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1. The Sixty-third Session of the WHO Regional Committee for South-East Asia was held in Bangkok, Thailand on 7-10 September 2010. It was attended by representatives of all the 11 Member States of the Region, UN and other agencies, nongovernmental organizations having official relations with WHO, as well as observers.

2. The joint inauguration of the Sixty-third Session of the Regional Committee and the Twenty-eighth Meeting of Ministers of Health of the South-East Asia (SEA) Region was held on 7 September 2010. His Excellency Mr Abhisit Vejjajiva, the Prime Minister of Thailand, delivered the inaugural address. (For the full text of the address, see Annex 1)
3. The Committee elected His Excellency Mr Jurin Laksanawisit, Minister of Public Health, the Royal Thai Government, as Chairperson and His Excellency Lyonpo Zangley Dukpa, Minister of Health, Royal Government of Bhutan, as Vice-Chairperson of the session.

4. The Committee reviewed the report of the Regional Director covering the period 1 January 2008 to 31 December 2009.

5. The Committee decided to hold its Sixty-fourth Session in 2011 in India, its Sixty-fifth Session in Indonesia, and its Sixty-seventh Session in Bangladesh.

6. A drafting group on resolutions comprising a representative each from DPR Korea, India, Indonesia, Maldives and Sri Lanka was constituted, with the representative from Sri Lanka elected as Convener.
7. The joint inauguration of the Twenty-eighth Meeting of Ministers of Health and the Sixty-third Session of the WHO Regional Committee for South-East Asia was held in Bangkok, Thailand on 7 September 2010.

8. His Excellency Mr Jurin Laksanawisit, Minister of Public Health, the Royal Thai Government, welcomed the distinguished delegates to the Joint Inaugural Session of the Twenty-eighth Meeting of the Ministers of Health and the Sixty-third Session of the WHO Regional Committee for South-East Asia. He conveyed his warmest greetings to the Prime Minister of Thailand, His Excellency Mr Abhisit Vejjajiva; the Health Ministers of countries of the WHO South-East Asia (SEA) Region; the Director-General of the World Health Organization, Dr Margaret Chan; the WHO Regional Director for South-East Asia, Dr Samlee Plianbangchang; and other distinguished participants.

9. Commending the leadership for global health provided by the WHO Director-General and the Regional Director, His Excellency Mr Laksanawisit lauded the Bangkok Declaration on Urbanization and Health as specifically relevant to the SEA Region. By 2030, 67% of Thailand’s population would live in the cities, compared with 36.11% urban population as of today. In this context, Thailand was participating in the “1000 Cities, 1000 Lives” initiative of WHO, and 51 municipalities in the country had already confirmed their participation.
at the Global Conference on Urbanization and Health scheduled to be held in Kobe, Japan, in November 2010.

10. The Royal Thai Government was concerned not only with urban but also rural health, and had initiated many projects and policies for the well-being of all people. A National Committee, chaired by the Prime Minister, had been created to deal with health in a multisectoral and integrated manner. The per capita expenditure for universal health care was increased last year, and more support was being provided for the treatment of HIV/AIDS, hypertension, cancer, diabetes, cardiovascular disease and mental health. Treatment of diabetes, paralysis, heart disease, cancer and other noncommunicable diseases (NCDs) cost nearly US$ 3 billion a year; the government had initiated a campaign for behavioural change and promotion of exercise and healthy lifestyles. A regulation on iodine deficiency was due to come into effect from 1 October 2010, which would make universal salt iodization mandatory, with special supplementation for pregnant women.

11. The Royal Government of Thailand, His Excellency said, had also initiated a gamut of health programmes for rural areas. These included a strategy to bolster 10 000 community health centres and upgrade them to subdivisional health centres by 2011. More than one million village health volunteers (VHVs) were in service to implement the community health plan, and mobilization of community health funds had been prioritized. (For the full text of the address, see Annex 2)

12. Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia, welcomed the Ministers of Health and representatives of Member States. He thanked the Royal Thai Government for hosting the two high-level meetings. He referred to the remarkable progress in national development made by Thailand in the past few decades. The country had achieved the health-related United Nations Millennium Development Goals (MDGs) ahead of schedule. Thailand was also a global pioneer in the implementation of the primary health care (PHC) approach, which was
the key to “Health For All”. Member States of the WHO SEA Region were on track to achieve most health-related MDGs, the Regional Director stated. Significant progress had been made in the Region to reduce child mortality, though the reduction of maternal mortality still lagged behind. Weak health systems remained a bottleneck, especially with hard-to-reach groups. Excellent progress had been made in eliminating neglected tropical diseases (NTDs) that primarily affected the poor. The health of the people was also adversely impacted by climate change. In this context, two important meetings were planned for October 2010: the Regional Conference of Parliamentarians on Protecting Human Health from Climate Change and the high-level preparatory meeting for the Sixteenth Conference of Parties to the United Nations Framework Convention for Climate Change (COP-16). The Regional Director concluded by saying that a high degree of political commitment would be necessary to reduce the disease burden in the Region. (For the full text of the address, see Annex 3)

13. Dr Margaret Chan termed Bangkok as a fitting venue for the two important regional meetings in the light of Thailand’s well-known achievements in public health and its government’s commitment to PHC, the hallmark of which was its innovative universal health-care coverage programme.

14. Dr Chan lauded Thailand’s “whole of government approach” which was directed towards the prevention and control of diseases at the source, with major contributions from other sectors such as education, agriculture, environmental health and transport. The success of the iodine deficiency campaign highlighted this preventive approach. Thailand, along with Sri Lanka, led the Region in achieving universal coverage of skilled attendants at birth, equally for the rich and the poor. The SEA Region also led the world in ensuring affordable medicines for the management of heart disease and diabetes.

15. Urbanization and health, the theme for World Health Day 2010, deserved the highest level of attention since cities concentrated people, opportunities and
services, as well as risks and hazards for health in the form of contamination of food and water, pollution, disease outbreaks and natural disasters. Cities also tended to promote unhealthy lifestyles leading to chronic diseases, the Director-General said. She praised the solidarity of the Region in its response to pandemic influenza H1N1 (2009) and urged Member States to facilitate technology transfer for vaccine manufacture.

16. The Director-General commended Thailand as a role model for its investment in human resources, capacity and infrastructure. She urged middle-income countries of the Region to enhance the capacity of other Member States through innovations in information and communication technology (ICT) and its transfer. (For the full text of the address, see Annex 5)

17. At the inaugural session, the Chief Guest, the Prime Minister of Thailand, His Excellency Mr Abhisit Vejjajiva, extended the warmest welcome to the ministers of health, the WHO Director-General and Regional Director, and other distinguished participants. Calling health a basic right of every citizen and a moral obligation, the Prime Minister highlighted the significant progress in health that Thailand had made in the last 40 years. This was made possible by a three-pronged development strategy that he summed up as the “3 Ps”:

- Primary health care: The primary health-care system initiated in the 1970s entailed extensive investment in local health infrastructure to provide “close-to-client services” and upgrading of health-care centres using ICT.
- People: Overriding emphasis had been placed on people and participation to provide health care to all.
- Protection: Protection services for target groups and the provision of free medical services had been initiated in 1975.

18. A significant reduction in maternal and child mortality and progress in combating HIV/AIDS had been achieved. Legislations on tobacco consumption
and alcohol use had also been enacted. Emerging and re-emerging diseases were being prioritized. Thailand had achieved the health-related MDGs well before 2015. All this, the Prime Minister noted, had been possible due to committed and planned development policies and strategic implementation. Thailand took pride in having achieved universal health coverage for the poor in 2002. Its commitment to the goal of a healthy society had been made possible by a generous health-care budget. Collaborative efforts with WHO and active engagement with multisectoral stakeholders were important parts of Thailand’s strategy, His Excellency added. *(For the full text of the address, see Annex 1)*
Opening of the session

19. In the absence of the outgoing Chairperson, the Sixty-third Session of the WHO Regional Committee for South-East Asia was opened by the Vice-Chairperson of the Sixty-second Session of the Regional Committee, H.E. Dr (Ms) Aminath Jameel, Minister of Health and Family, Maldives.

Subcommittee on credentials

(Agenda item 2.1)

20. A subcommittee on credentials, comprising representatives from Indonesia, Nepal and Timor-Leste, was appointed. The subcommittee met under the chairmanship of the representative of Nepal and examined the credentials submitted by Member States. The credentials submitted by all Member States of the SEA Region were found to be in order, thus entitling the representatives to take part in the work of the Regional Committee.

Election of office-bearers (Agenda item 3)

21. H.E. Mr Jurin Laksanawisit, Minister of Public Health, Royal Thai Government, was elected Chairperson and H.E. Dr Lyonpo Zangley Dukpa, Minister of Health, Royal Government of Bhutan, was elected Vice-Chairperson.
H.E. Mr Jurin Laksanawisit thanked the representatives for electing him Chairperson, which he considered an honour for himself and his country. He was confident that with the cooperation and support of all concerned, the Committee would successfully cover the agenda within the stipulated time. He looked forward to the support of the Regional Director and his team for the success of the meeting.

Adoption of the Agenda  
(Agenda item 4, document SEA/RC63/1Rev.)

22. The representative from Indonesia proposed that Agenda item 21 listed for discussion on 10 September 2010 (forenoon) be taken up on 9 September 2010 instead. This was agreed to by the Committee. The Agenda (document SEA/RC63/1) was adopted after incorporating the above-mentioned modification in the programme.

Drafting group on resolutions

23. The Committee constituted a drafting group on resolutions comprising the following representatives:

   (1) Dr Pak Jong Min (DPR Korea);
   (2) Dra (Ms) K. Niniek Naryatie (Indonesia);
   (3) H.E. Dr Ahmed Jamsheed Mohamed (Maldives);
   (4) Dr R. Wimal Jayantha (Sri Lanka); and
   (5) Mr Sanjay Prasad (India).

24. Dr R. Wimal Jayantha was appointed Convener by consensus.

Statement by representatives of UN and Specialized Agencies

25. Mr Najib Assifi, Deputy Regional Director, United Nations Population Fund (UNFPA) Regional Office for Asia and the Pacific, recalled the long tradition of collaboration that UNFPA had had with WHO at the global, regional and country levels. He stated that with the new regional identity of UNFPA-APRO, his organization’s vision was to make population and development, sexual and reproductive health (SRH) and gender, central to the development agenda at regional and national levels, based on the core principles of human rights, equity and cultural sensitivity.
26. Mr Assifi felt that the potential for a stronger partnership and a more strategic collaboration between WHO and UNFPA could be maximized by capitalizing on areas of mutual interest that extended beyond maternal health and family planning to adolescent sexual and reproductive health; integration of SRH issues in humanitarian response; and the integration of SRH and HIV issues, among others. In the context of UN reform and the principles of “Delivering as One”, opportunities to work together were numerous, and collaboration had become a requirement and an integral strategy to promote common goals. He felt that based on the comparative advantages, core specialities, experience and collective strengths of the two organizations, collaborative efforts in the Region could be further strengthened to produce more effective results.

**Introduction to the Regional Director’s Biennial Report on the Work of WHO in the South-East Asia Region covering the period 1 January 2008 – 31 December 2009 (Agenda item 5, document SEA/RC632/2)**

27. Introducing his report, *The Work of WHO in the South-East Asia Region – Biennial Report of the Regional Director, 1 January 2008–31 December 2009*, the Regional Director, Dr Samlee Plianbangchang, stated that the report covered a two-year period. He observed that the world was passing through turbulent times. Health systems were being challenged by unprecedented factors such as climate change and numerous natural calamities. In spite of them, however, progress had been made in the Region in promoting health and combating diseases, as a result of exceptional national commitment and collaboration among Member States. Countries of the Region had shown their resolve to achieve health targets, including MDGs.

28. The H1N1 influenza pandemic had swept across the entire Region. WHO worked closely with Member States for surveillance and rapid response within the context of the International Health Regulations (IHR) which came into force
in 2007, by providing advocacy materials to alert the public to the threat and to promote healthy behaviours to combat disease.

29. Though TB prevalence rates had declined, the disease still claimed half a million lives in the Region every year. In 2009, the Region reached 85% treatment success, thereby averting 300,000 deaths. Multidrug-resistant TB still presented a serious challenge.

30. The Region also carried the third-highest HIV burden in the world, with 3.5 million people living with HIV. Thailand had managed to reverse the HIV epidemic in the mid-1990s. In India, Myanmar and Nepal, HIV prevalence had also declined. Yet, even though the Region had adequate capacity to manufacture drugs for treatment, only 40% of those in need were receiving antiretroviral treatment.

31. With regard to control of vector-borne diseases like dengue, there had been a decrease in the number of deaths due to better case detection and case management. The biregional Asia-Pacific Dengue Strategic Plan (2008-2015) was developed to provide guidelines for the establishment of national plans to combat the disease. Malaria continued to remain a public health concern, but compared with 2006, the reported deaths in the Region in 2008 had declined by 30%.

32. The Region was making steady progress in eliminating several diseases of public health importance. During 2008, 67% of the global total of new cases of leprosy were detected in the Region. The Global Strategy for Further Reducing Leprosy Burden and Sustaining Leprosy Control Activities 2006-2010 was adapted and implemented in all endemic countries globally. Nearly 66% of the global estimate of 1.3 billion people at risk for lymphatic filariasis (LF)
were in the SEA Region. To address the issue, a Strategic Plan for Elimination of LF in the Region 2010-2015 was developed. With regard to kala-azar, the health ministers of Bangladesh, India and Nepal had committed to achieving the elimination targets by 2015.

33. Pneumonia also posed an enormous risk especially in terms of child mortality. A regional strategy framework to combat its challenges was in place. The Regional Director also informed the Committee that “antimicrobial resistance” would be the theme of World Health Day 2011.

34. The epidemiological profile of diseases in the Region was changing rapidly. Chronic noncommunicable diseases (NCDs) such as cardiovascular diseases, cancer and diabetes accounted for 54% of all deaths in the Region in 2009. Efforts were being made to provide support to Member States to strengthen their national capacity for formulation, implementation and evaluation of policies and programmes for the prevention and control of NCDs. The Regional Director also noted that a regional consultation on a strategic framework for promoting active and healthy ageing had been organized.

35. Significant progress had also been made in tobacco control. Global Adult Tobacco Surveys were undertaken in Bangladesh and Thailand. With regard to road safety and injury prevention, the First Asia-Pacific Congress on Community-based Rehabilitation had highlighted innovative activities and the need for research.

36. The year 2008 marked the thirtieth anniversary of the Alma-Ata Declaration on Primary Health Care (PHC), to which Member States had reconfirmed their commitment. Empowerment was considered an important tool for successful health promotion and disease prevention. The Regional Office had organized meetings on self-care and on use of herbal medicines in PHC.

37. A task force was established in the Regional Office to monitor the progress made towards achieving the Millenium Development Goals (MDGs) 4 and 5, which related to child mortality and maternal health. WHO supported Member States to improve the quality of training on maternal and neonatal health services, and reproductive health. A regional framework for implementing the reproductive health strategy was developed, and a regional strategy on early childhood development formulated in collaboration with UNICEF, was also shared with Member States.

38. Since vaccines remained the most cost-effective interventions to prevent disease, the Regional Director stressed the importance of high immunization
coverage to reduce child mortality and the disease burden. The Regional Strategic Framework for Improving and Sustaining Immunization Coverage was being implemented; national capacity was strengthened for regulation of vaccines.

39. The Regional Director stated that there was compelling evidence to show that the effects of climate change on health had been seriously underestimated. These effects were the consequence of economy-driven policies that ignore the planet’s ecosystem. Generic research protocols along with advocacy materials had been developed to assess the impact of climate change on health. An increase in natural disasters was one of the consequences of climate change. WHO responded rapidly in supporting Member States in their efforts to tackle disasters that struck the Region.

40. A regional meeting was held on teaching of public health at the undergraduate level in medical schools. Training in national health accounts; on economic principles for health policy development; and programme planning, was also organized.

41. The ultimate goal of WHO’s collaboration with Member States was to strengthen country capacity towards self-reliance, the Regional Director said, and added that the Country Cooperation Strategy (CCS) was the key instrument in this regard. The CCS documents for Bangladesh, Myanmar, Thailand and Timor-Leste were finalized during the period.
During the biennium, the SEA Region fully implemented its Assessed Contributions (AC) of US$ 102.9 million, and another US$ 260.3 million received as Voluntary Contributions (VC). Preparations were made during the biennium under review for the roll-out of the Global Management System (GSM) to increase the efficiency of work in WHO through effective management of corporate functions.

The Regional Director observed that while the SEA Region had seen continued economic growth in recent years despite the global downturn, making adequate resources available for health development with a just balance between preventive and curative care remained a challenge. Dr Samlee assured Member States of his and WHO’s unwavering support to further accelerate their efforts towards achieving the goal of better health for all people in the Region (For the complete text of the Regional Director’s introductory remarks, see Annex 4).

**Address by the Director-General of the World Health Organization (Agenda item 6)**

The WHO Director-General, Dr Margaret Chan, spoke about the growing vulnerability of the health sector. With the growing interdependence in the world, health had become an unintentional victim. For example, increased use of processed food products, rich in fat and sugar, was a fallout of globalization, which had led to obesity and deprivation of essential nutrients. In order to improve conditions for populations, it was important to focus on health, but to tackle the problem, officials needed to address the core problem since policy spheres were no longer distinct.

The adverse impact of climate change was clearly visible, with the world paying dearly in the form of heatwaves, floods and ruined crops in Bangladesh, China, Pakistan, Russia and Maldives, for example. The soaring price of food was especially hitting poor households.
46. The health sector faced new challenges, the Director-General said. People in all regions were living longer, but medicine and technology were becoming more expensive. Universal health coverage needed to be addressed. She stated that this year’s World Health Report would be launched shortly and would focus on this issue. The report of the Commission on Social Determinants of Health had made good recommendations, she noted.

47. The MDGs were another force driving the international community to address health issues and represented the most ambitious attack on human misery. From the Global Fund alone, the SEA Region had benefited to the tune of US$ 3.2 billion. The aim now was to maintain the momentum despite financial hardship in many quarters. It was equally important to safeguard evidence-based policy formulation through which countries could select appropriate interventions.

48. The SEA Region, Dr Chan said, was strongly committed to primary health care, equity, universal coverage, and to community aspirations. There was a need to align health plans to development plans and to collaborate with other sectors so as to tackle the diverse aspects of each problem. She stressed the importance of raising sufficient resources and removing financial barriers, citing the fact that about 20% to 40% of all health spending was wasted through inefficiency. Better policies and practices, she suggested, could exert a positive impact on expenditure. (For the complete text of the Director-General’s address, see Annex 5).

49. Following the introductory remarks made by the Regional Director on his biennial report and the Director-General’s address, the following observations were made by the Committee:

50. The Committee commended the leadership of the Regional Director in guiding Member States in their quest to improve the health of their peoples, and for the active collaboration between WHO and Member States in health development initiatives. The Committee also expressed its appreciation of the leadership in health provided by the WHO Director-General.

51. The Committee underscored the importance of the paradigm shift in the epidemiological profile of diseases in the Region from communicable to noncommunicable diseases; 54% of all deaths in the Region in 2009 were from NCDs, which involved several issues cutting across sectors. The example of food safety and water-borne diseases, with their inextricable links with sanitation, nutrition and air pollution, was cited.
In order to make investments in the health sector cost-effective, a holistic approach to health incorporating health education, information and advocacy was necessary. This multisectoral aspect of health care was particularly highlighted in the case of diseases arising from climate change, environmental pollution, and road safety and injury prevention.

The Committee stressed the importance of strengthening health systems through primary health care (PHC) and of bolstering health information systems through the creation of a complete PHC network. It acknowledged the technical and research assistance provided by WHO in this regard.

The Committee’s attention was drawn to the need to ensure universal coverage of immunization in spite of the challenges. It conveyed its appreciation to the WHO Director-General for recognizing the intensive polio eradication efforts made by India.

It was also noted that though malaria mortality had substantially fallen, dengue had returned to the Region with high morbidity in 2009-2010, especially in three Member States (India, Sri Lanka and Thailand). The Committee requested the WHO Regional Office to organize a regional meeting on re-examining strategies for the control of vector-borne diseases in view of the huge volume of cases of dengue.

The Committee also requested WHO to provide support to ensure drug and vaccine security in the Region by making sure that low-income countries got a guaranteed and steady supply of low-cost quality drugs, and to provide incentives to drug manufacturing companies to lower prices.

The Committee also sought support from WHO to advocate for inclusion of health in countries’ economic development policies. WHO was also requested to provide support to accelerate progress towards the achievement of the MDGs. Technical assistance was sought from WHO to facilitate research and build capacity in health-care financing and to share best practices in the Region.

The Committee highlighted the need to rationalize procurement and use of medical technologies and devices, and to improve governance of procurement of medicines. National essential drugs lists should also be reviewed by experts in terms of risk-benefit and cost-benefit ratios, with WHO support.

The need to bolster the capacity of community health workers in Member States was highlighted. The Committee was assured of WHO’s support in policy dialogue beyond the health sector. The importance of having an integrated
multisectoral approach to public health interventions based on country needs was reiterated.

60. The Committee, after extensively deliberating on the biennial report of the Regional Director, noted with satisfaction the progress made during the period under review on the collaborative programmes between WHO and Member States. The Committee also expressed its appreciation of the WHO Director-General for her inspiring address.

**Matters relating to Programme Development and Management (Agenda item 7)**

**Programme Budget Performance Assessment:**

2008-2009 (Agenda item 7.1, documents SEA/RC63/3, Inf.Doc.1 and Inf.Doc.2)

61. The Committee was informed that the Organization-wide Report on the Performance Assessment of Programme Budget 2008-2009 (SEA/RC63/3 Inf. Doc.1) was submitted to the Sixty-third World Health Assembly held in May 2010, following its review by the Twelfth Meeting of the Programme Budget and Administration Committee (PBAC) of the Executive Board. The PBAC, in its report to the World Health Assembly (SEA/RC63/3 Inf. Doc.2 - Document A63/49), had welcomed the report and proposed that it be further considered in relation to the forthcoming discussions on the Proposed Programme Budget 2012-2013 at its next meeting, by the Executive Board at its 128th session, and in the forthcoming sessions of the regional committees.
62. The working paper (SEA/RC63/3) presented to the Committee described the summary of the Performance Assessment including the financial implementation of the 2008-2009 Programme Budget, in relation to the WHO SEA Region.

63. The Committee noted that the Programme Budget Assessment Report had suggested linking the implementation of activities with the achievement of health-related MDGs, as well as assessing implementation of activities in terms of their cost-effectiveness.

64. The Committee noted that the Third Meeting of the Subcommittee on Policy and Programme Development and Management (SPPDM), held in WHO-SEARO on 2 July 2010, had reviewed the working paper, and had recommended that the report of the Programme Budget Performance Assessment: 2008-2009 be noted, and its findings used for preparation of the proposed Programme Budget 2012-2013 and also for operational planning of workplans for PB 2012-2013.

65. The Committee endorsed the recommendations made by the SPPDM on this agenda item.

**Implementation of workplans for Programme Budget 2010-2011**

**Part I - Review of the implementation of workplans for PB 2010-2011 (Agenda item 7.2, documents SEA/RC63/4)**

66. The Committee noted the details provided by the document SEA/RC63/4 on the status of implementation of workplans for Programme Budget 2010-2011. The Sixty-second World Health Assembly in May 2009 had approved the budget ceiling of US$ 544.5 million for the WHO SEA Region. The budget comprised US$ 102.3 million from AC and US$ 442.2 million from VC. The approved budget of US$ 544.5 million represented a 10.8% increase over the approved PB2008-2009 and a 5.8% decrease compared with the closing gross budget for the 2008-2009 biennium.

67. The actual operational budget approved by the Director-General for 2010-2011 (as of 30 May 2010) stood at US$ 500 million, against the final allocation of US$ 539.9 million for the 2008-2009 biennium. During the last biennium, the Region could mobilize about 79% of VC and implement 67% of the operational budget. Thus, in the context of the prevailing global economic scenario, it was estimated that VC for the PB2010-2011 would be between US$ 340 million and US$ 370 million. Additionally, efforts were needed to address the uneven
distribution of VC funds across WHO strategic objectives and between countries. Implementation during the 2010-2011 biennium would need to be enhanced in order to ensure delivery of the expected results. An adequate core technical and administrative capacity of WHO offices would be critical to the successful implementation of VC, which continued to increase.

68. The Committee noted that it was important for WHO to maintain its stewardship role as the lead technical agency in global health. Member States expressed the fear that country priorities and preferences would be compromised in situations where global agencies or entities other than WHO attempted to exercise a leading role in countries’ health matters. It was felt that with regard to VC, donor interests were not always likely to be in line with country priorities, or even with priorities set by the World Health Assembly. As such, there was a distinct “disconnect” between the two perspectives.

69. The Committee acknowledged the need for WHO to continue to provide technical support and guidance to Member States to: mobilize greater financial resources; enhance the core capacity and efficiency of country office staff, especially through increased recruitment of National Professional Officers (NPOs); and accelerate the rate of budget implementation. WHO would continue to organize regular meetings of planning focal points and programme managers with a view to involve country office staff in joint budgetary planning, and thereby enhance their technical capacity.

70. While appreciating the misgivings expressed by Member States about donors directing their contributions towards specific health programmes, for example communicable diseases, the Committee suggested that countries should start learning to discreetly refuse such donations if they felt that they would not serve the priority country-specific needs relevant at that point in time. It was agreed that as WHO was not a funding agency, it was imperative for countries to utilize their available resources optimally; it was also advisable
for Member States, especially in the context of the current global economic scenario, to actively explore innovative channels of funding, such as through imposition of taxes on tobacco consumption and alcohol use.

71. While it was acknowledged that the introduction of the WHO Global Management System (GSM) had presented countries with a few initial problems, especially with regard to its inflexibility in accommodating budgetary changes necessitated by new health developments, the Committee noted that the roll-out of the GSM had by and large been successful. WHO was fully committed to make the GSM work and support country needs, especially in the context of the huge financial investment that had been made for its operationalization. The Regional Office would intensify its efforts to train staff in all country offices, enhance their skills and achieve optimum utilization of GSM functions.

72. The Committee was apprised of the financial difficulties, challenges and constraints faced by WHO in providing support through technical experts for countries to draft proposals for funding from international donors. However, WHO would continue to help build country capacity in writing and drafting of such funding proposals.

73. The Committee was informed that the Third Meeting of the SPPDM, held in WHO-SEARO on 2 July 2010, had reviewed the implementation of workplans for Programme Budget 2010-2011.

74. The Committee endorsed the report on implementation of workplans for the PB 2010-2011, as well as the recommendations made by the SPPDM on this agenda item.

**Part II – The future of financing for WHO**

*Agenda item 7.2, document SEA/RC63/23*

75. The Committee was informed that in January 2010, the Director-General had convened an informal discussion on the future of financing for WHO. The background paper prepared by the Secretariat for the Regional Committee (SEA/RC63/23) provided a framework for its discussions on this issue drawing from the initial consultations, early responses to the web-based consultation, and informal discussions with Member States at the Sixty-third World Health Assembly and the 126th session of the Executive Board.

76. While appreciating the fact that VCs, which were increasingly comprising the predominant source of funding for WHO, were not fairly or evenly distributed, the Committee noted that there was an urgent need for Member
States to proactively engage themselves in the dialogue concerning the challenges of global health funding. It was important for countries to discuss the roles of the private sector and of civil society in the overall context of devising a “global health architecture” as it was being realized that UN reforms alone would not be able to provide all answers to future constraints in financing for WHO.

77. It was felt that in order for WHO to continue to play its role as the lead technical agency in global health matters, Member States had to take the lead as the “owners” and “stakeholders” of the Organization and delineate its role and functions explicitly. Member States were invited to clearly articulate their respective stand/position on this issue through the web-based consultation that had been initiated by the WHO Director-General in April 2010 and would continue till mid-October 2010; a formal report of the consultation would be placed before the Executive Board in January 2011. No Member State of the SEA Region had so far contributed to the web-based consultation.

78. The Committee noted that the Third Meeting of the SPPDM, held in WHO-SEARO on 2 July 2010, had reviewed the issues and made recommendations, which it endorsed.

Proposed Programme Budget 2012-2013 including implementation of the Regional Committee resolution SEA/RC63/R1 on “Programme Budget matters”

(Agenda item 7.3, document SEA/RC63/5)

79. The Committee noted that the 2012-2013 biennium would be the third and last biennium within WHO’s Medium-term Strategic Plan (MTSP), which covered the period from 2008 to 2013. The structure of the proposed Programme Budget (PB) 2012-2013 was a strategic one, similar to the two previous bienniums, with 13 strategic objectives (SOs) that had largely the same orientation as those for the two earlier bienniums (2008-2009 and 2010-2011).

80. Overall, the Programme Budget for 2012-2013 (Regional Committee version - Doc. SEA/RC63/5 Part I) had been proposed by the Director-General at the level of US$ 4 804 million, with an increase of US$ 264 million compared with the approved budget for the 2010-2011 biennium. The budget for the base programmes was US$ 3 419 million, with an increase of US$ 51 million over the approved PB2010-2011. The budget breakdown for the proposed PB2012-2013 had been presented only at the level of SOs by major offices.

81. The South-East Asia Regional Strategic Plan and Proposed Programme Budget for 2012-2013 (Doc. SEA/RC63/5 Part II), with the budget ceiling level
of US$ 505.6 million, reflected the current plans and proposed budgets of Member States and the Regional Office for the 2012-2013 biennium.

82. The Committee was informed that the Third Meeting of the SPPDM had reviewed the Proposed Programme Budget for 2012-2013 (Part I) including the South-East Asia Regional Strategic Plan and the Proposed PB2012-2013 (Part II), and that it had requested the Committee to consider the draft resolution on “Proposed Programme Budget 2012-2013”.

83. The Committee noted and endorsed the Proposed Programme Budget for 2012-2013, including the South-East Asia Regional Strategic Plan and the Proposed PB 2012-2013, as well as the observations and recommendations made by the SPPDM.

84. The Committee adopted resolution SEA/RC63/R1 on this agenda item.

Consideration of the recommendations arising out of the Technical Discussions on “Injury Prevention and Safety Promotion”
(Agenda item 8.1, document SEA/RC63/6)

85. The Committee’s attention was drawn to the decision of the Sixty-second Session of the Regional Committee in Kathmandu, Nepal, in 2009 recommending the topic “Injury Prevention and Safety Promotion” for technical discussions prior to the Sixty-third Session. Accordingly, experts on the subject of “injury prevention and safety promotion” discussed the issue and developed a paper with technical inputs from WHO.
86. The Committee noted that Technical Discussions on “Injury Prevention and Safety Promotion” were held by experts from eight Member States of the Region in New Delhi, India, on 25–26 May 2010. Representatives from WHO headquarters and the Regional Office also attended. The Technical Discussions dealt with all the key issues related to the subject and came up with a number of recommendations for Member States and for WHO.

87. The Committee noted that injuries were the leading contributor to deaths, disabilities and loss of DALYs (disability-adjusted life years) all over the world, imposing a significant burden on health systems and national economies. Injuries accounted for almost 9.8% of the world’s deaths and 12.3% of the global disease burden in 2009. Injuries were among the 10 leading causes of death among adults in the most productive age group of 15–29 years. The SEA Region had the highest proportion and rate of injury-related deaths among all six WHO regions.

88. The Committee was informed that road traffic injuries, suicides, drownings and burns were the most common injuries in the SEA Region. Motorcycles had become a major mode of transport in many Member States. In Maldives, Myanmar and Thailand, motorcycles comprised 64%–79% of all registered vehicles. Urbanization, unplanned land use and ever-growing roads and distances of daily commute had enhanced the demand. With an estimated 72.5 million motorcycles currently in the SEA Region, mortality and morbidity due to road accidents had increased substantially.

89. The Committee also observed that suicides and burns were predominantly seen among females in the SEA Region. It also noted that children were the most likely to be injured as a result of drowning, road traffic accidents, and unintentional falls and burns, which could be prevented through safety promotion and legislative measures.

90. The attention of the Committee was also drawn to the fact that several UN resolutions on the subject had been adopted in the recent past, and that the decade 2011–2020 had been designated as the UN Decade for Injury Prevention. However, efforts were needed in this area in collaboration with other UN agencies to ensure efficient use of resources.

91. The Committee discussed the background document on “Injury Prevention and Safety Promotion” and commended its comprehensiveness. Its attention was drawn to the fact that five Member States in the Region — Bangladesh, India, Maldives, Sri Lanka and Thailand — had established national and holistic programmes for injury prevention. In the case of Bangladesh, the presence of
a large number of waterbodies had led to increased instances of drowning in recent years.

92. The multidimensional aspect of injuries, injury prevention and safety promotion was highlighted by the Committee, which also felt that efficient implementation needed effective collaboration among various sectors and ministries, including health, transport (roadways, railways, water and aviation), law-enforcement, legislative affairs, home and civil society. Given the cross-cutting nature and involvement of sectors other than health in injury prevention, especially in the context of traffic accidents, and the role played by non-state health actors, the Committee suggested that a national task force be set up by each Member State with their Head of Government as Chair. This would enable other sectors to understand the issue of injury prevention from a public health perspective.

93. Within the health sector there was a need for collection of data, analysis of risk factors and use of this information in policy formulation. Equally important was building countrywide capacity to ensure rapid access to quality and comprehensive trauma-care services including pre-hospital care, care during the referral period, and emergency care.

94. The Committee noted that while post-injury hospital-based management had attracted the attention of national authorities, importance needed to be given to create an enabling policy for prevention with a multisectoral
approach and active involvement of nongovernmental and community-based organizations.

The Committee felt there was a need to have mechanisms in place to influence people to follow safety regulations. Such information, if incorporated into the school curriculum, would help to significantly reduce injuries.

The Committee urged WHO to facilitate the monitoring of implementation of the recommendations of the Technical Discussions on “Injury Prevention and Safety Promotion”, and to assist Member States to establish evidence-based public health policies and programmes for preventing injuries and mitigating their consequences.

The Committee endorsed the report and recommendations of the Technical Discussions as contained in document SEA/RC63/6 and adopted resolution SEA/RC63/R2 on this agenda item.

Selection of a subject for the Technical Discussions to be held prior to the Sixty-fourth Session of the Regional Committee

(Agenda item 8.2, document SEA/RC63/7)

The Committee noted that the High-Level Preparatory (HLP) Meeting held on 28-31 July 2010, had discussed this item as part of an in-depth and wide-ranging review of various issues relating to a subject of regional interest to be selected for Technical Discussions prior to the Sixty-fourth Session of the Regional Committee in 2011. The subjects that were considered by the HLP were:

- Tobacco control: Meeting the obligations of the WHO Framework Convention on Tobacco Control (WHO FCTC);
- Teaching of public health at the undergraduate level in medical schools;

95.

96. The Committee urged WHO to facilitate the monitoring of implementation of the recommendations of the Technical Discussions on “Injury Prevention and Safety Promotion”, and to assist Member States to establish evidence-based public health policies and programmes for preventing injuries and mitigating their consequences.

97. The Committee endorsed the report and recommendations of the Technical Discussions as contained in document SEA/RC63/6 and adopted resolution SEA/RC63/R2 on this agenda item.

Selection of a subject for the Technical Discussions to be held prior to the Sixty-fourth Session of the Regional Committee

(Agenda item 8.2, document SEA/RC63/7)

98. The Committee noted that the High-Level Preparatory (HLP) Meeting held on 28-31 July 2010, had discussed this item as part of an in-depth and wide-ranging review of various issues relating to a subject of regional interest to be selected for Technical Discussions prior to the Sixty-fourth Session of the Regional Committee in 2011. The subjects that were considered by the HLP were:

- Tobacco control: Meeting the obligations of the WHO Framework Convention on Tobacco Control (WHO FCTC);
- Teaching of public health at the undergraduate level in medical schools;
Strengthening of the community-based health workforce in the context of revitalization of primary health care; and

Occupational health: Formulation of policy and strategy.

99. Considering the importance of the subject, the Committee decided to select “Strengthening of the community-based health workforce in the context of revitalization of primary health care” as the subject of the Technical Discussions to be held prior to the Sixty-fourth Session of the Regional Committee in 2011.

Strategic planning for development of human resources for health in the Region

(Agenda item 9, document SEA/RC63/8)

100. All Member States of the Region faced health workforce-related problems and issues of a common nature, and this led the Regional Office to develop a Strategic Plan for Health Workforce Development. This plan identified 10 strategic areas for priority action, including scaling up of health workforce production, knowledge generation, and capacity-building in health workforce management.

101. The Committee noted that Member States had developed their own strategic plans with technical support from WHO. Regional partnerships and networks had been established. Efforts were being made to fill the void in the
regional health workforce information through the development by WHO of a Regional Human Resources Observatory, which would become part of the Health System’s Observatory, developed in collaboration with the Western Pacific Region. The issue of migration of trained health workers, both between countries and from rural to urban areas within the country, as well as from the public to the private sector within countries was being addressed. In addition, education on public health was being provided to the community-based health workforce in some Member States. Tangible results had been achieved through strategic planning for the development of human resources for health in the Region.

102. The Committee appreciated the support provided by WHO for the participation of representatives of Member States at the annual meetings of the Asia-Pacific Action Alliance on Human Resources for Health (AAAHR); this encouraged collaboration in health workforce development.

103. The Committee endorsed the recommendations made on this agenda item at the HLP Meeting held at WHO-SEARO, New Delhi from 28 June to 1 July 2010.

**Statements by representatives of international nongovernmental organizations (INGOs)**

104. While applauding the WHO Regional Office for South-East Asia for developing the Framework on Prevention and Control of Noncommunicable Diseases (NCDs) that sets out strategies to stem the tide of NCDs, Professor Ankana Sriyaporn, President, Nurses Association of Thailand, on behalf of the International Council of Nurses (ICN), stated that nurses were vital for efforts to support individuals, families and communities to reduce the NCD risk. They were also crucial for instituting risk-factor surveillance and integrated population-based interventions.

105. The special contribution of nursing in NCD control lay in primary prevention through health promotion, early detection and referrals for appropriate care. Nurses were most suited to this task and well positioned to deal with it. At the same time, nurses themselves must be the focus of interventions so that they can act as healthy role models for their families, their patients and their communities.

106. In order to prepare nurses and other health professionals to become effective in NCD prevention and control, Professor Sriyaporn, on behalf of the ICN, urged WHO and governments to: support a shift from the acute care
to chronic care model in educational programmes at all levels of nursing and medical curriculum; provide continuing education to ensure a sound knowledge base, skill development and ethical framework for practices; involve nurse leaders in national NCD control and policy development; and help remove legislative barriers that prevent nurses from working to their full potential on these critical issues.

107. **Professor Khunying Kobchitt Limpaphayom, President, World Federation of Medical Education**, stressed the need to ensure that educational outcomes were directed by the particular needs of society. The health workforce should also be supported for professional development through the right incentives. Social responsibility, professional development and collaboration with other fields of medicine are important attributes.

108. Doctors had many roles to play, i.e. as an educator, researcher, communicator, manager of health care, and community health leader. Leadership qualities were important, and medical students must be given opportunities to develop them. Professor Limpaphayom also highlighted the need to clarify the roles of different professions so that doctors would be able to take a step back from certain roles, activities and responsibilities, which according to them could be performed better by other professions. The development of the leadership role needed to be encouraged throughout the education and training of both undergraduates and postgraduates. With the rapidly-changing environment of health-care development and advancement of medicine, emphasis needed to be put on understanding the doctor’s role, starting from the undergraduate to postgraduate levels.

109. **Mr Tami Tamitegama of Alzheimer Disease International (ADI)**, an organization with 73 member country associations worldwide, said that
Alzheimer disease and other dementias were emerging as one of the major health issues of the present century. Dementia often went unrecognized due to lack of awareness, and WHO could make a difference by declaring dementia a global health priority. Mr Tamitegama stressed the need for promoting awareness and understanding regarding dementia to erase the stigma about the condition, supporting families and care-givers, and developing a research agenda.

110. Alzheimer disease and dementia had an increasingly debilitating impact throughout the world with 36 million people affected globally. This number was expected to double in the next 20 years, and to continue to increase up to 115 million by 2050 on account of increasing longevity. For people aged over 60 it was the main cause of years lived with disability.

111. The Committee noted that dementia was now part of WHO’s Mental Health GAP Action Programme. However, there was a great need for funding and implementation in all the countries. The ADI was set to launch the second World Alzheimer Disease Report on World Alzheimer Disease Day, 21 September 2010. The report would touch on the worldwide cost of Alzheimer disease and other dementias, and the costs specific to the SEA Region. The ADI had also pledged support for setting up national Alzheimer disease associations in countries where these did not exist.

112. Mr Mario Ottiglio of International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) reaffirmed the pharmaceutical industry’s commitment to help achieve the health-related MDGs. He informed the Committee that the innovative pharmaceutical industry was playing a unique role, which included research and development of innovative, safe and effective medicines. In developing countries, the industry had been working to reduce mortality and morbidity through multistakeholder dialogue and philanthropic partnerships on a “non-for-profit or reduced profit” basis.

113. Mr Ottiglio highlighted the need for a combination of targeted and inexpensive basic health interventions including nutrition for mothers and children, mass vaccination campaigns, access to basic antibiotics, and programmes to prevent the spread of HIV/AIDS and other sexually-transmitted diseases, as well as intensification of essential care for all mothers and babies to improve maternal and women’s health.

114. He reiterated IFPMA’s commitment to continue to provide to the global community the benefits of the products of their research, and assistance for technical and scientific capacity-building and educational programmes.
115. Dr Chandrakant S. Pandav, International Council for Control of Iodine Deficiency Disorders (ICCIDD), informed the Committee that the current year was the twenty-fifth anniversary of ICCIDD, which was specifically established to promote optimal iodine nutrition and sustainable elimination of iodine deficiency disorders (IDD). Dr Pandav stated that the global household coverage of iodized salt had increased from 20% to over 70% during the last quarter of the century due to efforts of the ICCIDD. Iodized salt producers, national governments, civil society organizations and bilateral international agencies had all collaborated in these efforts.

116. Despite progress, IDD continued to be the single most important cause of preventable brain damage globally. Thus, increased focus was needed on susceptible groups such as pregnant women, lactating women and young children, in order for them to attain the optimal level of nutrition.

117. During the last year, the ICCIDD was involved in a series of activities related to IDD including strengthening of IDD-monitoring laboratories in DPR Korea and Myanmar. Dr Pandav acknowledged WHO’s support for these activities. He reiterated the need for sustained efforts to achieve universal salt iodization; iodine supplementation; monitoring of national programmes; laboratory monitoring of quality assurance/quality control of the salt iodization process; strong legislation; national advocacy; and generating public information on problems of iodine deficiency.

Development of national health plans and strategies
(Agenda item 10, document SEA/RC63/9)

118. The Committee noted that National Health Plans (NHPs) and strategies had been placed at the centre of WHO’s support to countries by the high-level Global Policy Group in which the Regional Director represents the South-East Asia Region. In line with this commitment, WHO had developed a draft framework for National Health Policies, Strategies and Plans, with a view to help countries develop more robust, effective and credible national health plans, and to get such plans endorsed by the high-level decision-makers of their respective national governments.

119. Countries had been developing national health plans for some time, and WHO had been supporting this process as well. The renewed interest in reviewing national health plans was the result of the increasing complexity involved in their formulation and implementation, particularly with respect to the significant health impact of activities in sectors other than health.
120. In line with the Global Policy Group’s direction, the Regional Office had developed summary guidelines for assessing gaps in current national health plans in Member States. Detailed assessments in six countries had been carried out, and findings were discussed at a regional consultation held in Bali in August 2010, with the specific objective of agreeing on country needs and WHO’s role in addressing them. Seven countries of the Region had been identified for the first phase of country capacity-strengthening training. It was noted that the framework for national health policies, strategies and plans would be presented to the 128th session of the Executive Board in January 2011 for discussion, before being submitted to the Sixty-fourth World Health Assembly.

121. The Committee urged WHO to provide strong technical guidance and support to countries for preparing national health plans based on sound, timely and relevant health information. The need to develop and disseminate relevant tools for development of NHPs was also expressed. The Committee noted that at present, there was inadequate capacity for analysis of contextual issues that affect health, and there were weaknesses in health information systems. Monitoring and evaluation of NHPs were needed.

122. In view of the weak linkage between NHPs and national development plans, it was important to advocate effectively with policy-makers to accord due importance to the element of health planning in overall development planning. National health planning should ideally be a participatory and evidence-based process. The importance of improving the capacity of planning units in the ministries of health was emphasized. South-South collaboration was one of
the avenues by which the national health planning processes in Member States could be improved.

123. The Committee endorsed the recommendations made by the HLP meeting on this agenda item.

**Coordinated approach to prevention and control of acute diarrhoea and respiratory infections**  
*(Agenda item 11, document SEA/RC63/10)*

124. The Committee noted that acute diarrhoea and respiratory infections were high-burden diseases in the SEA Region. Dedicated programmes for both during the 1980s and the 1990s were successful in reducing mortality among the under-5 population. But, despite these programmes, high morbidity persisted. Furthermore, with the lack of focus on these two public health problems in recent years, they had continued to lead the causes of under-5 deaths in the Region and also globally. This had been one of the impediments in the achievement of MDG 4 in the Region.

125. The Committee was apprised of the need to design and launch national programmes that would encompass all age groups and integrate universal access to quality care with preventive interventions. These interventions needed to be well coordinated and supported by strong advocacy, community mobilization and empowerment, training, research, monitoring and evaluation, and by mobilization of national and international responses. WHO’s role should be
to support Member States both technically and in mobilizing international response, including resources.

126. The Committee noted with concern that in spite of the availability of simple, effective and low-cost interventions for both prevention and control of acute diarrhoea and respiratory infections, these conditions continued to cause more than 2.1 million deaths among children and adults in the SEA Region each year. Of the estimated 156 million annual new cases of childhood pneumonia globally, 61 million occurred in the SEA Region. It was also estimated that an average child in developing countries suffered more than three episodes of acute diarrhoeal illness every year.

127. The Committee reiterated that these diseases continued to be a challenge primarily because of unsafe water, poor sanitation, degraded environment and lack of information. Accordingly, an intersectoral approach involving multiple social sectors was needed.

128. The Committee observed that effective home-based preventive interventions, especially hand hygiene, needed to be encouraged through health education, especially among schoolchildren. Active participation of communities was critical to achieve sustainable success in combating these illnesses.

129. The Committee noted that the role of the PHC approach was essential, especially at the community-level. It also stressed the need to reexamine the ongoing Integrated Management of Childhood Illness (IMCI) activities and to prioritize them at the country level.

130. The Committee also recognized the need for appropriate research and development and technology transfer to manufacturers in the Region for the discovery, development and dissemination of newer tools including vaccines, simpler technologies for providing safe water in rural areas, and interventions for preventing and controlling indoor and outdoor air pollution.

131. The efforts made by WHO in developing a comprehensive strategy that articulated an integrated package of interventions and supported its implementation in Member States across all age groups was commended.

132. The Committee urged WHO to provide technical support to Member States to: adopt and implement the strategy in the national context; build capacity for implementation; prioritize appropriate interventions; understand the disease epidemiology; undertake research including operational research; and establish a robust monitoring mechanism.
The Committee endorsed the recommendations made by the HLP meeting and adopted resolution SEA/RC63/R3 on this agenda item.

**Prevention and containment of antimicrobial resistance** (Agenda item 12, document SEA/RC63/11)

134. The Committee noted that during the past six decades antimicrobial agents had played a critical role in reducing the burden of communicable diseases all over the world. But the emergence of antimicrobial resistance (AMR) and its rapid spread was negating the impact of these drugs, obstructing progress towards achievement of the MDGs for HIV, TB and malaria, and hindering effective application of modern technologies in mitigating human misery. While the appearance of resistance was a continuous phenomenon in microorganisms, its amplification and spread were affected by an array of practices of human beings. Improper utilization of antimicrobial agents, especially in high disease-burden settings and for non-therapeutic use as in the veterinary sector, resulted in strong selection pressure that allowed the resistant strain to grow and rapidly replace the susceptible isolates.

135. The Committee was informed that WHO had developed a regional strategy aimed at giving particular attention to interventions involving the introduction of legislation and policies governing the use of antimicrobial agents, establishing
laboratory-based networks for surveillance of resistance, and ensuring the rational use of these drugs at all levels of health-care settings.

136. The Committee acknowledged that antimicrobial resistance had assumed serious proportions and was becoming the single biggest threat facing the world in the area of infectious diseases. The major reason for emergence and spread of AMR was the wide and indiscriminate use of common anti-infective drugs. Multidrug-resistant bacteria had emerged as a serious health problem all over the world.

137. The Committee noted with concern that AMR was posing a growing threat to the treatment and control of endemic, epidemic-prone and pandemic diseases. Resistance in microorganisms cost money, livelihood and lives and threatened to undermine the effectiveness of health delivery programmes even in developed countries.

138. The irrational use of antimicrobial agents comprising inappropriate prescriptions, noncompliance with regimens, use of antibiotics as growth promoters in animals, and over-the-counter availability of these drugs, was the major driver for emergence of resistance.

139. The Committee recognized that antimicrobial resistance was not a local problem. It had international ramifications. In the modern era of travel and trade, resistant organisms could rapidly cross boundaries through humans or the food chain.

140. The Committee urged WHO to support the building of regional capacity in undertaking research and development.

141. The Committee appreciated the initiative of the WHO Regional Office for South-East Asia in developing a regional strategy that advocated a multipronged and multisectoral approach to mitigate the consequences of resistance and preserve the efficacy of antimicrobial agents.

142. There was a need for continuous education of prescribers of antimicrobials as well as of users for their rational use, reduction in the disease burden through the use of vaccines and other non-pharmaceutical measures, and encouragement of research on traditional medicine in treating infectious diseases. Accordingly, the Committee urged WHO to provide technical support to Member States in establishing national alliances and building national capacity in this critical area.
143. The Committee emphasized the importance of ensuring availability of diagnostic facilities to promote proper prescription of antimicrobials by physicians. It expressed its concern about the emergence of multidrug resistance in several organisms, leading to complexities in case management.

144. The Committee emphasized that WHO should undertake a systematic review of AMR and work with WHO collaborating centres and centres of excellence to forge an efficient regional surveillance network for the generation and sharing of data with Member States.

145. The use of antimicrobials as growth-promoting factors in animal husbandry was a major element in the emergence of resistance in pathogens that cause diseases in humans; the Committee urged the discontinuation of these practices.

146. The Committee also noted that the theme of the World Health Day 2011 would be “antimicrobial resistance”, and hoped that it would act as a strong catalyst for initiating development of multisectoral national plans and activities to combat AMR.

147. The Committee endorsed the recommendations made by the HLP meeting and adopted resolution SEA/RC63/R4 on this agenda item.
148. The Committee noted the gradual increase being recorded in the proportion of population aged 60 years and more in most countries of the Region, and how this would affect their social and health services. In this context, a range of supportive actions needed to be taken by Member States. These were: to increase political commitment for the promotion of healthy ageing; to develop or review the current interventions addressing the ageing issue, and relate this to the Regional Strategic Framework on Healthy Ageing; to scale up activities to establish national policies on ageing; to strengthen the existing national authority responsible for extending support to healthy ageing; and to continue to support the existing mechanisms for collaboration with other sectors and stakeholders that are involved in healthy ageing interventions.

149. The Committee was informed about the steps being taken in this regard by some Member States and the challenges faced by them. A success story cited by a Member State was an investment of US$ 100 million across hospitals in 80 districts of the country to set up 10-bed geriatric wards and outpatient department (OPD) facilities for the care of the elderly.

150. The Committee sought support from WHO for capacity building and to develop technical competence to tackle various aspects of geriatric care including psychosocial aspects. It reiterated its commitment to the Strategic Framework.

151. The Committee endorsed the recommendations made by the HLP meeting on this agenda item.
Accelerating the achievement of MDG 5: Addressing inequity in maternal and neonatal health
(Agenda item 14, document SEA/RC63/13)

152. The Committee was informed that improving maternal and neonatal health (MNH) continued to be the major challenge for many countries in the SEA Region. Overcoming the challenge would require an effective and efficient health-care system that allows all women to plan for their pregnancy and provides skilled care during antenatal, childbirth and postnatal periods, as well as neonatal care, and ensuring that these are backed up by referral services. Providing such health-care services is an important element of human rights that governments are obliged to provide for all their citizens without discrimination.

153. The Committee noted that while countries in the Region comprised about 27% of the global population, they contributed approximately 33% of the mortality from maternal and neonatal causes. The health inequities across and within countries were a major cause for concern especially in terms of accessing skilled care at birth and in utilization of modern family planning methods.

154. The Committee reiterated that the broader issues such as social determinants of health, education, and health must be incorporated into any initiative for MNH. It also pointed out that one reason for poor delivery of maternal and neonatal health care was the lower number of institutional deliveries in many Member States due to geographical inaccessibility and other factors. The
Committee requested WHO to facilitate information-sharing; assist Member States in building competencies in case-finding, care and follow-up; and in providing adequate training for health volunteers in MNH care.

155. The major concern in this area was having a proper monitoring and evaluation system. Social determinants of health, education, food and nutrition were important. The other important aspects were how to train health volunteers in communities, and exchange of information. The importance of WHO’s support in capacity building for life-saving procedures at peripheral levels, such as for dealing with postpartum haemorrhage and obstructed labour was emphasized. The causes of high maternal and neonatal morbidity and mortality were well known. The issue was how to design the most efficient and effective interventions, in line with the epidemiological, socioeconomic and cultural situation in respective countries. The review and assessment of the relevant situation would be important in dealing with this issue.

156. The Committee endorsed the recommendations made by the HLP meeting on this agenda item.

**Regional Strategy on Universal Health Coverage**  
*(Agenda item 15, document SEA/RC63/24)*

157. The Committee noted the consistent commitment of WHO and Member States to improve equity in health through universal coverage. An overall financing strategy towards achieving this goal had been developed for countries of the Asia-Pacific region jointly by the WHO Regional Offices for South-East Asia and the Western Pacific. Furthermore, regional priorities on universal health coverage would be the theme of the forthcoming report, “Financing for Universal Coverage”.

158. Universal coverage for health has three dimensions: (i) population dimension covering people; (ii) health service dimension covering services; and (iii) financing dimension covering the aspect of sharing of costs.

159. The key challenges to universal coverage in the Region were the high and potentially impoverishing out-of-pocket expenditure on health; a large informal sector that was most vulnerable to the high cost of access to care; a large and mostly unregulated private sector that dominated provision of care; and the increasing burden of noncommunicable diseases that required costly individual care.
160. The Committee was informed that there were three choices in the progress towards universal coverage that health financing reform needed to consider:

- reaching the priority population with a chosen benefit package at a feasible public subsidy;
- adopting a practical approach to bring about a shift from out-of-pocket payments towards equity and universal coverage, which was a step-by-step move, first to an intermediate stage of a mix of community initiatives to protect the informal sector along with social and tax-based health insurance for the formal sector with government revenues, while the next stage consolidated community and social insurance into national-level social protection schemes;
- ensuring long-term sustainability of health-care financing through more collaborative efforts with all stakeholders, while at the same time sharing information through workshops involving all Member States.

161. The Committee recommended in-depth technical assessments in Member States to sustain financing for universal coverage. Such assessments would help in the formulation of a strategy for the Region. WHO assured the Committee of its strong commitment to support Member States in this programme, including sharing of knowledge from within and outside the Region. It was also observed that universal health coverage was increasingly becoming a complex challenge partly on account of the rising costs of providing health care. The SEA Region had the highest figures for out-of-pocket expenditure among all the WHO regions, and this underscored the need for sustainable health-care financing.

162. The Committee endorsed the recommendations made by the HLP meeting and adopted resolution SEA/RC63/R5 on this agenda item.

**Capacity building of Member States on global health**
**(Agenda item 16, document SEA/RC63/25)**

163. The Committee was informed that the term “global health” had been used since the early days of WHO and implied a situation where the health needs of the people of the entire planet were responded to, above the concerns of particular nations.

164. The Committee was informed of a collaboration between the Ministry of Public Health, Thailand, the WHO Regional Office for South-East Asia, and the ThaiHealth Global Link Initiative Program (TGLIP), which had resulted in the First Regional Training Course on Global Health held in May 2010. The first
module—an introductory course on global health—organized from 1-5 May 2010 in Nakhon Pathon, Thailand, was attended by participants from seven countries of the South-East Asia Region who were selected from among the delegates attending the Sixty-third World Health Assembly. It was followed by a second module of learning on 17-21 May 2010 in Geneva. A wrap-up session, which was the third module, was conducted on 22 May 2010 in Geneva.

Organizing regional training courses on global health in Member States on a rotational basis had been envisaged.

165. The Committee endorsed the recommendations made by the HLP meeting and adopted resolution SEA/RC63/R6 on this agenda item.

**Regional Strategy on Health Information Systems**  
(*Agenda item 17, document SEA/RC63/26*)

166. The Committee noted that public health decision-making was critically dependent on timely availability of sound data. The role of the health information system was to collect, analyse and disseminate such data. Health information systems (HIS) in countries of the SEA Region were at various stages of development. Several global initiatives, networks, programmes and projects had been launched by development partners to assist Member States in developing HIS. Regarding HIS, there was a need for priority-setting of activities to be carried out. The importance of greater national investment in HIS to ensure its efficiency and sustainability, as well as quality of data was emphasized. The Committee also noted that critical analysis of available information at different levels of the health system was important.

167. The Regional Office took the initiative to develop a strategic framework to guide countries in strengthening and reorienting their national health information systems. After a series of country consultations, a 10-point Regional Strategy for Strengthening Health Information Systems was developed in 2005. The strategy was endorsed at the Fifty-ninth Session of the Regional Committee in Dhaka in
2006. All countries had reviewed their national health information systems and had taken action to align them with the regional strategic framework.

168. The Committee urged WHO to provide assistance for resource mobilization and generation of funds at the regional level, as well as support for the analysis of data at local, national and regional levels.

169. The Committee endorsed the recommendations made by the HLP meeting and adopted resolution SEA/RC63/R7 on this agenda item.

**Governing Bodies: (Agenda item 18)**

**Key issues and challenges arising out of the Sixty-third World Health Assembly and the 126th and 127th sessions of the WHO Executive Board (Agenda item 18.1, document SEA/RC63/14(Rev.1)**

170. The Committee noted that the HLP meeting was presented with a working paper highlighting the most significant and relevant decisions and resolutions emanating from the Sixty-third World Health Assembly.

171. The highlights from the main operative paragraphs, as well as the regional implications of each decision and/or resolution, as applicable, and actions proposed for Member States and WHO were presented.

172. In accordance with the World Health Assembly resolution WHA63.28, the Committee was informed that 10 nominations for experts were received from five Member States (India, Indonesia, Nepal, Sri Lanka and Thailand) for the Consultative Expert Working Group (CEWG) on Research and Development: Financing and Coordination.

173. The Committee **decided** to endorse the nominations.

174. The Committee requested the Regional Director to convey its decision to the WHO Director-General for inclusion of the names in the roster of experts.

**Review of the draft provisional agenda of the 128th session of the WHO Executive Board (Agenda item 18.2, document SEA/RC63/15)**

175. The Committee considered and noted the Draft Provisional Agenda of the 128th session of the WHO Executive Board, and made a particular reference to
the agenda item on “Cholera: Mechanism for Control and Prevention”, which it observed was of particular relevance to the Region.

Follow-up action on pending issues

Collaboration within the UN system and with other international agencies and partnerships
(Agenda item 19.1, document SEA/RC63/16)

176. The Committee noted that the recognition of health as a key element for sustainable development and global security had resulted in a substantial increase in global resources for health in recent years. At the same time, the diversity and number of health actors had also increased significantly. With this proliferation of actors in health, WHO—particularly at country level—must coordinate its work through effective partnerships not only with government authorities and other UN agencies, but also with donors, NGOs and the private sector, in order to ensure alignment of health strategies and goals, and other development objectives.

177. The Committee was informed that the Sixty-third World Health Assembly had endorsed the policy on “WHO engagement with global health partnerships and hosting arrangements”. This was in line with discussions held at the Sixty-second Session of the Regional Committee wherein WHO was requested to support Member States in building their capacity to take forward the harmonization and alignment agenda at country level.

178. The Committee observed that in addition to supporting Member States as requested, within the United Nations Development Assistance Framework (UNDAF) development process, WHO had been active at country level in three main areas of collaboration: (i) engagement in global health partnerships; (ii) coordination and collaboration with the United Nations System; and (iii) collaboration with regional intergovernmental organizations.

179. The need for greater collaboration with Ministry of Foreign Affairs officials to enhance their understanding of the implications of UN reforms on health
development activities at country level, and building capacity of Member States for taking forward the Harmonization and Alignment Agenda, was reiterated by the Committee.

180. The Committee endorsed the recommendations made by the HLP meeting on this agenda item.

**Follow-up action on RC resolutions**

**Nutrition and food safety in the South-East Asia Region (SEA/RC60/R3) (Agenda item 19.2, document SEA/RC63/17)**

181. The Committee was presented with a brief overview of the nutrition and food safety situation in Member States of the Region. Data indicated that while overall food consumption had increased and nutrition indicators had shown improvement, the global economic crisis and climate change might lead to food insecurity and increase the number of malnourished people.

182. The Committee noted that a range of supportive actions had been identified, which needed to be taken by Member States with regard to the promotion of nutrition and food safety in the Region: to increase political commitment in order to promote national nutrition and food safety programmes; to mainstream nutrition and food safety issues into all national health policies and strategies and ensure the implementation of global strategies on infant and young child feeding, food safety, diet, physical activity and health; to strengthen nutrition surveillance systems and implement the WHO Child Growth Standards and Growth References through their full integration into child and adolescent health programmes; to develop and maintain sustainable and comprehensive preventive measures for reducing the burden of food-borne diseases encompassing the complete food-production chain from farm to consumption; to enable active and appropriate participation of national authorities in activities of the Codex Alimentarius Commission, INFOSAN and other international networks; and to strengthen the laboratory capacity for investigating and reporting on food-borne diseases outbreaks.

183. The Committee urged WHO to increase its involvement in the area of food safety and to provide technical guidance and encouragement to Member States to actively participate in the Asia FoodNet in order to prevent and control food-borne diseases. WHO should also support establishment of National Food Safety Emergency Response units in Member States; monitoring and assessing changes
in nutrition profiles; development of food-based national dietary guidelines; and standard protocols for effective monitoring of food safety programmes.

184. The Committee endorsed the recommendations made by the HLP meeting on this agenda item.

**South-East Asia regional efforts on measles elimination (SEA/RC62/R3) (Agenda item 19.3, document SEA/RC63/18 and addendum)**

185. The Committee was informed that at the regional consultation on measles held at WHO-SEARO, New Delhi, in August 2009, there was agreement among participants that measles elimination was technically, biologically and programmatically feasible. The consultation proposed setting a regional goal to eliminate measles by 2020 to the Sixty-second Session of the Regional Committee, held in Nepal in September 2009, which had decided that setting a regional measles elimination goal would be considered at its Sixty-third Session in 2010.

186. The Committee noted the requirements that needed to be met before setting a goal for measles eradication, the Sixty-third World Health Assembly interim milestones towards global eradication of measles, situation analysis of measles control and progress towards measles elimination in Member States of the Region and potential challenges in achieving measles elimination in the Region.

187. The Committee urged WHO to continue to provide technical support for countries to maintain the high-level routine measles immunization coverage, especially among migrants and populations based in rural, remote and difficult-to-reach areas. WHO was specifically requested to provide full technical support for developing a framework for a regular monitoring system.

188. The Committee acknowledged the challenges being faced by countries in the Region in eliminating measles, in terms of continued financial assistance,
long-term vaccine supply, enhancement of health system capacity, and commitment to achieve immunization coverage targets.

189. The Committee endorsed the recommendations made by the HLP meeting on this agenda item.

**Challenges in polio eradication (SEA/RC60/R8)**
*(Agenda item 19.4, document SEA/RC63/19)*

190. The Committee was presented with an update on the progress and challenges in polio eradication, and noted that polio eradication continued to be a priority in the SEA Region.

191. To date, the endemic areas in Uttar Pradesh and Bihar in north India had reported only 33 cases associated with wild polio virus as compared with 363 cases in 2009 for the same period. Of these, 11 were due to type 1 wild polio virus (P1) and 22 were due to type 3.

192. The P1 case detected in Nepal in February 2010 in a district adjoining Bihar and the current P1 outbreak in Tajikistan, epidemiologically linked to India, indicated that the key challenge for other countries in the Region and beyond was to protect their polio-free status by preventing reinfection and spread. In this regard, WHO had an important role in alerting neighboring countries in the event of a polio outbreak occurring in a polio-free area.

193. A strong routine immunization programme that can deliver and maintain OPV3 coverage greater than 80% in all districts in all countries will help prevent reinfection and spread. Additionally, all polio-free countries must conduct periodic risk assessment to determine the level of risk of reinfection and spread,
and to decide whether or not polio immunization campaigns will be required to boost population immunity.

194. The Committee acknowledged the several challenges to eradication of polio in the Region. Every Member State needed to focus on maintaining high-quality acute flaccid paralysis (AFP) surveillance including cross-border monitoring and response, increasing and sustaining high routine immunization coverage, improving environmental sanitation, and responding early to importation of wild polio virus.

195. The Committee endorsed the recommendations made by the HLP meeting on this agenda item.

Scaling up prevention and control of chronic noncommunicable diseases in the South-East Asia Region (SEA/RC60/R4) (Agenda item 19.5, document SEA/RC63/20)

196. The Committee was informed that WHO’s action in the area of prevention and control of noncommunicable diseases (NCDs) in the SEA Region was guided by the Regional Framework for Prevention and Control of NCDs. The Framework was formulated in close collaboration with Member States and endorsed by the health secretaries of Member States of the Region at their Eleventh Meeting in 2006. The WHO Regional Committee for South-East Asia, vide its resolution on Scaling up Prevention and Control of Chronic NCDs in the SEA Region (SEA/RC60/R4), endorsed the regional framework and requested the Regional Director to report to the Sixty-third Session of the Regional Committee in 2010 on the progress achieved in its implementation.

197. The Regional Framework aims at facilitating the process of developing, updating and implementing national policies, plans and programmes for integrated prevention and control of major NCDs including cardiovascular diseases, cancer, chronic pulmonary diseases and diabetes. It is based on public health principles and on national, regional and global consensus on policy and technical actions for prevention and control of NCDs and their primary risk factors.

198. The Committee was also informed that the Regional Director had received a letter from the World Heart Federation, on behalf of the NCD Alliance, drawing attention to the historic importance of the three-day High-Level Meeting on NCDs, which had been planned for September 2011, in response to resolution 64/265 of the United Nations General Assembly on Prevention and Control of NCDs.
199. The Committee noted the actions taken by Member States and by the WHO Secretariat, since the adoption of the Framework, to scale up prevention and control of NCDs.

200. The Committee urged WHO to continue to provide technical support and guidance to Member States with increased emphasis on tackling the preventive aspect of NCDs. This would involve adoption of a holistic approach to prevention and control through intersectoral collaboration, and by increasing the awareness of general populations on NCD risk factors.

201. The Committee endorsed the recommendations made by the HLP meeting on this agenda item.

**Special Programmes: (Agenda item 20)**


202. The Committee noted that the report of the Thirty-third meeting of the UNICEF/UNDP/World Bank/WHO Special Programme for Research and
Training in Tropical Diseases: Joint Coordinating Board (JCB) held in Shanghai, China, from 14 to 16 June 2010 was presented to the HLP meeting held in the Regional Office, New Delhi.

203. The Committee nominated Nepal as member of the JCB for a period of four years effective 1 January 2011, and requested the Regional Director to inform WHO headquarters accordingly.


204. The Committee noted that the report of the Twenty-third meeting of the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction: Policy and Coordination Committee (PCC), held in Geneva, Switzerland, on 24-25 June 2010, was presented to the HLP meeting held in the Regional Office, New Delhi.
205. The Committee nominated Bhutan as member of the PCC for a three-year term starting 1 January 2011, and requested the Regional Director to inform WHO headquarters accordingly.

**Time and place of future sessions of the Regional Committee (Agenda item 21, document SEA/RC63/27)**

206. The Committee accepted the invitation of the Government of the Republic of India to host its Sixty-fourth Session in India from 6 to 9 September 2011.

207. The Committee also noted with appreciation the invitations from both the Governments of the People’s Republic of Bangladesh and the Republic of Indonesia to host the Sixty-fifth Session in 2012. Following extensive deliberations, the Government of the People’s Republic of Bangladesh expressed its intention to withdraw, in favour of the Government of the Republic of Indonesia, its proposal to host the Sixty-fifth session. Accordingly, the Committee decided to hold its Sixty-fifth Session in Indonesia in 2012.

208. The Committee also decided that the venue of the Sixty-seventh Session of the Regional Committee in 2014 will be in Bangladesh. The Committee also considered following a policy of rotation on the basis of past venues and in alphabetical order of the names of Member States to decide future venues of the Regional Committee sessions.

**Closure of the session**

209. Representatives of Member States participating in the Sixty-third Session of the Regional Committee expressed their whole-hearted appreciation of the Royal Thai Government and the National Organizing Committee for their warm hospitality and excellent arrangements.

210. The representatives congratulated the Chairman and Vice-Chairman for the smooth and successful conduct of the meeting.

211. They expressed their gratitude to H.E. Mr Abhisit Vejjajiva, Prime Minister of the Royal Government of Thailand for inaugurating the Joint Inaugural session of the Twenty-eighth Meeting of Ministers of Health and the Sixty-third Session of the WHO Regional Committee for South-East Asia.

212. The representatives thanked Dr Margaret Chan, Director-General of the World Health Organization, for her encouraging presence and active participation and also conveyed their deep appreciation to the Regional Director,
Dr Samlee Plianbangchang, and the WHO Secretariat for the excellent support provided for the smooth and successful conduct of the meeting.

213. The representatives also thanked other delegates for their active deliberations during the meeting which led to the adoption of very important resolutions.

214. The representatives expressed great satisfaction at the successful conduct of deliberations and sought the support of WHO in implementing the resolutions.

215. The Regional Director congratulated the representatives for the successful session of the Regional Committee, which he attributed solely to the active participation of the representatives and the manner in which the meeting was conducted by the Chairman and Vice-Chairman. He said the efficient manner in which the meeting was conducted enabled the participants to complete discussions of all agenda items within the stipulated time. The tone for this, he said, was set by the gracious presence of H.E. Mr Abhisit Vejjajiva, Prime Minister of the Royal Thai Government at the inaugural session of the Twenty-eighth Meeting of Ministers of Health and the Sixty-third Session of the WHO Regional Committee for South-East Asia.

216. He said that the Regional Committee was greatly benefitted by the presence of Dr Margaret Chan, Director-General of WHO, and sincerely thanked her for her thought-provoking address and her interventions.

217. He also thanked the members of the Drafting Committee who drafted a group of important resolutions which were expected to strengthen collaborative activities in the health sector within the Region.
218. He expressed his deep appreciation for the officials of the Ministry of Public Health, the Royal Thai Government, and the National Organizing Committee in ensuring smooth conduct of the meeting and the excellent arrangements. He also expressed his appreciation to the local organizing committee for the hospitality extended to all representatives.

219. He also appreciated the commendable efforts made by the staff from the WHO Country Office, WHO headquarters and the Regional Office in supporting the meeting arrangements.

220. The Vice-Chairman appreciated that all the resolutions were adopted in an atmosphere of fraternity and friendship. He thanked H.E. Mr Abhisit Vejjajiva, Prime Minister, the Royal Thai Government; H.E. Mr Jurin Laksanawisit, Minister of Public Health, Royal Thai Government and all representatives for providing him the opportunity to chair the meeting. He congratulated the drafting committee for finalizing the resolutions and draft report. He praised the Director-General of WHO for her inspiring address and her guidance, and the Regional Director for his vision. The Vice-Chairman thanked all the representatives from Member States, and representatives of international nongovernmental organizations and UN agencies for their contribution to the work of the Committee. He also thanked the Regional Director, Dr Samlee Plianbangchang and the WHO Secretariat for their hard work, which had contributed to the success of the meeting.

221. Finally, he thanked the Royal Thai Government for their warm hospitality and declared the session closed.
Resolutions

SEA/RC63/R1 Proposed Programme Budget 2012-2013

The Regional Committee,

Having considered the proposed programme budget for 2012-2013, which falls in the third and last biennium of the WHO’s Medium-term Strategic Plan (MTSP) 2008 to 2013,

Noting with appreciation the Director-General’s proposal to have an increase of US$ 264 million for the proposed programme budget for 2012-2013, compared with the previous biennium,

Appreciating that the proposed programme budget for 2012-2013 has been developed through a process of consultation with Member States under the guidance of the Organization-wide policy,

Noting that the South-East Asia Region proposes a budget ceiling level of US$ 505.6 million, consisting of three segments: (i) the base programmes of US$ 393.6 million with US$ 102.3 million from Assessed Contributions (AC), and US$ 291.3 million from Voluntary Contributions (VC); (ii) Special Programme and Collaborative Arrangements (SPA) with US$ 80 million (VC); and (iii) Outbreak and Crisis Response (OCR) with US$ 32 million (VC),

Concerned that the substantial amount of Voluntary Contributions might not align with programme priorities as reflected in the programme budget documents,

Further concerned that the capacity of national governments and WHO country and regional offices needs to be strengthened to mobilize and implement the high levels of VC budget,
Noting that the regional programme budget statement for each strategic objective, outlining the scope, key achievements, challenges to date, new areas of work, areas to be given more emphasis or less emphasis, and the resource requirement would guide the operational planning and implementation during 2012-2013,

Recalling Regional Committee resolution SEA/RC60/R7 on the establishment of the South-East Asia Regional Health Emergency Fund (SEARHEF) by apportioning the WHO Regular Budget (Assessed Contribution), and resolution SEA/RC62/R5, which acknowledged the voluntary contributions by Member States to this fund and also requested the Regional Director to provide US$ 1 million for the SEARHEF from the WHO Regular Budget (Assessed Contribution) for the 2010-2011 biennium,

Having endorsed the report and the recommendations of the Third Meeting of the Subcommittee on Policy and Programme Development and Management (SPPDM) (Document SEA-PDM-19), and

Having noted the proposed programme budget 2012-2013,

1. URGES Member States:
   (1) to make concerted efforts to improve the management and utilization of available resources, and
   (2) to increase resource mobilization, especially for underfunded programme areas of high-priority, and

2. REQUESTS the Regional Director:
   (1) to convey to the Director-General the Region's requirements for additional funding that would be flexible and that would align with the priorities of Member States, the large population residing in the Region, as well as the increasing trend in disease burden in the Region;
   (2) to support strengthening of capacity in policy and programme development and in resource mobilization in Member States with the objective of improving the efficiency and effectiveness of planning, implementation and monitoring; and
   (3) to provide US$ 1 million for the SEARHEF from the WHO Assessed Contribution allocated to Member States of the SEA Region in the proposed regional programme budget 2012-2013.
The Regional Committee,

Recalling World Health Assembly resolutions WHA56.24 on implementing the recommendations of the World Report on Violence and Health, WHA57.10 on Road Safety and Health, WHA58.23 on Disability, including Prevention, Management and Rehabilitation, and WHA60.22 on Health Systems: Emergency-Care System, and its own resolution SEA/RC47/R3 on Accident Prevention and Trauma Care Management, which recommends that Member States integrate prevention of traffic injuries into public health programmes and strengthen emergency and rehabilitation services,

Recognizing that countries in the Region suffer from a tremendous burden of injuries resulting in millions of deaths and disabilities, with considerable social and economic costs to health services, victims, families and the country,

Concerned that those who use motorized two- and three-wheelers, pedestrians and cyclists are the most vulnerable to road traffic injuries, and that the other major causes of injury in the Region are intentional self-harm, drowning, burns, unintentional falls, and interpersonal and political violence,

Noting that children are the most likely to be injured as a result of drowning, road traffic accidents, unintentional falls and burns, which are preventable through health and safety promotion, legislative and other measures,

Acknowledging the concerted efforts of Member States to implement national policies and multisectoral actions to reduce injuries including disability, through safety promotion, advocacy and support for appropriate legislation, enforcement of laws and regulations and providing acute trauma care for the injured,

Having considered the report and recommendations of the Technical Discussions on “Injury Prevention and Safety Promotion” (SEA/RC63/6),

1. ENDORSES the recommendations contained in the report; and
2. URGES Member States:
   (1) to advocate for the establishment of a national mechanism or authority at the highest level, and to declare injury prevention and safety promotion a national agenda and to direct, coordinate, monitor and evaluate, and to continue dialogue with all sectors including the private
sector (such as industries, corporations and insurance agencies) and
civil society organizations to enhance national action plans, strategies
and multisectoral programmes to establish a national healthy public
policy;

(2) to establish or strengthen the existing injury management unit
within ministries of health to plan, implement and coordinate injury
prevention and safety promotion programmes, with appropriate
budget and staff;

(3) to play a more active role in advocacy for active participation of the
non-health sector, lawmakers and politicians in injury prevention and
safety promotion to ensure that due consideration is given to public
health in their policies and decision-making;

(4) to support and foster the full involvement of communities, civil
society, the private sector, nongovernmental organizations, public
health institutions and the mass media when framing national policies,
strategies and multisectoral programmes on injury prevention and
safety promotion, including legislative measures;

(5) to strengthen national injury surveillance and other injury-related data
systems for generating evidence-based information for policies and
programme development, and monitoring and evaluation of injury
prevention and safety promotion programmes;

(6) to address local priorities through policy, research and interventions
emphasizing risk management and effective prevention of road traffic
injuries, in particular motorcycle-related injuries; suicides; drowning
burns predominantly affecting females and children; and interpersonal
violence;

(7) to integrate injury prevention and safety promotion activities into
public health programmes and policies, including strengthening them
as part of the primary health care package;

(8) to continue strengthening qualified pre-hospital emergency medical
services, basic and professional acute trauma services in national
and local hospital settings, and rehabilitation services for injured
persons;

(9) to create a network of national institutions, academia and individuals
who practise injury prevention, care and safety promotion, and
organize regular national conferences to share experiences and
advance the agenda of injury prevention and safety promotion; and
3. REQUESTS the Regional Director:

(1) to support the institutionalizing and strengthening of national capacity for injury prevention and safety promotion within ministries of health, especially the strengthening of national injury-related data system development including injury surveillance, health information systems and vital registration, as well as health research;

(2) to encourage operational research on evidence-based initiatives for injury prevention, such as considering the adoption of alternative, innovative and sustainable sources of financing for injury prevention and safety promotion similar to dedicated taxes on tobacco or alcohol products, or taxation on vehicles or from accident insurance;

(3) to coordinate the planning and implementation of plans for the Decade of Action in Road Safety (2011-2020) as requested by United Nations General Assembly resolution A/Res/64/255 in partnership with Member States and other concerned agencies;

(4) to organize a biennial meeting of international and national networks of institutions and individuals from Member States in the Region to review policies and exchange experiences in order to advance this agenda; and

(5) to report on the progress made by injury prevention and safety promotion programmes in the Region to the Sixty-seventh Session of the Regional Committee in 2014.

SEA/RC63/R3 Coordinated approach to prevention and control of acute diarrhoea and respiratory infections

The Regional Committee,

Recalling and reaffirming World Health Assembly resolutions WHA29.63 on child health, WHA56.21 on the right of children to the highest attainable standard of health and access to health care, and WHA63.26 on the treatment and prevention of pneumonia to achieve the Millennium Development Goal (MDG) 4 on child mortality reduction, and the report to the WHO Executive Board on cholera (Document EB127.4), as well as its own resolutions SEA/RC30/R11 on infant and child mortality, and SEA/RC32/R1 and SEA/RC42/R3
emphasizing the need to give priority attention to the neediest sections of the population,

Noting that acute diarrhoea and respiratory infections are still the two leading causes of child mortality and morbidity and the difficulty being faced in achieving the MDG on child mortality in several Member States of the Region, and that the high burden of these diseases is borne not just by young children, and that the outbreaks of acute watery diarrhoea and pneumonic illnesses with high mortality are common occurrences across all ages in many Member States,

Recognizing that the major burden of these health problems is borne by remote, marginalized and poor communities and that safe, effective and affordable solutions have been available for decades but have not reached those in need, and that a reduction in infant and child mortality and morbidity rates is essential for improving the quality of life and productivity of the people,

Further noting that a regional strategy for prevention and control of acute diarrhoea and respiratory infections could help to reduce the burden of disease and accelerate progress towards MDG 4 in the South-East Asia Region,

Affirming that revitalization of essential health services at the community level by strengthening primary health care is vital for sustainable progress in achieving the MDG, and

Acknowledging calls from Member States to address the issue of the high burden of acute diarrhoea and respiratory infections in the Region and the importance of a coordinated approach to integrate health promotion, disease prevention and early and appropriate case management at both community and facility levels for a sustainable reduction in morbidity and mortality across all age groups,

1. **URGES Member States:**

   (1) to develop a coordinated approach based on the country health systems context for the prevention and control of acute diarrhoea and respiratory infections;

   (2) to give this issue the highest priority on the health agenda and apply integrated approaches of prevention and control of diarrhoea and respiratory infections, including related issues such as water, sanitation and indoor air pollution, as one of the key interventions in achieving the MDG4 target;
(3) to undertake a situational analysis of the burden of acute diarrhoea and respiratory infections in their respective countries;

(4) to mobilize and invest additional resources to implement the strategy; and

(5) to conduct operational research and generate evidence on effective interventions that promote early care-seeking and improved family practices; and

2. REQUESTS the Regional Director:

(1) to provide support to Member States in developing and applying the strategy of a coordinated and integrated approach for prevention and control of acute diarrhoea and respiratory infections;

(2) to provide technical support to Member States in conducting the necessary training activities, operational research, and monitoring and evaluation of the implementation of the strategy; and

(3) to work with development partners to mobilize and invest additional resources for the strategy.

**SEA/RC63/R4 Prevention and containment of antimicrobial resistance**

The Regional Committee,

Recalling World Health Assembly resolutions (WHA37.33, WHA51.17, WHA54.11 and WHA58.27) on rational use of drugs and prevention of antimicrobial resistance,

Concerned at the emergence and rapid spread of resistance in several microorganisms to the available antimicrobial agents across the South-East Asia Region, the unregulated and unauthorized availability of antimicrobial agents, irrational use of antimicrobials in medical practice and in the community, and the extensive use of antimicrobial agents for non-therapeutic purposes in the veterinary and fishery sectors, thus creating avoidable selection pressure to emergence of resistance,

Noting that antimicrobial resistance is increasingly hampering treatment of infectious diseases as a result either of totally ineffective currently available antimicrobials or of the high cost and toxic effects of newer drugs,
Aware that there is a lack of investment in the development of new antimicrobials, and that the efficacy of existing antimicrobials must therefore be preserved,

Recognizing that antimicrobial resistance in tuberculosis, malaria and human immunodeficiency virus will impede the achievement of health-related Millennium Development Goals (MDGs),

Noting the impact of resistant organisms in the efficient utilization of modern technological and scientific advances in improving human health through complex surgeries and transplantation procedures, and the inadequacy of rational prescription and administration of antimicrobial agents,

Further noting the tendency of communities to use antimicrobial agents as a panacea for all illnesses and the poor adherence to the recommended regimen,

Aware of the international implications of the problem of resistant organisms crossing national boundaries through travel, trade and foodchains, and

Recognizing the growing public health importance of antimicrobial resistance and its increasing impact on health systems,

1. **URGES Member States:**

   (1) to encourage the development of coordination mechanisms against antimicrobial resistance and establishment of appropriate governance mechanisms to combat antimicrobial resistance;

   (2) to establish national surveillance systems for monitoring of antimicrobial resistance, use of antimicrobial agents in humans and animals and their impact on human health and economy;

   (3) to effectively enforce the legislation and regulations that counteract the manufacture, sale and distribution of substandard antimicrobial agents and prohibit the unauthorized sale of antimicrobial agents;

   (4) to work with relevant government departments in discouraging the non-therapeutic use of antimicrobial agents in the veterinary and fishery sectors;

   (5) to emphasize educational programmes for health and veterinary students and professionals to comply with the rational use of antimicrobial agents, to improve practices to prevent the spread
of resistant pathogens, and to promote appropriate antimicrobial use in health-care facilities, in the community, and in animal feed production;

(6) to strengthen infection control programmes to control infectious diseases, especially in hospital settings, in order to contain hospital-acquired infections;

(7) to support operational research on behavioural aspects and interventions to contain the irrational use of antimicrobials, and laboratory and clinical research to understand the technical dimension of antimicrobial resistance;

(8) to initiate community-awareness campaigns to solicit people’s active cooperation in the rational use of antimicrobial agents; and

2. REQUESTS the Regional Director:

(1) to assist in the development of coordination mechanisms to establish and implement sustainable national policies and strategic frameworks for rational antimicrobial use in the health and veterinary sectors;

(2) to support development of national surveillance networks, especially laboratory capacity, for monitoring antimicrobial resistance and use of antimicrobials;

(3) to facilitate sharing of knowledge and information between countries and regions, and to document best practices in combating antimicrobial resistance;

(4) to develop generic technical and educational material that can be adapted by countries in monitoring resistance and educating health professionals and communities;

(5) to collaborate with nongovernmental organizations that are engaged in containing antimicrobial resistance and bring about a synergy in their actions for the benefit of the Region;

(6) to support capacity building in research on prevention and containment of antimicrobial resistance; and

(7) to compile and share evidence with Member States on the use of antimicrobial agents in animals and its impact on the emergence of antimicrobial resistance and on human health.
Regional Strategy on Universal Health Coverage

The Regional Committee,

Recalling World Health Assembly resolutions WHA58.14, WHA58.33, and WHA62.12, and its own resolutions SEA/RC48/R5, SEA/RC50/R3, SEA/RC53/R3 and SEA/RC56/R5, on sustainable health financing, alternative financing of health, universal coverage and social health insurance, and equity in health and access to health care,

Noting that the World Health Report 2010 will cover the issue of financing for universal coverage, and aware of the Health Financing Strategy for the Asia-Pacific Region (2010-2015),

Reaffirming the need to build sustainable national health systems, strengthen national capacities, and fully honour financing commitments made by governments and their development partners, in order to fill the resource gaps in the health sector and protect people’s health with sustainable health financing,

Concerned that the high level of out-of-pocket payment for health by households in Member States of the Region is one of the major sources of catastrophic health expenditure contributing to impoverishment,

Recognizing that irrespective of the sources of health-care finance, the basic principles in financial-risk protection are prepayment and pooling of resources and risks,

Acknowledging that a number of Member States in the Region are pursuing various health-financing reforms that involve a mix of approaches, including introduction and extension of social health insurance for formal and informal sector employees, extension of financial protection to the poor and vulnerable and community-based health financing schemes, and

Recognizing the important role of legislative and administrative measures in reforming health-financing systems with a view to achieving universal coverage,

1. URGES Member States:

   (1) to further enhance investment in national health systems through the extension of health-care delivery systems, with the focus on primary health care, and minimize the geographical and financial barriers in access to care by the population;
(2) to take steps to analyse health-care financing and service provision in order to identify gaps in achieving better financial-risk protection for the poor and the vulnerable, and extension of coverage to persons in the formal and informal sectors;

(3) to seek national consensus and mobilize social and political support as well as financial commitment towards achieving universal health coverage with sustainable health financing for the whole population;

(4) to strengthen national capacity to facilitate evidence-based policy formulation and system design for universal health coverage that is affordable and leads to equitable and efficient health systems; and

(5) to actively participate in the development of the South-East Asia Regional Strategy on Universal Health Coverage; and

2. REQUESTS the Regional Director:

(1) to continue to support the work of the Health Economics and Financing Observatory on national health financing and expenditure reviews for identifying strengths and gaps in achieving universal health coverage and compiling them into a regional report;

(2) to prepare a draft regional strategy on universal health coverage based on technical evidence and the context of Member States in the Region, and to convene regional consultations in order to finalize the regional strategy; and

(3) to submit the Regional Strategy on Universal Health Coverage to the Sixty-fourth Session of the Regional Committee in 2011 for its consideration.

SEA/RC63/R6 Capacity building of Member States in global health

The Regional Committee,

Recalling World Health Assembly resolution WHA59.26 on international trade and health, which urged Member States to create constructive and interactive relationships across the public and private sectors to promote coherence in national trade and health policies, and also requested WHO to
support Member States to build capacity to understand the implications of international trade and trade agreements for health,

Recognizing that mainstreaming health into public policies is vital and that health interventions should move beyond national policies and boundaries, and also that the active collaboration and sharing of experience among partners in global health development has become essential for the development of healthy public policies,

Noting United Nations General Assembly resolutions A/RES/63/33 and A/RES/64/108 that highlighted the close relationship between foreign policy and global health and encouraged Member States to consider health issues in the formulation of foreign policy and to increase their capacity for training of diplomats and health officials on global health and foreign policy by developing best practices and guidelines, open-source information, and educational and training resources,

Acknowledging the importance of building and strengthening the capacity of health and health-related professionals of Member States in global health, which can lead to better collaboration and more active participation among them in preparing common regional statements and regional policy and strategy, taking into account the interests and concerns of all Member States in the Region,

Further acknowledging the successful innovation of the South-East Asia regional “One Voice” at the World Health Assembly in the last few years, reflecting regional solidarity and perspectives as a result of full engagement by Member States of the Region and support from the Regional Office; and

Considering the report on capacity building of Member States in global health (Document SEA/RC63/25),

1. URGES Member States:

   (1) to establish policies and programmes for capacity building in global health of concerned staff who would be representing their respective governments at high-level policy and programme meetings, by strengthening their skills to actively contribute and participate in global health issues;

   (2) to organize, with the support of the Regional Office, regional training courses and capacity-building on global health on a rotational basis;

   (3) to support and facilitate, as far as possible, an adequate number of competent members of a delegation, preferrably those who attended
regional training courses and related capacity-building programmes on global health, to represent the national and regional views at all sessions of the World Health Assembly and at similar global policy meetings and forums; and

2. REQUESTS the Regional Director:

   (1) to provide support to Member States in organizing regional training courses and related capacity-building programmes on global health on a continuous basis;

   (2) to report to the Sixty-fifth Session of the Regional Committee in 2012 on the progress made in implementing this resolution; and


**SEA/RC63/R7 Regional Strategy on Health Information Systems**

The Regional Committee,

Recalling World Health Assembly resolutions WHA61.18 and WHA63.15 on monitoring of the achievement of the health-related Millennium Development Goals (MDGs), and its own resolution SEA/RC59/R10 endorsing the 10-point Regional Strategy for Strengthening Health Information Systems and urging Member States to use this strategic plan, the country action plan and the framework adopted by the Health Metrics Network (HMN) in the collection of data pertaining to MDGs and core health indicators, particularly disaggregated data, in order to track progress and measure achievements,

Noting the Call to Action of the Global Health Information Forum 2010, organized in Thailand, which endorsed the principles of developing health information systems including mobilizing resources and investing at least 5% of health resources in national health information systems with at least 2% allocated to building vital statistics systems, as well as scaling up investments in information systems needed to track the emerging epidemiological transition, fostering integration of data and intersectoral collaboration and data-sharing, and supporting the development of health information workforce through capacity-building measures,
Acknowledging that WHO, with other international and multilateral agencies, has made many efforts to support Member States to improve their national health information systems,

Recognizing that health information, including vital statistics, would enable national health systems to achieve the best possible health outcomes through evidence-based policy decisions, as well as a better return on investment,

Concerned that inadequate national capacity to strengthen national health information systems and the declining external support in relation to strengthening of health information systems are the major constraints in the implementation of the regional strategy for strengthening health information systems and the Call to Action of the Global Health Information Forum 2010, at both national and regional levels, and

Noting that in order to continuously improve national health information to serve national, regional and global requirements of monitoring the health system’s progress, an action plan with a clear target and a strong commitment in terms of investment, capacity building and system implementation is essential,

1. **URGES** Member States:
   
   (1) to further commit investment in health information systems and institutional capacity for health information systems with support from national resources, and to mobilize other sources of funds;
   
   (2) to accelerate implementation of plans or programmes on strengthening national health information systems using the framework stipulated in the Regional Strategy for Strengthening Health Information Systems;
   
   (3) to monitor the progress and evaluate achievement of health information systems strengthening and the institutional capacities on a regular basis, and conduct mid-course corrections where necessary; and

2. **REQUESTS** the Regional Director:
   
   (1) to support Member States in implementing the Regional Strategy for Strengthening Health Information Systems and to follow up progress;
   
   (2) to conduct a series of technical consultations in order to improve essential health information systems, such as vital registration, health behaviour surveys and information systems for chronic diseases;
(3) to mobilize resources from development partners and foundations to support health information systems strengthening and capacity building at the national and regional levels; and

(4) to report progress and results of the implementation to the Sixty-eighth Session of the Regional Committee in 2015.

SEA/RC63/R8 Resolution of thanks

The Regional Committee,

Having brought its Sixty-third Session to a successful conclusion,

1. THANKS His Excellency, the Right Honourable Mr Abhisit Vejjajiva, Prime Minister of the Royal Thai Government, for graciously inaugurating the session and for his thought-provoking speech;

2. THANKS the Director-General of the World Health Organization, Dr Margaret Chan, for her inspiring address and participation;

3. CONVEYS its gratitude to His Excellency, Mr Jurin Laksanawisit, Minister of Public Health, Royal Thai Government, the staff of the Ministry of Public Health and other national authorities of the Royal Thai Government;

4. FURTHER conveys its appreciation to the Honourable Health Ministers, other distinguished representatives and participants from United Nations agencies and other organizations; and

5. CONGRATULATES the WHO Regional Director for South-East Asia, Dr Samlee Plianbangchang, and his staff for their efforts towards the successful and smooth conduct of the session.
Decisions

SEA/RC63(1) Technical Discussions: Selection of a subject for the Technical Discussions to be held prior to the Sixty-fourth Session of the Regional Committee

The Committee decided on “Strengthening of the community-based health workforce in the context of revitalization of primary health care” as the subject for Technical Discussions to be held prior to the Sixty-fourth Session of the Regional Committee in 2011.

SEA/RC63(2) Nomination of a Member State to the Joint Coordinating Board (JCB) of the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases

The Committee nominated Nepal as member of the JCB for a period of four years effective 1 January 2011, and requested the Regional Director to inform WHO headquarters accordingly.

SEA/RC63(3) Nomination of a Member State to the Policy and Coordination Committee (PCC) of the UNDP/UNFPA/World Bank Special Programme of Research, Development and Research Training in Human Reproduction

The Committee nominated Bhutan as member of the PCC for a three-year term starting 1 January 2011, and requested the Regional Director to inform WHO headquarters accordingly.

SEA/RC63(4) Time and place of future sessions of the Regional Committee

The Committee decided to hold its Sixty-fourth Session in India from 6 to 9 September 2011.

The Committee also decided to hold its Sixty-fifth and Sixty-seventh sessions in Indonesia and Bangladesh in 2012 and 2014 respectively.
Annexes
Annex 1

Text of address by the Prime Minister of Thailand

Your Excellencies Ministers of Health from the South-East Asia Region, Your Excellency Dr Margaret Chan, Director-General of the World Health Organization, senior officials, ladies and gentlemen, I warmly welcome you to Thailand and to the Twenty-eighth Meeting of the Ministers of Health and the Sixty-third Session of the WHO Regional Committee for South-East Asia.

Health is a basic right of every citizen. It is the moral obligation and the responsibility of governments to ensure that all citizens have equitable access to quality health care so that they can contribute fully to the economic and social advancement of the nation. Of course, maintaining a healthy lifestyle is the best medicine that one can have, and prevention is always better than cure.

In the last forty years, Thailand has achieved significant progress in health development, especially in the reduction of maternal and child mortality, improved life expectancy, combating HIV/AIDS, and introducing and enforcing legislation against tobacco and alcohol. Thailand has also achieved all the Millennium Development Goals on health well before our 2015 commitment.

The attainment of health goals was possible for Thailand thanks to our three-pronged development policy, which I will call the “3 P’s”. First is primary health care, in which there has been extensive investment in health service infrastructure since the 1970s, focusing on primary health care at the subdistrict and district levels. These local health systems provide “close-to-client” services, which are better accessible by the rural poor. The district health systems, such as community medical centres, have proven to be the key strategic approach in progressing towards more equitable health care in Thailand. We are also in the process of upgrading our health care facilities through the use of ITC to link up with other resources.
Second is the issue of people and participation. Primary health care functions best when there are enough well-trained health workers. Here in Thailand, for many decades we have put in place mandatory rural services by all medical, nursing and other health-care graduates. Various other schemes were also launched, such as rural recruitment, hometown placement, as well as financial and non-financial incentives to ensure rural retention of medical personnel. This also led to the creation of ThaiHealth and the Provincial Health Assemblies, as part of the effort toward people's participation.

Third, is protection. Financial risk protection for health expenses ensures adequate access to health care. Low-income households and vulnerable populations have been the target groups for free medical care coverage since 1975, while private employees have been covered by social health insurance since 1990. All civil servants are covered by a government medical benefit scheme.

Ladies and gentlemen, Thailand takes pride in having achieved universal health coverage in 2002, which produced a pro-poor and more equitable policy outcome that corresponds with our goal to become a welfare society. The vibrant and continuous economic growth in Thailand has made possible a more generous health-care budget, and for this government, this is concomitant with the strong political commitment to human development.

Like all countries in the Region, Thailand is faced with many health challenges. For example, successive governments and civil society have for a long time worked on tobacco control. And there is still room for more introduction of tax-related measures, as price is one of the most effective interventions for bringing down tobacco consumption. Moreover, emerging and re-emerging infectious diseases across the globe still pose a great threat to human health. A recent example is last year’s H1N1 pandemic influenza, which has taught us the great lesson that we must always be on full alert. As Minister Jurin has mentioned earlier, urban growth is continuous, and therefore environmental health problems are becoming more intensified. We also face many new diseases as the world faces climate change. In times of natural disaster, providing quality and affordable health-care is a highly challenging task. Indeed, we have to be very strategic in our health policies, in both planning and implementation.

As part of our international commitment, Thailand will actively share and exchange its experiences and expertise with our friends in the Region. We will continue to render close cooperation to WHO on health issues, and jointly tackle new diseases before they attack. Thailand will continue to reach out to
Countries to together solve global, regional and transnational health risks and threats. This collaborative effort requires a strong and effective platform, and an active engagement with multiple stakeholders to ensure that health implications are considered thoroughly in all public policy dimensions.

I hope that this meeting will serve as one such platform. I wish you all fruitful and productive discussions, to ultimately bring about good health and solidarity in the South-East Asia Region. Thank you and Sawasdee Krub.
Prime Minister Abhisit Vejjajiva; Honorable Ministers from WHO’s South-East Asia Region; Dr Margaret Chan, the Director-General of the World Health Organization; Dr Samlee Plianbangchang, WHO Regional Director for South-East Asia; distinguished delegates; ladies and gentlemen: on behalf of the Ministry of Public Health, it is my privilege to welcome Your Excellencies, the Health Ministers from the WHO South-East Asia Region to the Twenty-eighth Meeting of Ministers of Health and the Sixty-third Session of the WHO Regional Committee for South-East Asia being held here in Bangkok.

Our warmest welcome is extended to Dr Margaret Chan, the Director-General of the World Health Organization, and Dr Samlee Plianbangchang, the Regional Director of the WHO South-east Asia Region. Your leadership towards global and regional health has been very well recognized and truly deserves our commendation.

The highlight of this year’s Health Minister’s Meeting is the adoption of Bangkok Declaration on Urbanization and Health. This issue is specifically relevant to countries in this region as unplanned and crowded urbanization would increase natural resources consumption and greatly impact the well-being of the people. It is expected that by the year 2030, 67% of the world population will live in urban areas. Currently in Thailand, the percentage of urban population is 36.11%. With this alarming figure, Thailand has promptly embraced the “One Thousand Cities One Thousand Lives” initiative launched by WHO early this year. Surprisingly, 51 municipalities have actively participated in the campaign. Two have already been selected to participate in the Global Forum on Urbanization and Health in Kobe, Japan this November, and 11 are awaiting further approval from WHO. Additionally, we have established
a national committee chaired by the Prime Minister, comprised of concerned ministries, to work on this issue in a multisectoral and integrated manner.

Excellencies, distinguished delegates, the Thai government does not only place our concern to the urban health, but we also give high priority to the people scattered in rural areas all over the country. In this regard, we have initiated many projects and policy to ensure the well-being of all Thai citizens:

First, we increased the Universal Health Coverage budget from 2401 baht per capita to 2546 baht per capita. This is to provide free medical care, which would cover expensive treatment such as for AIDS, hypertension, diabetes mellitus, cancer, heart disease, renal disease and mental health problems.

Second, we expanded the social health insurance benefits for over 8.7 million private sector employees in Thailand to include both dependent and spouse.

Third, to prevent the problems of diabetes, hypertension, cancer, paralysis and heart disease, which cost us nearly US$ 3 billion for treatment per year, we have launched a social campaign to change the behaviour of consuming high sugar, fatty and salty foods to promote fruit and vegetable consumption, and increasing exercise.

Fourth, to solve the iodine insufficiency problem, we will give iodine supplements to pregnant women and issue a regulation to enforce universal salt iodization. This will take effect by the first of October this year.

Fifth, for people in the rural areas, we are using four strategies to strengthen the community:

(1) Upgrading 10 000 health centres to subdistrict health promoting hospitals nationwide. This will be completed by 2011.

(2) Promoting the role of village health volunteers as a key driving force.

(3) Setting up community health plans as a guidance towards community self-care.

(4) Establishing a community health fund.

Those are the things that I would like to share among us, and I look forward to further discussion with your excellencies as we move along the meeting agenda for today and the next three days.
Excellencies, Distinguished Delegates, may I once again welcome you all to Thailand. We are very pleased that you have taken your time off from the busy schedules to be with us. Our secretariat team will be at your disposal throughout the meeting to make sure that you have a pleasant and memorable stay in Thailand.

Thank you.
Annex 3

Text of address by the Regional Director, WHO South-East Asia Region

Your Excellency Abhisit Vejjajiva, Prime Minister, the Royal Thai Government; Your Excellency Jurin Laksanawisit, Minister of Public Health, the Royal Thai Government; Honourable Ministers of Health of Member States of the WHO South-East Asia Region; distinguished country representatives; honourable guests; Dr Margaret Chan, Director-General, World Health Organization; ladies and gentlemen: It is my privilege on behalf of WHO to warmly welcome you all to the joint inauguration of the Twenty-eighth Meeting of Health Ministers and the Sixty-third Session of the WHO Regional Committee for South-East Asia.

At the outset, I would like to express my overwhelming thanks to the Royal Thai Government for hosting these two important meetings of the WHO South-East Asia Region. And I gratefully thank the Right Honorable Prime Minister, Abhisit Vejjajiva, for graciously accepting to inaugurate the joint opening.

Thailand, a Member State of WHO’s South-East Asia Region, has made remarkable progress in its national development during the past few decades. Among others, Thailand has already achieved various targets set forth in the United Nations Millennium Development Goals (MDGs). Thailand is among the global pioneers in implementing the primary health care (PHC) approach, which is the key to health for all people. In close collaboration with WHO, Thailand has developed a tool guide for furthering the work in community empowerment, which is the essence of PHC development. This guide is being shared with other Member States, both within and outside the Region.

Excellencies, overall, the SEA Region is on track towards the achievements of the MDGs by the year 2015. Over the past two decades, Member States achieved significant progress in reducing child mortality. However, in some
countries this achievement is lacking, particularly in the area of maternal mortality reduction. Weak health systems have been identified as the main bottleneck in this regard. Strengthening of health systems based on PHC is considered to be the key to the achievements of the health-related MDGs.

In this connection, a regional seminar on decentralization of health-care services delivery was held recently and was considered very important. It was evident during the seminar that a majority of countries in the Region had made commendable progress in ensuring access to health-care services for hard-to-reach population groups.

At the same time, excellent progress has been made in the Region in eliminating neglected tropical diseases — diseases that primarily affect the poor, the vulnerable and underprivileged populations.

On another front, the health of the urban poor is being given due attention in the Region. WHO is devoting intensified efforts to advocating for the application of PHC principles in urban settings. A regional meeting on this important topic has been planned for next month.

The health of our people in the Region is profoundly affected by the impact of climate change. To mobilize political commitment, WHO-SEARO will hold two important meetings in the coming October. We have organized a Regional Conference of Parliamentarians on Protecting Human Health from Climate Change, and a High-Level Preparatory Meeting for the Conference of Parties, or COP 16. Unless the impact on health from climate change is properly addressed with political commitment and political will, the high disease burden in the SEA Region will be further aggravated.

Excellencies, in conclusion, I wish the honourable ministers and distinguished representatives a conducive atmosphere in deliberating upon various agenda items of regional importance. And I also would like to express my sincere thanks to the local organizing committee for the excellent arrangements made for the meetings.

Thank you.
Annex 4

Agenda

1. Opening of the session

2. Subcommittee on Credentials:
   2.1 Appointment of the Subcommittee on Credentials
   2.2 Approval of the report of the Subcommittee on Credentials

3. Election of Office-bearers

4. Adoption of the Agenda

5. Introduction to the Regional Director’s Biennial Report on the Work of WHO in the South-East Asia Region covering the period January 2008 to December 2009

6. Address by the Director-General of the World Health Organization

7. Matters relating to Programme Development and Management:
   7.1 Programme Budget Performance Assessment: 2008-2009
   7.2 Implementation of workplans for Programme Budget 2010-2011
   7.3 Proposed Programme Budget 2012-2013 including implementation of the Regional Committee resolution SEA/RC62/R1 on “Programme Budget matters”

8. Technical Discussions:
   8.1 Consideration of the recommendations arising out of the Technical Discussions on “Injury Prevention and Safety Promotion”
   8.2 Selection of a subject for the Technical Discussions to be held prior to the Sixty-fourth Session of the Regional Committee
9. Strategic planning for development of human resources for health in the Region

10. Development of national health plans and strategies

11. Coordinated approach to prevention and control of acute diarrhoea and respiratory infections

12. Prevention and containment of antimicrobial resistance

13. Strategic framework on healthy ageing in the Region

14. Accelerating the achievement of MDG 5: Addressing inequity in maternal and neonatal health

15. Regional Strategy on Universal Health Coverage

16. Capacity building of Member States on global health

17. Regional Strategy on Health Information Systems

18. Governing Bodies:

18.1 Key issues and challenges arising out of the Sixty-third World Health Assembly and the 126th and 127th sessions of the WHO Executive Board

18.2 Review of the draft provisional agenda of the 128th session of the WHO Executive Board

19. Follow-up action on pending issues and selected Regional Committee resolutions/decisions of the last three years:

Follow-up action on pending issues

19.1 Collaboration within the UN system and with other international agencies and partnerships

Follow-up action on RC resolutions

19.2 Nutrition and food safety in the South-East Asia Region (SEA/RC60/R3)

19.3 South-East Asia regional efforts on measles elimination (SEA/RC62/R3) and addendum

19.4 Challenges in polio eradication (SEA/RC60/R8)

19.5 Scaling up prevention and control of chronic noncommunicable diseases in the South-East Asia Region (SEA/RC60/R4)
20. Special Programmes:

20.1 UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases: Joint Coordinating Board (JCB) – Report on attendance at JCB in 2010 and nomination of a member in place of Bhutan whose term expires on 31 December 2010

20.2 UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction: Policy and Coordination Committee (PCC) – Report on attendance at PCC in 2010 and nomination of a member in place of Indonesia whose term expires on 31 December 2010

21. Time and place of future sessions of the Regional Committee

Adoption of the report of the Sixty-third Session of the Regional Committee

Closure of the session
Annex 5
List of participants

1. Representatives, Alternates and Advisers

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Department of External Affairs
Ministry of Public Health

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Adviser  
Mr Joby Antony  
Second PA to Minister  
Ministry of Health and Family Welfare  
Government of India  

Indonesia  

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Senior Adviser to Minister on Decentralization  
Ministry of Health  

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Centre of International Health  
Ministry of Health  

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Director of Noncommunicable Diseases  
Directorate-General of Communicable Diseases Control and  
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Ms Mariyam Nazviya
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<tr>
<th>International Federation of Gynaecologists and Obstetricians (FIGO)</th>
<th>Lt Gen S Muttamara</th>
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<td>The Royal Thai College of Obstetricians and Gynaecologists</td>
<td>8th Floor, Royal Golden Jubilee Building</td>
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<th>Mr Mario Ottoglio</th>
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<th>Ms Cecilia Anselm</th>
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<th>Dr Muki Reksoprodjo</th>
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<th>International Life Sciences Institute (ILSI)</th>
<th>Mr Teoh Keng Ngee</th>
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<th>Dr Jetn Sirathranont</th>
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<td><em>International Union Against Cancer (UICC)</em></td>
<td>Ms Ranjit Kaur</td>
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<td><em>Medical Women’s International Association (MWIA)</em></td>
<td>Dr Pattariya Jarutat</td>
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<td><em>Soroptimist International (SI)</em></td>
<td>Ms Dawn Lynn Bowness</td>
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<td><em>World Association for Psychosocial Rehabilitation (WAPR)</em></td>
<td>Prof Pichet Udomratn, M.D.</td>
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<td><em>World Confederation for Physical Therapy (WCPT)</em></td>
<td>Dr Kanda Chaipinyo</td>
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<td>World Federation of Medical Education (WFME)</td>
<td>Prof Khunying Kobchitt Limpaphayom</td>
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<td>World Federation of Occupational Therapists (WFOT)</td>
<td>Ms Suchada Sakornsatian</td>
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<td>World Heart Federation (WHF)</td>
<td>Dr Ms Prinya Sakiyalak</td>
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<td>World Medical Association (WMA)</td>
<td>Dr Wonchat Subhachaturas</td>
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<td>World Self-Medication Industry (WSMI)</td>
<td>Ms Sunee Namsakulcharoendee</td>
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<td>World Vision (WV)</td>
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Annex 6
List of official documents

SEA/RC63/1 Rev. Agenda
SEA/RC63/4 and SEA/RC63/23 Matters relating to Programme Development and Management: Implementation of workplans for Programme Budget 2010-2011
SEA/RC63/5 Matters relating to Programme Development and Management: Proposed Programme Budget 2012-2013 including implementation of the Regional Committee resolution SEA/RC62/R1 on “Programme Budget matters”
SEA/RC63/6 Technical Discussions: Consideration of the recommendations arising out of the Technical Discussions on “Injury Prevention and Safety Promotion”
SEA/RC63/7 Technical Discussions: Selection of a subject for the Technical Discussions to be held prior to the Sixty-fourth Session of the Regional Committee
SEA/RC63/8 Strategic planning for development of human resources for health in the Region
SEA/RC63/9 Development of national health plans and strategies
SEA/RC63/10 Coordinated approach to prevention and control of acute diarrhoea and respiratory infections
SEA/RC63/11 Prevention and containment of antimicrobial resistance
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<td>Governing Bodies: Key issues and challenges arising out of the Sixty-third World Health Assembly and the 126th and 127th sessions of the WHO Executive Board</td>
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<td>Follow-up action on pending issues and selected Regional Committee resolutions/decisions of the last three years: Collaboration within the UN system and with other international agencies and partnerships</td>
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<td>SEA/RC63/18 and addendum</td>
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<td>SEA/RC63/20</td>
<td>Follow-up action on pending issues and selected Regional Committee resolutions/decisions of the last three years: Scaling up prevention and control of chronic noncommunicable diseases in the South-East Asia Region (SEA/RC60/R4)</td>
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<td>SEA/RC63/21</td>
<td>Special Programmes: UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases: Joint Coordinating Board (JCB) – Report on attendance at JCB in 2010 and nomination of a member in place of Bhutan whose term expires on 31 December 2010</td>
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<td>SEA/RC63/24</td>
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<td>SEA/RC63/Draft</td>
<td>Draft Report of the Sixty-Third Session of the WHO Regional Committee for South-East Asia</td>
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<td>SEA/RC63/31</td>
<td>Report of the Sixty-Third Session of the WHO Regional Committee for South-East Asia</td>
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Mr Chairman, distinguished representatives, WHO Director-General, ladies and gentlemen,

I have great pleasure in presenting my biennial report on the Work of WHO in the South-East Asia Region for the period 1 January 2008 to 31 December 2009.

The world passed through turbulent times during this period. The global community faced multiple crises on many fronts. Our health systems were challenged by an unprecedented economic downturn, climate change, the influenza pandemic and numerous natural calamities. Yet, substantial progress was made in promoting health and combating illnesses. This was due to exceptional national commitment, extraordinary international collaboration, and the firm resolve of countries to achieve national and international health targets, including the Millennium Development Goals (MDGs).

My report highlights these achievements and the remaining challenges during the biennium under review.

Mr Chairman, distinguished representatives,

Please allow me to share some of the salient features of the report. The H1N1 influenza pandemic swept the entire Region in a short time. Our preparedness against avian influenza helped us greatly in the immediate response to the pandemic. The sheer volume of cases overwhelmed our health-care facilities and laboratories. Antiviral drugs and vaccines were rapidly deployed. The pandemic was the first Public Health Emergency of International Concern after
the International Health Regulations (IHR) came into force in 2007. All Member States, with support from WHO, are building their core capacity to meet the obligations of IHR.

Mr Chairman,

The Region is making good progress towards MDG 6, which relates to communicable diseases. Tuberculosis (TB) prevalence rates in the Region have declined by nearly 50%, and mortality has been reduced by one third since 1990. Nearly 300,000 TB deaths were averted in 2009. Around 3% of newly diagnosed patients suffer from multi-drug-resistant TB, which represents 180,000 cases each year.

The HIV epidemic is on the decline. However, 3.5 million people in the Region are still living with HIV; around half of this number are coinfected with TB. Thailand reversed the HIV epidemic in the mid-1990s; HIV infections have declined in India, Myanmar and Nepal. At the same time however, in Indonesia, HIV is increasing, especially among injecting drug users. Overall, only 40% people living with HIV/AIDS receive antiretroviral treatment. However, this low coverage can certainly be improved since the Region has adequate drug manufacturing capacity.

Malaria remains a priority public health concern in the Region. All malaria-endemic countries have adopted the WHO Revised Regional Control Strategy. The number of malaria deaths in 2008 showed a decline of almost 30% compared with 2006. Resistance to artemisinin has emerged as an important challenge. Integrated vector management, particularly environmental management, needs more attention. This management approach can be effectively used to control other vector-borne diseases, such as dengue fever. Although there was an increase in the number of cases of dengue, the number of deaths declined. This trend reflected better case detection and case management.

Mr Chairman,

I am happy to report that the Region is making steady progress in eliminating several diseases of public health importance. We are approaching the goal of polio eradication. India remained the only polio-endemic country in the Region. However, the number of affected districts was reduced by one third, compared with 2008. With the exception of one country, the leprosy elimination target has been achieved by all Member States of the Region.

The kala-azar elimination programme has been expanded in Bangladesh, India and Nepal. Lymphatic filariasis and kala-azar are targeted for elimination
by 2015. India declared elimination of Yaws in 2006 and is aiming for its ultimate eradication. Indonesia reports cases of Yaws from 18 out of the 33 provinces. The Yaws elimination programme in Indonesia is in place, and the country is striving to eliminate the disease by 2015. In Timor-Leste, Yaws is endemic in 6 of the 13 districts; an integrated approach has been planned for its eradication. Diarrhoea and pneumonia continue to cause enormous child mortality and morbidity. The Regional Strategic Framework to combat diarrhoea and respiratory infections has been implemented.

Mr Chairman,

Diseases originating from animals have assumed increasing importance. Almost 75% of new human pathogens can be traced to animals. A regional strategy for zoonoses control has been developed to promote intercountry collaboration and mobilization of resources.

The problem of antimicrobial resistance is growing rapidly. It reflects failure of policies on drug quality, rational use of medicines, infection control, surveillance and community education. Efforts are being intensified for combating antimicrobial resistance, especially through advocating multisectoral alliances at country level. “Antimicrobial resistance” will be the theme of the World Health Day next year.

Mr Chairman,

The epidemiological profile of diseases is changing rapidly. We are witnessing an increasing burden of noncommunicable diseases (NCDs). Cardiovascular diseases, cancer, chronic lung diseases and diabetes account for 54% of all deaths in the Region. These diseases also significantly affect the poor who are the least able to cope with the problems physically and financially. It is therefore essential to build national capacity for the integrated prevention and control of NCDs with emphasis on primary prevention.

Significant progress was achieved in surveillance of tobacco use. Global Adult Tobacco Surveys were completed in Bangladesh and Thailand. As far as accidents and injuries are concerned, the rapid expansion of roadways and traffic have led to their increasing trends. WHO continues to advocate for sustained political and financial commitment at all levels for injury prevention. The Organization organized the Asia-Pacific Congress on Rehabilitation in 2009, to highlight innovative approaches to the rehabilitation of the disabled, and to ensure their equal participation in society. In this connection, there is a need to call for revisiting “Community-based Rehabilitation (CBR)”.
Mr Chairman,

The year 2008 marked the thirtieth anniversary of the Alma-Ata Declaration on Primary Health Care (PHC). Commitment to the principles of primary health care in the context of changing health needs was reaffirmed by Member States at a regional conference. The Conference called for a shift in focus of PHC from mainly service delivery to a multisectoral development approach. Effective community education and empowerment are considered indispensable for successful health promotion and disease prevention within the context of PHC.

Accordingly, a regional strategy for health promotion was developed with emphasis on education and empowerment of people. In addition, meetings on Self-care, Use of Herbal Medicines, and Health Care Reforms, were organized to support PHC development.

Mr Chairman,

In 2015, we will be called upon to give an account of our achievements in health-related MDGs. In order to closely monitor our progress, a Task Force was established at the Regional Office. The regional situation with regard to MDGs 4 and 5, which relate to child mortality and maternal health, is a cause for concern. At the current rate of progress, some countries may not be able to reach the MDG 5 target relating to maternal mortality reduction. Lack of comprehensive maternal and newborn health care continues to be a major issue.

However, four Member States have achieved universal coverage for skilled care at birth. Sociocultural factors that play an important role in maternal and newborn health have received due attention. WHO supported countries to improve the quality of training on maternal and neonatal health services, and reproductive health. The training pays particular attention to community-based health workers and community health volunteers.

A regional framework for implementing the reproductive health strategy was developed. Concerning adolescents, this group of population in the Region constitutes about 25% of the total. Adolescent pregnancy is recognized as a contributing factor to high maternal and neonatal mortality. Member States have adopted a strategic framework to strengthen response to the health needs of adolescents. In collaboration with UNICEF, a regional strategy on early childhood development was formulated and shared with Member States.

Mr Chairman,

Vaccines are the most cost-effective interventions to prevent diseases. We need to sustain the high immunization coverage in order to reduce child
mortality and the overall burden of disease. The implementation of regional strategic framework for improving and sustaining immunization coverage has been supported. To ensure quality of vaccines, particular attention was paid to the strengthening of national regulatory capacity. Ten Member States have established National Advisory Committees for immunization practices. Support received from GAVI was utilized to strengthen health systems in Member States for improving immunization services.

Mr Chairman,

Awareness and knowledge about safe drinking water was promoted through training and provision of guidelines. Enhanced efforts were devoted to strengthening of drinking water quality standards and monitoring of their compliance.

Mr Chairman,

Demographic transition has resulted in an increase in the number of old-age people in the Region. By 2050, in over half the Member States, 20% or more of their populations will be 60 years of age or older. A regional consultation on strategic framework for promoting active and healthy ageing generated innovative ideas, which were shared among Member States.

Mr Chairman,

There is compelling evidence to show that the effects of climate change on health have been seriously underestimated. Climate change is the price we are paying for the economy-driven policies that ignored the planet’s ecosystem. WHO has produced a range of advocacy materials to raise public awareness on this critical issue. Generic research protocols have been developed to assess the impact of climate change on several aspects of health. Technical support for response to the impact of climate change on food production and consumption was provided to a number of countries.

With regard to occupational health, country capacity to implement the Global Strategy for Occupational Health for All and the Global Plan of Action for Workers’ Health were assessed in all countries.

Mr Chairman,

Several natural disasters struck the Region during the biennium. WHO responded rapidly in supporting Member States in their efforts to tackle the events, such as:

- Cyclone Nargis in Myanmar;
the post-conflict humanitarian situation in Sri Lanka; and
- a major earthquake in Indonesia.

Support was also provided through the South-East Asia Regional Health Emergency Fund established in 2007. The South-East Asia Disaster Health Information Network was formed through WHO facilitation. The network aims to improve proper collection, archiving and retrieval of information on disasters and health.

Mr Chairman,

Medicines are an essential component of health-care systems. Their management requires regulation, selection, procurement, supply and rational use. With WHO support, eight countries participated in the International Conference of Drug Regulatory Authorities. Regional meetings were organized on medicine pricing, the patent pool, and pharmacovigilance. Essential Medicines Lists were updated in six countries. Herbal medicines are widely used in the Region, and their use was further promoted through regional meetings and information dissemination. In order to develop evidence-based information on quality, safety and efficacy of herbal medicines, mechanisms for information exchange and inter-institutional cooperation were promoted.

Mr Chairman,

Several activities were undertaken in the Region to improve the quality of the health workforce. WHO supported the development and dissemination of:
- regional guidelines on health workforce strategic planning;
- guidelines on accreditation of medical schools and health laboratories;
- a tool guide for continuing medical education; and
- guidelines on teaching medical ethics at undergraduate level.

A regional meeting was held on the subject of teaching of public health at undergraduate level in medical schools. Training in national health accounts, and training on economic principles for health policy development, and programme planning were organized.

Mr Chairman, distinguished representatives,

The ultimate goal of WHO collaboration with Member States continues to be the strengthening of country capacity towards self-reliance and long-
term sustainable development in health. The Country Cooperation Strategy (CCS) is the key instrument for WHO to achieve this goal. This strategy was finalized during the review period for Bangladesh, Myanmar, Thailand and Timor-Leste.

During the biennium, WHO resources were further decentralized down to the country level. Involvement of nationals in the implementation of WHO collaborative programmes was augmented. WHO provided substantial support to Member States to mobilize resources from the Global Fund over the last nine rounds.

I am happy to report that our collective efforts have so far resulted in an allocation of US$ 3.7 billion for the Region from the Global Fund. This is in addition to the inflow of resources from many other sources of Voluntary Contribution (VC). During the biennium, WHO in the SEA Region, fully implemented its Assessed Contribution (AC) of US$ 102.9 million, and expended another US$ 260.3 million from VC. Preparations were made during the biennium under review for the rollout of the Global Management System (GSM) to increase the efficiency of the work of WHO by ensuring effective functioning of its corporate management.

Mr Chairman, distinguished representatives,

The SEA Region has seen unprecedented economic growth in recent years, despite the global economic instability. The challenge is to ensure that adequate resources are made available for health development, with an equitable balance in the allocation between preventive and curative care.

Mr Chairman,

I would like to conclude my remarks by acknowledging the more effective collaboration that took place between WHO and its Member States in the SEA Region during the biennium. We are now better prepared and better coordinated in our endeavours to improve health.

Our collaborative programmes will, I am confident, continue to pay rich dividends among countries. We now need to maintain our unwavering commitment and to further accelerate our efforts towards the achievement of the cherished goal of better health for all people in the SEA Region.

Thank you.
Excellencies, honourable ministers, distinguished guests, Dr Samlee, ladies and gentlemen, let me thank the government of Thailand for hosting this Twenty-eighth Health Ministers Meeting and the Sixty-third Session of the Regional Committee for South-East Asia. This is a fitting venue.

Thailand is well known for its achievements in public health. Let me mention just a few: a strong commitment by the government to primary health care, an innovative scheme for moving towards universal health coverage, and pioneering efforts to improve access to essential medicines.

Thailand, together with Sri Lanka, has achieved nearly universal coverage with skilled attendants at childbirth, with very little difference between rich and poor women.

These are laudable achievements. In fact, this Region as a whole is leading the worldwide effort to ensure appropriate and affordable medicines for the long-term management of chronic diseases, including diabetes.

During this joint session, you will be discussing urbanization. This was the theme for this year’s World Health Day, and it generated a great deal of attention and debate, also in the media.

Clearly, urban health matters. Clearly, this is an issue worthy of your high-level attention.

For the first time in history, more people are now living in urban settings than in rural areas. By the year 2030, an estimated six out of every ten people will be living in towns or cities, with the most explosive growth expected in Asia and Africa.
Cities concentrate people, opportunities, and services, including those for health and education. But cities also concentrate risks and hazards for health.

The examples are numerous: contamination of the food or water supply, high levels of air or noise pollution, a chemical spill, a disease outbreak, or a natural disaster.

Cities also tend to promote unhealthy lifestyles. These lifestyles are directly linked to obesity and the rise of chronic conditions, and these conditions are increasingly concentrated in the urban poor.

Urban poverty and squalor are strongly linked to social unrest, mental disorders, crime, violence, and outbreaks of disease associated with crowding and filth.

Let me also acknowledge the solidarity of this Region in responding to the influenza pandemic. Since 2006, WHO has supported the accelerated development and production of influenza vaccines in 11 low-and middle-income countries. Thailand participated in technology transfer by conducting clinical trials of pandemic vaccine and following up with rigorous safety assessments.

Ladies and gentlemen,

On 10 August, I announced that the world was no longer in phase 6 of influenza pandemic alert. Epidemiological data from around the world indicated that the new H1N1 virus had largely run its course. As I stressed at the time, the decision to declare the pandemic over was based on a global assessment.

In the current post-pandemic period, we expect to see localized outbreaks of different magnitudes, and some “hot spots” will continue to show high levels of H1N1 transmission. This pattern is indeed being seen in a few parts of the world, including here in South-East Asia.

Let me remind you: the pandemic virus has not gone away. Based on experience with past pandemics, we expect the H1N1 virus to take on the behaviour of a seasonal influenza virus and continue to circulate for some years to come.

In the immediate post-pandemic period, the virus is likely to continue to cause serious illness in the younger age group. Protecting high-risk groups and maintaining vigilance are recommended actions.
Some countries are continuing to protect at-risk groups with pandemic vaccine, and this policy is fully in line with WHO recommendations.

In fact, the actions of health authorities in India, in terms of vigilance, quick detection and treatment and recommended vaccination, provide a good model of how other countries may need to respond in the immediate post-pandemic period.

I thank all countries in this Region for their responsiveness during the pandemic and wish this Regional Committee a most productive session.

Thank you.
WHO Regional Committee
for South-East Asia

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