WHO Regional Committee for South-East Asia

Report of the Sixty-fifth Session

Yogyakarta, Indonesia, 5–7 September 2012
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1. The Sixty-fifth Session of the WHO Regional Committee for South-East Asia was held in Yogyakarta, Indonesia, from 5 to 7 September 2012. It was attended by the representatives of all 11 Member States of the Region, United Nations and other agencies, nongovernmental organizations having official relations with WHO, as well as Observers.

2. The joint inauguration of the Sixty-fifth Session of the Regional Committee and the Thirtieth Meeting of Ministers of Health of Countries of the South-East Asia Region was held on 4 September 2012. The Governor of Yogyakarta Special Region, Sri Sultan Hamengkubuwono X, gave the welcome address. Her Excellency Dr Nafsiah Mboi, M.Ped., MPH, Minister for Health, Republic of Indonesia, delivered the inaugural address. The Vice President, Republic of Indonesia, His Excellency Professor Dr Boediono, opened the conference after his keynote speech.
3. The Committee elected H.E. Dr Nafsiah Mboi, Minister for Health, Republic of Indonesia, as Chair, and H.E. Dr Ahmed Jamsheed Mohamed, Minister for Health, Republic of Maldives, as Vice-Chair of the session.

4. The Committee reviewed the Report of the Regional Director covering the period 1 January 2010 to 31 December 2011.

5. The Committee decided to hold its Sixty-sixth session in 2013 in the WHO Regional Office for South-East Asia, New Delhi.

6. A drafting group on resolutions comprising a representative from each of the Member States was constituted with Thailand as Convener. During the session, the Regional Committee adopted nine resolutions and took three decisions.
7. The joint inauguration of the Thirtieth Meeting of Ministers of Health of Countries of the WHO South-East Asia Region and the Sixty-fifth Session of the WHO Regional Committee for South-East Asia was held in Yogyakarta, Indonesia, on 4 September 2012.

8. In his welcome address, His Excellency Sri Sultan Hamengkubuwono X, Governor of Yogyakarta Special Region, warmly welcomed representatives of the Member States of the WHO South-East Asia Region to Yogyakarta. His Excellency said that he hoped for fruitful discussions that would produce beneficial results and commitments in health development at both national and regional levels. The Honourable Governor felt that the meeting agenda had well-selected topics that would play an important role in improving the health of the people of the Region.

9. Her Excellency Dr Nafsiah Mboi, Minister for Health, Republic of Indonesia, welcomed the distinguished delegates and conveyed gratitude to His Excellency Professor Dr Boediono, Vice President, Republic of Indonesia, on behalf of all participants for gracing the joint inaugural session with his presence. Her Excellency also extended a warm welcome to Dr Margaret Chan, Director-General, World Health Organization, Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region, and His Excellency Sri Sultan Hamengkubuwono X, Governor of Yogyakarta Special Region. (For the full text of the address, see Annex 2.)
10. The Health Minister termed this year’s World Health Day theme “Ageing and Health” significant in view of the increasing population of elderly persons in the Member States of the Region that necessitated a revamp of health care and social support systems. Her Excellency encouraged the ministers of health to adopt the Yogyakarta Declaration on Ageing and Health, which calls upon governments to commit to building partnerships among various stakeholders at the national, regional and global levels.

11. In conclusion, Her Excellency said that she earnestly hoped that selecting Yogyakarta as the venue of these meetings would contribute to the successful outcome of the deliberations. *(For the full text of the address, see Annex 2.)*

12. Dr Samlee Plianbangchang, WHO Regional Director, South-East Asia Region, welcomed the Ministers of Health and representatives of Member States. The Regional Director commended the achievements of the Government of Indonesia for making impressive progress in increasing access to health care for its population, despite major challenges being faced by the countries of South-East Asia Region. He attributed this progress to the various health insurance schemes covering 63% of the country’s population.

13. The Regional Director noted with appreciation that routine immunization in Member States had been successfully intensified to achieve the desired coverage of 90% or more. He further noted that the WHO South-East Asia Region was expected to attain polio-free status in January 2014.
14. The Regional Director stressed the need to build a strong health system based on the primary health care approach with a balance between preventive and curative care. He also called for mobilization of multisectoral partnerships.

15. Thanking the organizers of the host country for the excellent arrangements, he conveyed his greetings and best wishes to the distinguished participants for successful and fruitful meetings. (For the full text of the address, see Annex 3.)

16. In her inaugural speech, Dr Margaret Chan, WHO Director-General, thanked the Government of Indonesia for its generosity in hosting the meetings. She emphasized that the Indonesian Government was “delivering on its promises”, such as by providing free health care to pregnant women.

17. Dr Chan noted some key achievements in Indonesia, which were important for the South-East Asia Region as a whole, including strengthening surveillance for avian influenza, and capacity building for the International Health Regulations 2005. She spoke of the establishment, following the 2004 tsunami and earthquake, of the Centre for Health Crisis in Jakarta, which is now the WHO Collaborating Centre for Disaster Risk Reduction and has an important role in transferring best practices to countries in the Region.
18. The Director-General asked how WHO could support Member States in achieving their Millennium Development Goal targets. She noted too the importance of health in the post-2015 development agenda and concluded by wishing the representatives a constructive meeting. *(For the full text of the address, see Annex 8.)*

19. His Excellency Professor Dr Boediono, Vice President, Republic of Indonesia, jointly inaugurated the Thirtieth Meeting of Ministers of Health and the Sixty-fifth Session of the WHO Regional Committee for South-East Asia and extended a warm welcome to the ministers of health, the Director-General, the Regional Director, the Governor of Yogyakarta and the distinguished representatives.

20. His Excellency congratulated Dr Chan for her re-election to a second term in office. Recalling the statement of the President of Indonesia that global development collaboration should be based on the foundation of common but differentiated responsibilities and open participation of all stakeholders, he said that this cooperation must be aimed at empowering the poor in developing countries, and upholding the principles of proportionally shared responsibility and mutual benefits.

21. Noting that the World Health Day theme of 2012 of “Ageing and Health” was very relevant in view of the increasing number of elderly in the South-East Asia Region, he stressed the need to strengthen national
and regional policies on ageing and health and to ensure sufficient resources for the programme.

22. The Vice President reiterated the strong commitment of Indonesia to complete universal health coverage by 2019, considering its importance in ensuring the social and economic well-being of the population.

23. Recalling that Indonesia had pledged to fully implement the International Health Regulations (IHR) 2005, the Vice President urged all Member States in the South-East Asia Region to ensure their implementation.

24. The Vice President pointed out that his country was facing the double burden of communicable diseases coupled with rising trends in morbidities and mortalities in noncommunicable diseases (NCDs). He called upon all Member States of the Region to work together to cope with the alarming situation.

25. In conclusion, His Excellency conveyed his greetings and best wishes for the successful deliberations and fruitful outcomes of the meetings. (For the full text of the address, see Annex 1.)
Opening of the session (Agenda item 1)

26. The Sixty-fifth Session of the WHO Regional Committee for South-East Asia was opened by the Vice-Chair of the Sixty-fourth session, His Excellency Professor Dr Pe Thet Khin, Union Minister for Health, Republic of the Union of Myanmar, in the absence of the Chair of the Sixty-fourth session of the Regional Committee. His Excellency acknowledged the role of the Regional Committee in assisting Member States to address the formidable challenges facing the health sector in the Region through enhanced collaboration among Member countries. He commended WHO’s immense contribution to fighting the spread of communicable and noncommunicable diseases in the Region.

Appointment of the Subcommittee on Credentials
(Agenda item 1.1)

27. A Subcommittee on Credentials, comprising representatives from Bhutan, Democratic People’s Republic of Korea and Maldives, was appointed.

Approval of the report of the Subcommittee on Credentials
(Agenda item 1.2)

28. The Subcommittee nominated the distinguished representative for Bhutan as its chairperson and examined the credentials submitted by the Member States. The credentials submitted by the 11 Member
States, viz., Bangladesh, Bhutan, Democratic People’s Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste 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 1.3)*

29. Her Excellency Dr Nafsiah Mboi, Minister for Health, Republic of Indonesia, was elected Chair of the Regional Committee, and His Excellency Dr Ahmed Jamsheed Mohamed, Minister for Health, Republic of Maldives, was elected Vice-Chair. Dr Nafsiah Mboi thanked the representatives for the honour of electing her as the Chair of the Regional Committee. Recalling that it was the eighth Regional Committee hosted by Indonesia, she noted that this Regional Committee session would be taking up several key regional and global issues, and hoped that with the support and cooperation of all, the Committee would be able to transact its business and accomplish the agenda in a meaningful manner. The Honourable Minister for Health was hopeful that the meeting would provide a platform for the sharing of perspectives, ideas and initiatives to give a clear direction to the health agenda in meeting the aspirations of the people of the Region. Her Excellency acknowledged the support of the Director-General, the Regional Director and the WHO Secretariat in strengthening such efforts.
Adoption of the agenda (Agenda item 1.4: Document number SEA/RC65/1 Rev.2)

30. The Committee proposed that Agenda item 6.3 (Process for Nomination of the Regional Director) be brought forward for discussion immediately following Agenda item 2.2 (Address by the Director-General of the World Health Organization). The Provisional Programme was changed to reflect this request.

Drafting group on Resolutions

31. A drafting group on resolutions comprising a representative from each of the Member States was constituted with Thailand as Convener.

Key addresses and report on the work of WHO (Agenda Item 2)

Introduction to the Regional Director’s Biennial Report on the Work of WHO in the South-East Asia Region covering the period 1 January 2010–31 December 2011 (Agenda item 2.1: Document number SEA/RC65/2 and Inf.Doc)

32. Introducing his report for the period 1 January 2010 to 31 December 2011 the Regional Director said that with WHO’s supportive contributions, Member States of the South-East Asia Region had intensified their efforts to reduce the burden of communicable diseases. The Year 2012 has been declared by Health Ministers as the “Year of Intensification of Routine Immunization in the South-East Asia Region”. WHO worked closely with Member States in reviewing and further strengthening national immunization programmes.

33. Significant progress had been made in improving the coverage of diphtheria–pertussis–tetanus vaccine (DPT3) to reach 77%, with 90% or more in seven countries. Considerable progress had been made in improving the coverage of measles immunization, especially in India and Indonesia. Some countries were soon expected to reach the measles elimination target of 95%.

34. There had been no new cases of wild poliovirus infection in India since January 2011. The Regional Director said that if acute flaccid paralysis (AFP) surveillance remains strong and there are no further new cases of wild poliovirus, the South-East Asia Region is expected to be declared polio-free in January 2014.
35. With regard to neglected tropical diseases, all countries had achieved the leprosy elimination target with prevalence rate of less than 1 per 10,000 population. As the endemiaity of leprosy still prevails, especially in remote areas, efforts to reduce the disease burden need to be maintained.

36. Lymphatic filariasis continued to affect populations of many countries of the South-East Asia Region. With the intensification of mass drug administration in recent years, the Region was expected to reach the elimination target of reducing the microfilaria rate to less than 1% of the population at risk by 2020. In disease control, surveillance systems had been further strengthened, and WHO’s technical support had been enhanced through training staff and developing standard surveillance procedures.

37. As no country in the South-East Asia Region had achieved all core capacities required for effective implementation of the International Health Regulations (IHR) 2005, WHO had re-doubled its efforts during this period to strengthen and support Member States to ensure such capacities are in place by the extended deadline of June 2014.

38. All Member States have national plans in place for influenza pandemic preparedness and response, and WHO had been providing
support in strengthening alert and response capacities for possible outbreaks of emerging infectious diseases.

39. Over the past two decades, overall tuberculosis (TB) prevalence in the Region had decreased by almost 40%, although multidrug-resistant (MDR) TB remains a serious concern due to inadequate management of control programmes. More sophisticated laboratories and more expensive drugs are needed for the treatment of the 100 000 MDR-TB patients. TB coinfection with HIV remains another concern, with 1.1 million such patients in the Region.

40. In 2010 the Region had 3.5 million people living with HIV/AIDS and 210 000 new cases of HIV infection. While there had been an overall decline in new HIV infections in all Member States – especially among female sex workers – high transmission continued to be recorded among injecting drug-users, men having sex with men and transgenders. Antiretroviral treatment (ART) of advanced HIV infections had increased from 5% in 2003 to 34% in 2010. Member States had also been supported in efforts to prevent mother-to-child transmission of HIV. With two of every three pregnant women living with HIV not having access to ART, a large number of children were born with HIV.

41. Considerable progress had also been made in malaria control. Malaria in high-risk populations was reduced from 30 per 1000 population in 2005 to 22 per 1000 in 2010 largely due to insecticide-treated bednets, rapid diagnostic tests and artemisinin-based treatment.

42. Noncommunicable diseases (NCDs) now accounted for more than half of all annual deaths in the Region. A ministry of health-based coordination mechanism for NCDs had been established, and seven Member States had developed a multisectoral strategy for NCD prevention and control. The Regional Meeting on Health and Development Challenges of Noncommunicable Diseases in Jakarta, Indonesia, in 2011, issued a comprehensive Call for Action.

43. All Member States were increasingly paying more attention to control the use of tobacco products through designation of smoke-free areas, promotion of cessation programmes, and promotion of awareness. Several countries had also initiated actions to reduce harm from use of alcohol, drugs and other psychotropic substances.
44. Considerable achievements had been made with regard to Millennium Development Goals 4 and 5 on infant and maternal mortality, with the United Nations Secretary-General honouring Nepal and Bangladesh in September 2010 with a special award for significantly reducing their maternal mortality rate and under-five mortality rate, respectively.

45. Of the Member States where the maternal mortality ratio was greater than 100 in 1990, three had achieved the target of 75% reduction; and the Region is on track to reduce the under-five mortality rate by two thirds by 2015.

46. WHO is assisting countries in training of skilled birth attendants, preventing unplanned pregnancies and improving family planning services.

47. Promoting “active and healthy ageing” has become increasingly important with the increased life expectancy in the Region. WHO is supporting Member States in developing multisectoral strategies for promoting healthy ageing.

48. In addition to technical support from WHO, financial support was provided from the SEA Region Health Emergency Fund (SEARHEF) for immediate relief in a number of humanitarian emergencies in Member States. WHO is also collaborating with Member States to build capacity for effective preparedness and response, including safe health facilities during emergencies, and a framework to build up community resilience through the primary health care approach.

49. All Member States are in the process of reviewing their health strategies to improve universal health coverage as well as to tackle health inequity, especially between genders. Healthy environments were promoted through healthy workplaces.

50. The Regional Director observed that although the Region had achieved 90% coverage of safe drinking-water, much remains to be done in the area of sanitation, where the coverage is only 44%.

51. Undernutrition and micronutrient deficiencies, diet-related diseases, and infant and child nutrition demand continued attention. A framework for promoting safe street food was developed at a regional consultation in 2011, and the Region showed increased participation in
Codex Alimentarius and the International Food Safety Authorities Network (INFOSAN).

52. WHO’s support in strengthening country capacities within their national health systems had resulted in increasing the availability and accessibility of quality and essential medicines. The Regional Director lauded the significant progress that had been made by Member States in improving their health infrastructures and health systems performance. He also reiterated that WHO was committed to collaborating with Member States in developing and implementing their programmes to overcome the evolving health challenges.

53. WHO in the South-East Asia Region remained fully committed to taking ahead the initiatives of the Reform Agenda of the Director-General. (For the full text of the Regional Director’s introductory remarks see Annex 7.)

**Address by the Director-General of the World Health Organization**

*(Agenda item 2.2)*

54. The Director-General began her address by congratulating India for providing definitive proof that polio eradication was technically feasible. She stated that India’s success had proved that the poliovirus was not permanently entrenched. It was not destined to remain a perpetual threat
to each new generation of children. It could, indeed, be driven out of existence. “The Indian Government succeeded because of its passionate engagement in a mission to protect its people from a vicious disease,” Dr Chan said.

55. The most critical factor for success was ownership of the programme, from the local to the national level. The Government of India owned this programme, operating as the principal source of staff and funds. The other lessons learnt included the importance of tight-knit partnerships, constant innovation, and a relentless drive to improve quality and accountability.

56. The Director-General congratulated the Region on the Draft Strategy for Universal Health Coverage.

57. Dr Chan reminded the representatives that the South-East Asia Region has millions of low-income households living on the margins of survival. She stated that just paying for medicines could push them deeper into the abyss of abject poverty. The costs of care could cause patients to delay seeking treatment until the disease or condition became much more difficult and costly to treat, if treatment was still possible and available. This was an extreme example of waste and inefficiency.
58. The Director-General said that universal health coverage upholds the core values of solidarity, social cohesion and human security. Above all, universal health coverage is a powerful social equalizer that helps correct gaps in health outcomes that had been growing, almost unchecked, for decades. But market forces would never solve social problems all by themselves. This would happen only when equity is an explicit policy objective, as set out in the draft strategy.

59. Dr Chan said that universal health coverage stresses equity in entitlement to services and gives a prominent role to compulsory or public funding to ensure social protection. Based on their disease profile and epidemiology, countries must take leadership and ownership to decide what is important.

60. The target date for reaching the Millennium Development Goals (MDGs) is fast approaching. Debates about the next generation of internationally agreed development goals were already under way. As with the MDGs, international goals shape the political agenda and attract resources.

61. Dr Chan added that health is a precondition for development. It is a powerful driver of socioeconomic progress. The process for sustainable development goals had started. She exhorted the countries to ensure that their inputs are accommodated in the goals, in order to ensure that their health priorities are appropriately reflected.

62. The MDGs had been a powerful force in focusing implementation efforts and maintaining political support for development. They had been good for public health. Pursuit of the MDGs had left a legacy of innovations, including: the GAVI Alliance (Global Alliance for Vaccines and Immunisation); the Global Fund to Fight AIDS; Tuberculosis and Malaria; UNITAID; the International Health Partnership Plus; and numerous other global health initiatives focused on individual diseases. The need for accountability is just one of the many lessons that were part of the MDG legacy.

63. The Director-General noted that most donors now appreciated the need to channel aid for health development in ways that build capacities in countries and move countries towards self-reliance. “This is the best exit strategy for aid,” she said. Developing countries do not want charity, they want capacity. Given the success of the MDGs, most agreed that the post-2015 agenda should likewise focus on a limited number of measurable goals.
64. Some of today’s threats include a changing climate, more emergencies at the global level, disasters, soaring health care costs, soaring food prices, demographic ageing, rapid and unplanned urbanization and the globalization of unhealthy lifestyles. Dr Chan emphasized that one of the best ways to respond to these challenges is to make universal health coverage a part of the post-2015 development agenda.

65. In her closing remarks, the Director-General mentioned the case of the Australian High Court upholding legislation mandating plain packaging, with no branding, for tobacco products. The legislation had been aggressively challenged by several large tobacco companies. The court ruling was not only a huge victory for the Australian government, but also for public health, opening a “brave new world” for tobacco control. The Director-General quoted Australia’s Attorney-General Nicola Roxon: “The message to the rest of the world is that big tobacco can be taken on and beaten.” *(For the full text of the address, see Annex 8.)*

66. The Committee gave positive responses to the speeches of the Regional Director and the Director-General. Commending the Regional Director for his comprehensive report, the Committee noted that the report provided a comprehensive and excellent update on some of the notable and remarkable achievements made by the Member States of the Region, especially the momentous success achieved by India in polio eradication. The Committee also congratulated the Director-General for her thought-provoking and inspiring address.

67. Success achieved in areas of core capacity-building for IHR 2005, early and rapid treatment of malaria, child and maternal mortality, disease preparedness, and drinking-water and sanitation was noted by the Committee. It also acknowledged the challenges and hindrances faced by countries in areas such as vaccine production, climate and health interface, short absorptive capacity for utilization of aid from the Global Fund to Fight AIDS, Tuberculosis and Malaria, nutritional deficiency, lack of access to quality drugs, absence of a mechanism for bulk purchase of essential drugs and medicines for countries with small populations such as Bhutan, Maldives and Timor-Leste, and inefficient birth and death registration systems leading to weak and unreliable health information systems.
68. India’s polio eradication efforts received special mention from all Member States, and were attributed as a notable achievement for the whole Region. At the same time, countries of the South-East Asia Region emphasized the need to avoid complacency in order to sustain the progress recorded by the Region in many areas of health.

69. While commending the efforts of WHO in bringing the issue of UHC to the forefront and in highlighting its importance in the context of the current global economic downturn, the Committee underscored the fact that UHC could well be achieved even in low-income settings. What was important was to remember that UHC did not only imply health per se, but also poverty reduction. Thus, it is essential for all countries, irrespective of their economic status, to use their resources optimally, especially financial and human, for it is possible to achieve good health at low cost. Therefore, a concerted effort from not only the ministries of health of the Member States, but also all other ministries, especially the ministries of foreign affairs, would be needed for UHC to be a sustainable success. In this context, the Committee was apprised of the notable success achieved by countries such as India (in Kerala state), Sri Lanka and Thailand in implementation of UHC.

70. The Committee acknowledged WHO’s commitment to continued support to all Member States in the Region for UHC. It also noted that the Regional Office accorded considerable importance to the issue of bulk purchase of essential drugs and medicines for Bhutan, Maldives and Timor-Leste and that it was making all-out efforts to explore the possibility of creating a suitable mechanism to address this particular issue.

71. It is important to look at UHC not only as a financial investment but also as a health tool that impacted on the design and capacity of good health systems and in the formulation of a good health policy. Thus, while designing a good health system, it is important to ensure a proper balance between the preventive and curative aspects of health care, aspects that were adequately addressed by WHO’s Regional Strategy for Universal Health Coverage. The Committee also noted the need for WHO to utilize the WHO collaborating centres more productively; to review and update information, education and communication materials in order to adapt them to contemporary realities; and to develop sound and reliable health information systems, especially through updated health statistics.
Programme of reform for WHO
(Agenda item 3)

WHO reform
(Agenda Item 3.1: Document number SEA/RC65/3 Rev.1 and Inf. Doc.)

72. The Committee was informed that although WHO reform initially focused on financing and better aligning the Organization’s objectives and resources, it had since evolved into a process driven by Member States to address more fundamental questions about WHO’s priorities, governance and management, so that the Organization could be more effective, efficient and accountable.

73. A consolidated paper on WHO reform was submitted to the Sixty-fifth World Health Assembly for discussion in May 2012, which the Committee noted with appreciation.

74. Under each of the three main areas of reform, namely, programme and priority setting (including the six categories for the Programme Budget (PB) 2014–2015 and the Twelfth Global Programme of Work), governance, and managerial reforms, the paper summarized progress of implementation and, for each of the main sections, identified where further guidance or decisions by the World Health Assembly were needed.
75. The Committee urged the Secretariat to develop a strategy to assure funding for categories 2 and 3, i.e. noncommunicable diseases and promoting health throughout the life-course. The Deputy Regional Director, Dr Poonam Khetrapal Singh, informed the Committee that the Director-General had set up a task force on financing of WHO programmes. This task force, to include representation from all the six regions, would look into the issue of adequate resource allocation for all categories. The Committee noted that polio had been placed in Category 5 and questioned whether it would not be better placed under Category 1. Similarly it was questioned whether nutrition would not be better located under Category 3.

76. On the issue of managerial reform for organizational effectiveness, the Director-General stressed that reforms not only concerned the Secretariat, but also involved changes in Member States. In some cases, the capacity of Member States to adhere to their commitments needs to be strengthened for the success of the reform process. Other reforms require changes to staff rules. This issue would be taken up at the next session of the Executive Board.

77. In this connection, the Committee urged the Secretariat to support Member States in strengthening their human resources for health in order to address managerial reforms effectively. The Committee also requested WHO to help build and deploy communications capacity in country offices through improved coordination across the Organization, emphasizing efficiencies in the way communication functions are delivered. It was observed that there is need for more technical expertise to be made available in country offices in the form of additional staff. The Committee urged that the reform process should give priority to the critical health workforce shortage in countries.

78. The Committee underscored the importance of increasing delegation of authority to WHO country offices for better project management and effective implementation of reform. The Regional Director informed delegates that the South-East Asia Region had the highest degree of delegation of authority among the regions. He observed that this delegation of authority had been accompanied by strong accountability and internal oversight measures including review mechanisms in countries.
79. The Committee recalled that at the Sixty-fifth World Health Assembly, Member States had urged for better working relationships with non-health partners and stakeholders. WHO is exploring ways to more effectively collaborate with relevant stakeholders with a view to promoting greater coherence in global health.

80. The Committee observed that social determinants of health would be mainstreamed into all programmes in the next biennium as per recommendations of Member States.

81. As the Organization is currently facing financial constraints, in order to implement reforms in a timely manner, the Director-General urged Member States to make a strong political statement in favour of WHO reform by making an increase, even if small, in their assessed contributions. She underscored the need for more balance in the Budget with increased contributions from State actors.

82. While lauding the commitment of WHO in moving ahead with reform, the Committee expressed its desire that the reforms should result in tangible improvements. The importance of consulting with regional committees for all key decisions was also stressed.
Programme Budget matters
(Agenda item 4)

Programme Budget Performance Assessment:
2010–2011
(Agenda item 4.1: Document number SEA/RC65/4 and Inf. Docs. 1 and 2)

83. The Committee was informed that the Organization-wide report on the 2010-2011 Programme Budget Performance Assessment (PBPA) (SEA/RC65/4 Inf. Doc. 1) was submitted to the Sixty-fifth World Health Assembly in May 2012 after being initially reviewed at the Sixteenth Meeting of the Programme Budget and Administration Committee (PBAC) of the Executive Board. The PBAC, in its report to the World Health Assembly (SEA/RC65/4 Inf. Doc. 2 – Document A65/44) welcomed the 2010–2011 PBPA report and recognized the important results achieved by WHO in priority areas, in particular those related to the health-related MDGs, noncommunicable diseases and immunization. At the same time, the PBAC raised some concerns, especially in relation to the methodology of the assessment, querying whether the means of judging performance had not been too self-critical. The PBAC also raised concerns about variation in funding across regions and across Strategic Objectives.

84. The Committee’s attention was drawn to Document SEA/RC65/4, which provided a summary of the findings of the 2010–2011 PBPA exercise as conducted in WHO South-East Asia Region. The summary document included an overview of key achievements recorded during the biennium, WHO’s contributions to these achievements, an assessment of the degree of achievement of expected results in the South-East Asia Region, and an overview of financial implementation for each of the 13 Strategic Objectives (SOs) that comprised the 2010–2011 Programme Budget.

85. The Fifth Meeting of the Subcommittee on Policy and Programme Development and Management (SPPDM), on 6 July 2012, had reviewed the working paper and recommended that the WHO South-East Asia Regional Office should validate the statistics presented therein concerning malaria rapid diagnostics tests and the availability of long-lasting and insecticide-treated mosquito nets (LLINs/ITNs); revise the paper before presenting it to the Sixty-fifth Session of the Regional Committee, by clarifying that the figures showing unutilized voluntary contribution funds
included voluntary contribution funds to be carried forward to future bienniums; and add an annexure to the paper showing the breakdown of SO13 budget implementation by country. This had been complied with and the statistics had been validated and the papers revised.

86. The Committee commended the Programme Budget Performance Assessment report, which it noted was excellent and in alignment with the SPPDM recommendations. Countries felt that the Assessment Report was a vital tool for national health planning. The results of the assessment would provide lessons, which could be used as inputs for future programme planning and budgeting. WHO’s resources were expected to optimize collaboration between WHO and the ministries of health. Therefore, there needed to be synergy, harmonization and better coordination between Member States’ budget funding and WHO’s Programme Budget support in order to fill the gaps and avoid duplication of activities. Such an approach would help achieve the desired outputs and outcomes of health sector development. Countries expected WHO’s activities to support the priority programmes of ministries of health of countries in the Region, and for WHO to support strategic rather than logistical activities.

87. It was noted that out of the total of 1235 Office-specific Expected Results (OSERs) for the 2010–2011 biennium, 1138 (93%) were systematically assessed as part of the PBPA exercise. Out of the total 1138 OSERs assessed, 886 were deemed to be “fully achieved”, 199 were “partly achieved” and 53 were “not achieved” (this was a small number compared with the total).

88. Member States expressed the need for regular sharing of information on the financial situation of WHO, as well as on monitoring of results.

89. The Committee was assured that quality aspect of programme implementation would continue to be given its due importance.

90. The Director-General stressed the need for WHO and all Member States to “change the way we do business” by living within the means available in view of the serious financial and economic constraints being faced by the Organization as well as by countries in the present economic downturn, and pledged to improve WHO’s assessment process.
91. The Committee noted the PBPA (2010–2011) report as well as the revised working paper, and endorsed the recommendations made on this agenda item by the Fifth SPPDM.

Implementation of Programme Budget 2012–2013
(Agenda item 4.2: Document number SEA/RC65/5)

92. The Committee was informed that the approved Programme Budget for the South-East Asia Region for 2012–2013 was US$ 384.2 million, comprising US$ 102.3 million assessed contributions and US$ 281.9 million voluntary contributions to be mobilized. As of May 2012, the operational budget as per approved workplans stood at US$ 375.4 million. This was supported by assessed contribution resources of US$ 99.2 million and voluntary contribution resources of US$ 156.8 million (including carry-overs from 2010–2011). The overall implementation rate against budget was 19.4% in the first five months of the biennium. By extrapolation, this would give a performance level of 93% for the biennium, indicating that extra efforts were required to speed up the current pace of implementation.

93. The Committee also took note of the uneven distribution of resources across countries as well as across technical areas, i.e. SOs. While countries such as Bhutan, India, Indonesia, Nepal and Thailand had received resources up to more than 55% of the budgeted amounts,
Democratic People’s Republic of Korea, Maldives and Sri Lanka had less than 30% of their budgets financed at the end of May 2012. Similarly, a review of technical areas had revealed that SO1 and SO4 were comfortably placed with resources to budget ceiling proportions of 121% and 74%, respectively. At the same time, SO5, SO8 and SO9 were struggling with levels of resources lower than 30% of the budgeted figures.

94. The Committee noted with concern that in some areas, budget ceilings were insufficient to accommodate voluntary contributions flowing into the countries. It was clarified that to overcome this issue during the course of biennium, budget analysis was undertaken three times during each biennium. The objective of these analyses was to enable budget ceilings to be enhanced in areas of high implementation where new VCs were being mobilized. The Region had a small amount of flexible voluntary contributions (CVC funds) which were allocated to priority areas which had not been successful in raising sufficient voluntary funds to finance important priorities.

95. It was reiterated that countries, donors, and the Regional Office as well as headquarters must work closely together to ensure better alignment of resources with the priorities agreed to by the World Health Assembly and as specified in the Programme Budget.
96. The Committee noted the revised working paper including tables on AC implementation and the SPPDM recommendations submitted for its consideration, which were for Member States to: further strengthen joint initiatives involving WHO and other international agencies regarding mobilization of resources; and for the Regional Office to: support joint initiatives on resource mobilization, especially through involvement of senior management; and target resource mobilization efforts to ensure better financing of those areas and countries that are underfunded.

97. The Committee noted the request of the Member States for additional information on the technical and quality aspects of implementation. In this regard, the Committee noted that the PBPA process was undertaken to evaluate the quality of implementation of the WHO collaborative programme. A request was also made to provide updated financial utilization data as of 31 August 2012 as an additional annex to the working paper. In response to a request for provision of six-monthly implementation data to facilitate programme managers to monitor programme implementation, the Committee was informed that monthly and quarterly data on implementation was already being shared with WHO Representatives in countries. The Committee noted that WHO would provide more details on the implementation of activities.

98. The Committee also noted with concern the increasing proportion of voluntary contributions in the Programme Budget which could result in skewing WHO priorities, potentially leading to programme delivery becoming increasingly donor driven. This could adversely affect capacity development of countries. The Committee was informed that this problem was being addressed through the results-based Twelfth General Programme of Work and the Programme Budget 2014–2015 development processes, which were currently ongoing.

Twelfth General Programme of Work and Proposed Programme Budget 2014–2015 (Agenda Item 4.3:
Document number SEA/RC65/6 Rev.1 and Inf. Docs. 1 and 2

99. The Committee noted that the Twelfth General Programme of Work (GPW) 2014–2019 and Programme Budget 2014–2015 are essential means of taking forward the WHO reform process. Some of the key objectives of the Twelfth GPW and the Programme Budget 2014–2015 are: systematic and transparent priority setting; a simplified results
chain with clear outputs; realistic budget based on reliable projections of income and expenditure; and increased accountability of outcomes achieved against agreed outputs. The Twelfth GPW provides the vision and mission for WHO. It is a framework for priority setting and accountability. It is based on a six-year vision for WHO that takes into account new political, economic, social and environmental realities; a changing agenda for global health and the institutional landscape for global health.

100. It was further noted that the Programme Budget 2014–2015 is the key instrument for strengthening financing, resource mobilization and strategic communication. It is also the basis for detailed operational planning that will be initiated in late 2013. As such, it is the primary instrument for expressing the full scope of work of the Organization along with the roles and responsibilities at all levels of the Organization (country offices, regional offices and headquarters).

101. The Committee was apprised of the background developments, especially the recent global financial crisis that had brought the issue of results-based budgeting into sharper focus, spurring the Organization to change the way “we do business” by setting realistic and measurable outputs and sound performance indicators. This new approach of budget development implies that both Member States and WHO need to work together.

102. The Committee appreciated the need for country-specific and cost-effective innovative financing and cooperation focusing on technical,
rather than financial assistance, from WHO in order for countries to do more with less money. This will involve WHO resources being used strategically. It was also emphasized that the Regional Office should continue to review critically, and analyse objectively all resolutions, declarations and recommendations in the context of the regional situation. It is also important for the Organization to select the right kind of performance indicators, so that a proper assessment can be made of countries’ achievements/deficiencies in programme implementation. It was suggested that priorities identified under the six categories be further sub-prioritized and fine-tuned before presenting the Programme Budget document to the Executive Board Session to be held in January 2013.

103. The Committee appreciated the new categories identified under the Twelfth GPW and the results chain focusing on the Secretariat’s outputs. Concern was expressed regarding voluntary contributions by donors often forcing WHO to divert its core attention from country health priorities to donor priorities. The importance of alignment of the Budget with national health challenges, global health priorities, global and regional resolutions, regional declarations and decisions taken at its high-level meetings was stressed.

104. The Committee emphasized the need for all Member States to have a sense of ownership of the Twelfth GPW and Programme Budget 2014–2015. This requires that WHO adequately consults and engages Member States in the General Programme of Work and Programme Budget development process.

105. The need for WHO to review all global norms and standards in the field of public health and to make the updated information on these norms and standards easily available to all Member States through easily navigable and user-friendly web-based applications was stressed.

106. The Committee underlined the importance that Member States of the Region be adequately consulted in budget allocation matters. Implications of country priorities vis-à-vis regional priorities in respect of allocation of budgets to individual countries should also be articulated. This would help in delineating common but differentiated priorities. Country priorities as identified by WHO through the review of country cooperation strategies should be aligned to national policies/priorities identified by the respective countries.
107. The Committee acknowledged the need for Member States to leverage WHO’s expertise in resource mobilization at country level. Ministries of health in countries also needed to work in close collaboration with other partners engaged in the area of health in countries through intersectoral/multisectoral mechanisms.

108. The Director-General emphasized that the WHO country offices should facilitate dialogue with all partners – governments, United Nations, international government organizations/nongovernmental organizations, and the private sector – in support of the country programme. She noted, however, that both Member States and WHO should to have the courage to say “no” to money that does not support their programme of work.

109. The Committee’s attention was drawn to the working paper that discussed the sequence of events that took place in developing the Twelfth General Programme of Work and the Proposed Programme Budget for the 2014–2015 biennium. The Committee noted the working paper and endorsed the SPPDM’s recommendations on this agenda item for Member States to engage proactively with WHO in the 2014–2015 Programme Budget Development process; and for the Regional Office to: ensure country-level engagement in the next phase of the 2014–2015 PB development process and during 2014–2015 operational planning. This should involve a dialogue between WHO and national authorities in the development of a set of country priorities based on national health policies, strategies and plans. The agreed country priorities should then be consolidated into a set of WHO regional priorities.

**Technical matters**  
(*Agenda item 5*)

**Consideration of the recommendations arising out of the technical discussions on “Non-communicable diseases, including mental health and neurological disorders”**  
(*Agenda item 5.1: Document number SEA/RC65/7 and Inf. Doc.*)

110. The Committee was informed that the Regional Director had convened a regional meeting to hold technical discussions on “noncommunicable diseases (NCDs) including mental health and neurological disorders” from 24 to 26 April 2012 in Yangon, Myanmar, as per the decision of its Sixty-fourth session in September 2011. The Committee noted the
recommendations of the Yangon meeting to: (1) strengthen multisectoral actions to tackle NCDs; (2) develop a monitoring framework and voluntary global targets to prevent and control NCDs; (3) reduce harm from alcohol; and (4) promote mental health and well-being.

111. The Committee noted with concern that while communicable diseases were still highly prevalent in the Region, the rising trend in NCDs due to changing lifestyle patterns was posing a double disease burden in countries of the South-East Asia Region.

112. Noncommunicable diseases were the leading causes of mortality in the Region accounting for more than half of all deaths. The four most common NCDs – cardiovascular diseases, cancers, chronic respiratory diseases and diabetes – caused 80% of all deaths from noncommunicable diseases in the Region. The problem of NCDs was compounded by ageing populations, globalization, unplanned urbanization and other social determinants leading to unhealthy lifestyles characterized by tobacco use, unhealthy diet, harmful use of alcohol and physical inactivity. In addition to the four major NCDs, thalassaemia was a major public health problem in some countries and required effective prevention and care interventions. In the South-East Asia Region, a significant number of premature deaths among the younger population were caused by NCDs, linked to social determinants of health. Such premature deaths also have a catastrophic economic impact on poorer sections of the population.
113. Further, the prevailing weak health systems, limited human resources, weak health information systems and NCD morbidity and mortality data in the countries of the Region were major impediments to tackling the challenge of NCDs.

114. The Committee noted that lifestyles in countries are greatly influenced by cross-border marketing of unhealthy food and beverages, and tobacco use, particularly among children and adolescents; this calls for greater regulation of such marketing by countries.

115. The Committee noted that “what gets measured gets done”. Accepting the “4×4 model” (four risks and four diseases), it observed that there should be at least one target for each of the four risk factors and four diseases. Adding one target on mortality and one on health systems would result in a total of 10 targets, which was felt to be reasonable, given the huge magnitude of the problem of NCDs. Support was expressed for additional targets on reducing harm from alcohol, obesity, diabetes and cholesterol. As tobacco use was a major problem in several Member States of the Region, it was suggested that the proposed target on “tobacco smoking” be replaced by “tobacco use” to cover all forms of tobacco usage.

116. The Committee acknowledged that high-level political commitment and multisectoral actions from multiple stakeholders beyond the health sector were needed to tackle NCDs. It called for a “Health in All Policies” approach to address NCDs. An integrated approach should be used to tackle NCDs, rather than a separate approach for each condition.

117. Concerns were expressed with regard to achieving global targets proposed in the monitoring and evaluation framework to prevent and control NCDs as well as on the lack of availability of baseline data to measure some targets. The Committee was informed that the proposed targets were voluntary in nature and countries were encouraged to set their own targets based on national situations.

118. The Committee urged Member countries to strengthen capacity for surveillance, including measurement of baseline data to monitor and evaluate NCDs. Further, it requested Member countries to participate actively in the ongoing global consultation process, including WHO Governing Bodies and other forums, to advocate for inclusion of NCDs in the post-2015 UN development agenda.
119. The Committee also requested WHO to: (1) disseminate normative guidelines and best practices including achievements in the Member countries for prevention and control of NCDs; (2) build capacity of Member States for strengthening health systems and developing national multisectoral policies and plans; and (3) provide technical assistance to Member States in developing a national monitoring framework, including targets for prevention and control of NCDs.

120. The Committee observed that all Member States agreed with the emerging importance of mental health and neurological disorders. Member States agreed with the concept of including “mental health and neurological disorders” as being distinct from the overall spectrum of NCDs, as these were rapidly emerging as important causes of morbidity and mortality. It was suggested that, although at this time mental health and neurological disorders were part of the NCD resolution, in future, mental and neurological disorders should be considered separately because of their distinct epidemiology and magnitude.

121. The need for consistency between global and regional mental health action plans under development was emphasized.

122. The current scenario of mental and neurological disorders manifested with a huge treatment gap associated with social stigma. This had been documented in pilot studies in the Region. Also, the cost of care for these conditions was already high and rapidly increasing.
It was proposed that autism be given specific attention in documents dealing with mental and neurological disorders. Member States generally agreed that autism spectrum disorders are an important cause of morbidity among children and cause substantial social stigma to the affected child and the family. They were also of the opinion that autism should not be singled out in a resolution addressing mental health and neurological disorders. The proposed resolution on NCDs including mental health and neurological disorders, was based on the discussion held at the Yangon meeting during which autism was not discussed. The Regional Director proposed, discussed and finally decided that a separate resolution for autism spectrum disorders be considered by the Regional Committee.

Selection of a subject for the technical discussions to be held prior to the Sixty-sixth session of the Regional Committee (Agenda item 5.2: Document number SEA/RC65/8)

The Committee endorsed the recommendation of the High-level Preparatory Meeting and decided to hold the technical discussions on the subject of “Universal Health Coverage” prior to its Sixty-sixth session in 2013.

Role of WHO in managing emergencies (Agenda item 5.3: Document number SEA/RC65/9)

The Committee noted that this Agenda item had been discussed at the HLP Meeting in two parts. The first part related to World Health Assembly resolution WHA65.20 on WHO’s response and role as the health cluster lead in meeting the growing demands of health in humanitarian emergencies, while the second part dealt with the utilization of the South-East Asia Regional Health Emergency Fund (SEARHEF) as a follow-up to the Regional Committee resolution SEA/RC60/R7.

The new World Health Assembly resolution on emergencies confirmed the commitments of Member States to: (i) strengthen and integrate risk management capacities into the health sector; (ii) build capacities in this area of work across various phases of risk reduction, preparedness, response and recovery; and (iii) coordinate with other sectors. It also described WHO’s work as the health cluster lead and its commitments for better response through a new emergency response framework.

The Committee noted with concern that the Region was vulnerable to disasters and appreciated WHO’s support for preparedness and prompt
response to disasters and emergencies in the Region. It was stressed, however, that there was a continued need to build national capacities in collaboration with WHO.

128. The Committee also recognized the role of WHO as health cluster lead in humanitarian response mechanisms. It acknowledged the Emergency Response Framework as the overarching guide for emergency response for WHO.

129. The Committee noted with appreciation the progress made by Member States in improving capacities in disaster risk management in the health sector, highlighting new initiatives, increased focus in community resilience, the need for fostering partnerships and activities leading to better emergency risk management systems.

130. The following needs were mentioned as important to improve emergency risk management capacities in countries: comprehensive health systems strengthening for emergency risk management; human resource development; mobilizing resources according to country needs; strengthening capacities for mitigation/risk reduction; risk communication and early warning systems, especially for hard-to-reach areas; and efficient logistic systems.

131. It was noted that the Centre for Health Crisis in the Ministry of Health of the Government of Indonesia had been recently designated as the WHO Collaborating Centre for Disaster Risk Reduction.

132. Delegates recognized the usefulness of a comprehensive capacity assessment through the South-East Asia Region Benchmarks, which had been completed in some countries and is ongoing in some, to identify priorities and gaps.

133. The Committee was informed that the SEARHEF was established through Regional Committee resolution SEA/RC60/R7. As per the Fund’s policies and guidelines, a working group was established to oversee the management of the Fund. The working group comprised representatives nominated by all 11 Member States of the South-East Asia Region. The Fund’s resources had been successfully managed and utilized in respect of 13 emergencies since it was made operational in January 2008. These included emergencies that were either small in magnitude or chronic or insidious at onset.
134. The Committee noted the recommendations made by the HLP meeting on this Agenda item:

On the World Health Assembly resolution WHA65.20

Actions by Member States:

- To support capacity building and efforts aimed at integrating emergency risk management into the health sector.
- To coordinate with relevant sectors outside the health sector, to further support health interventions to reduce, prepare for, respond to and recover from emergencies and disasters.

Action by Regional Office for South-East Asia:

- To provide technical and operational support to Member States to integrate risk management capacities into the health sector in line with the recommendations of the World Health Assembly resolution and discussions held at the recent regional meeting on disaster risk management in the health sector, held in Bangkok, Thailand (June 2012).

On SEARHEF

Action by Member States:

- To support mobilization of additional resources for SEARHEF

Action by Regional Office for South-East Asia:

- To provide support to SEARHEF as the Secretariat of the fund and implement the recommendations made by the SEARHEF Working Group.

135. The Committee acknowledged the efficient support provided by SEARHEF in many emergencies that occurred in countries of the Region in the past few years. It was appreciated that the financial support from SEARHEF had been released within 24 hours upon request. Flexibility, transparency and quick response remained and should continue to be the guiding principles for the Fund.

136. Representatives of Member States emphasized the need to continue to contribute to, mobilize resources for, and advocate for more support to the Fund.
137. The Committee noted the conclusions reached at the SEARHEF Working Group meeting held in the Regional Office, New Delhi, from 23 to 24 August 2012. In summary, the SEARHEF Working Group: acknowledged the oversight role of the SEARHEF Working Group; affirmed that the Fund should continue to focus on support for emergency response; and provided various suggestions for additional resource mobilization, replenishment mechanisms and advocacy to partners for additional support.

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

**Statements by representatives of nongovernmental organizations and international nongovernmental organizations**

139. Dr Jacob Roy Kuriakose, Chairman of **Alzheimer’s Disease International (ADI)**, stated that his organization is the global umbrella organization of Alzheimer disease associations worldwide. He said that an estimated 38 million people were living with dementia worldwide, which was roughly the same number as those living with HIV/AIDS. Left unsolved, this number is estimated to grow to 65 million by 2030. Dementia, including Alzheimer disease, causes memory loss, confusion, disorientation to time and place, and which, when it progresses, leaves those affected unable to work or care for themselves.
140. The UN high-level political declaration emerging from the meeting on noncommunicable diseases held last year, called for recognition of Alzheimer disease and dementia as a major NCD. However, dementia had not yet been included in the global monitoring framework for NCDs that WHO was drafting. Dr Kuriakose conveyed his organization’s support for the draft monitoring framework, especially because of the growing consensus that dementia shared most of the risk factors of other NCDs.

141. Dr Kuriakose suggested that the WHO NCD plan adopt a multisectoral approach to rapidly identify evidence-informed dementia surveillance tools that could be integrated into country-level surveillance systems. Dr Kuriakose promised ADI’s support to WHO in this effort.

142. Dr Pustika Amalia Wahidyat, speaking on behalf of the Thalassaemia International Federation (TIF) said that her organization is a non-profit organization dedicated to improving the quality of life and life expectancy of patients with inherited haemoglobin disorders that fell within the scope of noncommunicable diseases. The Federation comprised 108 member associations from 55 countries, cooperating in official relations with WHO since 1996. The global burden of haemoglobin disorders including thalassaemia and sickle-cell anaemia continues to increase. The current epidemiological data are a gross underestimation of the magnitude of the problem, taking into account the increasing migration of populations worldwide.
143. Dr Wahidiyat commended WHO for adopting resolutions on sickle-cell anaemia (WHA59.R20) and thalassaemia (EB118.R1), which requested Member States to develop and implement comprehensive national programmes for the prevention and management of these diseases. She stated that TIF had taken steps to raise awareness across the South-East Asia Region for haemoglobin disorders by organizing national workshops and conferences in various countries, and noted that TIF actively advocates for universal health care coverage for these patients, whose treatment regimens put an unbearable burden on their families.

144. Dr Vinod S. Saxena of the International Bureau for Epilepsy stated that epilepsy was one of the world’s most common chronic neurological disorders with approximately 50 million people diagnosed worldwide. With a population of 1.8 billion in the Region, there were about 9–18 million people affected with epilepsy, with about 0.5–1 million new cases occurring each year.

145. Furthermore, the stigma attached to people with epilepsy was a barrier to the exercise of their human rights and social integration. In addition, 40% of children with epilepsy faced difficulties at school. Epilepsy also disrupted every aspect of life and could impose physical, psychological and social burdens on individuals and families. Scientific advances had improved the understanding and management of epilepsy and up to 70% of people with epilepsy could be seizure-free with appropriate treatment.

146. Dr Saxena called for WHO to prepare a strategic plan, as part of an integrated response to develop lifelong programmes for people with epilepsy, which would include prevention, treatment and rehabilitation. Some of the key areas that such a plan could address would be: prioritizing epilepsy as a major disease that imposes a significant burden and reducing existing treatment gaps; ensuring equal quality of life in education, employment, transport and public health care for persons with epilepsy; encouraging research and innovation in the area of prevention and early diagnosis and treatment; strengthening legal frameworks to protect human rights; strengthening human resources to improve national epilepsy programmes and training; and combating stigma and discrimination.
Mr Andi Putra Kevinsyah from the International Federation of Medical Students’ Associations (IFMSA) stated that the WHO South-East Asia Region was prone to many emergencies and disasters, because of its geography and socioeconomic conditions. The World disasters report 2010 had even reported that the populations of the countries of the South-East Asia Region continued to account for the greatest number of deaths due to disasters. Scientific evidence also suggested that increase in global warming may raise the incidence of natural disasters.

“Medical students laud the WHO Regional Office for South-East Asia for the capacity building and emergency risk management measures taken by it. We also laud WHO-SEARO’s initiative of establishing the SEARHEF to provide immediate financial support for emergencies and disasters,” said Mr Kevinsyah.

Mr Kevinsyah stated that the IFMSA was committed to assist the health sector in reducing the ill-effects of emergencies and disasters. The Federation is a unique network of 107 medical students’ associations from 100 countries, representing over 1.3 million medical students worldwide and has the capability to spread knowledge, and to mobilize medical students in every stage of disaster management – risk reduction, preparedness, response and rehabilitation.
150. Mr Kevinsyah expressed his association’s desire to involve medical students in emergencies and disasters. Medical students could be mobilized to engage in community-based initiatives that raise awareness, and enhance the capacity of communities for disaster preparedness and emergency management. Students could also be mobilized as medical volunteers, especially to provide psychosocial support and to engage in fundraising activities and community rehabilitation. “Medical students are ready to work with WHO and its Member States towards a healthier and safer South-East Asia Region,” Mr Kevinsyah concluded.

151. Mr Manindra Chaudhuri of the International Federation of Biomedical Laboratory Scientists (IFBLS) stated that many issues highlighted in The World health report 2006, “Working Together for Health”, are relevant even today. The education and development of health-care professionals and health systems in general, and the global employment opportunities for health professionals continue to be discussed. However, information on the biomedical science profession and specifically, biomedical laboratory scientists, was found to be lacking in such reports. As a result, the ageing of the biomedical science workforce along with reduced government budgets to support health services, education and training, continue to impact the biomedical laboratory profession.

152. IFBLS is dedicated to the global promotion of the biomedical laboratory science profession. Globally, IFBLS’s focus is on the absolute numbers of biomedical laboratory scientists in every country. WHO compiled data on health workforce populations from several sources, including population censuses, labour and employment-based surveys, health facility assessments, and administrative information systems. However, data summarizing the total numbers of biomedical laboratory scientists were often not included or incomplete. Mr Chaudhuri expressed the wish of IFBLS to partner with WHO in the promotion of quality patient care through the efforts of biomedical laboratory scientists and the biomedical laboratory science profession.

153. Ms Leena Menghaney from Medecins Sans Frontieres (MSF) stated that although some progress had been made in the past 10 years in the form of a few new medical products launched and some promising ones under development by public–private partnerships, the progress was fragile and ad hoc, financing was not secure, and that the research
and development (R&D) priorities were not clear, with most of R&D depending on donor philanthropy and corporate social responsibility. “We need a more sustainable solution, which is driven by the Member States themselves,” Ms Menghaney emphasized. The report of the Consultative Expert Working Group (CEWG) on Research and Development: Financing and Coordination had rightly concluded that multilateral action was needed. Member States from the Region have an opportunity to take the decisive step to support the central recommendation of the CEWG report — that Member States negotiate a convention that will establish adequate political framework to secure medical innovation for neglected populations. In conclusion, Ms Menghaney said, “We need collective action and leadership from WHO and from Member States.”

**Health workforce training and education**  
*A (Agenda item 5.4: Document number SEA/RC65/22)*

154. The Committee noted that countries are confronted with numerous health challenges, such as those related to health systems, sociodemographic changes, changing disease patterns and changing vulnerabilities and risks. These challenges require a multidisciplinary approach and multisectoral collaboration, which have an impact on the work of health-care providers and thus on how they are educated and trained. It was a common observation that health workforce (HWF) education and training had not been well adapted to address these challenges.

155. The Committee was informed that *The World health report 2006* had revealed that 6 out of 11 countries of the South-East Asia Region faced a human resources for health (HRH) crisis, with fewer than 23 health workers (doctors, nurses and midwives) per 10 000 population. However, the Member States of the South-East Asia Region are committed to achieving effective and well-motivated health workforces as witnessed in the 2006 Dhaka Declaration on Strengthening Health Workforce in the Countries of South-East Asia Region and the Regional Committee resolution on Strengthening the Health Workforce in South-East Asia adopted at its Fifty-ninth session.

156. The challenges associated with rational distribution of workforces within countries and their integration into community health clinics need to be addressed. Most countries in the Region are experiencing a decrease in the health workforce through migration. The Committee expressed concern for the fact that funding support for HRH development was not
sufficient to bring about the desired improvement in most countries. The Committee strongly supported the recommendation of the HLP meeting that, with regard to the changing patterns of the health workforce in the Region, there is a need for WHO and Member States to work together to achieve the objective of developing a committed and effective health workforce.

157. Concern was also expressed on the critical shortage of health workforce, especially in rural and remote areas. The numerous health challenges exacerbated the situation. Hence, greater collaboration and networking among countries was called for. There is also a need to strengthen interprofessional education and community-based health workforce training and education with a focus on both health promotion and disease prevention. Further, an effective community-based health workforce is one of the ways to ensure that essential health interventions reach even “unreached” populations in order to achieve universal health coverage.

158. There is thus a need to renew the commitment and investment to strengthening HWF training and education; and to have clear national health policies, strategies and plans on the focus of health systems, and on HWF requirements and education. Countries also need to find new
and better ways to educate their health-care providers to meet the needs of health systems and communities. The importance of strengthening institutional capacity building was also highlighted.

159. The Committee noted that the Regional Office had produced many guidelines on the subject of health workforce. It urged WHO to now strive for a greater focus on implementation.

160. The Committee noted the revised working paper and endorsed the recommendations made by the HLP meeting, incorporating them in a Regional Committee resolution.

Reports of WHO global working/advisory groups (Agenda item 5.5)

Substandard/spurious/falsely-labelled/falsified counterfeit medical products and strengthening drug regulatory authorities (Agenda item 5.5.1: Document number SEA/RC65/10)

161. The Committee was informed that the issue of substandard/spurious/falsely-labelled/falsified/counterfeit medical products (SSFFC) had been discussed at the World Health Assembly since 2010 following the seizure in 2008 of a consignment of generic medicines in transit through the Netherlands for infringement of intellectual property. Since
then, the lack of a uniform definition of “counterfeit” medical products and the International Medical Products Anti-Counterfeiting Task Force (IMPACT) set up in 2006 to combat counterfeit medical products had engaged the attention of Member States.

162. IMPACT as well as WHO’s relationship with the taskforce was discussed at the Sixty-third World Health Assembly in 2010. The World Health Assembly decided “to establish a time-limited and results-oriented working group on substandard/spurious/falsely-labelled/falsified/counterfeit medical products comprising and open to all Member States” to examine, inter alia, WHO’s role in ensuring the availability of quality, safe, efficacious and affordable medical products.

163. The Inter-Governmental Working Group (IGWG) presented its report to the Sixty-fifth World Health Assembly in 2012 and its recommendations were incorporated in Resolution WHA65.19. Indonesia was Vice-Chair of the IGWG meeting held in October 2011, at which there was unanimous support for WHO’s role to ensure the availability of good-quality, safe, efficacious and affordable medical products. The Committee agreed with the recommendations including additional funds for WHO’s work in this area.

164. The Committee noted the comprehensive report and commended the regional solidarity in countering the issue of SSFFC at global forums.

165. The Committee appreciated the role of WHO in combating SSFFC, strengthening drug regulatory authorities, improving access to safe, efficacious and affordable quality medicines, developing international norms and guidelines and providing technical assistance. Welcoming the new Member State mechanism on substandard/spurious/falsely-labelled/counterfeit medical products established in 2011, the Committee called for further deliberations on it and in addressing the challenges in its implementation through wholehearted participation of Member States of the Region.

166. The Committee raised concerns on the use of terminology such as substandard or counterfeit medicines and urged review of these definitions and their use. This issue had not been discussed in the October meeting of the IGWG.
167. It was felt that the Trade-Related Aspects of Intellectual Property Rights (TRIPS) and patents might hinder the availability and affordability of medicines to countries in need. In this regard, in-depth baseline assessment of the capacities of national drug regulatory authorities. Priority should be given to development of regional medium- and long-term plans for bulk procurement of life-saving drugs, medicines and vaccines of assured quality for humans, poultry and livestock.

168. The Committee called for sharing of information, experiences and best practices among Member States and the development of information sharing mechanisms at all levels. The Committee stressed that regional solidarity was the most effective tool in counteracting networks of crime and was assured full commitment and support from Member States.

169. The Committee noted the working paper and endorsed the HLP Meeting recommendations on this Agenda item which were for Member States to: participate in the proposed Member State mechanism; undertake in-depth assessments of the capacity of the NDRAs in combating SSFFC; and provide sufficient human and financial resources to strengthen the capacity of national drug regulatory authorities (NDRAs) in combating SSFFC. HLP recommended actions by the Regional Office were to: provide technical support to Member States to undertake in-depth assessments of the capacity of the NDRAs in combating SSFFC; develop, based on evidence from the assessment in Member States, a regional medium-term strategic plan to combat SSFFC; explore the possibility of establishing a mechanism for bulk purchase of drugs and vaccines of assured quality particularly for Member States who depend on importation of drugs and vaccines; and report the progress and outcome of the implementation of the regional medium-term strategic plan to the Sixty-eighth meeting of the Regional Committee.

**Pandemic influenza preparedness**  
*(Agenda item 5.5.2: Document number SEA/RC65/11)*

170. The Committee noted that since 1957 influenza viruses had been shared by Member States through the WHO Global Influenza Surveillance and Response System (earlier known as the Global Influenza Surveillance Network – GISN), but that in 2007 issues were raised about how this system might be linked to access to vaccines and other benefits.

171. To address these issues, the World Health Assembly Resolution WHA60.28 recommended the Director-General to: develop a framework
and mechanism for benefit sharing; establish an international stockpile of influenza A (H5N1) vaccine; and prepare guidance on vaccine distribution.

172. The resulting Pandemic Influenza Preparedness Framework (PIP Framework), adopted through World Health Assembly Resolution WHA64.5, was expected to enhance the capacity for surveillance, risk assessment and early warning.

173. The Committee was informed that in accordance with WHA64.5 the PIP Framework was also aimed at prioritizing financial and “in-kind” benefits to developing (H5N1-affected) countries that lacked the capacity to produce/access influenza vaccines, diagnostics and pharmaceuticals according to public health risk and needs.

174. In order to implement the PIP Framework at the national level, Member States should continue to share influenza viruses with pandemic potential with a WHO reference laboratory of their choice. Transfer of influenza viruses and products derived from them (also referred to as PIP Biological Materials) are governed by Type 1 and Type 2 Standard Material Transfer Agreements (SMTAs).

175. WHO was requested to accelerate Type 2 SMTAs with the industry and ensure that benefits are allocated in a transparent but flexible manner. It was suggested that an alignment between core capacities of the International Health Regulations and the PIP Framework should be ensured. The need for a Regional plan for implementation of the PIP Framework was emphasized. The issues of flexibility in the division of resources for preparedness and response, and of in-kind benefits, including technology transfer, were raised.

176. The Committee noted the working paper and endorsed the HLP recommendations on this agenda item which were for Member States to: ensure that concerned laboratories continue to share influenza viruses in a timely manner, including those with pandemic potential; and for the Regional Office to: accelerate the process of negotiating “type 2” SMTAs; advocate for flexibility in the proportional distribution of funds according to identified needs in order to ensure optimal use of resources from the Partnership Contribution; and strengthen national influenza centres and WHO collaborating centres.
Consultative Expert Working Group on Research and Development: Financing and Coordination
(Agenda item 5.5.3: Document number SEA/RC65/12)

177. The Committee was informed that the Consultative Expert Working Group on Research and Development: Financing and Coordination (CEWG), set up by the World Health Assembly, presented its report in May 2012. Pursuant to this report, World Health Assembly resolution WHA65.22 requested regional committees to discuss at their 2012 meetings, the report of the CEWG in the context of the implementation of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property in order to contribute to concrete proposals and actions.

178. The CEWG report made a number of proposals to improve the current financing and coordination of research and development related to Type II and Type III diseases and the specific research and development needs of developing countries in relation to Type I diseases. To provide input to the CEWG process, consultations were held in five WHO regions: in the South-East Asia Region these took place in New Delhi on 7 October 2011. The proposals under consideration were grouped into three sets: those that felt short of meeting the criteria; those that did not principally contribute to improved financing or coordination of research and development (R&D); and those that CEWG felt best met the criteria summarized under the headings of public health impact, technical, financial and implementation feasibility.

179. Based on a detailed analysis, CEWG recommended a coordination function under the auspices of WHO that would include: (1) a global health R&D observatory to collect and analyse data, including in the areas of financial flows to R&D; and (2) advisory mechanisms – a network of research institutions and donors that may include specialized sections according to the subject of research.

180. The Committee noted that CEWG had considered a number of innovative sources of financing for increased commitment for meeting the needs of developing countries. The Committee supported the commencement of negotiations for a proposed R&D convention, in principle, as suggested by CEWG.
181. The Committee emphasized the importance of capacity-building and technology transfer to developing countries. The Committee also suggested further strengthening commitment to improve R&D to better address the public health needs of developing countries. The need to include traditional medicine in the R&D agenda was also emphasized.

**Progress reports on selected Regional Committee resolutions (Agenda item 5.6)**

**Progress towards achievement of the immunization targets adopted in the Framework for Increasing and Sustaining Immunization Coverage (SEA/RC64/R3) (Agenda item 5.6.1: Document number SEA/RC65/13)**

182. The Committee noted that 2012 had been declared as the “Year of Intensification of Routine Immunization” in the South-East Asia Region. This was supported by the High-Level Ministerial Meeting on Increasing and Sustaining Immunization Coverage in South-East Asia, held in August 2011 in New Delhi, India, and the Sixty-fourth session of the Regional Committee held in Jaipur, India, in September 2011.

183. At its Sixty-fourth session, the Regional Committee passed a resolution (SEA/RC64/R3) to report the progress towards achievements of the immunization targets adopted in the Regional Framework for Increasing and Sustaining Immunization Coverage. Since then, all countries had developed plans for intensification of routine immunization and begun implementing them.
While according the highest priority to polio certification in early 2014, the Committee requested the Secretariat for its continued assistance to implement the action plan for intensification of routine immunization. In this regard, the Secretariat reiterated its commitment to the implementation of the Global Vaccine Action Plan.

The Committee requested the Secretariat for technical support to further strengthen the measles elimination efforts by drawing lessons from the success of the polio eradication programme. It, therefore, recommended including an agenda item on “Measles elimination and rubella control in the SEA Region” in the Sixty-sixth session of the Regional Committee in 2013.

The Committee thanked WHO for providing necessary support to the national immunization programmes to ensure that the immunization targets were met.

Ms Helen Evans, Deputy CEO, GAVI Alliance, congratulated WHO Member States of the Region and their partners for their joint efforts in strengthening immunization programmes. In this regard, Ms Evans stated that “the declaration of 2012 as the Year of Intensification of Routine Immunization in the South-East Asia Region is an important milestone, and we look forward to our continued collective efforts in working towards achievement of the immunization targets adopted in the regional framework”. On behalf of her organization, she commended the Regional Director and the Member States for their leadership and commitment to intensification of routine immunization in the Region, especially for the recent measures taken to make sure that GAVI’s funding for health system strengthening is more closely linked to immunization outcomes.

Elaborating on her organization’s work in the area of vaccines, Ms Evans said, “GAVI has been instrumental in reducing the delay between when a new vaccine is available in high-income countries, and when it is introduced into low-income countries, exemplifying another of the Global Vaccine Action Plan principles of ensuring equity in vaccine uptake. The Alliance is first and foremost a partnership: countries lead the vaccine uptake, integrating vaccines into routine immunization programmes built on stronger health systems and services. WHO ensures the quality and safety of vaccines through its prequalification system. Collectively, GAVI pools demand, shapes the market and coordinates the contributions from partners and countries. The achievements of one are the achievements of all.”
Challenges in polio eradication (SEA/RC60/R8)
(Agenda item 5.6.2: Document number SEA/RC65/14)

189. The Committee was presented with an update on the progress and challenges to polio eradication in the South-East Asia Region.

190. Commending India for the tremendous progress made towards polio eradication, the Committee noted that it was the only country in the Region that had endemic transmission of wild poliovirus in 2011. As a result of concerted effort over the previous 12–24 months, the number of polio cases in India decreased by over 99% compared with 2009. In 2011, only one wild poliovirus case was detected – the lowest number since surveillance was initiated in 1997. Success and lessons learnt in building a highly sensitive surveillance network for polio had been replicated to strengthen surveillance for other vaccine-preventable diseases and monitor routine immunization activities.

191. Strategies adopted to stop polio transmission in India represented a multipronged approach. Eradication challenges had been approached systematically with specific strategies: the 107 high-risk block initiative in historically polio-endemic areas of western Uttar Pradesh and central Bihar had focused on rapid improvement in sanitation, availability of clean water, hygiene and prevention/control of diarrhoea; migrant populations that played an important role in sustaining and spreading polio were targeted for surveillance and immunization activities; and the
introduction of bivalent oral polio vaccine provided an additional tool for epidemiological-based supplemental immunization activities.

192. With continued sustained effort in 2012–2013, the Region could look forward to certification as polio-free in January 2014, and the Committee agreed to intensify efforts to fill the gap towards this end. The Secretariat reaffirmed its commitment to fully support the activities of the National Certification Committee for Polio Eradication (NCC) and the South-East Asia Regional Commission for the Certification of Poliomyelitis Eradication (SEA-RCCPE).

193. The Committee requested WHO to look beyond polio certification and provide guidance on the polio end-game strategy and the role of oral polio vaccine and inactivated polio vaccine in implementing the oral polio vaccine cessation strategy. The Committee was advised that the integration of polio immunization into routine immunization, and integration of routine immunization into health systems may be considered by the Member States.

**Regional Strategy for Universal Health Coverage (SEA/RC63/R5)**
*(Agenda item 5.6.3: Document number SEA/RC65/15 and Inf. Doc.)*

194. The Committee was informed that countries in the Region were prioritizing UHC in their health and development policies with an urgent emphasis on improving equity. A key driver of inequities in health and a major challenge to UHC in the Region is out-of-pocket payments, particularly for the purchase of medicines. Further inequities as well as inefficiencies were evident in service delivery in the context of an increasing burden of noncommunicable diseases and largely unregulated private provision of curative care.

195. Based on an in-depth analysis and discussion of the South-East Asia Region’s and international experiences, the four strategic directions recommended to accelerate UHC in the Region were:

- **Strategic Direction 1**: Placing primary health care at the centre of UHC.
- **Strategic Direction 2**: Improving equity through social protection.
- Strategic Direction 3: Improving efficiency in service delivery.
- Strategic Direction 4: Strengthening capacities for UHC in the South-East Asia Region.

196. Countries supported strengthening of the public health system with the government being its primary provider supplemented by private health-care providers.

197. The Committee highlighted the need to have good primary health care services with proper referral mechanisms, technology assessment, comprehensive information systems and involvement of the private sector to achieve universal health coverage. The implementation of policy with inbuilt mechanisms for monitoring and evaluation was also considered important. Capacity-building was strongly advocated, including through South–South cooperation.

198. The Committee requested that the Regional Office secure funds to assist UHC action at country level including documentation and exchange of experiences. It also requested WHO to provide technical assistance in adapting the recommendations of the Regional Strategy to the specific country context and supporting its implementation.

199. The Secretariat informed delegates that as per the recommendation of the Sixty-fourth session of the Regional Committee, the Regional Strategy on Universal Health Coverage had been developed with a consultative and inclusive process with the Member States. As requested by the Member States, the Strategy had been developed as a practical document based on the recommended strategic directions on international experience.

**Capacity-building of Member States in global health (SEA/RC63/R6)**

*Agenda item 5.6.4: Document number SEA/RC65/16*

200. The Committee noted that the term “global health” had emerged as part of the larger political and historical process, and that it had replaced the term “international health”. The term was associated with the growing importance of actors beyond governments, intergovernmental organizations and agencies, and international nongovernmental agencies, etc.

201. Recognizing the need to provide support to Member States in organizing national, regional and global seminars and training workshops
on global health that could act as effective tools for strengthening national capacity, and enable participants to play active roles in international/global health forums with improved negotiation skills, many international training programmes on global health were conducted in 2010, 2011 and 2012 through multidisciplinary, didactic and experiential learning in collaboration with the Ministry of Public Health, Thailand, the Regional Office, the Thai Health Global Link Initiative Project (TGLIP) and the Rockefeller Foundation. The Committee noted that this had resulted in vast improvement in the quality of interventions by representatives of Member States at Governing Body meetings.

202. The Committee requested WHO to develop standard models for the national and international training courses on global health and to conduct comprehensive evaluation with a view to further improving the quality of the training course.

203. The Committee noted the importance of institutionalization of capacity on global health and expressed the need for sustaining capacity on global health in the long term. Regional experiences clearly show that hands-on, in-service training at global health forums not only sustains capacity but also fosters the Regional ‘one voice’. The Committee further noted that there are already several Master’s of Public Health courses that include global health in their curricula.

**Governing Body matters (Agenda item 6)**

**Key issues arising out of the Sixty-fifth World Health Assembly and the 130th and 131st sessions of the WHO Executive Board**

**(Agenda item 6.1: Document number SEA/RC65/17)**

204. The Committee took note of the most significant and relevant resolutions from the perspective of the South-East Asia Region emanating from the Sixty-fifth World Health Assembly (held from 21 to 26 May 2012) as well as the 130th and 131st sessions of the Executive Board (held from 16 to 23 January 2012 and from 28 to 29 May 2012, respectively). These resolutions were deemed to have important implications and merited follow-up action by both Member States and WHO at its regional office and country office levels.
205. Member States were urged to study and review these resolutions in the context of their country situations and take necessary follow-up actions as appropriate.

**Review of the draft provisional agenda of the 132nd Session of the WHO Executive Board**  
*(Agenda item 6.2: Document number SEA/RC65/18)*

206. The Committee was informed that the 132nd session of the WHO Executive Board would be held at WHO headquarters in Geneva in January 2013. It noted that any proposal from a Member State to include an item on the agenda should reach the WHO Director-General not later than 12 weeks after circulation of the draft provisional agenda or 10 weeks before the commencement of the session of the Executive Board whichever is earlier. Proposals should, therefore, reach the Director-General by 18 September 2012.

207. The Committee requested WHO to have the following two draft agenda items included in the forthcoming Executive Board meeting in January 2013:

- health workforce education and training for universal health coverage;
- multisectoral role for promoting health through the life-course.
Process for nomination of the Regional Director
(Agenda item 6.3: Document number SEA/RC65/19 and Inf. Doc.)

208. The Chair noted that a working paper suggesting proposed changes to the process for nomination of Regional Director was reviewed during the HLP Meeting in June 2011 in preparation for the Sixty-fourth session of the Regional Committee. The matter was noted at the Sixty-fourth session in September 2011 following which the Regional Director convened a consultative meeting in March 2012 to advise on the way forward.

209. The Chair of the consultative meeting, the distinguished representative from Nepal, summarized the results of the meeting. He informed the Committee that with the exception of Maldives, all other Member States of the Region had participated in the meeting. The consultative meeting considered all relevant background documents and information with regard to selection of the Regional Director in the regional offices of WHO, as well as the selection of the Director-General in headquarters and reached consensus on a draft resolution for consideration by the Regional Committee. The proposed resolution included criteria for assessment of candidates and a presentation process for candidates. The overall purpose was to further strengthen transparency, fairness and equity in the process for nomination of the Regional Director.

210. The Committee was informed that establishment of a presentation process for candidates of Regional Director would require a modification to Rule 49 of its Rules of Procedure.

211. The Director-General informed the Committee of the decision taken by the Sixty-fifth World Health Assembly in May 2012 for harmonization of the process of nominating Regional Directors. The Director-General commended the Member States of the Region for having started the discussion process to implement the decision of the Assembly. She encouraged the South-East Asia Region to act upon the matter expeditiously in light of the World Health Assembly decision.

212. Noting that the Consultative Meeting had set the date of implementation of the presentation process as 1 January 2014,
i.e. following the election of the Regional Director in September 2013, she urged the Committee to strongly consider implementation with immediate effect to fall in line with the procedures followed by other regions.

213. The Committee discussed establishment of a subcommittee under Rule 51 of the Rules of Procedure of the Regional Committee for the purpose of revision of Rule 49 “Nomination of the Regional Director” and whether to consider the Consultative Meeting held in March 2012 as a subcommittee of the Regional Committee.

214. The Regional Committee decided not to consider the consultative meeting to be a “subcommittee” for purpose of amendment to the Rules of Procedure, but rather to suspend the proceedings of the Regional Committee and immediately establish a subcommittee of all Member States to further discuss the matter.

215. Accordingly, the Regional Committee was adjourned to permit the Subcommittee to meet in private to review the draft resolution of the March 2012 consultative meeting with a view to preparing a recommendation thereon for consideration by the Regional Committee.

216. Under the chairpersonship of Dr Nafsiah Mboi, Minister for Health, Republic of Indonesia, the Subcommittee decided to recommend to the Regional Committee that Annexes A, B and C of the draft resolution of the March 2012 Consultative Meeting be approved as recommended by the consultative meeting.

217. The Subcommittee further decided to recommend to the Regional Committee that the presentation process included in the draft resolution presented by the consultative meeting of March 2012 be made applicable with immediate effect instead of 1 January 2014 as originally proposed.

218. The Regional Committee reconvened to take up the recommendations of the Subcommittee. After deliberation, the Regional Committee accepted the recommendations of the Subcommittee. The Regional Committee adopted the resolution including its Annexes A, B and C and approved the amendments proposed by the Subcommittee regarding the immediate effectiveness of the presentation process.
Special programmes *(Agenda item 7)*


219. The Committee noted that the report of the Thirty-fifth Meeting of the Joint Coordinating Board (JCB) of the UNICEF/UNDP/World Bank Special Programme for Research and Training in Tropical Diseases (TDR) held in Geneva, Switzerland, from 18 to 20 June 2012 was presented to the HLP meeting held in the Regional Office, New Delhi, from 2 to 5 July 2012.

220. The Regional Committee requested the Regional Office to make efforts to mobilize more resources from TDR for the Region. The Secretariat was also requested to provide information to the Sixty-sixth session of the Regional Committee on the support provided by TDR to this Region during the two previous bienniums.

221. The Committee also noted that the membership of Member States from the Region nominated in the JCB was valid until 2013.

222. The Committee noted that the report of the Twenty-fifth Meeting of the Policy and Coordination Committee (PCC) of the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, held from 21 to 22 June 2012 in Geneva, Switzerland, was presented to the HLP meeting held in the Regional Office, New Delhi from 2 to 5 July 2012.

223. The Committee nominated Maldives as a member of the PCC for a three-year term starting 1 January 2013, and requested the Regional Director to inform WHO headquarters accordingly.

Time and place of future sessions of the Regional Committee (Agenda item 8.1: Document number SEA/RC65/23)

224. The Committee decided to hold its Sixty-sixth session in September 2013 at the WHO Regional Office for South-East Asia, New Delhi.

225. The Committee noted with appreciation the confirmation by the Government of the People’s Republic of Bangladesh of its invitation to host the Committee’s Sixty-seventh session in September 2014.

Adoption of resolutions

226. The Committee adopted nine resolutions and three decisions.

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

227. The Vice-Chair noted that the draft report had been circulated to all Member States and that it would be finalized after incorporating any comments received. With this guidance, the report as presented was adopted.
228. The Chair offered to prepare, with the Committee’s concurrence, a summary to complement the final report for submission to the Executive Board in January 2013.

**Closure of the session**

229. The representatives of the Member States expressed their gratitude to Indonesia, the host country, for their excellent arrangements. They also thanked the WHO Secretariat for facilitating the smooth conduct of the Regional Committee meeting. They reiterated that the strength of the South-East Asia Region was unity. This solidarity, the representatives stated, was unique, especially with the backdrop of a huge population and disease burden, exacerbated by limited resources.

230. The Regional Director complimented the Committee on the successful conclusion of the Sixty-fifth session of the Regional Committee. He thanked the honourable ministers and the distinguished country representatives for their active participation and providing valuable guidance and recommendations.

231. The Regional Director expressed his gratitude to the drafting group on resolutions and, in particular, the Convener of the group, for drafting resolutions so well that they were adopted with minor amendments only. He stressed the need to diligently work on the recommendations of these resolutions so that progress could be reported to future sessions of the
Regional Committee. He stated that WHO would do its best to support Member States in implementing these resolutions.

232. The Regional Director thanked the Government of Indonesia for graciously agreeing to host the Regional Committee meeting in the beautiful city of Yogyakarta. He expressed his gratitude to the Vice President for opening the joint inaugural session and for his thought-provoking address. He also thanked the Honourable Minister for Health of Republic of Indonesia for chairing the session, and the Honourable Minister for Health of Republic of Maldives for graciously agreeing to be the Vice-Chair. He expressed satisfaction at the efficient and effective manner in which the proceedings were conducted, resulting in decisive recommendations that would guide countries to move forwards.

233. Appreciation was also conveyed to the staff of the Yogyakarta Special Region, and the staff of the Ministry of Health of Republic of Indonesia for the logistic support provided.

234. The Regional Director thanked the Honourable Minister for Health of Republic of Indonesia and the Governor of Yogyakarta Special Region for the dinners and entertaining cultural programmes organized for the distinguished representatives.

235. The Vice-Chair thanked the distinguished representatives for the in-depth discussion with mutual understanding and cooperation on vital issues relating to health development. He said that the decisions and recommendations arrived at during the meeting would go a long way in improving the health of the people of the Region.

236. The Vice-Chair also thanked the drafting group on resolutions and the Secretariat for enabling the meeting to be conducted in an atmosphere of cordiality and friendliness.

237. The Vice-Chair expressed appreciation to the Regional Director and the Director-General and hoped that they would continue to guide Member States. He also thanked the UN agencies, development partners and NGOs for their useful contribution to the proceedings.
Resolutions

SEA/RC65/R1  Process for the Nomination of the Regional Director

The Regional Committee,

Having considered the Report on the Process for Nomination of the Regional Director by the WHO Regional Committee for South-East Asia submitted by the sub-committee constituted under Rule 51 of the Rules of Procedure of the WHO Regional Committee for South-East Asia at its Sixty-fifth Session;

Desiring to improve the degree of transparency in the process for Nomination of the Regional Director;

Having considered the practice followed by the World Health Organization for the nomination of the Director-General and Regional Directors,

(1) DECIDES to amend Rule 49 of the Rules of Procedure of the WHO Regional Committee for South-East Asia, by adding a new paragraph (f)(bis) to Rule 49, regarding presentations by candidates for the post of Regional Director, as contained
in Annex A to this Resolution. This amendment will become effective immediately;

(2) DECIDES, with regard to such presentations, that the modalities set forth in Annex B to this Resolution shall also become effective immediately; and

(3) DECIDES that the criteria set forth in Annex C to this Resolution, should be used for assessing candidates for the post of Regional Director with immediate effect.

Annex A

Amendment to Rule 49 of the rules of procedure of the WHO Regional Committee for South-East Asia, regarding presentations by candidates for the post of Regional Director

Rule 49, (f)(bis) The persons proposed in accordance with Paragraph (b) of this Rule shall be invited to make a presentation at a private meeting of the Committee. The presentation shall consist of an oral statement by each candidate; in addition, members of the Committee may make requests for clarifications. The Committee shall determine, as appropriate, modalities for the presentations.

Annex B

Modalities for the presentation process for the nomination of the Regional Director

1. The presentation shall be made in a private meeting of the Regional Committee.

2. The presentation shall address the candidate’s analysis of current public health problems and priorities in the WHO South-East Asia Region and his/her vision on WHO’s Mission and role in addressing these issues.

3. The presentation shall consist of an oral statement by each candidate not to exceed 20 minutes; in addition, members of the Committee may make requests for clarifications, not to exceed 40 minutes. The time limits shall be strictly adhered to.

Other modalities shall be determined by the Regional Committee as appropriate.
Annex C

Desired criteria for assessing candidates for the post of the Regional Director

1. A strong technical and public health background and extensive experience in global health;
2. Competency in organizational management;
3. Proven historical evidence for public health leadership;
4. Sensitiveness to cultural, social, and political differences;
5. A strong commitment to the work of WHO;
6. The good physical condition required of all staff members of the Organization;
7. Commitment to personal compliance with the WHO policy on non-recruitment of smokers or other tobacco users; and
8. Sufficient skill in the official working language of the Region.

SEA/RC65/R2 Proposed Programme Budget 2014-2015

The Regional Committee,

Having considered the Proposed Programme Budget 2014–2015, which follows a significantly different approach from previous bienniums, and keeping in mind the recommendations of the Fifth Meeting of the Subcommittee on Policy and Programme Development and Management calling on WHO-SEARO to ensure country-level engagement in the 2014–2015 Programme Budget development process;

Recognizing that unlike in previous bienniums, the Proposed Programme Budget 2014–2015 is being developed in parallel with the 12th General Programme of Work;

Appreciating that the Proposed Programme Budget 2014–2015 is structured around the six Categories described in the 12th General Programme of Work, and noting that under each Category there is a description of priorities and rationale, challenges, strategic approaches, linkages and a series of outcomes and outputs;
Recognizing the need for adequate country-level consultation and engagement in the Proposed Programme Budget 2014–2015 development process in order to engender a sense of ownership among Member States;

Noting that the Proposed Programme Budget 2014–2015 does not as yet include initial Budget figures or performance indicators, and that work is still ongoing to standardize the outcome statements and improve their linkages to the priorities and outputs;

Recognizing the need for innovative funding mechanisms to help Member States fund national health programmes, and to ensure funding of the Proposed Programme Budget 2014–2015;

ENDORSES the recommendations of the Fifth Meeting of the Subcommittee on Policy and Programme Development and Management;

URGES Member States:

(1) To engage proactively with WHO in the 2014–2015 Programme Budget development process and the finalization of the 12th General Programme of Work;

REQUESTS the Regional Director to take up with the WHO Director-General for her consideration, when finalizing the Proposed Programme Budget 2014–2015:

(1) Inclusion of realistic, measurable indicators to track performance during implementation of Programme Budget 2014–2015.

(2) Consideration of the recommendations emanating from WHO-SEARO consultations with countries on country-level priorities and budgetary requirements when determining 2014–2015 budget allocations; and

FURTHER REQUESTS the Regional Director:

(1) To help ensure country-level ownership and engagement in the next phase of the Programme Budget 2014–2015 development process and during 2014–2015 operational planning.
SEA/RC65/R3  Consultative Expert Working Group on Research and Development: Financing and Coordination

The Regional Committee,


Further recalling resolution WHA63.28 on the establishment of a Consultative Expert Working Group (CEWG) on Research and Development: Financing and Coordination; requesting the Director-General, inter alia, to establish the CEWG to take forward the work of the Expert Working Group earlier established under resolution WHA61.21;

Noting the resolution WHA65.22 which requests Regional Committees to discuss at their 2012 meetings the report of the CEWG in the context of the implementation of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property in order to contribute to concrete proposals and actions;

Recognising the need for enhancing investments in health research and development (R&D) related to Type II and Type III diseases and the specific R&D needs of developing countries in relation to Type I diseases;

Recognising that improved access to medical products such as medicines, vaccines and diagnostics in relation to Type II and Type III diseases and specific R&D needs of diseases of Type I in developing countries are the paramount goals;

Acknowledging the importance of innovation, technology transfer and access to medical products for essential health R&D relevant to diseases which disproportionately affect developing countries, proposing clear objectives and priorities for R&D, estimating funding needs in this area, and coordinating, facilitating and promoting health R&D;
Recognising the importance of securing sustainable financing mechanisms for R&D to develop and deliver health products to address the health needs of developing countries and develop mechanisms to monitor and evaluate the implementation of the Global Strategy and Plan of Action, including reporting systems;

Realizing the need for improving priority-setting and transparent decision-making processes based on the public health needs of developing countries;

Appreciating the Regional Director for convening a regional technical discussion on the report of the CEWG where Member States take an active role in the discussions; and

Welcoming the recommendations made by the CEWG and the need of Member States of the Region to implement the same in phases starting with coordination mechanisms, including the setting up of a global health R&D observatory, inter alia, to determine the existing capacities, requirements and the absorptive capacities of developing countries in essential health R&D relevant to diseases which disproportionately affect developing countries which would enable the individual countries to decide the level of commitment of resources;

URGES Member States:

1. To strengthen health R&D capacities on diseases of Type II, III and specific R&D needs of developing countries on diseases of Type I, through increased financial resources from the existing government budgets and private sources through different incentive schemes, and explore potential new or innovative sources specifically for health R&D;

2. To build, strengthen and sustain human resources and infrastructure for health research and development;

3. To promote coordination of health R&D among public and private partners in the country, and support regional and global coordination for health R&D in order to maximize synergies and avoid duplications;

4. To establish or strengthen national health R&D observatories for tracking and monitoring human and financial resources spent on health R&D and contribute to the work of a global health R&D observatory;
To promote the establishment of Advisory Mechanisms and the Global Health R&D Observatory as suggested by the CEWG to enable WHO to play a central and stronger role in improving coordination of R&D directed at the health needs of developing countries;

To support the formation of a working group with equal representation from each Region to undertake future preparatory work for the convention as suggested by the CEWG;

To explore the potential role of pooled funding at the global level, from different sources of finance, in supporting health R&D, and that the promising medical products, technologies and innovations generated from the pooled fund are global public goods and made available free of R&D cost; and

To engage actively in the negotiations in an open-ended meeting of Member States in November 2012, inter alia, by supporting the development of the Global Health R&D Observatory, effective global R&D coordination, adequate and sustainable funding for R&D on diseases of Type II and III and specific R&D needs of diseases of Type I in developing countries; and

REQUESTS the Regional Director:

To support Member States in their endeavour to establish or strengthen health R&D capacities and national health R&D observatories, which inter alia also contribute to the Regional and Global Health R&D observatory;

To facilitate the establishment of Regional and Global Health R&D Observatories and related Advisory Mechanisms as suggested by the CEWG through technical and financial support;

To strengthen the capacity of Member States to access and benefit from mechanisms as suggested by the CEWG, including the Global Health R&D Observatory and the pooled fund mechanism;

To promote partnerships and coordination at the country, regional and global levels in order to maximize synergies in health R&D;

To convey to the Director-General the wish of the Member States for consideration that the Chair of the open-ended meeting of Member States be from the SEA Region; and
(6) To report to the Sixty-seventh Session of the WHO Regional Committee for South-East Asia in 2014 on the progress made in implementing this resolution.

**SEA/RC65/R4 Report of the Regional Director**

The Regional Committee,

Having reviewed and discussed the Biennial Report of the Regional Director containing highlights of the work of WHO in the South-East Asia Region for the period 1 January 2010 to 31 December 2011 (SEA/RC65/1), and

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

(1) NOTES with satisfaction the progress made during this period in the implementation of WHO’s collaborative programmes and activities in the Region; and

(2) CONGRATULATES the Regional Director and his staff for bringing out a clear and comprehensive report.

**SEA/RC65/R5 Noncommunicable Diseases, Mental Health and Neurological Disorders**

The Regional Committee,

Recalling World Health Assembly resolutions WHA53.17, WHA56.1, WHA57.17, WHA60.23, WHA 64.11 and WHA 65.4, and its own resolutions SEA/RC52/R7, SEA/RC53/R10 and SEA/RC60/R4, relating to the prevention and control of noncommunicable diseases including mental and neurological disorders;

Acknowledging the Political Declaration of the High-Level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases, the Moscow Declaration adopted at the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Diseases Control, and the Rio Political Declaration on Social Determinants of Health;
Reaffirming the World Health Assembly Decision WHA 65.8(7) on follow-up to the High-Level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases and the adoption of the global target of a 25% reduction in premature mortality from noncommunicable diseases by 2025;

Recognizing that noncommunicable diseases such as cardiovascular diseases, cancers, chronic respiratory diseases and diabetes are the leading cause of premature death and disability, and that the burden is likely to increase in the South-East Asia Region due to population ageing, globalization, changes in dietary patterns, unplanned urbanization and other social determinants;

Recognizing that mental and neurological disorders are common causes of disability, suffering and premature death;

Noting with concern that the rapidly increasing health-care costs associated with the treatment of NCDs, mental and neurological disorders disproportionately affect the poor, impoverish families, and overburden the public health-care systems;

Recognizing the substantial stigma against mental and neurological disorders;

Further recognizing the substantial harm from alcohol use that goes beyond health risks and includes social, psychological and economic risks;

Realizing that effective and affordable interventions are available to modify the common risk factors of NCDs such as unhealthy diet, physical inactivity, tobacco use and harmful use of alcohol;

Recognizing the role of the “life course” approach that emphasizes the critical importance of health promotion and disease prevention strategies to minimize the risk of NCDs, and mental and neurological disorders at each stage of life;

Appreciating that policies in sectors other than health have a major bearing on risk factors and environmental and social determinants of NCDs, and reiterating that there is a pressing need to strengthen multisectoral collaboration at all levels; and
Acknowledging the need for development of standard indicators and targets to monitor the progress towards prevention and control of NCDs and their risk factors at global, regional and national levels;

URGES Member States:

(1) To integrate NCD policies and programmes into national health planning processes and the global and national development agenda, and, by 2013, to strengthen national multisectoral policies and plans for the prevention and control of NCDs, including mental health and neurological disorders;

(2) To address NCD risk factors using the “life course” and an evidence-based approach beginning in the pre-pregnancy period and continuing through childhood and adulthood, including the elderly, with the emphasis on public health interventions;

(3) To accelerate implementation of the WHO Framework Convention on Tobacco Control, the Global Strategy on Diet, Physical Activity and Health, and the Global Strategy to Reduce the Harmful Use of Alcohol with the emphasis on implementation of “best buys”\(^1\);

(4) To develop and strengthen national strategies and plans to address NCDs with realistic indicators and targets, taking into account results of the global consultations on the NCD Action Plan and Global Monitoring Framework and voluntary targets, as well as national priority and context;

(5) To strengthen national surveillance systems and information systems, and encourage research on NCD prevention and control;

(6) To develop comprehensive policies and strategies that address the promotion of mental health, and prevention of mental and neurological disorders taking into account the results of the global consultations for development of the Global Mental Health Action Plan;

(7) To ensure adequate financial, technical and human resources for health promotion and primary prevention, and strengthen health systems for early identification, diagnoses and management of acute and chronic NCDs and mental and neurological disorders, particularly at the primary care level;

(8) To enhance participation in all steps of the noncommunicable diseases follow-up processes, including consultations and meetings of WHO Governing Bodies on the Global Monitoring Framework.

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\(^1\) Based on *Global Status Report on Noncommunicable Diseases 2010* (WHO)
Framework and the setting up of global targets, the Global Action Plan for Prevention and Control of Noncommunicable Diseases, and the comprehensive Mental Health Action Plan;

(9) To collectively advocate for the consideration of global targets for the prevention and control of noncommunicable diseases to cover all major risks, namely, tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol, as well as targets relating to health outcomes and health systems response; and

(10) To collectively advocate for NCDs to be included in discussions at the highest international forums, including in the post-2015 UN Development Agenda; and

REQUESTS the Regional Director:

(1) To work closely with Member States and partner agencies to address the regional and national burden of NCDs, including mental and neurological disorders, and to ensure optimum communication and advocacy messages in support of multisectoral actions for NCD prevention and control through existing forums such as WHO Governing Bodies, the UN General Assembly, the WHO Regional Committees, and other UN regional bodies;

(2) To provide technical guidance and support to Member States for building capacity, and for developing and strengthening national health systems and multisectoral plans and policies for the prevention and control of NCDs, including mental and neurological disorders; and

(3) To support Member States to develop and strengthen national strategies and plans with realistic indicators and targets to address noncommunicable diseases, including mental and neurological disorders;

**SEA/RC65/R6 Regional Strategy for Universal Health Coverage**

The Regional Committee,

Having considered SEA/RC65/15 Information Document on Regional Strategy for Universal Health Coverage;
Concerned that 1 billion people worldwide do not have access to health care, 150 million people face catastrophic health-care costs each year because of direct payments for health care, while 100 million are driven below the poverty line thereby contributing to avoidable morbidity and premature mortality, aggravating inequity and impeding sustainable social and economic development;

Recognizing the contribution of universal health coverage (UHC) towards achieving Millennium Development Goal 1, to eradicate extreme poverty and hunger; Goal 4, to reduce child mortality; Goal 5, to improve maternal health; Goal 6, to combat HIV/AIDS, malaria, TB and other diseases; and Goal 8, to develop a global partnership for development; and the achievement of wider social policy objectives as set out by the Joint UN Social Protection Floor Initiative;

Acknowledging the crucial importance and contributions of all health systems building blocks including human resources for health, medicines, and a resilient and responsive health services delivery with extensive geographical coverage of functioning primary health care with an effective referral system is a key foundation for UHC;

Noting that each country can start providing financial risk and social protection to targeted populations, taking into account harmonization across different schemes, and gradually accelerate progress towards UHC, which is possible and affordable even at a low level of economic development provided that there are strong and sustained political and financial commitments by governments; and

Appreciating the Director-General of the World Health Organization and the Regional Director of the WHO South-East Asia Region for their leadership and support to Member States in moving towards UHC and formulating the Regional Strategy for Universal Health Coverage, based on evidence and participatory processes;

ENDORSES the Regional Strategy for Universal Health coverage;

URGES Member States:

(1) To develop and/or strengthen country-specific strategies for UHC including health development and investment plans, as appropriate, applying the four Strategic Directions of the Regional Strategy for Universal Health Coverage.
To strengthen national capacity for monitoring and evaluation and regularly monitor progress towards UHC; and

To actively contribute to the work of the regional UHC platform for exchange of UHC experiences across countries, which could also accelerate the implementation of national UHC agendas; and

REQUESTS the Regional Director:

(1) To provide technical support to Member States in developing, implementing and monitoring country-specific strategies for UHC, applying the four Strategic Directions of the Regional Strategy for Universal Health Coverage;

(2) To strengthen capacity in the Region and the existing platform initiated by WHO-SEARO for sharing of UHC experiences, supporting collaborative research, monitoring progress and linking with other UHC networks;

(3) To support countries to produce evidence on impact of UHC, including on reduction of out-of-pocket expenditure, prevention of household catastrophic health expenditure and impoverishment; and using this for discussions on universal health coverage at the highest regional and global development forums;

(4) To convene regular workshops for Member States in the SEA Region to share experiences, identify challenges and their potential solutions, and monitor progress towards UHC; and

(5) To support mechanisms at regional and international levels for specific needs of Member States for health system strengthening for UHC, including bulk procurement of medicines.

SEA/RC65/R7 Strengthening Health Workforce Education and Training in the Region

The Regional Committee,

Recalling WHA63.16 WHO Global Code of Practice on the International Recruitment of Health Personnel, and its own resolution SEA/RC59/R7 on Strengthening the Health Workforce in SEA Region;

Reaffirming the Dhaka Declaration on Strengthening the Health Workforce in Countries of the South-East Asia Region;
Noting with serious concern on the critical shortage and imbalance of the health workforce, particularly in rural remote areas in the Region, and that the situation has not been improved;

Aware that current education and training of the health workforce need an urgent attention for improvement in order to produce competent health professionals to match the health needs of the population; and

Aware that an adequate, competent and equitably distributed health workforce is the backbone of Universal Health Coverage;

URGES Member States:

(1) To review national health workforce policies, strategies and plans to maximize their contributions to the health of the population and the achievement of universal health coverage;

(2) To conduct comprehensive assessments of the current situation of health workforce education and training, based on an agreed regional common protocol, as a foundation for evidence-based policy formulation and implementation;

(3) To develop or strengthen policies for education and training of the health workforce as an integral part of national health and education and training policies;

(4) To increase resources and support for the strengthening of education and training of the health workforce, including community-based health workforces, while ensuring appropriate accreditation, in support of universal health coverage, for which the training curriculum is relevant to country health and health systems needs.

REQUESTS the Director-General of the World Health Organization through the Regional Director for South-East Asia to propose the inclusion of an Agenda item entitled “Health Workforce Education and Training” in the Provisional Agenda of the 132nd Session of the Executive Board in January 2013; and

REQUESTS the Regional Director:

(1) To support Member States in conducting a comprehensive assessment of the current situation of health workforce education and training based on an agreed regional common protocol;
(2) To convene regional technical consultations to review the result of the country assessments and to formulate regional strategy on strengthening health workforce education and training in the Region;

(3) To support Member States in their efforts to further strengthen health workforce education and training, including community-based health workforces; and

(4) To submit the Regional Strategy on Strengthening Health Workforce Education and Training, as well as progress of the implementation of this resolution, to the Sixty-seventh session of the Regional Committee.

SEA/RC65/R8 Comprehensive and Coordinated Efforts for the Management of Autism Spectrum Disorders (ASD) and Developmental Disabilities

The Regional Committee,

Recalling the Universal Declaration of Human Rights 1948 and the Convention on the Rights of the Child 1989 by the United Nations General Assembly; and the Convention on the Rights of Persons with Disabilities 2007; and the Declaration of 2nd April as World Autism Awareness Day by the United Nations General Assembly in 2007; and the Dhaka Declaration on Autism Spectrum Disorders and Developmental Disabilities of July 2011; and further recalling World Health Assembly resolution WHA65.4 on The global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level;

Reiterating commitments of safeguarding citizens from discrimination and social exclusion on the grounds of disability or other condition, and ensuring citizens’ basic necessities of life, education, medical care and social security, and attention to vulnerable groups of the population;

Noting that more and more children are being detected to have autism spectrum disorders (ASD) and other developmental disabilities worldwide, and that the likelihood that still more remain unidentified in society due to lack of awareness;
Understanding that ASD and developmental disabilities are life-long and affect the functioning of the brain, and are characterized by impairments in social interaction, problems with verbal and non-verbal communication, and restricted, repetitive behaviour, interests and activities;

Further noting that such disabilities seriously influence everyday functioning of affected children, severely interfere with their developmental, educational and social attainments, and bring significant economic costs to their families and societies;

Concerned that, despite increasing evidence documenting the effectiveness of early interventions in improving the overall functioning of the child and long-term outcomes, children and families in need often have poor access to services and do not receive adequate treatment and care;

Deeply concerned about the dramatic rise in the numbers of children with autism and developmental disabilities and the growing costs involved in managing such disabilities;

Recognizing that children with ASD and developmental disabilities and their families often face major challenges associated with stigma, isolation and discrimination; and

Acknowledging that the Mental Health Gap Action Programme (mhGAP 2008) of the WHO Secretariat can be particularly instrumental for developing countries if it gives increasing focus on ASD and developmental disabilities;

URGES Member States:

(1) To give appropriate recognition to ASD and developmental disabilities in all policies and programmes related to early childhood development;

(2) To develop and implement policies and legislation, as appropriate, and multisectoral plans including public awareness, stigma removal campaigns, supported with adequate human, financial and technical resources to address issues related to ASD and developmental disabilities;

(3) To develop strategies for early detection and community-based interventions for children with ASD and developmental disabilities in line with WHA 65.4;
(4) To develop appropriate infrastructure for comprehensive management, including education, care, support, intervention, services and rehabilitation, of ASD and developmental disabilities;

(5) To provide social and psychological support and care to families affected by ASD and developmental disabilities;

(6) To promote research on the social and public health aspects of ASD and developmental disabilities; and

(7) To implement, as appropriate, the Dhaka Declaration on Autism Spectrum Disorders and Developmental Disabilities of 2011; and

REQUESTS The Regional Director:

(1) To collaborate with Member States and partner agencies for support to strengthen national capacities and implement national efforts to address ASD and developmental disabilities, including early identification, management and care, at all levels of facilities and monitoring progress;

(2) To support Member States upon request in the implementation of the Dhaka Declaration on Autism Spectrum Disorders and Developmental Disabilities of 2011;

(3) To support the activities of autism-related networks, including the South-East Asia Autism Network (SAAN); and

(4) To mobilize resources to address ASD and developmental disabilities in the South-East Asia Region.

(5) To coordinate with mhGAP of the WHO Secretariat for giving increasing focus on ASD and developmental disabilities;

(6) To submit a progress report to the Sixty-seventh session of the Regional Committee on implementation of this Resolution.

SEA/RC65/R9 Resolution of Thanks

The Regional Committee,

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

(1) THANKS His Excellency, Prof. Dr Budiono, M.Ec, Vice-President of the Republic of Indonesia, for graciously inaugurating the session and for his thought-provoking address;
CONVEYS further its gratitude to His Excellency, Sri Sultan Hamengku Buwono X, Governor of Yogyakarta Special Region, for his participation in the joint inaugural session and for his hospitality;

THANKS the Director-General of WHO for her inspiring address and active participation;

CONVEYS its gratitude to the Government of the Republic of Indonesia and the members of the National Organizing Committee, the staff of the Ministries of Health and Foreign Affairs, and other national authorities for organizing and hosting the session;

EXPRESSES its appreciation for the Chair, Dr Nafsiah Mboi, Honourable Minister of Health, Republic of Indonesia, and Co-Chair, H.E. Dr Ahmed Jamsheed Mohamed, Honourable Minister of Health, Ministry of Health, Maldives, for conducting the proceedings in a professional and efficient manner;

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

CONGRATULATES the Regional Director and his staff for their dedicated efforts towards the successful and smooth conduct of the session.

Decisions

SEA/RC65(1) Technical discussions: Selection of a subject for the technical discussions to be held prior to the Sixty-sixth session of the Regional Committee

The Committee decided on the subject of “Universal Health Coverage” as the subject for Technical Discussions to be held prior to the Sixty-sixth session of the Regional Committee in 2013.
SEA/RC65(2) Nomination of a Member State to the Policy and Coordination Committee (PCC) of the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction

The Committee nominated Maldives as member of the PCC for a three-year term starting 1 January 2013, and requested the Regional Director to inform WHO headquarters accordingly.

SEA/RC65(3) Time and place of future sessions of the Regional Committee

The Committee decided to hold its Sixty-sixth session in 2013 in the WHO Regional Office for South-East Asia, New Delhi.
Annexes
Annex 1

Text of keynote speech by the Vice President, Republic of Indonesia

Distinguished Delegates;
Ladies and Gentlemen.

It gives me great pleasure to welcome you all very warmly to the Thirtieth Meeting of the Ministers of Health and the Sixty-fifth Session of the WHO Regional Committee for South-East Asia. I hope the historical City of Yogyakarta will provide you an agreeable environment for the successful conclusion of these meetings.

I would like also to take this opportunity to congratulate Dr Margaret Chan for her re-election to a second term in office as the Director-General of the World Health Organization. This reflects the wide recognition of her past contributions to the World Health Organization and its Member States. We are extremely proud to see you continuing your important role in serving the global community.

Excellencies,
Ladies and Gentlemen,

We are truly honoured to host these meetings for the fifth time where all the 11 members of WHO SEAR get together, to review past commitments and embark on new initiatives to improve the health status of the peoples of our Region. The results of the meetings would certainly contribute significantly to the global quality of life, since our Region is home to approximately 25 per cent of the world’s population and includes the most dynamic economies in the world.
At this juncture, I would like to recall that recently President Susilo Bambang Yudhoyono stated that global development collaboration must be built upon the principles of common but differentiated responsibilities and respected capabilities, and open participation to all stakeholders. This principle seems to be applicable to our ways in establishing sustainable health cooperation.

This cooperation must be aimed at empowering the poor in developing countries, and upholding the principles of proportionally shared responsibility and mutual benefits. Moreover, it should also serve to strengthen our effort to overcome global health challenges. I believe these meetings will create momentum toward these ends.

We meet at a time when great challenges loom over the global landscape. These challenges include the occurrence of emerging and re-emerging diseases, an economic slowdown in many parts of the world, rapid population growth and urbanization, as well as fierce competition for scarce resources. These are major flash points which we must watch out for, since they inevitably have impact on the health status of our people.

Excellencies,
Ladies and Gentlemen,

The theme of the World Health Day this year focusing on Ageing and Health is apt given the current situation of the increasing number of the elderly population in the world including in our Region. The estimated number of population of the WHO SEA Region above the age of 60 years is 142 million people or 8 per cent. This number will continue to increase. To address this situation we need to develop and strengthen national and regional policies on Ageing and Health, improve the primary health care system as well as health facilities. Moreover, we also need to ensure the provision of sufficient resources for programs dealing with Ageing and Health - taking into consideration the economic aspects of long-term care of the elderly persons, both at the facility and household levels.

Excellencies,
Ladies and Gentlemen,

At this opportune time, allow me to update you on recent initiatives that we have taken in this country. To ensure the community access towards quality health care, Indonesia has strong commitment to achieve
Universal Health Coverage. Continuous efforts have been made towards this end. We have had some good and some not-so-good experiences. Indonesia stands ready to share with other countries in the region its experience and to cooperate closely with them with a view to achieving the Universal Health Coverage for the whole people in the Region.

The ultimate goal of the Universal Health Coverage is to create social and economic well-being of the whole population. Unfortunately, progress toward that goal, at any time, could be undermined by various health problems such as pandemics caused by communicable diseases.

Therefore, implementation of International Health Regulations 2005 (IHR) needs strong commitment from all the WHO SEAR Member States. Indonesia is of the view that the IHR is a good framework to secure national, regional and global health. We are fully committed to implement IHR 2005 in due course.

In relation to the prevention of, and response towards, pandemics I would also like to refer to the World Health Assembly (WHA) resolution 64.5 on Pandemic influenza preparedness, namely sharing of influenza viruses and access to vaccines and other benefits. This resolution ensures a fair, transparent and equitable framework which shall guide all WHO Member States in dealing with pandemic influenza preparedness.

Communicable diseases are still the main health problem in Indonesia. However, the country is at present facing a double burden of health care where at the same time the morbidities and mortalities caused by noncommunicable diseases (NCDs) also show rising trends. It is sad to note that NCDs have become serious health problems affecting all groups of population including the elderly, and in all countries.

Referring to all of the global strategies including the WHO recommendations on the WHO Global strategy for the prevention and control of NCDs and implementation of the Action Plan, I would like to invite all member countries of the WHO SEAR to continue working together to cope with this alarming situation.

Excellencies,
Ladies and Gentlemen,

Cooperation in the health sector should complement the overall efforts in the social and economic development in Member countries of WHO.
SEAR. Therefore, it is my sincere hope that these meetings will reinforce our common goal to ensure higher health status in the Region.

The current inhospitable global situation which also affects our Region should encourage us all to work closer together in implementing various global and regional commitments.

As the global demography and the global health challenges face greater complexities, the problems of population and health development will need better and proper solutions acceptable to all of us.

In closing, allow me to wish you a memorable and enjoyable stay in Yogyakarta and successful deliberations. Finally, by asking the Grace of God the Almighty hereby I declare the Thirtieth Meeting of the Ministers of Health and the Sixty-fifth Session of the WHO Regional Committee for South-East Asia officially open.

Thank you.
Annex 2

Text of address by the Minister for Health, Republic of Indonesia

Your Excellency, Bapak Boediono, Vice President of the Republic of Indonesia,

Your Excellencies, Ministers of Health of Member States of the WHO South-East Asia Region,

Your Excellency, Dr Margaret Chan, Director-General of the World Health Organization,

Your Excellency, Dr Samlee Plianbangchang, Regional Director WHO South-East Asia,

Honourable Sri Sultan Hamengku Buwono X, Governor of Yogyakarta Special Region,

Representatives from Partner Countries and International Organizations, Distinguished Delegates, Ladies and Gentlemen,

A very good morning to you all,

Your Excellency, Mr Vice President, this morning ministers of health from Member States of WHO South-East Asia Region or their representatives, and their delegations are assembled in Yogyakarta to hold the Thirtieth Meeting of the Ministers of Health of Countries of the WHO South-East Asia Region. The ministerial meeting is being held to exchange views and share experiences on policy matters related to health of common concerns in the region. The Meeting was preceded by the Senior Advisers Meeting which took place yesterday.

We are particularly pleased and honoured of the presence of Your Excellency Mr Vice President to grace this joint inaugural session of both meetings.
Allow me to report to Your Excellency that the ministerial meeting will address a number of important issues in health cooperation among the Member countries. Among others, the meeting will review implementation of the six declarations of previous Health Ministers Meetings during the last six years. Furthermore, the ministers will also discuss follow-up actions on the decisions and recommendations of the Twenty-ninth Meeting held in Jaipur in 2011.

The Sixty-fifth Session of the Regional Committee as Governing Body will be held from 5 to 7 September 2012. The Session will first listen to the Regional Director’s Biennial Report on the work of WHO in the South-East Asia Region. It will also address, at the regional perspective, various key and technical health issues arising out of the Sixty-fifth World Health Assembly and the 130th Executive Board Meeting.

The delegations come from the 11 Member States of WHO South-East Asia Region namely Bangladesh, Bhutan, Democratic People’s Republic of Korea, India, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste and Indonesia. Also present in this session are representatives from various international organizations.

Your Excellency Mr Vice President,

In line with this year’s World Health Day’s theme, this Yogyakarta Meeting will also take up the issue of Ageing and Health. The growth of elderly population has increased significantly in recent years as a result of the improvement of health programmes in many countries including SEAR Member States. Such increase would require necessary adaptation of healthcare and social support systems.

This situation affects the overall quality of life and poses challenges for families, communities, and national governments. At the end of this meeting it is expected that the ministers of health will adopt the Yogyakarta Declaration on Ageing and Health.

This declaration calls on governments to commit on building partnership among various stakeholders at the national, regional, and global levels leading to the strengthening policies and services related to Ageing and Health. Special attention will also be given to the issues of International Health Regulations 2005 and Universal Health Coverage.
Your Excellency Mr Vice President,

In closing, we would like to assure you that the selection of Yogyakarta as the venue of these meetings will contribute to the successful outcome of our deliberations. Allow us to express again our utmost gratitude to Your Excellency Bapak Boediono, the Vice President of the Republic of Indonesia, for allocating your precious time to officiate both the Ministerial Meeting and the Regional Committee Meeting of the WHO South-East Asia Region. It is also a pleasure for us to thank the Honorable Sri Sultan Hamengkubuwono IX, Governor of Yogyakarta Special Region, for your support for the success of these meetings.

Finally we have the honour to respectfully request Your Excellency Mr Vice President to deliver your keynote address and declare the meetings officially open.

Thank you.
Excellency, Professor Boediono, Vice President of the Government of the Republic of Indonesia; Excellency, Dr Nafsiah Mboi, Minister for Health of the Government of the Republic of Indonesia; Honourable Ministers of Health from countries of WHO SEAR; Distinguished country representatives; Honourable guests; Ladies and gentlemen,

On behalf of the WHO South-East Asia Region it is my privilege to warmly welcome you all to the joint inauguration of the Thirtieth Meeting of Health Ministers of WHO SEAR, and the Sixty-fifth Session of WHO Regional Committee for SEA.

I sincerely thank the Government of the Republic of Indonesia for hosting these two important meetings. I overwhelmingly thank Excellency, Professor (Dr) Boediono, Vice President of the Government of the Republic of Indonesia for graciously accepting to inaugurate this joint opening.

Excellencies, ladies and gentlemen,

Increasing access to health care and curbing catastrophic health expenditure has been a major challenge in SEAR. Through various schemes of health insurance, Indonesia has made impressive progress in this area during the past few years. Health services coverage in Indonesia has now extended to more than 58% of the population of about 240 million people. What is particularly encouraging is that public health work is getting higher priority.
Through the provision of a dedicated budgetary allocation the outreach activities have been expanded to all health centres. This strategy is indeed important because it will help ensure reaching the hard to reach people. And thereby steadily improve health equity in the country.

Excellencies,

Countries of SEAR continue making progress in improving health of their populations. As far as the infectious disease is concerned there have been no new cases of wild polio virus infection since January 2011 and high-quality surveillance of acute flaccid paralysis is maintained throughout the Region; this is to ensure that we can formally declare polio-free in early 2014.

Measles vaccination coverage in some countries is increasing to reach the elimination target of 95% coverage. Routine immunization has been successfully intensified as declared by Honourable Health Ministers in 2011, and the desired coverage of 90% or more is sustained in most countries.

As far as maternal mortality is concerned, between 1990 and 2010 the number of women dying from complication of pregnancy and childbirth had decreased by 66%. However, this is not yet sufficient for all countries in the Region to meet the 75% mortality reduction target of MDG 5 by 2015. Nonetheless, many countries are on track in their progress towards reaching this goal.

During the recent past, countries had accorded high priority to prevention and control of NCDs especially in view of increasing longevity of life of people due to several factors. At the same time, efforts should be enhanced to ensure that our ageing populations remain healthy and they continue to lead a socially and economically productive and satisfied life. Towards this end, a life-course approach in our health-development endeavours needs to be adopted.

Excellencies,

Universal Health Coverage needs balanced development between preventive and curative care. It needs health systems based on the primary health care approach and UHC cannot be achieved by the health
sector alone; efforts of other sectors need to be mobilized in a more efficient manner through partnerships.

Furthermore, climate change will further exacerbate the disease burden in all countries. Our public health programmes need vigorous strengthening for effective mitigation of the health impact of CC. And with the current environmental conditions, we may expect more public health emergencies of international concerns, and we need to move fast to strengthen country capacity in implementing the International Health Regulations (2005).

Excellencies, ladies and gentlemen,

Under the leadership of Director-General, Dr Margaret Chan, our top priority in SEAR is the implementation of collective decisions of Member States in the WHO Reform Agenda. The Member States will have opportunity to review the issues involved during this course of their meetings.

Finally, ladies and gentlemen, I wish the Honourable Health Ministers and distinguished representatives fruitful deliberations. I sincerely thank the local organizing committee for the excellent arrangements made for the two meetings. I also wish you all an enjoyable stay in this historic city of Yogyakarta.

Thank you.
Annex 4

Agenda

1. Opening of the Session
   1.1 Appointment of the Subcommittee on Credentials
   1.2 Approval of the report of the Subcommittee on Credentials
   1.3 Election of Office-bearers
   1.4 Adoption of the Agenda

2. Key Addresses and Report on the Work of WHO
   2.1 Introduction to the Regional Director’s Biennial Report on the Work of WHO in the South-East Asia Region covering the period 1 January 2010 – 31 December 2011
   2.2 Address by the Director-General of the World Health Organization

3. Programme of Reform for WHO
   3.1 WHO reform

Sea/RC65/2 and Inf. Doc.

Sea/RC65/3 Rev.1 and Inf. Doc.
4. Programme Budget Matters

4.1 Programme Budget Performance Assessment: 2010-2011

4.2 Implementation of Programme Budget 2012-2013

4.3 12th General Programme of Work (GPW) and Proposed Programme Budget 2014-2015

5. Technical Matters

5.1 Consideration of the recommendations arising out of the Technical Discussions on “Non-communicable diseases, including mental health and neurological disorders”

5.2 Selection of a subject for the technical discussions to be held prior to the Sixty-sixth session of the Regional Committee

5.3 Role of WHO in managing emergencies

5.4 Health workforce training and education

5.5 Reports of WHO global working/advisory groups:

5.5.1 Substandard/spurious/falsely-labelled/falsified/counterfeit medical products and strengthening drug regulatory authorities.

5.5.2 Pandemic Influenza Preparedness (PIP)
5.5.3 Consultative Expert Working Group on Research and Development: Financing and Coordination

5.6 Progress reports on selected Regional Committee resolutions:

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8.4 Closing of the Session
### Annex 5

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### Annex 6

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Madam Chair,

Please allow me to present my Biennial Report on the Work of WHO in the South-East Asia Region covering the period from 1 January 2010 to 31 December 2011. Since the full report (document SEA/RC65/2) has already been distributed, I will only touch on some of its salient features.

Madam Chair,

With WHO supportive contributions, the countries in the South-East Asia Region have intensified their efforts to reduce the burden of communicable diseases. 2012 was declared by the Health Ministers to be the “Year of Intensification of Routine Immunization in South-East Asia Region”. Towards this end, WHO had worked closely with Member States in reviewing and further strengthening national immunization programmes.

As of 2010, the average coverage of DPT3 was 77% for the Region with seven countries above 90%. Significant progress had also been made in improving the coverage of measles immunization especially in India and Indonesia. Some countries are to reach measles elimination target of 95% coverage in the near future.

Since January 2011, there had been no new cases of wild poliovirus infection in India. Provided that AFP surveillance remains strong and there are no more new cases of wild polio virus, the SEA Region should be declared polio-free in early 2014.
Madam Chair,

Regarding neglected tropical diseases, all countries had achieved leprosy elimination target at national level; the prevalence rate of less than one per 10 000 population had been achieved. However, endemicity of this disease still prevails, especially in the remote areas. Therefore, leprosy still requires our continued attention. Efforts to further reduce the disease burden of leprosy must be maintained in the years to come.

Lymphatic filariasis continued to affect populations of many countries and mass drug administration (MDA) had been intensified during the past years. In the Region it is expected to reach the elimination target of reducing the microfilaria rate to less than 1% of the population at risk by the Year 2020. Timely expansion of integrated vector control is really needed to prevent the resurgence of this disease.

In the area of disease control, surveillance systems had been further strengthened including the one for vaccine preventable diseases. Most countries now can regularly report priority and epidemic-prone diseases. WHO’s technical back up in this area had been enhanced especially for training of staff and development of standard surveillance procedures.

As far as the International Health Regulations 2005 are concerned no country in the SEA Region had achieved all core capacities that are required for effective implementation of the Regulations. WHO had doubled its efforts in strengthening and supporting Member States to ensure such capacities of the countries, with the new target date of June 2014.

Disease epidemics continue threatening countries of the Region. All Member States have national plans in place for influenza pandemic preparedness and response. With WHO support, the governments’ efforts are intensified to strengthen their alert and response capacities for possible outbreaks of emerging infectious diseases.

Madam Chair,

From 1990 to 2010, the TB prevalence rate had been reduced by almost 40%. However, due to shortcomings in management of the control programmes, multidrug resistant TB had emerged as a serious concern that requires more sophisticated laboratories for investigations and more expensive drugs are needed for treatment. It was estimated that the South-East Asia Region had more than 100 000 TB patients with
multidrug resistance. Progress in TB Control was also being threatened by coinfection with HIV. About 1.1 million TB patients in the South-East Asia Region are coinfected with HIV.

In SEA, there were about 3.5 million people living with HIV and there were 220,000 new cases of HIV infection occurring each year however, these cases were decreasing in almost all countries. While HIV prevalence had decreased among female sex workers, high HIV transmission continued among people using drugs injections, men having sex with men and transgenders.

Anti retroviral treatment (ART) of advanced HIV infections had increased from 5% in 2003 to 34% in 2010. WHO's priority attention has also been paid to supporting Member States in their efforts to prevent mother-to-child transmission of HIV; it was evident that two out of three HIV-infected pregnant women did not have access to antiretroviral treatment resulting in a large number of children being born with HIV.

Progress had also been made in malaria control. Between 2005 and 2010, the estimated number of malaria cases in at-risk areas was reduced by almost one third, from 30 to 22 per 1000 population. This success was contributed by the increased use of insecticide-treated bed nets (ITN), rapid diagnostic tests (RDT), and treatment with artemisinin-based combination therapy (ACT). Artemisinin-resistant malaria detected in Thailand and Myanmar had been our serious concern. With support from partners, efforts were being made to contain the spread of this drug resistant malaria.

Madam Chair,

Noncommunicable diseases in SEAR are now responsible for more than half of all deaths. For effective control, all countries in the Region had established a coordination mechanism in the ministry of health, and seven have developed a national multisectoral strategy for NCD prevention and control. Last year, a Regional Meeting on Health and Development Challenges of Noncommunicable Diseases was held in Jakarta: the meeting declared a Call for Action for NCD Prevention and Control.

As an important activity in this area, all countries had paid more attention to the control of tobacco use mainly through designating smoke-free areas, educating youths about the dangers of tobacco use, and promoting tobacco use cessation. Countries also started taking actions
to reduce harm from alcohol use as well as to control the abuse of drugs and other psychotropic substances.

Madam Chair,

With regard to MDG 5, the SEA Region had reduced the maternal mortality ratio by 66% from 1990 to 2010. Of the countries where the MMR was greater than 100 in 1990, three had already achieved the target of 75% reduction of maternal mortality ratio. The UN Secretary-General awarded Nepal in September 2010 for its work in reducing MMR from 770 in 1990 to 170 in the year 2010.

WHO’s support to the governments’ efforts had centered on training of skilled birth attendants as well as on maternal death reviews to track the causes of such deaths. Progress was also visible in area of MDG 4 – reducing the under-five mortality rate by two thirds by the year 2015. Three countries had already reached this goal and four countries are on the track. Bangladesh received a special award from the UN Secretary-General in September 2010 for the achievement in reducing under-five mortality from 133 per 1000 live births in 1990 to 53 per 1000 in 2010.

Ladies and gentlemen,

All Member States recognized the urgent need to address the excess fertility and to address its consequences of unplanned pregnancies. WHO had been working with other agencies and partners to improve family planning services, as requested by Member States.

With the increase in life expectancy there had been more concern with health of the ageing population. WHO had emphasized a need for promoting “active and healthy ageing” and Member States had been supported in the development of national multisectoral strategy for promoting healthy ageing.

Madam Chair,

During the period under review, Member States had faced a number of emergencies:

- post-conflict situation in Sri Lanka;
- fire accident in Bangladesh in 2010;
- Mount Merapi eruption in Indonesia in the same year;
- then, a prolonged country-wide flood in Thailand in 2011; and
torrential rains in DPR Korea in 2011 and this year.

In addition to WHO technical backup financial support for immediate relief in those emergencies had been provided from SEARHEF (SEAR Health Emergency Fund). Besides, WHO had worked closely with Member States to help ensure effective preparedness and response including safe health facilities during emergencies a framework to build up community resilience through PHC approach was also developed and disseminated.

Madam Chair,

Countries were reviewing their health strategies to improve the efficiencies of their universal health coverage. As we are well aware, the poor often do not have access to health services. This situation led to an increasing attention to the importance of social and economic determinants of health in the efforts to improve equity in health.

Progress in tackling health inequity depends, to a large extent, on disaggregated health data by age, sex, income and geographical location. This is especially important for addressing the issue of gender where inequities are common. The efforts to reduce gender-based violence has received due attention from Member States during the period under review.

Madam Chair,

In the area of environmental health, healthy environments were promoted through healthy settings approach such as healthy workplaces, healthy islands and health promoting hospitals.

With 90% coverage of drinking-water the Region has already achieved the MDG target related to access to safe drinking-water. However, much needs to be done in area of sanitation for which the coverage in the Region had been only around 44 per cent. Member States were supported in the development and application of guidelines and standards in areas of water safety, chemical safety and occupational health.

As far as nutrition is concerned all Member States had paid particular attention to the four key areas:

- under-nutrition
- diet-related chronic diseases
- micronutrient deficiencies
- as well as infant and young child nutrition.
However, the extent of interventions in these areas in countries still markedly varied from country to country. The Member States also devoted more efforts to the emerging issues of food safety. A broad framework for promoting safety of street food was developed at a regional consultation held in 2011. Participation from the Region in Codex Alimentarius and INFOSAN, in particular, has been increased during the period under review.

Madam Chair,

WHO support was provided for reviewing and revamping of health workforce in Member States especially in those Member States facing human resource crises. Technical discussions held prior to the previous session of WHO Regional Committee dealt especially with the roles of community-based health workers in the context of revitalization of primary health care.

Most countries established a national mechanism to coordinate health research activities and took steps to establish research ethics review boards/committees; special efforts had been made in strengthening research capacity in three countries – Bhutan, Maldives and Timor-Leste.

Madam Chair,

Medicines are an essential part of health care. Challenges in this area, among others, might include:

- drug policies that were often not implemented;
- suboptimal functioning of drug supply systems;
- inadequate drug quality; and
- weak drug regulation.

These are the key areas for WHO support in strengthening country capacity within the national health systems to ensure availability and accessibility of quality medicines.

Madam Chair,

I have noted the significant progress made by Member States over the last two years in improving their health infrastructures and health system performance. Much of this progress in the countries could be attributed to
WHO collaborative work and also to the contributions from many partners and stakeholders both within and outside the UN system.

Nonetheless, significant challenges still remain. It is the commitment of WHO, in South-East Asia in particular, to focus its work, along with the contributions of its partners on strengthening the country capabilities and capacities of the health systems through country focus and country-specific approaches in developing and implementing the collaborative programmes organized by Member States, so that the countries can effectively face the evolving health challenges in the years to come.

Finally, Madam Chair, under the leadership of the WHO Director-General, Dr Margaret Chan, WHO has embarked on several initiatives to implement the WHO “Reform Agenda” the agenda that covers the priority areas as collectively decided by Member States in the Governing Bodies. I am fully committed, as the team leader of WHO in South-East Asia Region, to taking forward these initiatives towards the ultimate goal of the current WHO reform in the most efficient manner.

Madam Chair,

With these words, I have great pleasure in submitting to the Regional Committee my report on the Work of WHO in the South-East Asia Region for the period 1 January 2010 to 31 December 2011.

I thank you for your kind attention. Thank you.
Mr Chairman, Excellencies, honourable ministers, distinguished delegates, Dr Samlee, colleagues in the UN family, ladies and gentlemen,

Let me begin with some well-deserved praise. On present trends, this region is set to be declared polio-free in January 2014.

India, the skeptics said it could not be done. But you did it. You stopped wild poliovirus transmission dead in its tracks. You have silenced the critics.

You have provided definitive proof that eradication is technically feasible, and you have done so in what was arguably the most challenging of all the remaining strongholds of this virus.

This is what your experience tells the world. The poliovirus is not permanently entrenched. It is not destined to remain a perpetual threat to each new generation of children. It can indeed be driven out of existence.

I fully agree with the assessment of the Independent Monitoring Board. This is a “magnificent” achievement. The Indian government succeeded because of its passionate engagement in a mission to protect its people from a vicious disease.

I appreciate, too, the specific lessons from the Indian experience set out in your report on polio eradication.
The most critical factor for success is ownership of the programme, from the local to the national level. The Indian government owned this programme, operating as the principal source of staff and funds. Other lessons include the importance of tight-knit partnerships, constant innovation, and a relentless drive to improve quality and accountability.

The May World Health Assembly elevated polio eradication to the level of a global public health emergency. This region has the expertise, bolstered by success, to lead the world in such an emergency response.

Medical officers from India, Bangladesh, and Nepal are now directly assisting countries that are still battling polio. I urge you to continue this leadership role. We can and must win.

As the IMB report noted, polio is now at its lowest level worldwide since records began.

Public health faces some heavy challenges, some bad trouble heading our way. Any longstanding problem that can be solved, once and for all, will free much-needed capacity and resources.

Ladies and gentlemen,

I also want to congratulate the region on the draft strategy for universal health coverage that you will be discussing during this session. This is an extremely ambitious and courageous strategy, and a smart path for your countries to follow.

The strategy rightly emphasizes equity as its core objective. It rightly singles out the principles and approaches of primary health care as the starting point for reform.

In this regard, the region has a head start. Several countries are long-standing models of how, with the right policies and strong political commitment, low-income countries can achieve health outcomes comparable to those seen in the wealthiest places in the world.

Like the World Health Report 2010, on health systems financing, the draft strategy sets out a richly diversified menu of options for moving towards universal coverage in any resource setting.
All of these options are firmly rooted in successful strategies and solutions worked out by countries. Again, this region shows its value as a resource of experiences and a repository of instructive best practices.

Universal coverage is the right thing to do from an ethical perspective. It is the smart thing to do in terms of improving the efficiency of the health system.

At a time of nearly universal financial austerity, improving efficiency is a far better option than cutting back on services or imposing fees that punish the poor.

And you can have both. That is: efficiency and equity. The economists will tell you there must be a trade-off between the two. Experiences, also in this region, tell us that the two goals are fully compatible.

I described the draft strategy as courageous. Universal coverage is the best way to tackle some major barriers to equity that are unique to this region. These include the exceptionally high reliance on out-of-pocket payments and the dominance of a largely unregulated private sector offering mainly curative care.

This region has millions of low-income households living on the margins of survival. For these people, it does not take major illness and catastrophic medical bills to push them deeper into poverty. Just paying for medicines can have the same tragic effect.

As data set out in the draft strategy show, mark-ups in the price of medicines, as they move through the supply and distribution chains, can increase the price charged by the private sector several hundred times.

As we all know, the costs of care can cause patients to delay seeking treatment until the disease or condition has become much more difficult and costly to treat, if treatment is still possible.

This is an extreme example of waste and inefficiency. And this is what you are tackling, head on.

Moving towards universal coverage improves health and fights poverty at the same time. It upholds the core values of solidarity, social cohesion, and human security.
Above all, universal coverage is a powerful social equalizer that helps correct gaps in health outcomes that have been growing, almost unchecked, for decades.

Market forces and incentives can be used to improve the efficiency of health systems. But market forces will never solve social problems all by themselves. This happens only when equity is an explicit policy objective, as set out in your draft strategy.

Universal coverage is a unifying concept that makes various pieces of the health care puzzle fit together in a focused and coherent way. A move towards universal coverage is a move to tackle some of the other items on your agenda.

Moving towards universal coverage depends on stronger, more efficient health systems, with access to essential medicines of good quality at affordable prices and a well-trained and motivated work force.

It also requires reliable information systems for generating data and evidence, and support from a well-functioning regulatory authority.

Universal coverage stresses equity in entitlement to services and gives a prominent role to compulsory or public funding to ensure social protection.

At a time when the international community sees better health as a poverty reduction strategy, we cannot let the costs of health care drive millions of people below the poverty line each and every year.

I commend SEAR countries for taking such an ambitious, courageous, and timely step forward.

Ladies and gentlemen,

The target date for reaching the Millennium Development Goals is fast approaching. The debates about the next generation of internationally-agreed development goals are already under way.

As we learned with the MDGs, international goals shape political agendas and attract resources. We need to get this right, just as we need to get the process of WHO reform right.
From the outset, the reform process has been in the hands of Member States. You have before you drafts of the next ProgrammeBudget and the 12th General Programme of Work. These documents let you see how priority setting works in practice.

Member States have asked that these documents be reviewed and discussed by Regional Committees and subsequently revised by the Secretariat. Please keep in mind that both documents are works in progress.

Concerning the post-2015 debate, evidence supports a central place for health on any development agenda. Health is a precondition of development. It is a powerful driver of socioeconomic progress.

Because its determinants are so broad, health is a sensitive indicator of the impact that policies in all sectors of government have on the well-being of citizens. As just one example, if trade policies, tariffs, and agricultural subsidies cause food prices to soar, the adverse effects will be most visible in the health sector.

Changes in health status will also be the most readily and reliably measured signal that policies need to be adjusted.

The MDGs have been a powerful force in focusing implementation efforts and maintaining political support for development. They have been good for public health.

They demonstrated the value of concentrating international efforts on a limited number of time-bound goals. They brought impressive results, sometimes stunning results.

For example, at the start of this century, AIDS, tuberculosis, and malaria were public health emergencies. This is no longer true. All three diseases are showing a slow but steady decline, though the battle is by no means over.

The health-related MDGs were largely an infectious disease agenda. Most agree that we dare not reduce the current drive to expand childhood immunization and combat AIDS, tuberculosis, malaria, and the neglected tropical diseases.
As we know from deep experience, complacency creates a perfect opportunity for these diseases to roar back with a vengeance.

Pursuit of the MDGs has left a legacy of innovations, including the GAVI Alliance, the Global Fund, UNITAID, the International Health Partnership Plus, and numerous other global health initiatives focused on individual diseases.

Most recently, the UN strategy for women’s and children’s health, Every woman, every child, has responded to calls for accountability in tracking resources and using them.

Among its objectives, the strategy aims to build capacity for vital registration as the foundation for accountability within countries. The need for accountability is just one of many lessons that are part of the MDG legacy.

Here is another one. If the international community wants better health to work as a poverty-reduction strategy, good quality interventions must reach the poor. If we miss the poor, we miss the point.

At their outset, single-disease initiatives depended on a well-functioning health system to reach their goals. Yet these initiatives rarely made the strengthening of health systems an explicit or budgeted goal. This, too, is no longer true.

Most donors now appreciate the need to channel aid for health development in ways that build capacities and move countries towards self-reliance. This is the best exit strategy for aid.

Developing countries do not want charity. They want capacity.

Given the success of the MDGs, most agree that the post-2015 agenda should likewise focus on a limited number of measurable goals.

Most also agree that the current focus on human development and poverty alleviation should remain at the core of the new agenda, together with an emphasis on respect for human rights, equality, and sustainability.
While diseases targeted by the MDGs remain extremely important, today’s health challenges are much broader, and this should be reflected in any new development agenda.

The Millennium Declaration and its goals were basically a compact between developing countries and their needs and wealthy countries that promised to address these needs through the commitment of funds, expertise, and innovation. In short: a compact between the haves and have-nots aimed at reducing gaps in living conditions and relieving vast human misery.

When we consider the nature of today’s major threats to health, a simple compact between the haves and have-nots fails to capture the complexity of these threats.

I mentioned some bad trouble heading our way.

I am talking about a changing climate, more emergencies and disasters, soaring health care costs, soaring food prices, demographic ageing, rapid urbanization, and the globalization of unhealthy lifestyles.

I am talking about an enduring economic downturn, financial insecurity, shrinking opportunities, especially for youth and the middle classes, poverty that keeps getting deeper, and social inequalities that keep growing wider.

These are universal trends. Many of them are fuelling the relentless rise of chronic noncommunicable diseases, which are hitting this region especially hard.

For nearly all, the root causes lie beyond the direct purview of the health sector.

In my view, one of the best ways to respond to these challenges is to make universal health coverage part of the post-2015 development agenda.

At a time when policies in so many sectors are actually increasing social inequalities, I would be delighted to see health lead the world towards greater fairness in ways that matter to each and every person on this planet.
Ladies and gentlemen,

As I have said before, the job of public health keeps getting harder.

More and more, we are on the receiving end of policies made in other sectors. Our ability to shape these policies is often limited, especially at a time when so many economies are fragile. If a health-promoting policy is perceived to threaten the profits of an economically important industry, we can expect to have a battle on our hands.

Sometimes we win those battles. As I conclude, let me mention one encouraging case.

Last month, Australia’s High Court upheld legislation mandating plain packaging, with no branding, for tobacco products. The legislation had been aggressively challenged by several large tobacco companies.

The court ruling was a huge victory for the Australian government, but also for public health, opening a brave new world for tobacco control. In this case, concern about protecting the public’s health took precedence over issues of intellectual property rights.

As Australia’s Attorney-General Nicola Roxon noted, “The message to the rest of the world is that big tobacco can be taken on and beaten.”

I think we can all take heart from a game-changing story where the good guys win.

Thank you.
WHO Regional Committee for South-East Asia

Report of the Sixty-fifth Session

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