# SUMMARY RECORD OF THE THIRD MEETING

Auditorium Level 2
Sydney Convention and Exhibition Centre, Sydney
Tuesday, 23 September 1997 at 2 p.m.

CHAIRMAN: Dr Michael WOOLDRIDGE (Australia)

## CONTENTS

1. ANNUAL REPORT ON SEXUALLY TRANSMITTED DISEASES, HIV INFECTION AND AIDS: Item 10 of the Agenda (Document WPR/RC48/5) (continued from the second meeting, section 4)

Dr CLARO (Macao) reported that since January 1996 the authorities in Macao had identified three cases of AIDS, bringing the total number to 11, and 29 HIV infections, bringing the cumulative total to 151. Most had been infected through heterosexual transmission.

Compulsory testing of imported workers in entertainment facilities had become routine. Consistent health education, exchange of information and HIV surveillance had considerably raised awareness of AIDS.

Mr ROKOVADA (Fiji) reported that the cumulative number of HIV cases in Fiji was 38. The work of the National Advisory Committee on AIDS had been reviewed, and a workshop was to be held to formulate a plan of action for the next four years. Fiji was promoting a strategy of syndromic case management for control of sexually transmitted diseases, and was working on a policy that would allow nurses to prescribe antibiotics.

He expressed concern that the number of HIV infections reported in the Region continued to rise each year, while funding from UNAIDS was declining. Support should be directed to those countries that were experiencing HIV epidemics. Three issues raised in the document should be considered for action by the theme groups: development of surveillance for sexually transmitted diseases, use of health services for their treatment, and harm reduction for commercial sex workers and injecting drug users.

Dr SURENCHIMEG (Mongolia) noted that Mongolia, with only one case of AIDS, had so far been relatively isolated from the infection, but that situation could change rapidly. Incidence of sexually transmitted diseases was rising rapidly, particularly among young people. The National Committee on STD/AIDS aimed to strengthen prevention programmes, improve health education, and retrain health workers in case management and detection methods. Mongolia, in collaboration with UNAIDS, had just formulated a plan of action to implement a two-year national STD/AIDS control programme.

Dr INFANTADO (Philippines) expressed concern that the annex to the report showed that the Philippines had one of highest projected rates of increase in HIV incidence and AIDS prevalence in the Region. Efforts to check the trend would be intensified. She supported the request made by

the representative of New Zealand to include in future reports the assumptions and methods used to prepare projections, and the request for updates on antiretroviral therapy.

The Philippines had been among the few countries to formulate an HIV/AIDS strategy that provided a framework for both individual and community responses to the infection. The country had proclaimed 1997 as AIDS Prevention Year, and would be hosting the fourth international congress on AIDS in Asia and the Pacific. The Government fully covered provision of medical and social care for people with HIV/AIDS. Among other measures, care teams had been created in all regional hospitals, model clinics had been set up in high-risk areas of the capital, and the media campaign on responsible sexual behaviour had been intensified. HIV/AIDS organizations were offered opportunities to exchange information and experiences in order to improve prevention interventions, and case management and counselling had been incorporated in the training of frontline health workers. Partnerships with other sectors had greatly enhanced prevention efforts.

Dr ABRAHAM (United States of America) expressed his appreciation of the assertive approach of the Regional Office to tackling the HIV/AIDS epidemic. Strengthening national surveillance capacities was particularly important in order to measure progress of the epidemic and success of interventions and investments. WHO should redouble its efforts in that regard: no additional contributions could be expected unless donors understood the full impact of an uncontrolled epidemic.

Noting the absence in the report of comment on tuberculosis, he requested information on the incidence and secular trends of the disease in the Region, its association with HIV/AIDS, and the way in which the Regional Office was responding to that association. In view of the reference to lack of coordination among UNAIDS cosponsors, he enquired about its causes, impact, and the steps that WHO was taking to tackle the problem.

Mr SCOTTY (Nauru) observed that no case of AIDS had yet been identified in Nauru, but that the situation could change rapidly on account of extensive cross-border travel and promotion of tourism. Appropriate health education measures had therefore been taken through the media and advisory services, and an AIDS committee had been set up to monitor progress. His country received expert support from the more advanced countries in the Region and he looked forward to it continuing in the future.

The Ministry of Health was envisaging introduction of legislation that would authorize AIDS screening of citizens returning from abroad, but he recognized that this would be a controversial measure that infringed on personal rights and freedoms.

Dr Tran Thi Trung CHIEN (Viet Nam) reported that her country had adopted the strategy of broad-based, multisectoral community-level responses to HIV and AIDS, led by the Ministry of Health in partnership with other ministries, national bodies and people with HIV and AIDS. Despite serious public health financing constraints, Viet Nam continued to allocate government funds for HIV prevention and care for people with AIDS. It also deeply valued collaboration with all its international partners. During the past two years effective partnerships had been established with a number of international bodies, including all six UNAIDS cosponsors.

Viet Nam was focusing especially on expanding its response to the infection. The population would benefit from the support of all potential partners in tackling the many health and social aspects of HIV/AIDS. That broad national effort was being coordinated through the HIV/AIDS Action Group, whose Co-Chairman was the WHO Representative in Viet Nam. It included all partners, and met regularly to share information and ideas, and to design and implement joint prevention and care programmes.

Dr PRETRICK (Federated States of Micronesia) said that the prevalence of HIV infection was still not known in his country, although two cases had been reported. The population had considerable contacts with visitors from abroad, and the potential of viral introduction leading to indigenous cases could not be ruled out.

Certain sexually transmitted diseases were prevalent in the country and incidence was rising, but tests could not be performed for lack of laboratory capabilities.

His Government, in collaboration with several international organizations, would in future focus on: strengthening prevention and control of sexually transmitted diseases through syndromic case management; mobilization of support for appropriate prevention and control responses; promotion of health-care-seeking behaviour; strengthening of epidemiological surveillance of HIV/AIDS and sexually transmitted diseases; and targeting of individuals most exposed to infection. The country would therefore continue to need the technical support provided by the international community.

Dr DANIEL (Cook Islands) said that, although Cook Islands had no case of HIV/AIDS infection, the Ministry of Health had undertaken an active health education programme on its

prevention and control, mainly through the media, including training of its personnel in counselling. He thanked the governments of Australia, Japan, and New Zealand, the South Pacific Commission, and WHO for the support they had given to these efforts.

Mr KAM (Republic of Korea) stated that since identification of its first HIV infection in 1986, 679 HIV infections had been reported in the country as of June 1997. These cases were primarily due to sexual contacts, particularly among the homosexual community. The increasing number of young people infected by the virus was equally alarming. In response, the Government had embarked on an educational programme for the prevention of AIDS. Blood safety was also a priority. Likewise, support was extended to victims of the disease through confidentiality and counselling.

In response, the REGIONAL DIRECTOR thanked the representatives for their encouragement, support and guidance in the implementation of programmes in HIV/AIDS and other sexually transmitted diseases.

Concerning the comment from the representative of Japan relating to injecting drug users, he explained that the harm reduction programmes for drug users developed in Australia and New Zealand had proved effective, and consideration would be given to extending implementation. A year ago, UNAIDS had established a task force dealing with injecting drug users whose services would be made available to all Member States. Various strategies to ensure availability of safe needles and syringes were also being carried out. Study tours after the current session had also been arranged for countries, such as China, to observe how activities were being implemented in other countries. In Viet Nam, methadone substitution had been introduced for heroin addicts.

He regretted that the report had not given detailed information on the antiretroviral therapeutic agents; unfortunately, treatment using such drugs was not affordable in most countries. However, the information would be included in the following year's report.

Similarly, New Zealand's suggestion to include the methodologies used for the projections shown in the annex to the document was noted and would be done for next year's report.

Coordination with UNAIDS should not be a source of concern as WHO was one of its cosponsoring organizations. As such, coordination was achieved at the different hierarchical levels of both organizations. At the country level, 8 out of the 11 theme groups were chaired by WHO Representatives. A direct line of communication between the Regional Director and the Director of UNAIDS in the event of an outbreak had been established.

He believed that HIV/AIDS, being a health problem, should be mainly WHO's responsibility, although coordination with other agencies should not be discounted. He therefore requested Member States to give priority to HIV/AIDS when preparing their country programme budgets. In the past, funding had been relegated too much to external donors to the programme's detriment.

With regard to the query from the Representative of the United States of America concerning the link between AIDS and tuberculosis, the Regional Director repeated his reply to the same question from the previous day (see page 94).

Dr PIOT (Executive Director, UNAIDS), referring to concerns raised by representatives regarding insufficient coordination between the cosponsors at country and global level, supported the views expressed on the subject by the Regional Director. The picture at country level was mixed but, as some representatives had indicated, there were examples of effective United Nations system coordination. However, coordination was not an end in itself but rather a mechanism for achieving added value for existing resources in working towards a common goal. Experience in the Region and elsewhere had shown that, with effective coordination and a common plan of action, resources could be mobilized and improved technical support provided at the country level.

Efforts to control the spread of HIV/AIDS had shown how difficult it was to alter individual behaviour. Changes in institutional behaviour were even more difficult to achieve but pressure from countries would encourage organizations to work together. There were some excellent examples of effective leadership of joint efforts at country level by WHO Representatives, some of which were being used as models in documenting best practice for United Nations system coordination.

At the global level, in addition to the aspects mentioned by the Regional Director, there were several interagency working groups, for example on HIV prevention in schools and epidemiological surveillance, through which a clear division of responsibilities had been agreed in order to ensure best use of resources and to avoid duplication of effort.

He endorsed the Regional Director's comments on collaboration between WHO and UNAIDS in the Region. Collaboration in the areas of sexually transmitted diseases, epidemiological surveillance and blood safety were also important, and funds provided by France and Japan had been transferred to the Regional Office for blood safety activities, an area where WHO had specific expertise.

Thanks to the coordination efforts at country level, new contributors were coming forward. For example, following the allocation of seed money from UNAIDS core funding, UNDCP was providing some US$ 700 000 in support of harm-reduction programmes, including needle exchange, in Viet Nam where, as in some other countries, injecting drug use was a driving force in the HIV/AIDS epidemic.

Replying to questions about funding, he said that it was important to recognize that UNAIDS, like WHO, was not itself a fund. In fact there had been an increase in the contributions from the United Nations system as a whole to national HIV/AIDS activities at a time when overall development assistance was declining. However, there were some countries where funding was a problem. The UNAIDS Programme Coordinating Board had recognized those difficulties and would be discussing how they might be overcome at its next meeting. The central role of UNAIDS was to mobilize resources within and outside the United Nations system. The Programme Coordinating Board had recommended that all future financial support to countries should be channelled through the UNAIDS theme groups. He regretted that in some cases disbursement of funds had so far been slow, but mechanisms had been established to speed up disbursements.

In the area of prevention, in addition to the task force on injecting drug use mentioned by the Regional Director, UNAIDS was supporting an Asian network on harm reduction, which was also receiving support from Australia, and activities at country level such as the harm-reduction efforts in Viet Nam which he had just mentioned. The representatives of Malaysia and the Republic of Korea had rightly drawn attention to the importance of young people in relation to the HIV/AIDS epidemic. Worldwide, 50% of all new infections in people over the age of 15 years were in the age group 15-25 years, a group that formed a large proportion of the population in many countries. Moreover, young people were especially vulnerable to sexually transmitted diseases. For these reasons it had been decided to take children and young people living with HIV/AIDS as the theme of World AIDS Day in 1997 and 1998. In addition, UNICEF and UNFPA were becoming increasingly involved in HIV/AIDS activities targeted at young people.

The DIRECTOR-GENERAL said that it was important to understand precisely what was meant by coordination and cooperation at global, regional and country levels and how best plans of action could be formulated and funding secured. At the global level there was room for further improvement in the dialogue between the Committee of Cosponsoring Organizations and the UNAIDS Programme Coordinating Board, a body elected through the United Nations Economic and Social Council. The United Nations Secretary-General would be participating in the next meeting of

the Committee of Cosponsoring Organizations and it was hoped that further thought could be given to the matter at that time.

As the Regional Director had said, HIV/AIDS remained a serious public health problem and WHO therefore had responsibilities in the areas of epidemiological surveillance and forecasting, issues related to sexually transmitted diseases and transmission, including transmission through injecting drug use. It was also concerned, in collaboration with the pharmaceutical industry, with the development of pharmacotherapy and vaccines. The report of a recent consultation on new antiretroviral therapies would be made available shortly. Phase II trials of a vaccine were currently under way in Thailand. The WHO Global Programme on Tuberculosis was working in the area of coinfections of the disease and HIV/AIDS. It appeared that in many developing countries, tuberculosis represented the final stage of the immunodeficiency syndrome and was the cause of death, while in developed countries it was regarded as an opportunistic infection which could be treated, thereby extending life. There was currently some debate regarding the administration of antituberculosis drugs as a prophylactic measure in HIV-infected people.

While WHO would strengthen its cooperation and collaboration with UNAIDS and the cosponsoring agencies at country level, it would also continue to fulfil its responsibilities for the health and medical aspects of the epidemic. HIV/AIDS activities should be maintained as a priority public health programme along the lines mentioned by the Regional Director.

The CHAIRMAN requested the Rapporteurs to prepare an appropriate draft resolution for consideration at a later meeting.

## 2. SUB-COMMITTEE OF THE REGIONAL COMMITTEE ON PROGRAMMES AND TECHNICAL COOPERATION: Item 12 of the Agenda

### 2.1 Country visits: Report of the Sub-Committee, Part I: Item 12.1 of the Agenda (Document WPR/RC48/7)

Dr MENG (Cambodia), introducing the report, said that four members of the Sub-Committee had visited Cambodia and Vanuatu in June 1997 to observe the initiatives of those countries in the area of prevention and control of emerging and re-emerging communicable diseases, and to assess WHO collaboration in supporting those initiatives. The findings had subsequently been extensively discussed by all members of the Sub-Committee in order to reach the conclusions and recommendations described in the document.

The members of the Sub-Committee expressed their gratitude to the health authorities of Cambodia and Vanuatu for their excellent arrangements and for the careful attention given to them during the visits. The visits had been very well organized, which had greatly facilitated the Sub-Committee's task. In both countries, the Sub-Committee had been impressed by the determination of the health authorities to combat various communicable diseases.

The attention of the Regional Committee was drawn to some responses to emerging and re-emerging communicable diseases which were common to both countries. These were: (1) a strong commitment to taking measures to limit the impact of emerging and re-emerging communicable diseases; (2) the implementation of common control mechanisms, such as directly-observed treatment, short course (DOTS) techniques for tuberculosis, and AIDS awareness information campaigns for at-risk groups; (3) the recognition of the importance of health information systems; (4) an extensive networking of partnerships with international, governmental and nongovernmental organizations; and (5) an emphasis on addressing human resources issues.

The Sub-Committee members believed that responses to communicable diseases in other countries and areas in the Region would benefit from attention to those issues. The Sub-Committee had made one recommendation to the Regional Committee, three to the Member States, and two to WHO. The Regional Committee was requested to carefully consider and endorse those recommendations.

Mr WABAIAT (Vanuatu) commended the efforts of the Regional Director in ensuring that countries continued to receive support for their health development programmes. Vanuatu expressed appreciation for having been selected for a country visit by the Sub-Committee and was committed to implementing the Sub-Committee's recommendations.

Among the issues highlighted by Dr Meng in his introduction to the report, human resources development was a key area which would be essential to ensure the strengthening of the institutional base and capacity-building of the health sector in Vanuatu. He thanked donors for their contributions to Vanuatu in that area and to activities on emerging and re-emerging infections.

Vanuatu was taking steps to implement the recommendations of the Sub-Committee and, in July 1997, the Government had emphasized its political will to undertake a reform programme. In that context he expressed appreciation for the support provided by AusAID in developing a national health strategic plan focusing on the priority areas identified.

Like other small island countries, Vanuatu, while encountering difficulties in implementing certain programmes, was seeking to ensure that through collaboration with WHO and other agencies and through community awareness and participation exercises the necessary health programmes would be maintained.

Dr BART (United States of America) reminded representatives that the forty-sixth session of the Regional Committee had initiated discussion of the evaluation process involved in country visits. The main question was whether the country visits were cost-effective, and some countries considered that the question had not been answered. Dr Bart asked why an evaluation covering only one year had been made rather than a desk audit covering several years of a very expensive activity involving up to thirty man-days and travel around the Region. He proposed a review of the terms of reference of the country visits, asking the secretariat itself, possibly with consultation, to review the methodology and consider undertaking the evaluation in a more systematic way.

The CHAIRMAN invited the Regional Director to respond.

The REGIONAL DIRECTOR said that it was up to the Committee to decide whether the Sub-Committee were needed. If so it had to be asked whether the current terms of reference were still valid. The Sub-Committee had been making country visits to check on selected programme areas, and in 1997 it also had to review the draft renewal of health for all policy, since the Regional Committee could not spend several days doing so. Whether the budget were optimal or whether the field and country visits could be replaced by desk work were matters for the Regional Committee to discuss. If a further review were required it would be arranged, but it was the Sub-Committee members themselves who knew whether the country visits were hard work or merely free trips.

Dr BART explained that he did not call the work into question but the methodology of its evaluation.

Dr DURHAM (New Zealand) said that the Sub-Committee members worked very hard on the country visits, but that the essential question was whether their work resulted in substantial gains in health in the Region. Sometimes less effective activities had to be stopped, and the question was whether country visits constituted such activities.

The CHAIRMAN asked that note be taken of the questions, and invited the Regional Director to comment.

The REGIONAL DIRECTOR agreed to evaluate country visits, providing budgetary figures.

Dr BART expressed the gratitude of his delegation for the positive response of the Regional Director, and suggested that the Secretariat continue to evaluate country visits over the longest period for which data are available. These would lead to a qualitative and quantitative evaluation of benefits to WHO, the participants and the host countries.

The CHAIRMAN asked the rapporteurs to prepare a draft resolution on item 12.1, with the question of the evaluation being noted in the record.

2.2 Membership of the Sub-Committee: Item 12.2 of the Agenda

The REGIONAL DIRECTOR said that the current members of the Sub-Committee of the Regional Committee on Programmes and Technical Cooperation were Cambodia, Fiji, Japan, Malaysia, Mongolia, Tuvalu, United States of America (represented by the Northern Mariana Islands) and Viet Nam.

The members of the Sub-Committee whose periods of tenure were due to expire were Japan, Malaysia, Tuvalu and the United States of America (Northern Mariana Islands).

In considering countries to replace the four outgoing members, it had been thought desirable to maintain a representative variety of health and socioeconomic situations.

He therefore suggested considering Hong Kong, China; France (French Polynesia); the Philippines; and Palau to replace the four outgoing members of the Sub-Committee.

It was so decided.

2.3 Renewing the Strategy for Health for All: Report of the Sub-Committee, Part II: Item 12.3 of the Agenda (Document WPR/RC48/8 Rev. 1)

The REGIONAL DIRECTOR drew the attention of the Regional Committee to the first two annexes of the document under discussion.

Also for discussion was the global document "Health for All in the 21st Century" which was provided as WPR/RC48/8 INF.DOC. 1. Annex 1 provided the draft of the Third Evaluation of the Implementation of the Strategy for Health for All by the Year 2000. Annex 2 was the draft regional document "Renewing the Policy for Health for All". However the distinguished representatives were asked to note that, because it was an integral part of health-for-all renewal, *New horizons in health*

had been included as Part II of this document. It was not to be confused with the next agenda item, also entitled *New horizons in health*, which concerned progress so far under the heading of the *New horizons in health* policy framework. *New horizons in health* was attached to the current agenda item so that it could be taken into account in the review of future health-for-all policy. In the previous year, the Regional Committee had noted that in 1997 the Sub-Committee would play a central role in the review of the document presenting an overview of the policies and strategies needed for the 21st century in the Region. The Sub-Committee had now completed its task and had reviewed a third evaluation of implementation of the strategy for health for all by the year 2000 and the draft regional policy for the 21st century. The Regional Director drew attention to the fact that the document was entitled Renewing the Strategy for Health for All. He explained that when the draft regional document had been reviewed by the Sub-Committee it had been agreed that the document itself outlined a policy for the 21st Century and that the document should be given the subtitle "Draft Regional Policy for the 21st Century". This was in line with changes at the global level where the draft document was in fact called a draft policy. The Regional Director then asked Dr Isamu Abraham, Chairman of the Sub-Committee, to introduce its report to the Regional Committee.

Dr ABRAHAM (United States of America), Chairman of the Sub-Committee, introduced the report. He said that the Sub-Committee had been given a heavy task this year. At its meeting in June in Manila, it had thoroughly reviewed the first draft of the document presented to the Regional Committee.

Annex 1 of the document was the report on the Third Evaluation of the Strategy for Health for All by the Year 2000. As with previous evaluation and monitoring exercises, a common framework for evaluating health-for-all strategies had been used to guide the national evaluation process. The document provided a synthesis of findings from the reports which had been submitted by countries and areas in the Region. When the Sub-Committee had met in June, reports had been received from 16 countries and areas. The document had been based on those reports. Since the Sub-Committee's meeting and the drafting of the document, more reports had been received and the total number of reports received currently stood at 26.

In reviewing the Third Evaluation, the Sub-Committee had been greatly encouraged by the many efforts that were already being carried out to meet the challenge of the epidemiological transition that was taking place in the Region.

Annex 2 reviewed the Renewal of the Policy for Health for All in the Western Pacific Region. The document before the Regional Committee was an abridged version of a more

comprehensive document on Renewing the Health-for-all Policy which was being compiled at the Regional Office. In particular, it looked ahead to the potential health problems of the 21st century. By projecting to 2020 existing and emerging health issues, it aimed to provide a framework within which individual countries and areas could formulate policies to suit their own particular needs. For the Region as a whole, there was a clear transition from a health profile dominated by communicable diseases, nutrition, perinatal and maternal conditions, to one where noncommunicable diseases and injuries would play a far more important role. However, the Western Pacific Region contained countries and areas at virtually every stage of the transition and they would have to determine for themselves the most appropriate policies for their own situations.

Renewing the Policy for Health for All highlighted the relevance of both the Global Strategy for Health for All and the regional policy framework *New horizons in health*, which formed Part II of Annex 2. The purpose of Annex 2 was to guide Member States in their review of health for all in the light of the new health policies which would be needed for the 21st century.

The Chairman of the Sub-Committee pointed out that there were some exciting ideas in the document, some enormous challenges and also opportunities. Each country and area would need to develop its own specific policies at the start of the 21st century, but there were a lot of features common to the countries of the Region. It was apparent from the document that Member States and WHO had a great opportunity to share experiences and to optimize their resources as they dealt with the rapid changes and developments confronting them. What the document also showed was the increasing relevance of the concepts of *New horizons in health* and the roles of the individual and the community supported by appropriate public policy and a sustainable environment.

Attention of the Representatives was drawn to WPR/RC48/8/INF.DOC. 1, "Health for All in the 21st Century". The global draft policy document was proposed in accordance with resolutions WHA48.16, EB99.R15 and EB99.R16 for review and comments by the regional committees. It gave a framework and part of the content of the global document which would be supplemented further by the six regional policy documents currently under consideration by the regional committees. The consolidated document would be presented to the 101st session of the Executive Board in January 1998, and after review to the Fifty-first World Health Assembly. In resolution WHA50.28, which was attached as Annex 4, the Fiftieth World Health Assembly agreed that the renewed health-for-all strategy should become the principal guiding framework for translation of WHO's mandate into the development of the Tenth General Programme of Work.

This renewal proposal for the Western Pacific Region, as approved by the Sub-Committee, was presented to the Regional Committee for review and endorsement.

The CHAIRMAN asked for comments.

Mr KANEKO (Japan) expressed appreciation of the document presented by the Chairman of the Sub-Committee. He made the following criticisms of the draft document prepared by headquarters entitled "Health for All in the 21st Century". The global document did not state what the health-for-all policy and strategy were; it did not state what had and had not been achieved to date; it did not set out the major challenges for improvement of health in the world, nor did it explain how "health for all" should be revised in order to respond to such challenges. The document offered no operational framework for implementation of health for all. Important subjects were presented without logical justification: the set of targets on page 31 entitled "Global targets for Health for All to 2020" had no logical or scientific background; the statement on "The role of WHO in the 21st century" on page 37 was presented without reference to the current roles of WHO; there was not enough clarity about the mission and mandate of WHO, nor on how the work being done related to the ongoing review of the Constitution of WHO. The document provided abstract principles and no framework for action; the logical and analytical basis for renewal of health for all was inadequate, and there had been no consultation or provision of information on its components. It was not clear what points the Regional Committee was supposed to discuss. The Japanese delegation expressed its disappointment at these aspects of the document and the process of its preparation.

Turning to the document prepared by the Regional Office (WPR/RC48/8 Rev.1) on the basis of *New horizons in health*, which had been unanimously recognized as an excellent policy basis for the Region, Mr Kaneko noted that the document was easy to read and informative. However, it was hardly related to the headquarters document. Although the regional document was valuable, it would not be effectively used unless it were linked with the global framework. Because of this lack of communication, Member States of the Western Pacific Region should have another opportunity to express their opinions, in the light of all the requisite information, including a revised headquarters document, before the next session of the Executive Board.

Professor WHITWORTH (Australia), concurring with many of the remarks of the representative of Japan, noted that the two documents on health-for-all policy and strategy both purported to do the same thing, i.e. to set out the policy framework for health for all in the 21st century. Their different approaches were difficult to reconcile. The regional document was essentially empirical, using an epidemiological approach; the global report was more theoretical, and

based on the concepts of embracing the values for health for all, making health central to development, and developing sustainable health systems. There was some convergence in the way the two reports dealt with equity in health care and sexual discrimination as it affected health.

She noted that the Regional Sub-Committee's report did not refer to the headquarters document, which she understood other regions were using as the reference for the global consultation. The Western Pacific could not isolate itself, or its voice might not be heard.

The regional document stated that *New horizons in health* would form the basis of future policy development in the Region. As a Region, we had been very comfortable with the directions provided in *New horizons in health*, but could Member States from the Region give it precedence over a global strategy document adopted by the Health Assembly?

Australia's comments on the global document were related not so much to the broad goals and policy directions as to their constituent elements. The overarching goal was greater equity, within and between countries. We should be looking more closely at equity of health outcomes and the inputs needed to improve outcomes. Differential measures are often required to achieve greater equity of outcomes, whether it be special provision for gender-focused programmes or a variable approach to the public/private mix in health care.

The advantages to be expected from science and technology, and particularly information technology, were mentioned in the global report. Health care based on sound practical evidence should be seen as an essential aim.

Good care at reasonable cost ultimately depended on the capacity of decision-makers to design and implement it effectively.

Information technology offered great possibilities, for improved health care through research and data dissemination. However, we should be alert to inequities between those rich and poor in information.

The inclusion of the discussion of health financing in the context of sustainable health systems was valuable, although the commentary in the document needed more careful analysis of its economic premises.

Australia favoured emphasis on the benefit of primary health care and strong partnerships within the health sector and with other sectors.

The document needed an "operational framework" to guide Member States in its implementation, translating concepts into action. There should also be a better linking of the evaluation of the current health-for-all strategy, and the lessons learnt in its implementation to the policy for the future (what worked and why; what did not work and why?).

While she endorsed the use of indicators to monitor performance, those proposed should be more fully discussed.

Finally, commenting on the last section of the regional document on the role of WHO in the 21st century, she said this should take into account the work of the Executive Board special group to review the Constitution concerning WHO's mission and functions.

Professor Whitworth requested more information on the proposed development of a global "health charter", how Member States might contribute, and how it would be affected by the current health-for-all renewal process.

Dr YU Dezhi (China) expressed appreciation to the Secretariat for its preparation, at the different levels, of the health-for-all documentation. The third evaluation report was an improvement on the two preceding reports, with proper attention paid to the relation between health and socioeconomic and cultural development and environmental change.

Supporting Japan's suggestion that another meeting should be held to review document WPR/RC48/8 Rev.1, he said that China wished to include revisions of the following in Annex 1:

- in the second paragraph under "Social trends" (page 14 of the English text), education should be mentioned as receiving emphasis in China besides science, technology and communications;
- in the subsection on "Training of health sector workers" in the section on "Human resources" (page 19), the reference to China "exploring market mechanisms" should be expanded to distinguish two aspects: the encouragement of practitioners to run their own clinics or consultations, and the encouragement of healthy competition between medical institutions to improve efficiency and reduce costs, thus matching demand for care at different levels;
- in the second paragraph of the section on "Organization of the health system" (page 26), the reference to hospital reform in China should make it clear that the purpose was to have a three-tier system, from the grass-roots level in rural areas to specialized hospitals for the treatment and operation of severe cases.

Regarding Annex 2, his general comment was that greater challenges would have to be faced in the next century, placing increased emphasis on health education and promotion and more rational use of resources, extending the reforms that characterized the 1990s, which had captured worldwide attention, especially reform of health care and its delivery. Health care financing, including health insurance, would require close attention. Only thus could social equity and health for all be achieved in an integrated way, with optimum use of resources and community service. Member States would require guidance along these lines that at the same time respected their individual needs and conditions for health. For that purpose he felt an earlier target than 2020 might be set.

More would have to be done in relation to section 4.4 of Annex 2, on "Health economics and financing". A distinction had to be made between efficiency of allocation of resources and efficiency of utilization of resources.

Regarding section 4.9, "Reform process", he saw the need for reference to micromanagement in central government. Over-decentralization might lead to errors in overall health development. There must be balanced decentralization and micromanagement to ensure appropriate reform.

The DIRECTOR-GENERAL said that he thought it should be conceded that, as the representatives of Australia and Japan, among others, had said, the draft global policy document on health for all in the 21st century was not altogether satisfactory. He had pinpointed two major reasons. Members of the Regional Committee who were also members of the Executive Board would recall that when the Executive Board had discussed the matter, more attention had been given by some to the findings of the Commission on Health and Development than to the rational evidence for change; the resulting confusion must now be clarified. The other reason was that when the document had been prepared the third evaluation of the health-of-all strategy had not been received from all regions, although adjusted data had been derivable from other sources. *The world health report 1997* had already been published showing current trends in communicable and noncommunicable diseases (preparation of *The world health report 1998* had begun with a brief to cover the outlook to the year 2025).

The observations of members of the Regional Committee from Europe and others, besides his own, were that the final policy document should comprise two or three elements. An executive summary of about 10 pages at the most for guidance of policy and decision-makers at country, district and community level should be provided. The short version of the document should be based on the need to update the policy established at Alma-Ata in the light of changing priorities. A more complete document would certainly be needed to quantify targets for the year 2025 as a first step in

establishing policy and strategy for the 21st century; that was in line with discussions in the OECD and G7 and with the more detailed analysis expected at the Birmingham Summit in 1998. The aim was thus to determine how to implement the policy. and targets must be very clear: for example, one of the shortcomings of primary health care had been, surprisingly, that although mortality in the under-five age-group had been significantly reduced, there had been no change in mortality in infants under one week of age in developing or developed countries. That indicated a failure in communication with mothers and families.

The comments of members at the Regional Committee would be used to base the report on more reliable evidence for essential health policy formulation, as had been done years ago for WHO's revised drug policy.

The Health Charter would be based on the first part of the report as he had described it, taking into account the evidence of the need for change, demographic factors, the environment and lifestyles. Thus when the Executive Board finalized the policy document it would also consider the Health Charter, which would be developed further in discussions with the Global Policy Council and the Management Development Committee.

He wondered whether there was time for the further country consultations suggested by Japan, but that was a matter for decision at the regional level. The documents prepared by the European and South-East Asia Regions had been considered too voluminous at over 200 pages. A balance must be achieved between general and regional issues and country-specific issues such as health care financing.

Note would be taken of all comments for improvement of the report.

The meeting rose at 5.15 p.m.