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**REGIONAL IMPLICATIONS OF THE DECISIONS AND RESOLUTIONS
OF THE FIFTY-NINTH WORLD HEALTH ASSEMBLY AND THE 117TH
AND 118TH SESSIONS OF THE EXECUTIVE BOARD**

The 43rd meeting of the Consultative Committee for Programme Development and Management (CCPDM), held in WHO/SEARO, New Delhi from 14-16 June 2006, took note of the regional implications of the decisions and resolutions of the 59th World Health Assembly and 117th and 118th sessions of the Executive Board.

The CCPDM felt that all resolutions passed by the World Health Assembly and the Executive Board were important. Their relative importance may, however, vary in terms of their implications for a particular region. The CCPDM recommended that a precise note on the regional implications and action points for all resolutions should be provided as an information document at the 59th session of the Regional Committee (agenda item 17.1). As such, the document (SEA/PDM/Meet.43/8) is attached as information document SEA/RC59/Inf.5.

The CCPDM further recommended that 11 selected resolutions, which were identified after detailed deliberations, should be elaborated with regard to their implications for the Region and presented to the 59th session of the Regional Committee. These selected resolutions are described in this document.

The document is submitted to the Fifty-ninth session of the Regional Committee for its review, comment and noting as appropriate.

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WHA59.1 Eradication of Poliomyelitis

1. Since the adoption of the World Health Assembly (WHA) resolution WHA41.28 in 1988, tremendous progress has been achieved in the efforts to eradicate poliomyelitis from the world. By the end of 2005, there were only four countries still endemic for polio as compared to 125 countries in 1988. However, recently there has been a setback, both globally as well as regionally, in that by mid-2005 a total of 18 countries had been re-infected. This is a potential threat that can undermine the achievements made so far. To ensure that poliovirus importation into poliomyelitis-free areas does not pose an international health threat, the 59th World Health Assembly in May 2006 reaffirmed the global commitment to the urgent need to achieve the goal of poliomyelitis eradication.

2. WHA59.1 URGES (1) Member States in which **poliomyelitis is endemic** to act on their commitment to interrupting transmission of wild-type poliovirus through the administration of appropriate monovalent oral poliomyelitis vaccines, and (2) All **poliomyelitis-free** Member States to respond rapidly to the detection of circulating polioviruses.

3. Country support and cooperation are sought for:

- Rapid investigation and emergency response;
- Use of type-specific monovalent oral polio vaccine (OPV);
- Continued high quality surveillance for acute flaccid paralysis (AFP), and
- Sustaining the high coverage of routine OPV immunization of at least 80%.

4. The Regional Office for South-East Asia (SEA) needs to ensure: (1) adequate quantities of monovalent type 1 and type 3 oral polio vaccines; (2) country cooperation for rapid response to detection of wild poliovirus circulation and for accepting WHO-led international mission of experts to conduct risk assessment and providing advice on most appropriate response, and (3) that the Regional Office and countries need to make all efforts to mobilize resources from both within and outside the country, to the extent possible in responding to an emergency.

5. Actions taken by WHO in the Region till now include: (1) Sharing of the resolution with Member States; (2) Bangladesh, Indonesia and Nepal have implemented response to importation in accordance with the WHA resolution, and (3) Working closely with vaccine manufacturers in India and Europe in ensuring the availability of type-specific oral polio vaccines. Furthermore, mOPV1 has been used extensively and in large quantities in Bangladesh, India, Indonesia, and Nepal. It has been developed, licensed and used in India.

6. Actions to be taken in the Region include: (1) Continue to provide high quality technical support for surveillance, laboratory and outbreak response, including regular information update of status of programme, and (2) Continue to work with partners to raise necessary funds to implement critical activities.

WHA59.2 Application of International Health Regulations (IHR 2005)

7. On 26 May 2006 the World Health Assembly adopted resolution WHA 59.2 on Application of the International Health Regulations (IHR 2005) which will come into force on 15 June 2007. The 59th World Health Assembly recalling resolutions WHA 58.3 on revision of IHR, and WHA 58.5 on strengthening pandemic influenza preparedness and response, called upon WHO Member States to comply, immediately on a voluntary basis, with provisions of the IHR (2005). The Director-General of WHO will report to the 60th World Health Assembly through the Executive Board at its January 2007 session on implementation of this resolution, and annually thereafter on progress achieved in providing support to Member States on compliance with, and implementation of IHR-2005.

8. The provisions considered relevant to the risk posed by avian and potential human pandemic influenza include:

- Prompt notification to WHO of human influenza caused by a new virus sub-type;
- Designation of a national IHR focal point and WHO IHR contact points and definition of their functions and responsibilities;
- Systems in place for surveillance, information-sharing, consultation, verification and public health response;
- Public health measures for travellers;
- Treatment of personal data, and
- Transport and handling of biological substances, reagents and materials for diagnostic purposes.

9. The influenza pandemic taskforce can be used as a temporary advisory mechanism by the Organization until entry into force of the IHR-2005.

10. WHO should collaborate with Member States through: (a) facilitating technical cooperation and logistical support; (b) mobilization of international assistance, including financial support; (c) production of guidelines to develop capacities for response; (d) stockpiling of necessary drugs, and (e) facilitating the production of vaccines and technical resources, using where possible, capacities available in the Regional Office and collaborating centres.

11. In the regional context, the Regional Office should:

- Strengthen collaboration on human and zoonotic influenzas among national organizations;
- Work with WHO collaborating centres to ensure the sharing of information and relevant biological materials;
- Develop regional vaccine production capacity in the event of a public health emergency of international concern caused by a novel influenza virus;
- Ensure adherence to timeframes particularly for reporting, verification and response to requests for further information from WHO by countries;
- Engage in resource mobilization to strengthen capacity for influenza surveillance and response, and
- Initiate a process of identifying and addressing the constraints for timely implementation of the Regulations.

12. In the Region, focal points have been assigned in each Member country and in the Regional Office. The Regional Office is engaged in training in rapid response, field epidemiology and laboratory methods. A Strategic Health Operations Centre has also been established.

13. The Regional Office will formally assess countries' baseline core capacities and will continue to strengthen capacity within the Region in the areas of epidemic surveillance, alert and response, and laboratory capacity including information reporting systems.

WHA59.3 Nutrition and HIV/AIDS

14. More than 40 million people are living with HIV/AIDS worldwide, and their numbers are increasing. Between 2002 and 2010, an estimated additional 45 million people may become infected with HIV in 126 low and middle-income countries if adequate prevention efforts are not implemented. While HIV progressively weakens the immune system, malnutrition increases the susceptibility to infections. Malnutrition rates are already high in the SEA Region, and now the Region is second to Africa regarding prevalence of HIV/AIDS.

15. Member States are urged to make nutrition an integral part of their response to HIV/AIDS. This can be done by mainstreaming nutrition issues in HIV programmes and vice versa.

16. The implications of this resolutions on collaborative activities in the Region are:

- Plans and policies for Nutrition, and for HIV/AIDS, would need to be examined and suggestions made to address the Health Assembly resolution;
- Workplans need to identify means for incorporating nutrition issues into HIV programmes and vice versa;
- Support needs to be provided for implementing the Global Strategy for Infant and Young Child Feeding, and for preventing mother-to-child transmission of HIV/AIDS, and
- Capability of hospital and community-based health workers to improve the nutritional care of people living with HIV/AIDS, including malnourished infants and young children, has to be built in partnership with other agencies.

17. The Regional Office conducted an intercountry workshop (for high HIV-prevalence countries) to train master trainers who in turn will train caregivers for providing nutritional care and support for people living with HIV/AIDS.

18. Member States have been assisted to organize similar national orientation and training workshops. India has included a session on "Nutrition and HIV" in the training of national consultants. Myanmar and Thailand have conducted three-day national workshops (May and June 2006), and Indonesia is being assisted to adapt and translate the training materials.

19. The Regional workshop organized for implementation of the Global Strategy for Infant and Young Child Feeding emphasized the importance of appropriate guidance for HIV-positive mothers.

20. Technical assistance to Member States will need to be provided in the following areas:

- Advocacy for joint implementation of the resolution by the Nutrition and HIV/AIDS programme;
- Discussions with Member States for organizing a regional meeting to highlight the nutrition and HIV issues;

- Facilitate and support relevant national training workshops for capacity building in the areas mentioned above, and
- Facilitate research for improving nutritional interventions in programmes.

WHA59.17 Outcome of the First Session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control

21. The WHO Framework Convention on Tobacco Control (FCTC) was adopted by the 56th World Health Assembly and came into force on 27 February 2005. The First Session of the Conference of Parties to the WHO Framework Convention was held from 6 to 17 February 2006 in Geneva which adopted a number of resolutions and made some important decisions which necessitated the World Health Assembly to adopt this resolution.

22. The main operative paragraph of the resolution requests the Director-General of WHO to establish a Permanent Secretariat of the Convention within WHO to be located in Geneva, which will eventually mark the beginning of implementation of the Framework Convention. It also requests the Director-General to strengthen the Tobacco Free Initiative (TFI) in order to support the Convention Secretariat for implementation of the Convention. The Resolution also calls upon the WHO Member States which have not yet become Party to the Convention to do so through appropriate means as relevant for them.

23. In order to provide effective support to the Parties to the Convention to implement the WHO Framework Convention, TFI needs to be strengthened. Special efforts need to be made to encourage Indonesia and Nepal to become Party to the Convention.

24. The Regional Office collaboration with countries in relation to this resolution needs to focus on assisting countries in complying with the provisions of the WHO Framework Convention, in particular in submitting the completed Reporting Instrument to the Convention Secretariat by 27 February 2007. In order to do this, the Regional Office collaborative approach also needs to focus on helping countries in gathering information for this Reporting Instrument.

25. An intercountry meeting on implementation of WHO Framework Convention would be organized in Dhaka, Bangladesh from 31 July - 3 August 2006 to discuss and suggest the best ways for meeting the immediate Treaty obligations. The workshop would also identify ways and suitable mechanism as to how WHO could be helpful for countries in meeting these obligations.

26. In addition, the Parties to the Convention need to be supported in the implementation of the WHO Framework Convention, in particular in strengthening their surveillance system and in developing and enforcing tobacco control measures including national tobacco control legislation, national policy and plan of action.

WHA59.19 Prevention and Control of Sexually Transmitted Infections: Draft Global Strategy

27. WHO has estimated that globally over 340 million new cases of curable sexually transmitted infections (STIs), i.e. syphilis, gonorrhoea, chlamydia and trichomoniasis occur

annually in men and women aged 15 to 49 years. Out of those new cases, 150 million occur in the SEA Region.

28. The Region includes countries at both ends of the 'STI control spectrum', i.e. both strong and weak programmes. The draft global strategy for prevention and control of sexually transmitted infections addresses both situations with emphasis on scaling up basic services and controlling common bacterial STIs, as well as on new technologies and strategies for viral STIs such as the human papilloma virus (HPV) vaccine.

29. The resolution urges Member States to adopt and draw on the Strategy, as appropriate to national circumstances, in order to ensure that national efforts to achieve the Millennium Development Goals (MDGs) include plans and actions, appropriate to the local epidemiological situation, for prevention and control of STIs, including mobilization of political will and financial resources for this purpose. Such plans and actions should also aim to make the prevention and control of sexually transmitted infections an integral part of HIV prevention, and sexual and reproductive health programmes.

30. The Strategy is highly relevant to the Region with emphasis on coverage and scaling up response, introduction of appropriate emerging technologies and setting of disease control targets.

31. WHO should provide support to Member States, on requests, for adapting and implementing the Global Strategy in ways that are appropriate to the local epidemiology of STIs, and for evaluating its impact and effectiveness through appropriate surveillance and monitoring systems.

32. Some actions have already been taken in the Region with an emphasis on building capacity of health workers in STI management using standard guidelines, targeting most-at-risk populations, such as sex workers and their clients, and promoting public-private partnership. WHO is providing technical assistance in HIV prevention with expertise in STI control through funding by the Bill and Melinda Gates Foundation for the Avahan Initiative (HIV prevention programme) in India.

33. WHO will prepare, in collaboration with other partners, an action plan that sets out priorities, actions, a timeframe and performance indicators, for implementing the Strategy and will provide support for country-level implementation and monitoring of national plans for control and prevention of STIs. STI surveillance as well as laboratory settings for diagnosis and monitoring of drug resistance will be strengthened through training and country support in collaboration with WHO collaborating centres.

WHA59.22 Emergency Preparedness and Response

34. This resolution was adopted in the light of various emergencies which occurred during the past year, and of lessons learnt that will have implications on the work of WHO and Member States. Although less detailed as compared to WHA 58.1, the key operative issues which need to be focussed on are as follows:

- Member States are urged to further strengthen national emergency mitigation, preparedness, response, and recovery programmes with a special focus on building health systems and community resilience, and

- Comprehensive risk management and coordination mechanisms within countries and UN agencies need to be improved.

35. For the SEA Region, with its extensive experience derived from the tsunami and recent emergencies whether natural or man-made, the resolution can be taken further by capitalizing on these lessons and experiences.

36. Some of the work already started which relates to this resolution includes the following: (i) Development of benchmarks for emergency preparedness and response - developed in November 2005 at the regional meeting held in Bangkok; and (ii) Proposed multi-country activities on risk management.

37. Clearly, the need to achieve benchmarks for emergency preparedness and response provides a framework within which a stronger emergency preparedness and response system can be built in countries. There has been progress in achieving these benchmarks. However, WHO can assist further in contributing to this achievement in countries through technical assistance, information management and joint preparedness planning.

38. Working through intercountry exchange of information to improve risk management is also an effective way of working. Some countries are already in the process of discussing intercountry programmes in the areas of mass casualty management and risk mitigation.

39. There are still a number of efforts that need to be done. Following the regional consultation held from 27-29 June 2006 in Bali, Indonesia the following issues have been identified for action: (i) further refinement of benchmarks and clarity of scope; (ii) development of a regional emergency fund; (iii) communicating UN reform issues in emergencies such as the cluster approach and discussing this in the light of national and local systems, and (iv) enhancing and strengthening activities which promote community resilience.

WHA59.23 Rapid Scaling up of Health Workforce Production

40. Health workforce shortages are interfering with efforts to achieve MDGs and other priority programmes. There are alliances (for example, the Global Health Workforce Alliance) aiming at achieving a rapid increase in the number of health workers. Many countries lack the financial means, facilities and sufficient educators to train adequate health workforce.

41. The World Health Assembly resolution urges Member States to: (a) Give consideration to mitigate the adverse impact of personnel migration; (b) Promote training in accredited institutions of a full spectrum of quality professionals, community health workers, public health workers and paraprofessionals; (c) Encourage financial support by global health partners; (d) Promote training partnerships between schools in industrialized and developing countries; (e) Promote the creation of multi-stakeholders planning teams to formulate a comprehensive national strategy, and (f) Use innovative approaches to teaching through innovative use of information and communication technology.

42. In terms of policy-options for the Region, scaling up of health workforce production should be matched to specific country's need and there is a need to revisit the policy on community-based health workers.

43. The implications of the resolution for the Regional Office's collaborative activities with countries are:

- Strengthen human resources planning and management through creating multi-stakeholders planning teams;
- Strengthen the quality and quantity of production of human resources for health;
- Promote the concept of training partnership between schools in industrialized and developing countries, and
- Develop innovative approaches to teaching with state-of-the-art teaching materials and continuing education through innovative use of information and communication technology.

44. Some actions have already been taken in the Region. The South-East Asia Public Health Initiative 2004-2008 aims to strengthen public health in the Region with five goals: (a) Position public health high on regional and national agendas; (b) Strengthen public health education; (c) Enhance technical cooperation with national public health training institutions; (d) Establish public health education institutions' network, and (e) Facilitate the definition of an appropriate package of essential public health functions in countries.

45. The following are the action points to be considered for the Region:

- Advocate for Member countries to recognize and commit themselves to the Health Assembly resolution 59.23 on rapid scaling up of health workforce production;
- Support Member countries in strengthening health workforce management through, among others, creating multi-stakeholders planning teams whose task would be to formulate comprehensive national strategy for health workforce, including consideration of effective mechanisms for utilization of trained volunteers;
- Facilitate countries in establishing training partnerships between schools in industrialized and developing countries, and
- Support countries in developing innovative approaches to teaching with the state-of-the-art teaching materials and continuing education through innovative use of information and communication technology.

WHA59.24 Public Health, Innovation, Essential Health Research and Intellectual Property Rights: Towards a Global Strategy and Plan of Action

46. The 59th World Health Assembly adopted this resolution establishing an intergovernmental working group to develop a global strategy and plan of action to follow-up the recommendations of the WHO Commission on Intellectual Property Rights, Innovation and Public Health (CIPIH), with a focus on research and development (R&D).

47. In brief, the problem being addressed is that research in health has been led by the "market"; as an example, new medicines are developed only if there is a prospect of profitable sales. Diseases such as malaria, TB do not have new and effective drugs.

48. The Resolution urged Member States to ensure that the report of the CIPIH is included on the agendas of WHO's Regional Committees in 2006.

49. This resolution in the long term has the potential to address some of the major health care needs of the developing world through fundamental changes in the research related to health. It is an issue that the developing world has been aware of, and persistently tried to bring to the attention of the global community. The resolution encapsulates an idea "whose time has come". However, the huge potential of this idea is ranged against the existing procedures and rewards in research related to health.

50. The implementation of the resolution will be through an intergovernmental working group (IWG) under the auspices of the World Health Assembly. The IWG will be responsible for developing "a global strategy and plan of action in order to provide a medium-term framework based on the recommendations of the Commission. Such a strategy and plan of action aims at, inter alia, securing an enhanced and sustainable basis for needs-driven, essential health research and development relevant to diseases that disproportionately affect developing countries, proposing clear objectives and priorities for research and development, and estimating funding needs in this area".

51. A concrete and long term output from the activities of this resolution could be development of new medicines for neglected diseases. Such development would strengthen Drug Regulatory Authorities as well as clinical trial facilities in the developing countries and also address the issue of access – the new medicines would be available to patients on the basis of need rather than the ability to pay.

52. In the Resolution the Director-General has been requested to "convene immediately" the IWG. Given that the first report of the IWG shall be made to the Executive Board in January 2007, this would necessitate the first meeting of the IWG to take place before the end of 2006. It is understood that the decision has been made to schedule the first meeting of the IWG for 4-9 December 2006. It important to ensure that each WHO region is adequately represented in the IWG.

53. The CIPIH report (the basis for the Resolution) stressed that drug discovery and development are not driven by scientific and technical considerations alone - economic, policy and institutional issues are equally pertinent. The innovation process involves a complex interaction among a wide range of economic, social and political actors. Therefore, the IWG programme of work could focus on identifying the gaps in the innovation process for diseases affecting developing countries, and the required policy interventions to address these gaps.

54. Some of the gaps in the current innovation process include inadequate or unsustainable funding, inadequate incentive systems chief among which is the intellectual property rights (IPR) system that provides incentives for innovation only when there is a profitable market. There is gross under-investment in vaccines for developing countries and treatments for neglected diseases. Current investment in the latter is left to *ad-hoc* public funding and philanthropy. Under these circumstances, it is difficult to facilitate systematic and sustainable health R&D policies and priority-setting in developing countries.

55. The IWG would focus on developing a global strategy, based upon the identification of R&D needs and priorities in developing countries. The strategy should address the need to ensure sustainable funding, to address needs-based R&D priorities. A different system of rewarding innovation and funding would need to be developed. It is important that these new systems will not be a barrier to access to the new products that are developed. A number of mechanisms were considered and noted by the CIPIH report, including the establishment of patent pools for essential medicines used in developing countries with new "voluntary" incentives to place patents into pool, global coordination and funding of medical R&D (such as the medical R&D treaty proposal) and initiatives in "open source" methods for research.

56. This represents a historic opportunity to set the agenda for health research in the developing world, an agenda that would be relevant to its health care needs. In addition there would be methods of implementing this agenda, often the major problem in past plans.

WHA59.26 International Trade and Health

57. This resolution was initially proposed by a group of 14 Member States including Bhutan, Nepal and Thailand from this Region. It was then adopted by the Executive Board in January 2006 and the draft submitted to the 59th World Health Assembly in May 2006. In the process, disagreements initially observed in 2005 between developed and developing Member States were resolved.

58. It is intended to address the need to promote a constructive dialogue at national level and to base policies on sound evidence, so that countries could maximize the positive effects of trade liberalization and minimize the negative impact on health.

59. The operational part of the resolution urges Member States to promote intersectoral dialogue and create coordination mechanisms. These are very relevant points for most countries in the Region and beyond, since this is often what is lacking. The health sector tends to find out about trade policies and decisions only when they have already been finalized, and is deprived of real possibilities to influence the decisions.

60. The resolution also urges WHO to build capacity to understand the implications of trade agreements, and address relevant issues through coherent policies and legislation that take advantage of opportunities and address challenges. Most importantly it provides WHO with an explicit mandate to continue working on trade and health.

61. In the SEA Region, WHO's work in this area has benefited from the support it has received from the Regional Committee's resolutions and the Regional Director's guidance. However, this resolution would strengthen WHO's mandate to continue supporting countries in this area.

62. In line with the resolutions passed by the Regional Committee, the Regional Office conducted a workshop in April 2006 in Colombo, Sri Lanka to build capacity of Member countries focusing on the public health impacts of trade in health services. In addition to continuing providing technical support to Member States, the Regional Office in collaboration with WHO headquarters and the Regional Office for the Western Pacific, plans to develop a "Trade and Health Tool Kit" for a comprehensive trade and health national analysis and assessment in the near future.

EB118.R1 Thalassaemia and other Haemoglobinopathies

63. The 118th session of the Executive Board of WHO considered the report on thalassaemia and other haemoglobinopathies prepared by the Secretariat on request of Member States. The draft resolution was discussed, revised and adopted by the Executive Board.

64. The Executive Board resolution urged the Member States to design, implement, monitor, and evaluate national programmes for prevention and management of thalassaemia and other haemoglobinopathies, intensify the training of health professionals, strengthen medical services, and promote community education and counselling.

65. The resolution requests the Director-General to raise awareness of the international community, to provide technical support and advice to Member States in framing of national policies and strategies, to promote international collaboration and to continue its normative functions by drafting guidelines on prevention and management of thalassaemia.

66. The specific policy-related technical issues are:

- The capacity and commitment to control genetic diseases are limited in the Region;
- Potential importance of human genetics in addressing public health problems in developing countries is poorly understood (even among experts);
- There is a considerable preventive potential of thalassaemia programmes;
- Thalassaemia is an important public health problem in majority of the countries of the Region: India, Indonesia, Maldives, Sri Lanka and Thailand have initiated programmes for thalassaemia;
- Thalassaemia can serve as an entry point for establishing genetic services, and
- There are complex ethical issues in the context of different religious and cultural values.

67. There is a need to strengthen technical support to Member States in designing, implementing, monitoring and evaluating national programmes for prevention and management of thalassaemia and other haemoglobinopathies.

68. The Regional Office needs to support intercountry collaboration and facilitate exchange of information, expertise and technology related to prevention and management of thalassaemia and other haemoglobinopathies.

69. The following are some of the actions that have already been taken in the Region:

- Information sharing and capacity building through consultations, fellowships, and trainings;
- National thalassaemia programmes/activities supported in select Member countries (Bangladesh, Maldives, Sri Lanka);
- The Regional Committee resolution on "Prevention, Control and Treatment of Thalassaemia" adopted in 1995;
- Scientific debate on Regional Perspectives in Human Genetics, held at the 26th meeting of the South-East Asia Advisory Committee on Health Research (ACHR), 2001; Scientific debate on Health Research on Prevention and Control of Thalassaemia conducted at the 28th meeting of the ACHR, in Maldives in 2003;

- Consultation on Identifying Regional Priorities in the Area of Human Genetics in the SEA Region, held in 2003;
- Guidelines for the Prevention and Management of Thalassaemia are being developed through the WHO Collaborating Centre in Thailand;
- Member countries of the SEA Region have joined the Asia Network for Thalassaemia Control (established in 2003);
- Thalassaemia featured in important regional publications such as “Asia and the Pacific Health Report”, and
- Regional centres of excellence in the area of genetics have been mapped and the availability of genetic services analysed in select Member countries.

70. There are many actions which need to be taken in the Region, such as, (1) Thorough regional situation analysis of thalassaemia and other haemoglobinopathies need to be undertaken in the Region; (2) Capacity of the Regional Office needs to be strengthened through initiating genetic programme (creating a separate technical unit or establishing an appropriate coordination mechanism to bring together several technical programmes/units); (3) Finalize the Regional Guidelines for Prevention and Management of Thalassaemia, and (4) Facilitate and support the networking of thalassaemia programmes.

EB118.R4 Strengthening Health Information Systems

71. Sound information is critical in framing evidence-based health policy. It is also critical in decision-making and in monitoring progress towards internationally agreed health-related development goals including the Millennium Development Goals (MDGs).

72. Health information systems in most developing countries are weak, fragmented, understaffed, and inadequately resourced.

73. The Executive Board resolution urges Member States to mobilize the necessary scientific, technical, social, political, human and financial resources to strengthen their health information systems. It also calls upon concerned partners and stakeholders to provide strong and sustained support for strengthening of health information systems. It requests the Director-General of WHO to increase the activities of the Organization in areas of health statistics and health information systems, and to report on the progress at the 62nd World Health Assembly.

74. The Regional Strategy 2006-2015 for strengthening Health Information System (HIS) has been drafted and discussed with the country HIS focal points along with their national statistical offices. The nine strategic areas (with details of initiatives and actions, WHO/donor assistance, and indicator for each area) cover the whole spectrum of HIS. This detailed strategic framework is expected to provide generic guidelines for the Health Metrics Network (HMN) and any other global/regional/country initiative for building sound and vibrant HIS at national and sub-national levels in countries of the WHO SEA Region.

75. Based on the Regional Strategy, 10 out of the 11 Member countries of the Region submitted quick draft action plans at the intercountry consultative meeting held in Chiang Mai,

Thailand, from 14-17 December 2005. Countries need to expand on those draft action plans in order to finalize country-specific strategies for HIS strengthening.

76. Under the HMN initiative for strengthening HIS in countries, proposals from five countries of the Region (Bangladesh, Bhutan, Indonesia, Myanmar and Timor-Leste) have been accepted for HMN funding. However, none of the five countries has received HMN funding till date (May 2006). The remaining countries of the Region should accelerate the process of proposal writing in order to submit these in time for HMN's second round this year. The deadline for receipt of proposals is 31 August 2006.

77. A majority of countries have proposed that HMN funds be channelled through the Regional Office and country offices.

78. To ensure balanced and sustainable development of HIS in countries, a triangular dialogue between the Regional Office, HMN and countries is on regarding contents of technical assistance in respect of HMN to countries, while countries are seizing the opportunity of financial support offered by HMN. WHO would be monitoring the technical quality of HMN workplan implementation at the country level.

79. Five countries of the Region have made commitment, under the multi-country activity (MCA) mechanism for the 2006-2007 biennium to share the experience in strengthening at least three components of HIS: (i) Vital Registration; (ii) Reporting on country health information, and (iii) Mapping health infrastructure and services offered at district level. Depending on their priorities, other countries may suggest other areas of HIS development for the Regional Office to facilitate. However, for Vital Registration, participation of all Member countries of the Region is proposed.