SUMMARY RECORD OF THE FOURTH MEETING

Mandarin Court, Singapore
Wednesday, 3 October 1979 at 2.30 p.m.

CHAIRMAN: Dr A.G.K. Chew (Singapore)

CONTENTS

1. SUB-COMMITTEE ON THE GENERAL PROGRAMME OF WORK: Item 13 of the Agenda (Document WPR/RC30/11 Part I) (continued from the third meeting, section 5)

1.1 Membership of the Sub-Committee on the General Programme of Work: Item 13.2 of the Agenda

The REGIONAL DIRECTOR said that, at the twenty-ninth session, membership of the Sub-Committee on the General Programme of Work had been expanded to seven. Representatives of Australia, Japan, Malaysia, Philippines and Viet Nam were reappointed and representatives of New Zealand and Tonga were appointed. The Committee had decided to consider membership again, including rotation, at the thirtieth session.

He had already mentioned the desirability of having an equitable distribution of representatives as members of both Sub-Committees. It would also seem desirable, in the interest of good order, to achieve the same durations of membership for both - that was, three years. Should the Regional Committee still wish membership to be on a rotational basis, it was proposed that three members should be replaced at the present session and that henceforth membership should be for three years. If the Committee agreed with that proposal, it had to decide which three members should retire and which should replace them. It was suggested that representatives of China, Samoa and Singapore should be appointed to replace those of Australia, Malaysia and Philippines.

It was so agreed. (For consideration of the draft resolution, see the fifth meeting, section 1.3).

2. STRATEGIES FOR HEALTH FOR ALL BY THE YEAR 2000: REVIEW OF PROGRESS TOWARDS DEVELOPMENT OF NATIONAL STRATEGIES AND PLANS OF ACTION Item 14 of the Agenda (Documents WPR/RC30/11 Part II, WPR/RC30/11 Part II Add.1, WPR/RC30/11 Part II Add.2, WPR/RC30/11 Part II Add.3)

The REGIONAL DIRECTOR said that the Declaration of Alma Ata, adopted by the International Conference on Primary Health Care, held in Alma Ata, USSR, in September 1978, had called on all governments to formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. The Declaration had also called for urgent and effective international - in addition to national - action to develop and implement primary health care throughout the world, particularly in developing countries. The World Health Organization had lost no time in responding to that call. The Executive Board, at its sixty-third session in January 1979, had prepared guiding principles and essential issues for formulating strategies for health for all by the year 2000. The document had been presented to the Thirty-second World Health Assembly in May 1979. The Health Assembly had invited Member States to consider the immediate use of the document, individually as a basis for formulating national policies, strategies and plans of action, and collectively as a basis for formulating regional and global strategies. The document also provided for a first review of progress by the regional committees in 1979.

In the Western Pacific Region, the tasks involved in preparation for the Regional Committee's first review of progress had been undertaken by the Sub-Committee on the General Programme of Work. The report of the Sub-Committee, document WPR/RC30/11 Part II, contained its comments and recommendations, and abstracts of the progress reports submitted by Member States. Annex 2 of the document contained a list of ten issues it was proposed should be addressed by regional strategies. The regional strategy was intended to give effect to regional health and related socioeconomic policies. It would thus have to be based on national policies, strategies and plans of action, as seen from a regional perspective. It would have to indicate priority issues for international action within the Region, as well as the broad lines for that action in the health and other sectors concerned, to be undertaken by the Member States of the Region individually and collectively.

After considering the Sub-Committee's report, the Committee would wish to comment on the proposal that regional strategies, based on national strategies, should be formulated. If the proposal were approved, the mechanism for formulating regional strategies would have to be discussed. The Committee might wish, as suggested by the Sub-Committee, first of all to authorize the Regional Director to take whatever steps were necessary: (a) to develop an outline for Member States to follow when preparing their reports on national strategies and plans of action and providing information which would help to formulate regional strategies, and (b) to develop an outline of suggested indicators, targets and objectives for the Region.

The timetable agreed to at the World Health Assembly provided for the submission of reports on national strategies and plans of action to the Regional Committee in 1980 and for progress in formulation of a regional strategy to be reviewed at the same session. It followed that the reports of Member States on national strategies and their proposals for a regional strategy would be needed by mid-April 1980 at the latest, to enable the Sub-Committee to meet, carry out its heavy schedule, and prepare its report in time for it to be despatched to Member States as a Regional Committee document.

Dr TALIB (Malaysia), Chairman of the Sub-Committee on the General Programme of Work, said that, after it had undertaken the studies connected with the formulation of strategies for health for all by the year 2000, the Sub-Committee had reviewed the short reports on national strategies received from Member States in the Region. Unfortunately, it had been unable to review the countries' responses to the four questions listed in document WPR/RC30/11 Part II Add.1. Representatives might now wish to report verbally.

The CHAIRMAN read out the four questions as follows:

(1) What steps have been taken or will be taken in the country to obtain political commitment at highest governmental and political level, and what obstacles have been or will be faced?

(2) What are the main preparatory steps being taken and mechanisms being established to promote intersectoral and intrasectoral action and support?

(3) What has been done or is being planned for the exchange of information, experience, training and expertise among countries for the formulation of policies, strategies and plans of action, in the spirit of TCDC?

(4) What WHO support is being used or will be required, and in what form, for support to the formulation of national policies, strategies and plans of action at country level?

Dr ACOSTA (Philippines), commenting on document WPR/RC30/11 Part II, said that he was concerned about the timing of the submission of the outline of suggested indicators, targets and objectives for the Region. It was listed last of the three steps to be considered by the Regional Committee, and he felt it should take priority over the other two, if the proposals were to be submitted to the Executive Board as planned.

Dr HAN (Director, Programme Management) said that national strategies should form the basis for the development of regional strategies, which would include the indicators, targets and objectives. He understood that that was the intention of the Sub-Committee.

Dr ACOSTA (Philippines) said that he thought that approach would prove difficult.

Dr CHRISTMAS (New Zealand), confirming the interpretation given by Dr Han from his own experience in the Sub-Committee, said that he felt no targets or indicators could be developed unless the recommended procedure were followed.

Dr FAAIUASO (Samoa) said that it was very difficult to develop formulas to be shared by countries pursuing different policies, but, taking that constraint into account, he agreed that the recommended procedure should be followed, keeping in mind the overall target of health for all by the year 2000.

He referred to a letter sent by his Government to the Regional Director in July 1979 indicating strategies, based on resolution EB63.R21 of the WHO Executive Board. The definition of the principal goal of WHO as a level of health that would permit each person to lead a socially and economically productive life was acceptable. Samoa was fortunate in that it would have no difficulty in fulfilling the specific targets of a life expectancy of 63 years and an infant mortality rate of not more than 50 per 1000. The Fourth Five-Year Plan, 1980-1984, comprising Samoa's strategies, was to come before Parliament later in 1979, which meant that the recommended time set by the Sub-Committee would be met.

A national seminar was to be held in December 1979 to determine views on the health strategy in the community. He explained that Samoa had a unique cultural background of community work in support of health services. He referred particularly to the role of the women's committees, whose presidents - wives of chiefs and public orators - he had met with in

preparation for the establishment of women's health committees. The plan for primary health care, the subject of a national conference for community consultation to be held by the Department of Health in 1979, was geared to these and other community efforts.

Dr HSU SHOU-JEN (China) said that his country supported the goal of health for all by the year 2000 as a global strategy. The guiding principles of China's health plan for the year 2000 stipulated that health work should be oriented towards preventive medicine, amalgamating Chinese traditional medicine with Western medicine, and integrating health work with mass movements. The achievements of medical research and technology were to be applied for the benefit of the people, while health workers strove to improve the nation's standard of health. Since those guidelines had been adopted 30 years previously, significant results had been obtained. It was hoped that, by the end of the century, China would have achieved advanced standards of medicine and health, thanks to improved equipment, personnel, and management.

China's health plan for the year 2000 comprised five main objectives: (1) establishment of a national system providing free health care for everyone; (2) setting up of a complete medical and health network, covering both urban and rural areas and laying special stress on national minorities and economically backward areas; (3) modernization of traditional medicine and its accelerated integration with Western medicine, with the aims of producing a combined medical curriculum and creating a new Chinese medical science; (4) continuing emphasis on prevention and on the eradication of cancer and other grave diseases, using health campaigns and health education to improve hygiene throughout the country, particularly in rural areas; and (5) intensified activities in the fields of family planning and maternal and child health.

In order to achieve those aims, it would be necessary to raise the quality and quantity of health manpower; develop more and better drugs, medical equipment, and biomedical products; invest more money in health as China's economy improved; enlist the cooperation of industrial, educational, and other sectors; and, while maintaining self-reliance and independence, selectively and in an orderly manner, introduce urgently needed advanced techniques and reinforce exchanges and cooperation with the medical circles of other countries.

Dr Hsu went on to suggest that, in order to encourage the formulation of national plans to achieve health for all by the year 2000, WHO should organize more study groups or seminars, such as had been held in Bangkok in June 1979. Meetings of that type provided good opportunities for countries to exchange information on the progress of work, besides helping them to improve their country health planning. China intended to take an active part in such activities and would learn from the advanced experience of other countries.

Mr NGUYEN VAN TRONG (Viet Nam) enumerated the basic principles governing the organization of health services in his country: responsibility of the Government; services free of charge; emphasis on prevention; and combination of traditional and modern medicine. The authorities were working towards conditions favourable to health in all fields, such as improved living and

working conditions, nutrition and housing, and towards the reduction or elimination of adverse conditions, particularly through disease control, so as to reduce morbidity and mortality to the lowest possible level. Integrated with economic development planning, health plans aimed at setting up and strengthening the basic health network, organizing research for protection of the environment and of places of work, applying experience acquired through the practice of traditional medicine and developing an adequate pharmaceutical industry. Great importance was attached to participation of the population. For example, posts for health workers were included in the budgets of cooperatives, and activities were carried out by women and by associations for the young or the aged. In almost every family there was also a member trained by the Red Cross in hygiene and first aid. Viet Nam wished to collaborate with WHO and all the Member States of the Region, with a view to achieving the noble objective of health for all by the year 2000.

Dr SABURI (Japan) welcomed WHO's efforts to attain the highest possible level of health, with the main focus on the developing countries. In designing a strategy for health for all by the year 2000, the Organization was rightly encouraging each country to prepare its own action plan, and was prepared to provide technical cooperation in the planning process when needed. He also welcomed WHO's emphasis on primary health care, which was important in both developed and developing countries, though the content would differ from country to country. WHO should focus on the strengthening of primary health care in the developing countries, following the principle of self-help and drawing on the cooperation of United Nations agencies, advanced countries, and other developing countries.

He was honoured that a compatriot of his was the new Regional Director. To meet the responsibility that implied, his country was anxious to contribute to the utmost, especially in the Western Pacific Region. It would continue its contributions - through the regular budget, the Voluntary Fund for Health Promotion, and in such fields as health manpower development - to enable WHO to expand its technical cooperation to improve health conditions in the developing countries. Japan also hoped that the Organization would tackle health problems affecting both developed and developing countries; in that regard, it was considering an increase in its contribution to cancer research. It would like to see more Japanese nationals on the WHO staff, to enable it to make a greater contribution to the international health effort.

Dr CHANG (Republic of Korea) reported briefly on some of his country's achievements in moving towards health for all by the year 2000.

Replying to questions (1) and (2) in document WPR/RC30/11 Part II Add.1, he said that a National Health Council had been established under the chairmanship of the Deputy Prime Minister, who was also head of the Economic Planning Board. The members of the Council were the Ministers of Health and Social Affairs, Home Affairs and Education, a member of the health committee of Congress, a public health specialist, and the dean of a nursing college. The Council was responsible for the development of national health policy and for intersectoral coordination.

In reply to question (3), exchange visits were taking place between the Republic of Korea and neighbouring countries, in the spirit of TCDC, to compare experience on health care delivery systems, community development, family planning and other health activities in connexion with the Saemaul movement initiated in 1971.

With regard to question (4), WHO was collaborating in health planning, health and hospital administration, environmental protection, and health manpower planning and training. With WHO's support, his Government was particularly interested in formulating intensive programmes of environmental protection and manpower development.

Dr NOORDIN (Malaysia) said that, after independence in 1957, his country had started to develop health services in rural areas. In 1975, when it had prepared a prospective plan for services for all by 1995, coverage had been estimated at less than 50%. A two-tier system had been set up, with mobile teams to cover the rural areas. However, to meet the people's expectations and to ensure better community involvement, it had embarked on a strategy of primary health care. It had endeavoured, firstly, to provide essential health care for underserved areas, after identifying those areas; secondly, to study the services provided; and thirdly, to upgrade that essential health care. The work had been done through the community health renewal movement. The Government had provided mobile teams to balance the communities' own efforts, together with community health education integrated with non-health subjects.

A survey of 47 districts in 1977 had shown that 88% of the population was reached by health care; a survey of the rest of Malaysia would be carried out later in 1979. The result would be reflected in the fourth national plan, starting in 1981. An attempt would then be made to extend and improve services. An evaluation would be completed by the end of 1985. It was possible that coverage with essential health care could be complete by then. An attempt would be made to complete the upgrading process by 1990.

Outside peninsular Malaysia, in Sabah and Sarawak, the situation was different. It was realized that new approaches were needed, and studies were being made, for example, to find how best to use traditional healers among the Iban tribe.

As to the first question in the document, the question of health for all had been included in the mid-term review of the current national plan. A cabinet paper had been submitted on the Alma Ata Declaration, and a further paper on the training of voluntary health workers and other policy questions was being put up.

Regarding question (2), the committee preparing the essential health care programme had included representatives from the Prime Minister's department and the districts. The National Coordinating Committee for Community Development was being used for the infrastructure. As to question (3), Malaysia had held an intercountry workshop in cooperation with the Republic of Korea on primary health care, and would welcome any exchange of ideas with other countries, especially with a view to greater community involvement. With respect to question (4), WHO had cooperated in a national workshop, and it was hoped that it would support health services research over the coming year. Malaysia was also cooperating with UNICEF, UNFPA and the World Bank in its health programme.

Dr CHASTEL (France) said that, following reorganization in 1977, responsibility for health matters in French Polynesia had been assumed by a member of the Territorial Council, who was a member of the local government and of the Territorial Assembly. The authorities had become aware of the need to amend regulations and legislation still in force, in order to adapt them to present realities in Polynesia. It had been decided to establish an Institute of Paramedical Sciences to train various categories of health personnel and to expand primary health care services on the islands through multidisciplinary teams, with the assistance of those responsible for social affairs.

Dr TARUTIA (Papua New Guinea), answering the first question in document WPR/RC30/11 Part II Add.1, on political commitment, said that his Ministry of Health had prepared a submission which was now before the Cabinet for endorsement.

In answer to the question on intersectoral action, support was being received from other governmental departments and also, in the non-governmental field, from Church groups.

With regard to exchange of information and experience, Samoa, like other developing countries, was receiving technical cooperation from WHO. Recently, the Organization had conducted a seminar for intermediate-level health workers on rehydration and another, for intermediate-level health managers, on the expanded programme on immunization.

A brief statement on his country's position would be found in document WPR/RC30/11 Part II, page 6.

The CHAIRMAN, noting that there were no more comments from representatives, asked Dr Cohen to reply to the questions raised.

Dr COHEN (Office of the Director-General), said he would first try to answer the question of the representative of the Philippines regarding objectives, targets and indicators. He purposely put them in that order because one had first to define the objectives and then the targets, after which the indicators measured how fast and to what extent the targets were being met and even the quality of what was being provided - a point made by the representative of Malaysia.

With regard to objectives and targets, the Executive Board had felt very strongly that, in so far as they were worked out at the regional and global levels, it must be on the basis of national targets, otherwise they would not mean very much.

Indicators had been discussed at length in the Executive Board, but their importance must not be overemphasized. They were not substitutes for targets, but indicators of the extent to which the targets were being reached. Different kinds of indicators would therefore be needed, depending on the target. For example, in the case of the global targets of providing immunization and safe water for all by 1990, the indicator must show what progress was being made in terms of coverage. But there were other indicators that could not be pinpointed to one specific action, such as the infant

mortality rate, or life expectancy at birth. There were also psychosocial indicators, such as drug addiction or suicide rates, indicators of socio-economic status, etc. The essential point the Executive Board had noted was that the top political echelons were really interested in a very few indicators of whether the target of health for all was being attained or not.

With regard to targets, a second point he wished to refer to was the difficult time schedule in the document.[1] The Board had discussed that point, but had agreed that even if more time were allowed it would not change the position much, since it was not starting from scratch with a situation of zero health; different countries had reached different stages of development; nor was the process entered upon a finite one, ending with a report to the Board in January and the Health Assembly in May. The launching of the ideas concerned, following the Alma Ata Conference, at the global and regional levels formed an integral part of the global and regional strategies.

With regard to the place of country health programming in the overall socioeconomic development process, he wished to stress that it was not synonymous with that process but one part of it.

Finally, after listening to the comments on WHO support, he would like to refer to the discussion that morning on how WHO could support Member States in general and particularly with regard to the strategy for the attainment of health for all by the year 2000, because regional strategy was almost synonymous with what WHO support to Member States should be, in order to attain that objective.

The REGIONAL DIRECTOR said that, among the strategies for health for all by the year 2000 the Committee had just discussed, were the establishment of global and regional health development advisory councils. The Director-General intended to establish a global council (GHDAC) after preliminary discussions on the form it could take. It was felt that recommendations made by such a council should be supported by an appropriate body of participating countries for attracting bilateral and multilateral funds. Such a group would be called the International Health Funding Group and would be composed of representatives of contributing countries and representatives of benefiting countries. To prepare for that, each Regional Committee was being requested to nominate a participant from a developing country. The Regional Director proposed that Papua New Guinea should be selected from the Western Pacific Region, and that, if the Committee agreed, it might wish to leave it to him to discuss with the Government the most appropriate person to be nominated.

Dr CHRISTMAS (New Zealand) asked for more information on the GHDAC. Had its creation been decided on by the Health Assembly and the Executive Board, or was it a specific instrument of the Director-General? Had the Regional Committee received any prior notification with regard to it? - for he himself confessed that it was new to him.

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[1] Document A32/8, presented to the Regional Committee as document WPR/RC30/11 Part II Add.2; reproduced with revised timetable in document WHA32/1979/REC/1, Annex 2.

Dr HOWELLS (Australia) said that he too would like some information in writing before an actual nomination was made.

With regard to Dr Cohen's excellent summing up, frequent references had been made therein to regional strategy, but he would point out that some health problems did not follow regional boundaries.

The REGIONAL DIRECTOR said that the GHDAC had been discussed at some length within WHO. It would be a purely internal group, with the function of advising the Director-General. A regional group, if established, would have the function of advising the Regional Director. The proposed international health funding group was an idea stemming purely from Headquarters. Perhaps Dr Cohen could explain about it.

Dr COHEN (Office of the Director-General), replying to Dr HOWELL's question regarding regional strategy, observed that since, as he had already said, the purpose of a regional strategy was to support national strategies, then, if the same health problem was arising in adjacent regions, it might be part of the regional policy to draw to the attention of the Health Assembly that there was a matter needing to be dealt with at the broader, global level.

With regard to the GHDAC, the matter was referred to very generally in the document.[1] The essential idea was to establish a mechanism for consultation with the other sectors - agricultural, environmental, etc. - whose participation would be needed for the attainment of health for all.

The purpose of the International Health Funding Group was quite different. In 1977, over 700 million dollars from governmental sources alone had been devoted to international health work, and it was at the instigation of some donor and recipient groups that the Director-General had envisaged convening a body to decide how all that money could be most advantageously invested for achieving health for all.

Dr CHRISTMAS (New Zealand) said he had understood one of the tenets of WHO's new policy to be technical cooperation and involvement of participating countries. To set up such a remote global advisory body as Dr Cohen described seemed to be a return to the old system of centralized decision-making. If the proposal had been endorsed by the Regional Committees and the Health Assembly he would have no objection, but otherwise he would like to see something in writing before rubber-stamping it. He stressed that his reservations had nothing whatsoever to do with the proposed nomination of a participant from Papua New Guinea.

Dr TARUTIA (Papua New Guinea) said that he was in the same position himself. He had heard nothing of the proposal before and would not like to commit his Government without consulting his Minister.

Dr HOWELLS (Australia) said that if, as Dr Cohen had said, the matter was referred to in the Executive Board's paper, it was in such general terms that it had not caught his attention.

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[1] Document A32/8, presented to the Regional Committee as document WPR/RC30/11 Part II Add.2; reproduced with revised timetable in document WHA32/1979/REC/1, Annex 2.

Dr COHEN (Office of the Director-General) reiterated that the proposal had not originated from the Director-General, but from a group of donor and recipient countries. The problem was that in such circumstances there was always pressure to act quickly, but there had been no intention of not fully consulting the regional committees on the matter.

He undertook to present the proposal in writing and trusted that it would then be quite clear to the representatives. (For continuation of discussions, see the fifth meeting, section 2).

The meeting rose at 5.00 p.m.