuberculosis was a major impediment to socio-economic development and a significant cause of premature deaths and human suffering. The Member Countries should implement and expand the DOTS strategy. Training of manpower and integration of TB control within PHC should be intensified.

Recommendation

DOTS is acknowledged as a universal strategy. However, the strategy could be adapted to meet the needs of the Member Countries. Further research on multi-drug resistance should be undertaken.

(2) *Regulations for Expert Advisory Panels and Committees* (WHA53.8)

The CCPDM took note of this resolution.

(3) *International Decade of the World's Indigenous People* (WHA53.10)

The CCPDM took note of this resolution.

(4) *Global Alliance for Vaccines and Immunization (GAVI)*

(WHA53.12 & EB105.R4)

The CCPDM urged the Member Countries to maximize their collaboration with this initiative. Of the 29 proposals submitted globally for GAVI funding, none has yet been approved.

Recommendation

WHO should play a proactive role to enable the Member Countries to interact with GAVI, to enhance resources for immunization.

(5) *HIV/AIDS: Confronting the Epidemic* (WHA53.14 & EB105.R4)

The CCPDM noted the resolution and made the following recommendation:

Recommendation

Prevention aspects should be given priority by WHO and Member Countries to successfully control the HIV/AIDS epidemic. The PPB 2002 -2003 should highlight the preventive aspects of HIV/AIDS.

(6) Food Safety (WHA53.15 & EB105.R16)

The CCPDM shared the deep concern expressed by the World Health Assembly about food safety. Food safety should be integrated with health promotion programmes for consumers and in school curricula. Sustainable food safety programmes should be established and strengthened. There is a need for technical assistance to develop/update rules/regulations for controlling the allowable claims regarding marketing and labelling of food products including health foods.

Recommendations

- (1) WHO should provide technical assistance to develop/update rules/regulations for controlling the allowable claims regarding marketing and labelling of food products including health foods.
- (2) Representatives from the health sector of Member Countries should actively be involved in the regional and global Codex Committees. WHO should provide assistance to the Member Countries to participate in these meetings.
- (3) WHO and Member Countries should recognize the importance of food safety and highlight this in the PPB 2002-2003.

(7) Framework Convention on Tobacco Control (WHA53.16)

The CCPDM noted that the success of the Framework Convention on Tobacco Control (FCTC) depended on the active participation of the Member States in the negotiation process. An Intergovernmental Negotiating Body has been established by the World Health Assembly to draft and negotiate FCTC protocols. WHO should facilitate the participation of the Member Countries especially the least developed ones, at the global negotiation process. A progress report of this Negotiating Body would be submitted to the fifty-fourth World Health Assembly.

In some countries of the Region, the livelihood of a number of people depends on tobacco farming and distribution. Any measures to control tobacco usage should take this into account. Experience from Thailand showed that after many years of effective tobacco control campaigns, prevalence of tobacco use had declined without adversely affecting the tobacco farmers.

The CCPDM suggested that control of tobacco use could be initiated through health education in schools, in addition to other effective tobacco control measures.

Recommendation

All Member Countries should vigorously implement tobacco control measures, including development of their own legislative frameworks, with a realistic time-frame.

(8) Prevention and Control of Noncommunicable Diseases (WHA53.17)

The CCPDM noted the resolution.

In conclusion, the CCPDM proposed that, from its next meeting, all resolutions and decisions from the EB/WHA should be submitted for their information, review, suggestions or comments.

The CCPDM then considered the review of the draft provisional agendas of the Governing Bodies.

Mr David M. Nolan, Director, Administration and Finance, WHO-SEARO presented the draft agenda for the 107th session of the Executive Board. He stated that the draft provisional agenda for the fifty-fourth World Health Assembly had not yet been received. While reviewing the draft provisional agenda for the 107th session of the Executive Board, the CCPDM made the following recommendations:

- (1) WHO/SEARO should organize a comprehensive briefing for all EB members and the WHA delegates from the Region, well before these sessions.
- (2) The important issue pertaining to arsenic contamination in ground water affecting some countries of the Region had already been discussed in the previous sessions of the EB/WHA. The CCPDM suggested that it should be included as one of the agenda items for the fifty-fourth session of the Regional Committee.

10. ADOPTION OF REPORT

The CCPDM adopted the draft report of its 37th meeting with minor modifications.

11. CLOSURE

The Deputy Regional Director and Director, Programme Management, Ms Poonam Khetrpal Singh, congratulated the members of the CCPDM for a very productive meeting and useful recommendations which would be placed before the Regional Director for his consideration before being submitted to the fifty-third session of the Regional Committee. The CCPDM sessions were very interesting and informative which led to very lively discussions. She congratulated the Chairman for not only conducting the meeting effectively with his adroit handling of the discussions but also for ensuring a cordial environment that helped fruitful deliberations.

The Chairman, Dr Gado Tshering, in his concluding remarks, congratulated the Rapporteur and the drafting group for preparing a report that truly reflected the discussions and for completing the report on time. He appreciated the support provided by the WHO secretariat to the Rapporteur and the drafting group.

Thanking the participants for their cooperation in successfully conducting the meeting, the Chairman wished them a safe journey home.

He then declared the meeting closed.

Annex 7

RECOMMENDATIONS ARISING OUT OF THE TECHNICAL DISCUSSIONS ON EQUITY IN ACCESS TO PUBLIC HEALTH¹

1. INTRODUCTION

Technical Discussions on “Equity in Access to Public Health” took place on 31 August 2000 under the Chairmanship of Dr Kyi Soe, Director-General, Department of Health Planning, Ministry of Health, Myanmar. Mr Mir Shahabuddin Mohammed, Joint Secretary (Public Health and WHO), Ministry of Health and Family Welfare, Bangladesh, was elected Rapporteur.

1.1 Introductory Remarks by the Chairman

Dr Kyi Soe opened the discussions by emphasizing the importance of equity in access to public health in view of its close relation with efforts to achieve health for all in the 21st century. Equity was the most salient feature of the HFA movement initiated by the Alma-Ata Declaration in 1978. In the *World Health Report 2000* also, equity was given considerable importance in the health system performance assessment. It was seen that ‘equity’ and ‘equality’ were used interchangeably both in the health field and outside. Similarly, the term ‘access’ need not necessarily imply ‘having

¹ Originally issued as document SEA/RC53/18 dated 3 September 2000.

access to health care'. He hoped that despite the different perceptions and backgrounds of the participants, the meeting would deliberate on the topic in the spirit of "one WHO". The outcomes of these discussions would help facilitate the Member Countries in achieving health for all in the 21st century.

1.2 Introduction by Dr Rita Thapa, Director, Health Systems and Community Health, WHO/SEARO

Introducing the topic, Dr Thapa highlighted its significance. Countries of this Region had almost half of the world's total poor. She mentioned that 70% of all deaths and 92% of deaths from communicable diseases occurred among the poorest 20% of the people. There was evidence that 70% of the world's poor were women who suffered the most damaging and mutually reinforcing inequities of poverty and gender. This affected women's health most disproportionately with the adverse effects transcending to the next generation as well. An adoption of the equity approach in public health would help to reduce such unfair gaps regardless of people's ability to pay, geographical location, sex, ethnicity and other variables. Four major international conferences during the last decade had addressed these issues of equity approach to health and health determinants. She hoped that the recommendations of the technical discussions, duly endorsed by the Regional Committee, would help guide the Member States in building a bridge to the 21st century by reducing the gap between the poor and the rich.

1.3 Presentation by Dr N. Kumara Rai, Regional Adviser, Health Systems Development, WHO/SEARO

Dr Kumara Rai stressed the importance of having a common understanding regarding the notion of equity and equality. Although these terms have different meanings, they are frequently used interchangeably.

Equity adheres to predetermined norms or standards which are considered fair or just when describing gaps, differences or disparities. These norms or standards vary from place to place, from time to time and from one community to the other. It was due to the difficulties in setting these norms or standards – usually laden with values or judgements – that the notion of inequality is more frequently used. Contrary to equity, equality does not take into account whether the existing gaps, differences or disparities are fair or just. In other words, we may say that inequity is unjust or unfair inequalities. Equity in health was defined by WHO as minimizing avoidable disparities in health and its determinants – including but not limited to health care – between groups of people who have different levels of underlying social attributes (income, gender, ethnicity, geography, etc). He emphasized the importance of differentiating equity in health with equity in health care.

He also explained the ambiguity regarding the term access. Having access to health care does not automatically lead to utilization. Based on this, a conceptual framework was presented. This concept explains the transformation of potential access (or health system characteristics) into realized access or utilization, after a dynamic interaction with demand or felt need and various

enabling factors such as ability and willingness to pay, travel time, quality of care, etc.

Dr Kumara Rai explained three views of equity, i.e. focus on the health of the most vulnerable, inclusion and narrowing gaps. He said that so far, only the European Region had selected the focus of equity on narrowing gaps between the poorest and the richest segments of the population.

Concluding his presentation he stressed two issues. First, the need for disaggregated data by various social attributes described above to be able to reflect the existing inequity in health and health care. For this purpose, routine household surveys seemed to be the only alternative. Secondly, the need to pursue equity in other sectors as well if we were aiming at attaining equity in health and health care. Hence, the challenge to the health sector was how to influence the other sectors, particularly the economic sector to put equity on their respective agendas as well.

2. DISCUSSIONS

The presentation was followed by a lively discussion. Practical country experiences were exchanged which further complemented the issues raised in the presentation. The major issues discussed were:

- (1) Equity in health was construed as minimizing avoidable disparities in health and its determinants.
- (2) The purpose of minimizing health inequities is to contribute to poverty reduction and promotion of economic development.

- (3) Ensuring equity in health requires equity in other sectors as well. Thus, political commitment is needed essentially for all related sectors.
- (4) There is a need to define the level of equity, i.e., equitable distribution of health care resources in relation to the specific country situation and the needs of nomadic populations, populations residing in remote mountain areas or islands, those in emergency situations and displaced persons.
- (5) There is a need for total health sector reform for improving equity in health.
- (6) Health sector reform shall give priority to the provision of an essential health care service package, specific to country needs, to all, regardless of their ability to pay and social attributes.
- (7) In view of increasing globalization and privatization, there is an urgent need to adhere to ethical practices and standards of health care including certification of health institutions in both the public and private sectors. Preventive and promotive health services should also be included in private health institutions.
- (8) There is a clear need for improving peoples' access to health information.

3. RECOMMENDATIONS

- (1) Political commitment is essential to reduce unfair gaps in health and health care, regardless of peoples' ability to

pay, geographical location, sex, age, ethnicity and other variables.

- (2) Concerted efforts must be made from political and policy levels to redress the disparities in health and its determinants.
- (3) Concerted efforts should also be made to set up/update and follow the standards of good health practices, and accordingly, institute accreditation of health institutions, both public and private.
- (4) Private health institutions should provide not only curative, but also preventive and promotive health services.
- (5) The process for a “total health sector reform” should be initiated. In order to plan for such reform, disaggregated data should be collected, analyzed and utilized in assessing gaps in health and health care.
- (6) Provision of essential health care services of good quality to all, particularly the poor and vulnerable groups of populations, should form an essential component of health sector reform.
- (7) Access to and use of essential health care services must be governed by needs rather than by individuals’ purchasing power.
- (8) Countries of the Region need to further refine the conceptual framework, methodologies, indicators and related data, as required, to measure inequity in health and health care.

- (9) Health information systems should be strengthened in the countries so that disaggregated data could be obtained to better reflect the inequity in health and health care.
- (10) Partnership with other sectors should be further strengthened and operationalized to improve equity in health and its determinants.

Annex 8

RECOMMENDATIONS ARISING OUT OF THE TECHNICAL DISCUSSIONS ON HEALTHY SETTINGS¹

1. INTRODUCTION

The Technical Discussions on Healthy Settings were held on 31 August 2000 under the chairmanship of Dr B.D. Chataut, Director-General, Department of Health Services, Ministry of Health, Nepal. Mr Ibrahim Shaheem, Director, Disease Control and Prevention, Department of Public Health, Ministry of Health, Maldives, was elected Rapporteur. The agenda and annotated agenda (SEA/PDM/Meet.37/TD/2.1 and SEA/PDM/Meet.37/TD/2.2 respectively) and the working paper for the Technical Discussions (SEA/PDM/Meet.37/TD/2.3) formed the basis for the discussions. A set of six discussion questions was also circulated which facilitated the discussions.

1.1 Introductory Remarks by the Chairman

While welcoming the participants, representatives of the nongovernmental organizations (NGOs) and all others present, Dr B.D. Chataut, Chairman, highlighted the importance of the subject in today's context. He said that health is not limited to one sector only; it encompasses environment, education, sanitation and hygiene, advocacy and public awareness programmes etc. He

¹ Originally issued as document SEA/RC53/19 dated 3 September 2000.

recognized the “healthy settings” viewpoint as a more inclusive way of looking at the present WHO-assisted community development programmes being promoted in different countries.

1.2 Presentation by Dr A. Sattar Yoosuf, Director, Sustainable Development and Healthy Environment (SDE), WHO/SEARO

Dr A. Sattar Yoosuf (SDE), presented the working paper and introduced the subject. He highlighted the importance of the subject, especially to developing countries in the Region. He hoped that the topic would be discussed extensively and recommendations made in the light of the prevalent situation in the countries of the Region.

Dr Sattar explained the meaning of ‘setting’ as a physical or geographically-demarcated location, where people live and work. Healthy settings could be conceptualized as an approach or a process. A healthy setting is one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to support each other in performing all the functions of life and in developing themselves to their maximum potential. He mentioned that “Healthy setting” as emphasized in this technical discussion, is merely a generic term that takes into consideration the many types of community development actions being undertaken in society at large; which in effect are actions being carried out in community settings. It was further stated that the health status of any setting is determined more by the quality of the environmental conditions and risk factors than by the health care facilities that are provided. He also clarified the hierarchical nature of settings; each being a subset of the other. These may be called contextual and elemental settings respectively.

Betterment of health and well-being of the community thus become one of the goals of community development. Community development action could either be issue-based or target population-based, and could take the form of campaigns, donor-initiated development projects, government programmes, NGO community efforts or a combination of one or more of these. The target population-based community action can be viewed in the form of a community development programme, such as taking up of a slum area, mother and child health, disadvantageous groups etc. The action will depend upon the needs of the country and on the way the policy-makers view the problem.

The South-East Asia Region has undertaken various community development programmes in the form of (a) metropolitan environment improvement programmes; (b) Sarvodaya in Sri Lanka; (c) Adipura in Indonesia; (d) model village in Bhutan; (e) basic minimum needs action in Thailand; (f) cooperative group housing; (g) Grameen bank and micro-credit banking in Bangladesh; (h) Gonashasthya Kendra in Bangladesh, and (i) Sulabh in India, etc. The concept of healthy settings is of concern to WHO due to its relevance to public health, urban health and managerial factors for enhancing partnership.

A Healthy Settings is achievable through the practical application of the principles of health promotion. Health promotion constitutes a preponderance on public health rather than on individual health; focus on causes of ill-health; use of a multitude of approaches; active participation of public, and ensuring the critical role of PHC staff. The success of the programme will largely depend upon good strategic planning and issue prioritization; effective managerial mechanisms, and involved community participation.

Regional experiences indicate certain constraints in the implementation of healthy settings. They include lack of awareness of the concept, weak planning and management, weak coordination and team-work, low advocacy focus, unrealistic time-frames, turnover of government staff and NGO-Government distance. Constraints to sustainability included non-involvement of the community, too much focus on external resources, over-dependence on specific individuals, and project-based nature of work. The challenges beyond the technical aspects related to the lack of political commitment, partnerships and decentralization.

The application of the Healthy Setting process at the district level was perceived as particularly desirable. Thus, the added utility of a "healthy district" approach for the WHO collaborative effort would constitute strengthening the county capacity for integrated management, promotion of health systems research and demonstration of the effect of technical inputs being used.

2. DISCUSSIONS

- (1) It was agreed by the participants that a resolution on the Healthy Settings approach to health promotion should be proposed for adoption by the fifty-third Session of the Regional Committee meeting.
- (2) Participants considered that although the term "Healthy Settings" was new, the concept and practice of the elemental components of healthy settings had already been demonstrated in numerous health promotion projects in countries of the South-East Asia Region, such as healthy cities projects, healthy schools projects, healthy islands,

healthy marketplaces, healthy workplaces etc. Therefore, the concept is already well known and widely accepted at the country level.

- (3) It was stated that a district is the lowest politically-demarcated geographical entity with its distinct administrative infrastructure and decentralized government, where peripheral development sectors are present. A district will encompass various smaller settings, such as villages, markets, schools, hospitals, health centres and offices. Therefore, a healthy district could be an umbrella for various healthy settings.
- (4) It was agreed that political commitment, partnerships between governmental and nongovernmental organizations, and community participation are necessary for the success of healthy settings- type projects.
- (5) There should be a proper coordination mechanism between the different stakeholders in healthy settings projects and programmes. Sanitary engineers, scientists, the media, architects, the community at large, politicians and religious leaders, etc. should therefore meet regularly for achieving the planned goals.
- (6) It was agreed, however, that the goals of healthy settings projects and programmes cannot usually be achieved within a short time-frame. Sustained effort over a prolonged period of time is required.
- (7) Participants discussed that in many countries, decentralization facilitates local collaboration in healthy settings projects. Model village or model basti projects

have been successfully implemented in a number of countries. Integrated management and coordination of large-scale projects, such as healthy cities projects, are more complex and require greater effort.

- (8) Participants were aware of the various difficulties in adopting the healthy cities concept as it is practised in the European Region. European cities generally enjoy a more developed physical infrastructure and a more stable population base. It is easier to achieve a healthy supportive physical environment since this is largely a matter of single-sector infrastructure development. Building supportive social environments requires multi-sectoral collaboration.
- (9) Some of the common challenges that have been noted in healthy settings-type projects in SEAR countries include high turnover of government personnel, a culture of verticalism and weak coordination, insufficient community participation, poverty and ignorance.
- (10) Countries will require external support in order to strengthen and expand the healthy settings approach to health promotion. Such support should be primarily technical.
- (11) While initial seed money from donors may be useful in initiating projects, other fund-raising mechanisms should be sought for sustaining projects. Dependency on donor-financing compromises the sustainability of projects. Sometimes, fee for services, charity and donations, private sector support, self-help approach, cross-subsidies,

establishment of cooperatives and micro-enterprises, micro-credit, and volunteerism should also be considered.

(12) Although many healthy settings-type projects have been implemented and are ongoing in SEAR countries, the aim now should be to institutionalize the concept as a national programme in all countries.

(13) Participants agreed that basic water supply and sanitation are priority issues in virtually any setting in SEAR countries. A diagnosis of needs in most healthy settings projects and programmes will inevitably give emphasis to these areas.

(14) Participants also agreed on the vital importance of air pollution issues in creating healthy settings, not only with respect to urban air quality but even more so on indoor air quality in rural settings. Other health issues considered by the participants to be important for achieving healthy settings in SEAR countries included food safety; vector control; solid and hospital waste management; malnutrition; diarrhoeal diseases; illicit drug use; alcohol and tobacco use; HIV, and TB. These have to be addressed on a priority basis.

3. RECOMMENDATIONS

(1) Member Countries should each identify a pilot district where a Healthy District project may be undertaken using the Healthy Settings concept, and should establish the necessary infrastructure to manage such projects by the end of 2001.

- (2) Member Countries should give priority to strengthening human resources capabilities for managing Healthy Settings projects, and should advocate intersectoral action for health towards strengthening future application of the primary health care approach at the district level.
- (3) Member Countries should strengthen the capacity and active involvement of communities, NGOs, and the private sector towards healthy settings approach, particularly in the areas of priority settings, monitoring and evaluation of projects.
- (4) Member Countries should build an existing mechanism of local intersectoral management approach such as municipal councils, district and community development committees, for the planning, implementation, monitoring and evaluation of healthy district projects.
- (5) WHO should provide technical support to Member Countries while advocating healthy districts using the healthy settings approach at the national level. Strategic advocacy will generate collaborative support starting from the national level down to the implementation at the district level.
- (6) WHO should provide necessary technical support to Healthy District projects in countries of the Region, particularly in the areas of project planning, capacity-building, monitoring and evaluation. To extract and learn from lessons regarding the current healthy settings-type projects, in terms of both successes and failures, should be a priority.

- (7) WHO should support the development of healthy settings management information systems and assist with networking among the various Healthy District programmes in Member Countries.