WHO Regional Committee for South-East Asia

Report of the Sixty-fourth Session

Jaipur, India, 6-9 September 2011
WHO Regional Committee for South-East Asia

Report of the Sixty-fourth Session

Jaipur, India, 6-9 September 2011
## Contents

**Part 1: INTRODUCTION** ................................................................. 1

**Part 2: INAUGURAL SESSION** .................................................... 3

**Part 3: BUSINESS SESSION** .................................................... 9

- Opening of the session ................................................................. 9
- Appointment of the Subcommittee on credentials ....................... 9
- Election of Office-bearers ............................................................ 10
- Adoption of the Agenda .............................................................. 11
- Drafting group on resolutions ..................................................... 11
- Key Addresses and Report on Work .......................................... 11
- Statements by representatives of UN and Specialized Agencies .... 11

- Introduction to the Regional Director’s Annual Report
  on the Work of WHO in the South-East Asia Region
  covering the period 1 January to 31 December 2010 .................. 12

- Address by the Director-General of the World Health Organization ... 16

- Programme of Reform for WHO ................................................ 19

- Future of financing and programme of reform for WHO ............ 19

- Statements by representatives of nongovernmental organizations
  and international nongovernmental organizations .................... 25

- Programme Budget Matters ....................................................... 28

- Implementation of Programme Budget 2010-2011 ......................... 28

- Proposed Programme Budget 2012-2013 .................................... 29

- Technical Matters ................................................................. 31

- Consideration of the recommendations arising out of the Technical
  Discussions on “Strengthening of the community-based health
  workforce in the context of revitalization of primary health care” ..... 31
Selection of a subject for the Technical Discussions to be held prior to the Sixty-fifth Session of the Regional Committee .......... 32

2012: Year of Intensification of Routine Immunization in the South-East Asia Region: Framework for increasing and sustaining coverage................................................................. 33

Regional Nutrition Strategy: Addressing malnutrition and micronutrient deficiencies .............................................................. 38

National essential drug policy including rational use of medicines..... 40

Regional Health Sector Strategy on HIV, 2011-2015.................... 43

Governing Body Matters.................................................................. 44

Key issues and challenges arising out of the Sixty-fourth World Health Assembly and the 128th and 129th sessions of the WHO Executive Board............................................................. 44

Review of the draft provisional agenda of the 130th session of the WHO Executive Board................................................. 45

Follow-up action on pending issues and selected Regional Committee resolutions: ................................................................. 46

Regional Strategy for Universal Health Coverage ...................... 46

Challenges in Polio Eradication...................................................... 48

Utilization of South-East Asia Regional Health Emergency Fund ...... 50

Special Programmes.................................................................... 51

UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases:
Joint Coordinating Board – Report on attendance at JCB in 2011 ..... 51

UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction:
Policy and Coordination Committee – Report on attendance at PCC in 2011 and nomination of a member in place of Sri Lanka whose term expires on 31 December 2011 ................. 51

Closure of the Session .................................................................. 52

Time and place of future sessions of the Regional Committee....... 55
Part 4: RESOLUTIONS AND DECISIONS .................................................. 57

Resolutions................................................................................................. 57

SEA/RC64/R1 Proposed Programme Budget 2012-2013 ..................... 57
SEA/RC64/R2 Strengthening of the community-based health
workforce in the context of revitalizing
primary health care ............................................................... 59
SEA/RC64/R3 2012: Year of Intensification of routine immunization
in the South-East Asia Region: Framework for
increasing and sustaining coverage .................................... 61
SEA/RC64/R4 Regional Nutrition Strategy: addressing
malnutrition and micronutrient deficiencies .......... 64
SEA/RC64/R5 National essential drug policy including
the rational use of medicines ........................................... 67
SEA/RC64/R6 Regional Health Sector Strategy
on HIV, 2011–2015 ........................................................... 70
SEA/RC64/R7 Resolution of Thanks ............................................. 72

Decisions.................................................................................................. 74

SEA/RC64(1) Introduction to the Regional Director’s Annual Report
on the Work of WHO in the South-East Asia Region
covering the period 1 January - 31 December 2010 ... 74
SEA/RC64(2) Technical Discussions: Selection of a subject for the
Technical Discussions to be held prior to the
Sixty-fifth Session of the Regional Committee ........ 74
SEA/RC64(3) 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 .............................................................. 74
SEA/RC64(4) Time and place of future sessions of
the Regional Committee ............................................... 74
Annexes

1. Text of address by the Minister of Health and Family Welfare, India .................................................. 77
2. Text of address by the Regional Director, WHO South-East Asia Region ........................................... 82
3. Agenda ............................................................................................................................................. 85
4. List of participants ....................................................................................................................... 88
5. List of official documents ........................................................................................................... 101
6. Text of the Regional Director’s introductory remarks on Report on the Work of WHO in the South-East Asia Region covering the period 1 January – 31 December 2010 .......... 103
7. Text of Address by the Director-General, World Health Organization ........................................... 111
1. The Sixty-fourth Session of the WHO Regional Committee for South-East Asia was held in Jaipur, India from 6 to 9 September 2011. It was attended by representatives of all the eleven Member States of the Region, UN and other agencies, nongovernmental organizations having official relations with WHO, as well as observers.

2. The joint inauguration of the Sixty-fourth Session of the Regional Committee and the Twenty-ninth Meeting of Ministers of Health was held on 6 September 2011. His Excellency Mr Ghulam Nabi Azad, Union Minister of Health and Family Welfare, Ministry of Health and Family Welfare, Government of India, delivered the inaugural address. *(For the full text of the address, see Annex 1)*
3. The Committee elected H.E. Mr Ghulam Nabi Azad, Union Minister of Health and Family Welfare, Ministry of Health and Family Welfare, Government of India as Chairman and H.E. Prof. Pe Thet Khin, Union Minister for Health, Ministry of Health, Myanmar as Vice-Chairman of the Session.

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

5. The Committee decided to hold its Sixty-fifth session in 2012 in Indonesia.

6. A drafting group on resolutions comprising a representative from each of the Member States was constituted with Mr Jayendra Sharma as Rapporteur. During the session, the Committee adopted 7 resolutions.
7. The joint inauguration of the Twenty-ninth Meeting of Ministers of Health and the Sixty-fourth Session of the WHO Regional Committee for South-East Asia was held in Jaipur, India on 6 September 2011.

8. Dr V.M. Katoch, Director-General, Indian Council of Medical Research and Secretary, Department of Health Research, Government of India, welcomed the ministers and distinguished delegates to the historic and cultural city of Jaipur. He also extended a warm welcome to Dr Margaret Chan, Director-General of the World Health Organization, and Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia.

9. Dr Katoch referred to the crucial role that a strong WHO can play in collaborating with national governments to address the various health challenges, especially those related to noncommunicable diseases (NCDs), faced by the people of the WHO South-East Asia (SEA) Region. As NCDs are a prime health concern of our times,
Dr Katoch drew the attention of the delegates to the Jakarta Declaration and Moscow call for action on NCDs, as well as to the resolutions passed by the Sixty-fourth World Health Assembly. The United Nations General Assembly has also scheduled a High Level Meeting on NCDs (UNHLM) in New York, in September 2011. He also referred to the National Summit on NCDs organized by the Government of India in August 2011 with participation of all stakeholders, which led to the New Delhi Declaration.

10. In conclusion, Dr Katoch expressed the hope that deliberations at the Health Ministers’ Meeting and at the Regional Committee Session would help in formulation of strategies and priority actions towards addressing the health problems faced by people in the SEA Region.

11. Dr Samlee Plianbangchang, Regional Director for South-East Asia, welcomed the Ministers and other distinguished representatives, and conveyed his grateful thanks to the Government of India for hosting the meeting in Jaipur.

12. Terming India “a dynamic member of WHO,” he praised the Member States for consistently demonstrating unwavering commitment to the mandate of the Organization in promoting the attainment by all peoples of the highest possible level of health, which is the stated mission of the Organization. The National Rural Health Mission launched in India in 2005 to revitalize the primary health-care approach in the country was a shining example of this commitment, Dr Samlee remarked, expressing WHO’s deep appreciation of India’s longstanding involvement in its work.
13. Dr Samlee said that the current key health indicators provide clear evidence of significant progress in health development in the SEA Region. Among other achievements, all countries have reached leprosy elimination targets, HIV and TB prevalence are showing a downward trend in most countries, and the Region is very close to achieving the goal of polio eradication. However, in areas of maternal, newborn and child health few countries still face formidable challenges in their efforts towards meeting the targets of MDGs 4 and 5. At the same time, there are troublesome trends needing urgent attention, such as the burden of chronic NCDs which is expected to rise steeply in the next decade. Injuries; disabilities and mental disorders also rank high on the list of concerns. Mortality due to NCDs has already surpassed that due to communicable diseases, which reflects the inability of health systems to mainstream health promotion along with disease prevention through the population-based primary health care approach. Furthermore, the Regional Director pointed out that most chronic NCDs needed long-term or even lifelong medical treatment that created an additional “economic burden” on individuals and families and contributed significantly to the skyrocketing of health-care costs. He urged the delegates who would be attending the
UNHLM in New York in September 2011 to voice regional concerns in this regard.

14. In conclusion, the Regional Director stressed the need for public health work to be given due emphasis in national health policies and in allocation of national resources so that national health development endeavours reach their full potential. *(For the full text of the address, see Annex 2)*

15. The Director-General of the World Health Organization, Dr Margaret Chan, expressed her happiness to be in Jaipur and thanked the Government of India, especially His Excellency, Mr Ghulam Nabi Azad, Minister of Health and Family Welfare, for hosting the two important meetings.

16. Speaking on NCDs, the Director-General said that diseases such as heart disease, stroke, diabetes and cancer were already the world’s biggest killers, and that diabetes and stroke were responsible for half of all disabilities worldwide. Developing countries face a major challenge from these diseases that were spreading with stunning speed and sweep due to several factors such as rapid modernization coupled with irreversible population ageing, rapid unplanned urbanization and the global spread of unhealthy lifestyles. The Director-General hoped that the UN High-Level Meeting would serve as a wake-up call for the Heads of States regarding the enormity of the costs involved in tackling NCDs.

17. On the major issues on the agenda of the Regional Committee, the Director-General noted that more concrete steps needed to be taken on essential drug policies including rational use of medicines both at global and country levels. On antimicrobial resistance, she cautioned that the world was on the brink of losing its miracle cures due to irrational and inappropriate use of antibiotics making the world vulnerable to new and virulent microbes. Easy availability of antibiotics and their inappropriate use by the population were the major factors behind drug resistance. She cautioned that drug resistance had the potential to become the next major global crisis if remedial action was not taken urgently by stating “No action today means no cure tomorrow”! *(For the full text of the address, see Annex 7)*
18. The Chief Guest, at the inaugural session, His Excellency Mr Ghulam Nabi Azad, Minister of Health and Family Welfare, Government of India, extended a warm welcome to the ministers of health of Member States of the WHO SEA Region, the WHO Director-General, the Regional Director, and all distinguished delegates to the historic city of Jaipur.

19. The Health Minister highlighted that countries of the WHO SEA Region comprise one fourth of the world’s population and, as such, had a significant imprint on the health map of the world. He expressed satisfaction with the theme for this year’s Health Ministers’ Meeting terming “antimicrobial resistance” and “irrational use” of antibiotics issues of great concern. Despite technological advancements in the field of health, there had been negligible development of new antimicrobial agents over the past few decades. Mr Azad stated that inadequate attention to this problem would hinder the attainment of the MDGs.

20. Elaborating on the steps taken by the Government of India to tackle NCDs, the Health Minister mentioned the ongoing nationwide screening for diabetes and hypertension that was under way, and the Prime Minister’s commitment to increase the allocation for health in
the Twelfth Five Year Plan commencing in April 2012. While reiterating India’s strong commitment to polio eradication, he expressed his satisfaction on the substantial progress made by the country in this regard in 2011. So far, there had only been one case of wild poliovirus in the country this year as against 741 cases reported in 2009 and 42 in 2010.

21. Mr Azad thanked the Hon’ble Chief Minister and Government of Rajasthan for extending all cooperation and assistance in organizing the meetings, and appreciated the efforts made by the WHO Secretariat in this regard.

22. Mr B.N. Sharma, Principal Secretary (Health and Family Welfare), Government of Rajasthan, proposed the vote of thanks. He thanked the ministers, and distinguished delegates, as well as Dr Margaret Chan, and Dr Samlee Plianbangchang, for their presence in Jaipur. He extended his deep appreciation for the efforts put in by staff from the Ministry of Health and Family Welfare, New Delhi and the Government of Rajasthan for organizing both the high-level meetings.
Opening of the session *(Agenda item 1)*

23. The Sixty-fourth Session of the WHO Regional Committee for South-East Asia was opened by Dr Samlee Plianbangchang, Regional Director for WHO South-East Asia Region, owing to the absence of Chairman and Vice-Chairman of the Sixty-third session of the Regional Committee (Rule 12 of Rules of Procedure of the WHO Regional Committee for South-East Asia).

Appointment of the Subcommittee on credentials *(Agenda item 1.1)*

24. A subcommittee on credentials, comprising representatives from Bangladesh, Sri Lanka and Thailand was appointed. The Subcommittee met under the chairmanship of Prof. Mohammad Abul Kalam Azad (Bangladesh) and examined the credentials submitted by all Member States. The credentials submitted by nine Member States were found to be in order, thus entitling their representatives to take
part in the work of the Regional Committee. Pending the arrival of the original credentials from Nepal and Timor-Leste, the Subcommittee recommended that their representatives be permitted to take part in the work of the Regional Committee and vote until such time as the Subcommittee on Credentials could reconvene to examine the credentials and report thereon to the Regional Committee.

**Election of Office-bearers (Agenda item 1.3)**

25. H.E. Mr Ghulam Nabi Azad, Union Minister of Health and Family Welfare, Ministry of Health and Family Welfare, Government of India was elected Chairman and H.E. Prof. Pe Thet Khin, Union Minister for Health, Ministry of Health, The Government of the Union of Myanmar was elected Vice-Chairman. Mr Ghulam Nabi Azad thanked the representatives for electing him Chairman, which he considered an honour for himself and his country. He was confident that with the cooperation and support of all concerned, the Committee would successfully cover the agenda. He looked forward to meaningful deliberations and discussions that would lead to productive efforts towards greater health development in the SEA Region.
Adoption of the Agenda *(Agenda item 1.4)*

26. The Committee adopted the Agenda as contained in document SEA/RC64/1 Rev.1.

Drafting group on resolutions

27. The Committee constituted a drafting group on resolutions comprising one representative from each Member State. Mr Jayendra Sharma (Bhutan) was nominated Rapporteur of the Resolution Drafting Group.

Key Addresses and Report on Work *(Agenda item 2)*

Statements by representatives of UN and Specialized Agencies

28. Speaking on behalf of Ms Karin Hulshof, **UNICEF** Representative, India, Mr Sam Mawunganidze, said that it was a great honour to address the WHO Regional Committee for South-East Asia that represented and acted as the lighthouse for public health. He added that it was through WHO’s leadership that public health indicators, especially of child survival and development had shown a positive decline in the last 10 years. This had been made possible due to modelling, demonstration and universal scale-up of evidence-based essential child survival and development interventions that had been adopted and promoted by Member States of the SEA Region.

29. Referring to the agenda item on “Strengthening of the community-based health workforce in the context of revitalization of primary health care”, Mr Mawunganidze said that work in this area would provide the greatest opportunity for reaching the most deprived population groups, using an equity lens.

30. Speaking on behalf of Ms Frederika Meijer, **UNFPA** Representative, India and Bhutan, Mr Sunil Thomas Jacob said that UNFPA in the South-East Asia Region was working towards the use of population data for policies and programmes to reduce poverty and ensuring that every pregnancy was wanted, every birth was safe, every
young person was free of HIV/AIDS and that every girl and woman was treated with dignity and respect. The UNFPA would prioritize its programme around adolescents since the demographic figures indicated that more adolescents were entering the reproductive age. Access to information, counselling and quality reproductive health services, including provision of reversible contraceptive methods, will contribute tremendously in the reduction of maternal and newborn mortality, thereby facilitating the achievement of Millennium Development Goals (MDGs) 4 and 5.

Introduction to the Regional Director’s Annual Report on the Work of WHO in the South-East Asia Region covering the period 1 January to 31 December 2010 (Agenda item 2.1: Document number SEA/RC64/2 and Inf.Doc.)

31. Introducing his report for the period 1 January to 31 December 2010 the Regional Director stated that the South-East Asia (SEA) Region continued to advance steadily towards the goal of reducing the burden of communicable diseases. In this regard, he made special mention of the campaign against polio in India that was in its last stages. In 2011, the country had reported only one case of wild polio virus type 1 as against 24 cases of type 1 reported in 2010. Sensitive surveillance and high-quality immunization need to be maintained and strengthened.

32. In the post-pandemic phase of influenza (H1N1), the early detection and prompt management of cases was facilitated in a big way in the countries of the SEA Region. Such experience will be useful in future for continued effective influenza surveillance, as well as for responding to outbreaks of other emerging infectious diseases.

33. The Region achieved the target set for leprosy elimination at the end of 2010. Maldives and Sri Lanka have reached the point of elimination of lymphatic filariasis.

34. Substantial progress continues to be made in combating HIV/AIDS, tuberculosis, malaria, and other communicable diseases.
Although the HIV epidemic is generally on the decline, 3.5 million people in South-East Asia are living with HIV/AIDS. The new HIV infections among children are now being targeted for elimination in the Region.

35. All countries have made steady progress in tuberculosis control. Since 1990, there has been a 25% decrease in TB prevalence rates in the Region. During the period under review, major achievements included the scaling up of interventions against TB-HIV co-infection and against multidrug-resistant TB.

36. Significant progress was also made in malaria control. Thirty per cent of the population at risk were covered with long-lasting insecticide nets and indoor residual spraying. However, such coverage is still very low and much more needs to be done.

37. Noncommunicable diseases, including mental health and injuries are emerging as important public health concerns in the South-East Asia Region. Most countries in the Region are paying greater attention to the promotion of mental health and mental well-being at community level. The basic health services facilities at primary care level are being supported to deliver essential mental health care. Several Member
States have demonstrated strong commitment towards prevention and control of injuries and violence.

38. Most countries have a national integrated policy on prevention and control of NCDs. Bhutan, DPR Korea and Maldives have recently enacted comprehensive tobacco control legislation in line with the WHO Framework Convention on Tobacco Control.

39. Rising food prices have compromised food security. This situation has led to unsatisfactory food safety practices and to a high proportion of undernutrition among the most vulnerable population groups in South-East Asia. The rate of exclusive breastfeeding in infants up to the age of six months remains far from optimal in the Region.

40. The Regional Director underscored the need to accelerate progress in achievement of MDGs 4 and 5, particularly in the areas of home-based newborn care and management of the sick child at community level.

41. The SEA Region is particularly prone to natural disasters. According to the World Disaster Report from 2000 to 2009, the Region accounted for 62% of global deaths due to natural disasters.
The South-East Asia Regional Health Emergency Fund (SEARHEF) continues to be the key mechanism for supporting relief operations in these events.

42. WHO is also providing support to help strengthen the capacity of countries in intellectual property, as well as in trade and public health. To improve workers’ health, strategies were developed by countries for the implementation of Global Plan of Action on Occupational Health.

43. In the area of environmental health, strategic approaches to the management of chemicals were reviewed and strengthened in most countries in the Region. National action plans to address the health impact of climate change are in place in most countries. Water safety plans have been developed and are being implemented in Bangladesh, Bhutan, India and Nepal. Appropriate technologies for sanitation were piloted in many other countries.

44. Strong PHC-based health systems are the foundation on which public health interventions can be implemented effectively. The South-East Asia PHC Innovations Network (SEAPIN) was established in 2010 to provide a platform for information exchange, evidence generation and intensification of advocacy for PHC-based health system strengthening.

45. The Regional Office for South-East Asia has developed Rapid Health Systems Assessment Guidelines. These guidelines should be used to assist countries in identifying gaps in health systems and to assist needs that could be included in funding proposals to GAVI; the Global Fund and other relevant funding agencies.

46. Regarding human resources for health, special emphasis was placed during the review period on strengthening of the public health workforce. Notable among others, was the support provided to Bhutan in launching the Bachelor Degree Programme in Public Health.

47. Health care financing is an area that received renewed attention during the review period. The Region records the highest out-of-pocket expenditures on health and most countries in the Region are yet to
achieve the recommended 5% GDP allocation for health. In order to move forward more effectively in this important area, Regional Offices for the South-East Asia and the Western Pacific regions have jointly developed a Health Financing Strategy for Asia and the Pacific, 2010-2015.

48. In the area of essential medicines, the SEA Region continues to face daunting challenges: high prices; lack of availability; low or lack of quality; and irrational use. Likewise, many drug regulatory authorities are weak. Antibiotics continue to be either overused or misused; as such, antimicrobial resistance is increasing. Though nine Member States out of eleven now have a National Blood Safety Policy or Act in place, unsafe blood transfusions continue in some countries.

49. Dr Samlee noted that under the leadership of the Director-General, Dr Margaret Chan, WHO had embarked on a programme of reform. This was aimed at making the Organization more effective and efficient in responding to the needs of Member States. He underscored the importance of undertaking this reform in the context of the rapidly changing global health landscape. In this connection, the Regional Director underscored his commitment to successfully steer the SEA Region through this period of reform so that WHO, as a whole, emerges to be a stronger and more effective partner of Member States. (For the full text of the address, see Annex 6)

Address by the Director-General of the World Health Organization (Agenda item 2.2)

50. The Director-General, Dr Margaret Chan, in her address highlighted the challenges to public health faced globally on account of “uncertainties and real but unpredictable risks”. Pointing out that the world is beset by one global crisis after another which, profoundly unfair in their consequences, are contagiously sweeping across the world and adversely affecting countries that had nothing to do with their causes. These crises have profound implications for national health budgets, financial support for health development, food security, impoverishment of populations and the future of financing for WHO.
Global food prices reached a historic high in February 2011 and undermined dietary diversity, which is very important for healthy nutrition. Drought and famine in the Horn of Africa resulted in movements of people fleeing starvation and violence. The earthquake and tsunami in Japan compounded by an accident at a nuclear energy plant became one of the most expensive disasters ever. Haiti and Pakistan are yet to recover from the devastating earthquakes and floods of 2010. Wave after wave of civil unrest and protest across the world, the Arab awakening in particular have made humanitarian assistance challenging. In the bombing of the UN compound in Nigeria many WHO staff were severely injured or lost their lives. This cascade of calamities, crisis and uprisings has had an impact on high-level thinking about the way the 21st century world has been designed to work. These events have triggered the question whether economic growth for its own sake is the solution to all problems and if market forces alone can solve social problems.

Policies, including fiscal ones, have shrunk the capacity of public health services and encouraged the growth of the private sector where neither price nor quality can be regulated. The persistence of malaria monotherapies, substandard TB care, paucity of essential medicines and abundance of non-essential ones leaves households impoverished because they turn first to the private sector even for
routine care. More than 60% of health expenditure in the Region is out-of-pocket, contributing to widespread poverty.

53. The Director-General urged public health stakeholders to show a “thirst for efficiency and an intolerance of waste”, and make improving efficiency and effectiveness the basic objective of all health strategies. Endorsing the Regional Director’s commitment to primary health care, Dr Chan noted that a community-based health workforce is the backbone of the PHC-based health system.

54. Childhood immunization programmes are an early opportunity to deliver a range of primary health-care interventions that improve child survival, the Director-General said. Another pillar of primary health care is nutrition, which has been notoriously neglected in recent years. She stressed the importance of simple low-cost interventions such as breastfeeding and iodization of salt that make a huge difference in population-wide outcomes.

55. Dr Chan drew the attention of delegates to the many problems and obstacles to health in the world and the WHO South-East Asia Region in particular. These range from the simple fact that public health services are perceived by the public as providing low-quality, second-rate care to the complex reality of multiple financial incentives that fuel the irrational use of medicines, to the difficulty of extending immunization coverage beyond the current average of 80%.

56. While reiterating the problems that beset health in the Region, Dr Chan said the best way to address the double burden of infectious and chronic noncommunicable diseases along with the added challenges of natural disasters and health threats from climate change is primary health care. She also outlined the programme of reform for WHO as the need to identify country-specific roles and responsibilities for WHO.

57. Dr Chan commended India and the Region for winning the battle against polio. Only a single case of wild poliovirus was reported since January this year in India, which is the world’s most technically challenging area for the interruption of transmission. At the request of the World Health Assembly an Independent Monitoring Board
was established to track progress towards the agreed eradication milestones and recommend adjustments in strategies. Dr Chan said the Board in its report has observed that “all that we see from India looks positive”. She lauded India for having achieved its country-specific goals for polio for the end of 2010. Polio eradication is feasible, she said.

58. The Director-General concluded by thanking the ministers of health of the Region for their unwavering commitment to equity, fairness and social justice with regard to both prevention and cure. She described the approach of the Region’s health ministries to solving long-standing problems that stand in the way of the universal coverage promoted by primary health care as “smart”, and called for keeping up the momentum.

Programme of Reform for WHO (Agenda item 3)

Future of financing and programme of reform for WHO (Agenda item 3.1: Document number SEA/RC64/3 Rev.1 and Inf.Docs 1,2,3 and 4)

59. The Committee was informed that the rapidly changing environment in which WHO worked required changes in terms of new ways of working and improved clarity on the Organization’s role in
relation to other global players. When WHO was established in 1948 it was the only global health player. The situation has since changed, and WHO now needs to identify what it does best. The ongoing global financial crisis adds urgency to the need to effect suitable reforms, the expected objectives of which are to:

(1) achieve greater coherence in global health, with WHO playing a leading role in enabling the many different actors to play an active and effective role in contributing to the health of all peoples;

(2) improve health outcomes, with WHO meeting the expectations of its Member States and partners in addressing agreed global health priorities, focused on the actions and areas where the Organization has a unique function or comparative advantage, and financed in a way that facilitates this focus; and

(3) ensure that the Organization pursues excellence; and is effective, efficient, responsive, objective, transparent and accountable.

60. The vision for WHO remains unchanged: It is the “attainment by all peoples of the highest possible level of health”. The five pillars of primary health care provide the strategic approaches for achieving this vision. These five pillars are:

(1) reducing exclusion and social disparities in health;
(2) organizing health services around people’s needs and expectations;
(3) integrating health into all sectors;
(4) pursuing collaborative models of policy dialogue; and
(5) Increasing stakeholder participation.

61. The five core business areas for WHO’s future work and the four sections that show how it will be supported by increased organizational effectiveness, stronger results-based planning, management and accountability, human resource policy and management and financing, resource mobilization and strategic communications were presented to the Sixty-fourth World Health Assembly, which endorsed them. The core business areas are (i) Health systems and institutions;
(ii) Health and development; (iii) Health security; (iv) Evidence on health trends and determinants; and (v) Convening for better health. The task now is to identify:

(1) the priorities in each area of core business;
(2) the expected outputs and outcomes; and
(3) the proposed measurements of performance.

62. The 129th Session of the Executive Board had requested the Director-General to prepare three concept papers on “Governance of WHO”; “independent evaluation of WHO”, and “World Health Forum”, which have been shared with Member States.

63. The Director-General clarified to the Regional Committee that the reform process was intended to improve the performance of WHO and was a long-term process to be taken up in a phased manner. The guidance from the Committee was sought on the content and process of reform. Similar guidance would be sought from Regional Committees of other regions of WHO. The summaries of these discussions in Regional Committees would be reported to the Special Session of the Executive Board to be held in November 2011.

64. The Director-General addressed the apprehensions of some Member States about the involvement of civil society groups and other stakeholders in the World Health Forum, confirming that WHO decision-making would continue to rest with Member States.
The Director-General further clarified that independent evaluation of health systems strengthening was intended to review WHO capacity to support countries in strengthening health systems and was not intended to review the work of the Member States.

Following deliberations on Agenda items 2.1, 2.2 and 3.1, the Committee made the following observations:

The Committee endorsed the Regional Director’s report on the Work of WHO in the South-East Asia Region during 2010 and agreed that it was well organized, comprehensive and covered all areas.

The Committee agreed to the involvement of other stakeholders subject to the condition that decision-making in the health sector was vested in the Member States.

The Committee observed that a World Health Forum with defined goals and criteria for participation of non-state actors could be acceptable. The Committee suggested that WHO take a lead role in coordinating with civil society and other stakeholders and ensure the efficient use of resources. Efforts to support these stakeholders/partners to upgrade their capacities as well as ensure that there is no duplication of effort should also be encouraged. The Committee also
suggested that the issue be discussed further at subsequent forums such as the next session of the Regional Committee.

70. The Committee welcomed the reforms proposed by WHO, considering it timely to adapt WHO’s role to the changing times. The Committee suggested that greater transparency, accountability and operational efficiency might be brought about through effective and sustainable implementation of WHO reforms.

71. The Committee emphasized that WHO should develop more effective work procedures and ensure more efficient and transparent management of funds. This would make WHO more accountable and enable it to fully achieve its goals. The Committee also proposed that WHO develops a mechanism to exercise more oversight over activities in country and regional offices, and avoids irrelevant programmes and activities. The Committee also observed that WHO should not only respond to donors’ demands but also be more flexible about funding effective strategies to achieve its health objectives and those of Member States.

72. The Committee emphasized that WHO should develop more effective work procedures and ensure more efficient and transparent management of funds. This would make WHO more accountable and enable it to fully achieve its goals. The Committee also proposed that WHO develops a mechanism to ensure the required capacity to support Member States and avoid irrelevant programmes and activities at regional and country levels. The Committee also observed that WHO should not only respond to donors’ demands but also be more flexible about funding effective strategies to achieve its health objectives and those of Member States.

73. The Committee suggested that WHO identify and adopt quicker ways of achieving health development and stressed for vertical and horizontal collaboration and coordination.

74. The Committee also suggested that WHO provide funds to Member States on the basis of actual need and not on the basis of global income rankings.
75. The Committee was assured that its concerns with respect to WHO's programme of reform would be addressed. Such reforms would enable the Organization to effectively engage with partners within the context of a rapidly changing global health landscape.

76. The Committee was informed that guidelines on rapid assessment of health system strengthening are being revised. However, health information systems needed to be improved at the country level for better planning and management of health programmes.

77. The Committee recognized the importance of strengthening country capacity. It took note of Member States’ concern that activities undertaken by various UN and other international agencies in countries should be appropriately coordinated so as to avoid wasteful resource duplication.

78. The Director-General of WHO, Dr Margaret Chan stated that the supremacy of the World Health Assembly should be preserved. She reassured Member States that WHO would continue to provide whatever technical assistance was required to support and strengthen specific requirement of countries, be it health financing; access to commodities or procurement methods. She also called for better planning and coordination of activities for effective global health governance at local level.

79. In order to strengthen the national capacity of Member States, Dr Chan suggested that recruitment of National Professional Officers in country offices should be timebound, i.e. for a limited period. Their work in WHO should be viewed as an opportunity for professional development and National Professional Officers should return to service in their respective governments.

80. On the topic of strengthening internal governance, there was need to set priorities, so that WHO could work in tandem and harmony with the countries. This would facilitate broadening of the funding base of the Organization without compromising the best interests of the Member States. The Director-General stated that the Organization is seeking more sustainable funding and means to ensure that funding is better aligned with organizational priorities.
The Committee noted, with satisfaction, the progress made during the period under review on the collaborative programmes between WHO and Member States. It also expressed its appreciation for the Director-General for her inspiring address.

The Committee endorsed the recommendations made on this agenda item by the High Level Preparatory (HLP) meeting held in the Regional Office, New Delhi, from 27 to 30 June 2011.

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

Dr Jacob Roy Kuriakose, Chairman Elect, *Alzheimer’s Disease International (ADI)* UK, spoke about his organization, which has 76 country members worldwide. He said that Alzheimer’s disease was now recognized as a major noncommunicable disease, since it shared many risk factors with other NCDs like physical inactivity, obesity and smoking. The number of people with Alzheimer’s disease and other dementias was estimated to be 36 million at the end of 2010; this figure was expected to double in the next 20 years.
84. Dementia was now part of WHO’s Mental Health GAPAction programme. Moreover, WHO was working with ADI and experts from around the world, to put together a specific report on dementia that will be launched in 2012. This will be an important guide for developing national policies.

85. Dr Chantanee Buranathai, from the World Organization of Animal Health (OIE), expressed concern that emerging infectious and zoonotic diseases continued to pose health problems for human beings and animals. Collaborative efforts and coordinated activities were required from the three focal organizations – FAO, OIE and WHO - to focus on the disease burden posed by these diseases.

86. Ms Shalini Bassi of the World Heart Federation commended WHO for the progress made by it towards implementation of the SEA Regional Noncommunicable Disease Framework and on the adoption of the Jakarta Call for Action on NCDs.

87. The Committee was informed that the four main NCDs: cardiovascular disease, diabetes, cancer and chronic respiratory disease, were responsible for 60% deaths worldwide. The Committee was requested to encourage attendance of its members at the
forthcoming UN High Level Meeting on NCDs, increase the budget allotted to prevention and treatment of cardiovascular diseases, and to renew WHO’s commitment to NCD surveillance.

88. Strongly believing that strengthening the community health workforce is of tremendous importance, Mr Salahuddin Mohammad, of the International Federation of Medical Students’ Associations, said that the voice of physicians-to-be, i.e., medical students, should be heard when considering any recommendation on this subject. The role of community health workers and community health volunteers must encompass more than just health care to achieve health equity, and this includes education, social determinants of health and awareness and capacity building. Citing the example of Indonesia and Thailand where medical students initiated successful community sexual education projects, he said youth and especially students of health-related professions should be involved in discussions on training and capacity building of the community health workforce. A responsive professional health education system must forge better ties between the community health workers and trainee health professionals such as medical students to ensure that local health needs are better met and health-care delivery remains people-centred.

89. On iodine deficiency disorders, Dr C.S. Pandav of the International Council for Control of Iodine Deficiency Disorders (ICCIDD) recalled World Health Assembly resolution WHA43.2 in 1990 that gave a call for the elimination of iodine deficiency disorders as a public health problem that was reaffirmed in resolution WHA49.13 in 1996. He also informed the Committee about resolution WHA58.24 in 2005 that urged Member States to monitor the state of iodine nutrition and to report to the Assembly on iodine status of their populations every three years.

90. Stating that currently around 503 million people or 30% of the population of the South-East Asia Region have insufficient iodine intake, Dr Pandav said Bhutan is the only Member State in the Region that has achieved universal household use of iodized salt. In India, iodized salt coverage reached 91% in 2009-2010. The progress towards universal salt iodization is on track in Bangladesh, Indonesia, Maldives, Nepal, Sri Lanka and Thailand.
Programme Budget Matters *(Agenda item 4)*

Implementation of Programme Budget 2010-2011 *(Agenda item 4.1: Document number SEA/RC64/4Rev.1)*

91. The Committee noted that the Fourth Meeting of the Subcommittee on Policy and Programme Development and Management (SPPDM) held in the Regional Office, New Delhi, on 1 July 2011 had reviewed the working paper providing information on the status of implementation of Programme Budget 2010-2011. The working paper spelt out both the technical and financial aspects of implementation, with the initial section of the paper providing a summary overview of progress towards the achievement of expected results as determined during the End-of-Year Review exercise, and the latter part of the paper dealing with financial implementation to 31 May 2011. As such, the paper allowed for simultaneous consideration of technical and financial progress in implementing the Programme Budget 2010-2011.

92. A summary of progress ratings assigned to Office-Specific Expected Results during the End-of-Year Review monitoring exercise was presented in the paper, as well as a summary of the main reasons for ‘At Risk’ and ‘In Trouble’ progress ratings, and the corrective actions proposed by the Regional Office to improve performance during the remainder of the biennium.

93. As regards financial implementation, the paper provided an analysis of available resources and of budget utilization in relation to Programme Budget 2010-2011 to 31 May 2011. The analysis was conducted in relation to country offices and Regional Office budget centres, and in relation to the 13 Strategic Objectives of Programme Budget 2010-2011.

94. The Committee noted the concern raised by Member States on the implementation rate as well as inadequate country capacity to utilize resources. The Committee was informed that 73% implementation had been achieved as of the end of August 2011 and that financial implementation was at par with the previous biennium.
95. It was suggested that mid-term monitoring be conducted by an external agency rather than as self-evaluation. The Committee was informed that WHO is in favour of evaluating its performance through external evaluation agencies and that this is one of the elements of the process of WHO reform.

96. The Committee noted the report on implementation of Programme Budget 2010-2011 and endorsed the recommendations made on this Agenda item by the SPPDM.

**Proposed Programme Budget 2012-2013**  
(*Agenda item 4.2: Document number SEA/RC64/5 Rev.1*)

97. The Committee was informed that the Proposed Programme Budget 2012-2013 for WHO South-East (SEA) Region, which was finalized during 2010, based on the recommendations of the Third Meeting of the Subcommittee on Policy and Programme Development and Management (SPPDM) and the Sixty-third session of the Regional Committee, had been reduced in response to the recommendations made to the 128th session of the Executive Board by the Member States.
98. The necessity for WHO to further focus on priority health challenges of the world, regions and countries in line with its comparative advantage of dealing with matters related to health leadership in the context of the current financial crisis, triggered this reduction.

99. During the discussions at the 128th session of the Executive Board on the WHO Proposed Programme Budget for 2012-2013, there was clear consensus among representatives of Member States on the need for a downward revision of the Proposed Programme Budget. The Member States provided clear directions that the 2012-2013 Programme Budget should be based as much as possible on realistic estimates of the Organization’s income and expenditure rather than on its aspirations, and provide impetus for a results chain of tangible outputs and outcomes.

100. The Proposed Programme Budget for the SEA Region has been reduced to US$ 384.2 million, which is a 29% reduction from the current biennium’s budget.

101. The reduction in the Proposed Programme Budget is not evenly distributed across all Strategic Objectives (SOs). Within the overall Programme Budget for 2012-2013, the emphasis on Strategic Objectives 3, 4, 6, 9 and 10 has been further strengthened through enhanced allocation of Assessed Contribution resources. This was largely due to the Member States requesting further support for Strategic Objectives related to the Millennium Development Goals, noncommunicable diseases and health systems development.
102. The Committee reiterated that funding be focused on priority areas rather than spread across thinly over various non-priority programme areas so that better and more tangible results are achieved and there is maximum as well as optimal use of resources.

103. The Committee also noted that the Assessed Contributions had remained at the same level as in the 2010–2011 biennium and budget cuts would not have any adverse impact on the ongoing priority country programmes as these cuts would be mostly absorbed at Headquarters and Regional Office levels. Efforts have been made to ensure that an increased proportion of AC resources was dedicated to priority Strategic Objectives such as 3, 4, 5, 6, 9 and 10.

104. The Committee was also informed that to tide over the current challenge of reduced inflow of resources, concerted efforts were required for efficient and optimal use of available resources. The need to improve bottom-up planning processes to allow flexibility of budget was mentioned.

105. The Committee endorsed the recommendations made by the SPPDM on this agenda item and adopted resolution SEA/RC64/R1.

**Technical Matters (Agenda item 5)**

**Consideration of the recommendations arising out of the Technical Discussions on “Strengthening of the community-based health workforce in the context of revitalization of primary health care” (Agenda item 5.1: Document number SEA/RC64/6 and Inf. Doc.)**

106. The Committee was informed that the Regional Director had convened the Technical Discussions on “Strengthening of the community-based health workforce in the context of revitalization of primary health care” from 1 to 3 June 2011 at the National Institute of Health Sciences, Kalutara, Sri Lanka, as per decision of the Sixty-third Session of WHO Regional Committee for South-East Asia.
107. The Committee observed the lack of uniformity in the standard of the community health workforce and community health volunteers in different Member states in terms of qualifications, training, recruitment process, incentives and outcomes. It however noted that a uniform standard for the health workforce is not possible and country specific approaches are more feasible.

108. The Committee recommended that an assessment be made on the level of incentives that may make the community-based health workforce perform better. Country experiences in this regard should be shared.

109. The Committee endorsed the report and recommendations of the Technical Discussions as contained in document SEA/RC64/6 on this agenda item and adopted resolution SEA/RC64/R2.

**Selection of a subject for the Technical Discussions to be held prior to the Sixty-fifth Session of the Regional Committee** *(Agenda item 5.2: Document number SEA/RC64/7 Rev.1 and Inf. Doc.)*

110. The Committee noted that the HLP meeting had discussed this item as part of an in-depth and wide-ranging review of various issues relating to a subject of regional interest. The
proposed subjects that were presented to the HLP meeting were: (i) Occupational health: Review of regional policy and strategy; (ii) Community-based rehabilitation; (iii) Working with Member States to accelerate progress to achieve MDGs 4 and 5; and (iv) Review of the Malaria Control Strategy in the SEA Region.

111. The HLP meeting suggested that the following three additional subjects be added to the proposed list of subjects: (i) Noncommunicable diseases, including mental health and neurological disorders; (ii) Universal health coverage, and (iii) Health sector reform.

112. Following intensive discussions, and considering the importance of the subject, the HLP recommended to hold Technical Discussions on “Noncommunicable diseases, including mental health and neurological disorders” prior to the Sixty-fifth Session of the Regional Committee in 2012.

113. The Committee endorsed the recommendations of the HLP and decided to hold the technical discussions on the subject of “Noncommunicable diseases, including mental health and neurological disorders” prior to the Sixty-fifth Session of the Regional Committee in 2012.

2012: Year of Intensification of Routine Immunization in the South-East Asia Region: Framework for increasing and sustaining coverage (Agenda item 5.3: Document number SEA/RC64/8 and Inf. Doc.)

114. The Committee was presented with the Strategic Paper “2012: Year of Intensification of Routine Immunization in the South-East Asia Region” and noted that increasing and sustaining immunization coverage is timely.

115. The Committee noted the progress made in protecting children in Member States of the Region against vaccine-preventable diseases. Immunization of children is the most cost-effective public health initiative to prevent diseases and ensure a healthy life for children, the Committee reiterated. The administration of three doses of diphtheria,
tetanus and pertussis (DTP3) vaccines is the most common indicator to assess the effectiveness of routine immunization services.

116. The Global Immunization Vision and Strategy (GIVS) adopted at the Fifty-eighth World Health Assembly in 2005 envisaged the achieving of 90% DTP3 coverage at the national level and 80% coverage at the district level in all Member States. In the SEA Region, the DTP3 vaccine coverage increased from 66% in 2000 to 73% in 2009. Seven Member States of the Region have achieved the national-level coverage target of 90% while four have met the district-level target of 80%. Due to the consistent increase in coverage of routine immunization, the incidence of vaccine-preventable diseases in under-five children has significantly declined in most Member States of the Region.

117. However, estimates from national demographic health surveys (DHS) reveal that approximately 10 million under-five children in the Region still do not receive the DTP3 vaccination during their first year of life, making them more vulnerable to disease, disability and death in their later years.

118. Based on the review of the situational analysis for coverage of routine immunization in the Region, the Committee observed that Member States need to intensify their routine immunization comprising BCG, OPV, DTP-3 and measles vaccines—the six basic antigens that are used for routine immunization—to reach all unreached populations and bridge the existing gaps, thereby ensuring that equitable access and total coverage is achieved.

119. The Committee noted that the proposed Regional Framework for increasing and sustaining routine immunization coverage outlines the key determinants, goal, strategies and priority areas, and action required to be taken at the regional as well as national levels.

120. The Committee reiterated that immunization is one of the most cost-effective interventions to achieve Millennium Development Goals 4 & 5, and the national immunization programmes continue to be an area of significant interest to policy-planners in Member States.
Given the cost-effectiveness of immunization per se, the Committee noted that new technologies, safer vaccines and competent public health distribution systems can further mainstream the immunization initiatives and help Member States to attain the highest levels of health. Active collaboration of WHO was sought in this regard.

121. Seven Member States in the Region have achieved the Global Immunization Vision and Strategy goal of 90% national-level coverage of DTP3 and four of these Member States have achieved the second goal of at least 80% coverage of DTP3 at the district level. However, within the same country there are pockets of population groups that have not yet been reached fully and need focused and intensified efforts to achieve universal coverage.

122. In these pockets of low-performing districts the Expanded Programme of Immunization (EPI) needed to be bolstered through measures such as home visits by community health workers, volunteer mobilization, incentives and more efficient cold chain management. WHO’s assistance with specific operation plans for such low-performing districts was sought by the Committee.

123. The Committee acknowledged several challenges including reaching the unreached; ensuring safe and assured quality of
affordable vaccines at all levels of delivery; trained human resources; the need for mobilizing additional resources and carrying out research on vaccine development for further expanding services.

124. The Committee also discussed that introduction of new vaccines should be according to local epidemiology and context taking into account its financial requirements and sustainability in the future.

125. The Committee’s attention was also drawn to the need for collaboration of partners for sustaining immunization and monitoring and management of adverse effects following immunization (AEFI). The Committee also sought the active assistance of WHO in the important area of technology transfer for vaccine production. The Committee urged WHO to assist countries in enabling them to sustain and strengthen their national immunization programmes by allocating more budgets for trained manpower and developing public health infrastructures.

126. The Committee urged WHO to support the expansion of vaccine production capacity in Member States to ensure the uninterrupted supply of quality and affordable vaccines to the national immunization
programmes. The Committee urged WHO to especially assist low-income Member States in buying quality vaccines at subsidized rates to ensure uninterrupted supply to the national immunization programmes.

127. The Committee raised the issue of the pressures being faced by the national programmes to introduce new antigens in their routine immunization programmes despite the lack of disease burden studies. In this regard, the Committee urged WHO to develop regional guidelines and policies based on evidence-based planning to enable countries to address this issue. The importance of sharing experiences and results of vaccine research in Member States was also underscored.

128. The Committee was informed that WHO will continue to assist Member States in strengthening national regulatory authorities, vaccine research, developing and sustaining routine immunization plans, and identifying deficiencies. The Committee was also assured of WHO support in case Member States planned to introduce new antigens in their routine immunization services in addition to the six basic antigens that are dispensed currently. However, such introduction of new antigens must also be sustainable.

129. The focus of WHO over the past three years leading to 2012 has been in the areas of developing country-specific operation plans; adapting the regional guidelines to the suitability of individual Member States; and mobilizing resources from external agencies, donors and partners.

130. The Committee endorsed the declaration of 2012 as the Year of Intensification of Routine Immunization in the South-East Asia Region made at the High-Level Ministerial Meeting in New Delhi, India, on 2 August 2011; and stressed the need for developing country-specific operational plans and guidelines for implementation of targeted activities. The Committee also agreed to review progress in mid-2012 and evaluate the achievements in early 2013 and adopted resolution SEA/RC64/R3 on this agenda item.
Regional Nutrition Strategy: Addressing malnutrition and micronutrient deficiencies
(Agenda item 5.4: Document number SEA/RC64/9 Rev.2 and Inf. Doc.)

131. The Committee was apprised that Member States of the Region accounted for over 70% of the world’s undernourished children. While children with severe undernutrition have high mortality, a larger number of deaths occur among the more numerous but less severely malnourished children. Over-nutrition and obesity are also becoming a public health problem in this Region. Iodine deficiency continues to be a public health problem despite several programme interventions. Systematic and comprehensive application of available nutrition interventions can prevent most of these deficiencies and two-thirds of all deaths while contributing to child survival in Member States.

132. The Committee noted that the regional nutrition strategy was intended to assist Member States in developing a multisectoral approach by identifying and prioritizing nutrition action in all relevant sectors. The strategy has taken into consideration the diversity exhibited in the nature and magnitude of nutrition problems in Member
States, as well as the available national capacities and technical expertise to address such problems.

133. The Committee’s attention was drawn to the working paper and the HLP Meeting recommendations based on it for Agenda Item 5.4, Regional Nutrition Strategy: Addressing malnutrition and micronutrient deficiencies.

134. The Committee noted that in spite of progress, malnutrition in different forms continued to affect a large proportion of the populations of Member States in the Region. Undernutrition in infants, children and women, widespread micronutrient deficiencies, overnutrition leading to overweight and obesity and diet-related noncommunicable diseases were the nutrition challenges facing the Region. All Member States had established national nutrition policies and/or plans of action with interventions targeting the common food and nutrition problems. However, the extent of these interventions, their effectiveness and corresponding impact upon the nutrition issues being addressed, showed wide variations.

135. The Committee discussed the working paper and the background information document and agreed that the introduction of the Regional Nutrition Strategy: Addressing malnutrition and micronutrient deficiencies was both timely and relevant. The Strategy with its broad-based approach, emphasis on a multisectoral approach and identification of core nutrition interventions, was considered appropriate. The assistance provided by WHO-SEARO to Member States in order to respond to the existing nutrition issues and ensure food security was noted. The Committee suggested that in order to assuage the pace of progress in Member States a time-frame for the indicators should be added and operational research on existing nutrition challenges should be included.

136. The Committee unanimously endorsed the Regional Nutrition Strategy: Addressing malnutrition and micronutrient deficiencies and the recommendations made by the HLP meeting on this Agenda item and adopted resolution SEA/RC64/R4.
National essential drug policy including rational use of medicines (Agenda item 5.5: Document number SEA/RC64/16)

137. The Committee was informed about the irrational use of medicines, a serious public health crisis, that was causing considerable harm to patients in terms of poor patient outcomes, impoverishment (through large and unnecessary expenditure), unnecessary side-effects, antimicrobial resistance, morbidity and death. It is estimated in low- and middle-income countries that more than half of all medicines are used inappropriately. There are multiple causes of irrational use, including economic, legal, information-related, workplace and workgroup factors, as well as educational ones. Due to these multiple causes, which involve many stakeholders, WHO has long advocated a comprehensive approach to address this issue and recommends a core set of medicines policies. Unfortunately, most efforts globally and in the Region to promote rational use of medicines have been educational in nature, small-scale and fragmented, with very limited impact. Furthermore, implementation of national medicine policies has been sub-optimal. A coordinated effort between so many different stakeholders is difficult in health systems where there is often no forum to meet nor a mandated body to facilitate the process.

138. The Committee noted that the intercountry meeting on Promoting Rational Use of Medicines, held in the South-East Asia Region in July 2010, recognized these problems and recommended that the issue of how to tackle irrational use of medicines be discussed at the Regional Committee and that a comprehensive regional strategy be developed. The meeting further recommended that countries establish a dedicated, fully resourced unit in the government to monitor medicines use and coordinate the implementation of national policy to promote rational use of medicines; that the unit be guided by a broad-based steering committee involving all stakeholders; that each country undertake a situational analysis to develop a roadmap for action; and that WHO-SEARO support countries in these endeavours.

139. The Committee noted that the subject of irrational use of medicines had already been discussed in the context of promoting
rational use of antibiotics to contain antimicrobial resistance, both at the Regional Committee Session last year and as part of World Health Day this year, and very recently in the Jaipur Declaration on Antimicrobial Resistance.

140. All Member States recognized the serious problem of irrational use of medicines. The consequences of irrational use of medicines were mentioned including large waste of resources, antimicrobial resistance from overuse of antibiotics, and hepatitis B and C and HIV from the use of non-sterile injections. Taking note of the multiple causes of irrational use involving many stakeholders and including lack of diagnostics, fear of poor outcome and commercial interests, the Committee expressed the need for coordinated action to implement strategies that involve many different stakeholders.

141. The Committee recognized that promoting rational use of medicines is a difficult matter to solve. However, it was pointed out that promoting rational use of medicines would be one of the strategies to achieve universal coverage of health care. The urgency of the situation with regard to promoting rational use of antibiotics was highlighted as antimicrobial resistance is increasing and the number of new antibiotics in the pipeline is very few.
142. The Committee stressed the need to have a national coordinated approach to promoting rational use of medicines. This would require a high-level mandated body or board to oversee the monitoring of medicines use and prescription audit, particularly for antibiotics, and to mandate strategies and regulations to limit the misuse of medicines, such as over-the-counter use of new generation antibiotics and unethical drug promotion. The Drug Regulatory Authorities needed to be strengthened and regulations more strictly enforced, particularly with regard to registration of irrational fixed-dose combination products and unethical drug promotion.

143. The Committee highlighted some of the core strategies recommended by WHO to promote rational use of medicines, including: national essential medicines lists and clinical guidelines, which should be regularly updated and used in the private as well as the public sectors; mandated prescription audits particularly with regard to antibiotics and generic prescribing; properly regulated ethical drug promotion; public education and community participation in implementing strategies; and a comprehensive national drug policy incorporating all the aforementioned issues. The need to conduct a situational analysis to plan action in this area was also expressed.

144. The Committee adopted resolution SEA/RC64/R5 on this agenda item.
Regional Health Sector Strategy on HIV, 2011-2015 (Agenda item 5.6: Document number SEA/RC64/10 and Inf. Doc.)

145. The Committee was informed of the progress made and lessons learnt within the HIV programme in the Region that included prevention, treatment, care and support. This, in turn, guided the development of the Regional Health Sector Strategy on HIV (2011–2015). After sub-Saharan Africa, the WHO SEA Region has the second highest burden of HIV in the world with 3.5 million people affected with HIV living in the Region though the overall adult prevalence is below 1%.

146. Despite the burden and challenges, significant progress had been made and achieving universal access to HIV services seems feasible. New directions and opportunities aimed at achieving the Millennium Development Goal (MDG) related to HIV/AIDS include more efficient and effective HIV approaches and technologies, the crucial contribution of civil society to service delivery and decentralization, and integrated service delivery for maximizing synergies for a strengthened health sector response to HIV.

147. The Committee noted that the framework for the Regional Strategy has been developed in consultation with national HIV/AIDS programmes as well as with experts in the Region. The Regional Strategy follows the Global Health Sector Strategy on HIV/AIDS: 2011–2015, which was presented and endorsed by the Sixty-fourth World Health Assembly. The Regional Strategy covers a period of five years (2011–2015) and will guide the health sector response for achieving universal access to prevention, treatment and care for HIV.

148. The Committee noted that the SEA Region has the second largest burden of HIV in the world and that the proposed strategy is timely to work towards achieving universal access to HIV prevention, treatment, care and support.

149. It was felt that the proposed strategy should be adapted as per the epidemiology of HIV in the countries, and that innovative approaches and partnerships are important, including community-based interventions that are culturally acceptable. Partnership with the private sector is also essential in the context of national HIV
response. It was stressed that integration of interventions should be evidence-based. In this regard, the Committee also urged WHO to support cross-border activities.

150. The Committee also noted that, in the future, resources from donors are likely to become limited and therefore it is important to maintain high visibility of national AIDS programmes. HIV/AIDS has substantial impact on the health and economy of a country; therefore national AIDS programmes should be considered priority programmes. In this connection it was highlighted that a synergistic response involving bilateral and multilateral actions would be critical to combat HIV.

151. It is important to harmonize national efforts, backed by a strong multisectoral approach and an efficient monitoring and evaluation system. It was noted that such efforts would require additional technical and financial resources.

152. The Committee appreciated the strategic strengthening of health systems based on PHC as this is relevant to all countries in the Region. It was also felt that effective use may be made of health insurance for HIV management—an initiative that has already been put to practice in South Africa.

153. The Committee endorsed the Regional Health Sector Strategy on HIV (2011-2015) and recommendations made by the HLP meeting on this Agenda item and adopted resolution SEA/RC64/R6.

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

**Key issues and challenges arising out of the Sixty-fourth World Health Assembly and the 128th and 129th sessions of the WHO Executive Board (Agenda item 6.1: Document number SEA/RC64/11 Rev.1)**

154. The Committee was presented with the highlights, from the perspective of the SEA Region, of the most significant and relevant resolutions emanating from the Sixty-fourth World Health Assembly (held from 16-24 May 2011) as well as the 128th and 129th sessions
of the Executive Board (held from 17-25 January 2011 and on 25 May 2011 respectively). The committee noted that these resolutions are deemed to have important implications and merit follow-up action by both Member States as well as WHO at the Regional Office and country office levels.

Review of the draft provisional agenda of the 130th session of the WHO Executive Board (Agenda item 6.2: Document number SEA/RC64/12)

155. The Committee was informed that the 130th Session of the WHO Executive Board would be held at WHO headquarters in Geneva in January 2012. It noted that any proposal from a Member State or Associate Member to include an item on the Agenda should reach the 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 14 September 2011.

156. Several Member States requested that an item on Global Burden of Mental Disorders be added to the agenda of EB 130. Mental
disorders posed a significant public health burden. A comprehensive and coordinated response was needed to address the issue. They were advised that a request be sent to the Director-General before the deadline under Rule 9 of the Rules of Procedure of the Executive Board as amended by the Board at its 122nd Session (EB 122.R8).

**Follow-up action on pending issues and selected Regional Committee resolutions:** *(Agenda item 6.3)*

**Regional Strategy for Universal Health Coverage (SEA/RC63/R5) (Agenda item 6.3.1: Document number SEA/RC64/13 and Inf. Doc.)*

157. The Committee noted that universal health coverage (UHC) was usually equated with health insurance for medical care by many, with insufficient emphasis on disease prevention and health promotion or public health interventions. The regional strategy advocates the importance of health systems strengthening based on primary health care (PHC) where public health interventions are delivered in good balance with medical care including a balance in resource allocation.

158. Universal health coverage is one of the four areas advocated for reform of health systems based on PHC. Reform of UHC will adhere to
the value upheld by PHC i.e. equity and social justice. This translates into giving special emphasis on protecting the poor, the vulnerable and the marginalized. Equity and social justice is an overarching goal of health development to achieve health-related MDGs and ultimately health for all.

159. The Committee noted that the following five Strategic Directions were identified for inclusion in the Regional Strategy:

- Strengthen national health policies, strategies and plans that reflect government’s commitments to health systems strengthening based on PHC.
- Move towards pre-payment and risk-pooling to reduce out-of-pocket expenditure in a phased manner.
- Implement demand-side financing for major health problems.
- Generate more resources for health, preferably from domestic sources, supplemented with innovative financing.
- Monitor and evaluate health equity among various economic strata of the population using community-based surveys.

160. The Committee was assured that the Draft Regional Strategy would be further improved, keeping in mind the experiences of countries of the Region. It was decided to include the issue as an agenda item at the Sixty-fifth Session of the Regional Committee in Indonesia in 2012. It was also agreed that innovative approaches to reach the poor will be considered along with social health insurance, and the issue will be discussed at the Parliamentarians’ Meeting.

161. The Committee supported and endorsed the importance of health-care financing. They stressed primary health care as a means to achieve universal health care coverage. The success stories of other countries, both within and outside the Region, should also be shared.

162. The Committee noted the overriding importance of ensuring equitable access to the poor, while observing that universal health
coverage encompasses both public health as well as medical care. The Committee observed that public health interventions, being public goods, should be given higher resource allocations so that out-of-pocket expenditure, which is the highest in the SEA Region among all WHO regions and a major cause of impoverishment, is reduced.

**Challenges in Polio Eradication (SEA/RC60/R8)**

*(Agenda item 6.3.2: Document number SEA/RC64/14)*

163. The Committee was informed that polio eradication continued to be a priority in the Region. In the first five months of 2011, only one wild poliovirus case (subtype P1) was detected in India.

164. Since November 2009, not a single P1 case had been detected in India representing the lowest level of transmission since the beginning of acute flaccid paralysis (AFP) surveillance in India in 1997.

165. The Committee took note of the significant progress made in India over the last 12-24 months. The programme had been proactively identifying risks to polio eradication and taking action to address these risks. India appeared to be on track for meeting the milestones in the Global Polio Eradication Initiative (GPEI) strategic plan; so there was cautious optimism that India could achieve polio eradication.

166. The wild poliovirus cases detected in Nepal in 2010 in districts adjoining Bihar, India and the large wild poliovirus outbreak in Tajikistan epidemiologically linked to India indicated that the key challenge for other countries in the Region and beyond is to protect their polio-free status by preventing re-infection. A strong routine immunization programme that can deliver and maintain OPV3 coverage greater than 80% in all districts will help prevent re-infection. Additionally, all polio-free countries must conduct periodic risk assessment to determine the level of risk of re-infection and spread, and decide whether or not polio immunization campaigns will be required to boost population immunity.

167. Polio eradication requires substantial funding. A substantial proportion is being met through external funding; Member States
can help the eradication effort by committing funds for surveillance, outbreak response, and strengthening routine immunization delivery.

168. The Committee reiterated the need to sustain high coverage rates and to strengthen surveillance systems. The need for surveillance was especially critical. The Committee, while taking note that there were no new polio cases reported from India’s two endemic and high-risk states of Uttar Pradesh and Bihar since April and September 2010, respectively, warned against complacency. The next three years would be critical with the stress on continued routine immunization and surveillance while guarding against importation of polio cases.

169. WHO support was solicited for monitoring and to frame policies and strategies in the post-eradication era. There was need to continue collaboration and cooperation among Member States and to formulate emergency plans. The results of operational research in Member States in collaboration with WHO should be shared by all countries of the Region, the Committee urged, while urging WHO to help countries strengthen surveillance systems and monitoring.

170. The Committee endorsed the recommendations made by the HLP meeting on this agenda item.
Utilization of South-East Asia Regional Health Emergency Fund (SEA/RC60/R7) (Agenda item 6.3.3: Document number SEA/RC64/15)

171. The Committee was informed that the South-East Asia Regional Health Emergency Fund (SEARHEF) was established through the 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 the 11 Member States of the South-East Asia Region. The fund’s resources have been successfully managed and utilized in respect of the following nine emergencies since it was made operational in January 2008: Cyclone Nargis in Myanmar (May 2008); flash floods in Sri Lanka (June 2008); Kosi river floods in Nepal (September 2008); the civil conflict in the north of Sri Lanka (April 2009), earthquake in West Sumatra province, Indonesia (October 2009); conflict in Sri Lanka (January 2010); fire in Bangladesh (June 2010); Mt. Merapi Volcanic eruption in East Java province, Indonesia (November 2010), critical health needs of resettlements in Sri Lanka (February 2011) and most recently the floods in DPR Korea.

172. In efforts to sustain the fund and improve mechanisms for replenishment of its resources, the Regional Committee, vide resolution SEA/RC61/R2 requested the Regional Director to take steps to roll-over assessed contributions of the fund. Though efforts were made, this could not be implemented due to legal constraints. However, a continued commitment was made to provide an Assessed Contributions (AC) allocation for 2010-2011, as was done for the 2012-2013 biennium through resolutions SEA/RC62/R5 and SEA/RC63/R1, respectively. Increasing the corpus of the fund through Voluntary Contributions (VC), and adopting replenishment procedures will help in sustaining the fund. The guidelines, procedures and principles initially developed remain specific and efficient enough when applied to various emergencies. Moreover, it was noted that the SEARHEF has become a model for other Regions in their efforts to set up their own emergency funds.
173. The Committee appreciated the creation and management of SEARHEF and the support it provided in recent emergencies in the Member States.

174. Acknowledging the donations of the Royal Government of Thailand (USD 100,000) and the Democratic Republic of Timor-Leste (USD 10,000), WHO reiterated its commitment to further augment the corpus of the fund through resource mobilization. Considering the vulnerability of the Region to disasters, the available corpus of US$ 1 million per biennium may become insufficient and therefore Member States were requested to voluntarily contribute to the SEARHEF.

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

**Special Programmes (Agenda item 7)**


176. The Committee noted that the report of the Thirty-fourth Meeting of the Joint Coordinating Board (JCB) of the UNICEF/UNDP/
World Bank Special Programme for Research and Training in Tropical Diseases held in Geneva, Switzerland, from 13 to 15 June 2011 was presented to the HLP meeting held in the Regional Office, New Delhi from 27 to 30 June 2011.

177. The Committee also noted that the membership of Member States from the Region nominated in the JCB is valid up to 2013.


178. The Committee **noted** that the report of the Twenty-fourth 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 on 16–17 June 2011 in Geneva, Switzerland, was presented to the HLP meeting held in the Regional Office, New Delhi from 27 to 30 June 2011.

179. The Committee **nominated** Bangladesh as a member of the PCC for a three-year term starting 1 January 2012, and requested the Regional Director to inform WHO headquarters accordingly.

**Closure of the Session (Agenda item 8)**

180. The Subcommittee on Credentials met on 9 September 2011 for the second time under the chairmanship of Prof. Dr Abul Kalam Azad of Bangladesh. It examined the credentials deposited by the Representatives of Nepal and Timor-Leste for the Sixty-fourth session of the Regional Committee. The credentials of the above-referenced Member States were found to be in order, thus entitling them to take part in the work of the Regional Committee. The Subcommittee,
therefore, proposed that the Regional Committee recognize the validity of the credentials presented by the representatives of Nepal and Timor-Leste.

181. Representatives of Member States participating in the Sixty-fourth Session of the Regional Committee expressed their wholehearted appreciation of His Excellency Mr Ghulam Nabi Azad, Union Minister of Health and Family Welfare, Ministry of Health and Family Welfare, Government of India, for inaugurating the Joint Inaugural session of the Twenty-ninth Meeting of Ministers of Health and the Sixty-fourth Session of the WHO Regional Committee for South-East Asia. The Representatives also thanked the Government of India for their warm hospitality and excellent arrangements.

182. The Representatives congratulated the Chairman and Vice-Chairman for the smooth conduct of the meetings.

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

184. The representatives also thanked other delegates for their active participation and constructive deliberations leading to the adoption of some of very important Resolutions to further the collaborative work between WHO and Member States.

185. The Regional Director congratulated the representatives for the successful session of the Regional Committee, which he attributed solely to the active participation of the representatives and the manner in which the meeting was conducted by the Chairman and Vice-Chairman.

186. He expressed his deep appreciation for and gratitude to Mr Ghulam Nabi Azad, Union Minister of Health and Family Welfare, and the Government of India for making excellent arrangements for the smooth conduct of the meeting. He said the efficient manner in which the meeting was conducted enabled the participants to complete the discussions of all agenda items within the stipulated time.
187. He also thanked the Chairman and Vice-Chairman for their effective leadership during the meeting. He also thanked the members of the Drafting Committee who drafted high-quality Resolutions which were expected to further strengthen the health agenda in the Region.

188. He said that the Regional Committee was greatly benefited by the presence of Dr Margaret Chan and sincerely thanked her for her thought-provoking address and interventions.

189. He thanked the Honourable Chief Minister of Rajasthan and the Government of Rajasthan for organizing social events and the state dinner for the distinguished representatives and the WHO Secretariat.

190. He also appreciated the commendable efforts made by the staff from the WHO country offices, WHO headquarters and the Regional Office for the meeting arrangements.

191. The Vice-Chairman thanked all representatives for in-depth and fruitful discussions on wider issues and for the important decisions and resolutions adopted. He thanked the Director-General for her inspiring address and for her concern for the Region. He expressed his deep appreciation of the Regional Director for his dedication towards the successful conduct of the meeting and hoped the delegates were further motivated in their efforts to improve the health of the people.

**Time and place of future sessions of the Regional Committee (Agenda item 8.1: Document number SEA/RC64/19)**

192. The Committee accepted the invitation from the Government of the Republic of Indonesia and decided to hold its Sixty-fifth Session in 2012 in Indonesia.
Resolutions

SEA/RC64/R1  Proposed Programme Budget 2012-2013

The Regional Committee,

Having considered the progress in implementing the 2010-2011 Programme Budget and workplans in the South-East Asia Region,

Noting the Proposed Programme Budget for 2012-2013 along with Programme Proposals for implementation of this Budget in the coming biennium,

Considering the Regional Committee’s resolution SEA/RC63/R1 that emphasizes the challenges of mobilizing of Voluntary Contributions
aligned with programme priorities reflected in the WHO workplans for Member States,

Noting the report of the Fourth Meeting of the Sub-committee on Policy and Programme Development and Management (SPPDM),

Considering the impact of the ongoing global financial crisis on both the health sectors of Member States in the Region and the reduction in Voluntary Contributions to the Region,

1. ENDORSES the report of the Fourth Meeting of the SPPDM, including its recommendations;

2. URGES Member States:
   (a) to continue to monitor the impact of the financial crisis on the health of the poor and vulnerable people, initiating safety-net programmes as appropriate;
   (b) to further increase resource mobilization, especially for countries with great resource needs to implement high-priority areas, while further enhancing flexibility in diverting resources to priority areas, and
   (c) to improve programme management, monitoring and evaluation to increase the efficiency and effectiveness of implementation, given the possible reduction in funding due to the financial crisis, and

3. REQUESTS the Regional Director:
   (a) to convey to the Director-General the Region’s requirements for additional Voluntary Contributions that are flexible and that align with the priorities of the Member States in the Region and with the disease burden of the South-East Asia Region;
   (b) to support the mobilization of voluntary contributions within the Region, especially for countries with limited mobilization capacities, as well as programmes that have not been able to achieve full funding of their workplans, as well as to
promote flexibility in using voluntary contributions to meet the needs of Member States, and

(c) to continue efforts to develop programme management, monitoring and evaluation capacities in Member States with the objective of improving the efficiency and effectiveness of implementation.

**SEA/RC64/R2 Strengthening of the community-based health workforce in the context of revitalizing primary health care**

The Regional Committee,

Recalling World Health Assembly resolution WHA62.12 on primary health care, including health system strengthening and its own resolution SEA/RC61/R3 on revitalizing primary health care (PHC),

Reaffirming the commitment for revitalizing PHC to address the emerging epidemiological and demographic transition within the socio-cultural context of Member States and the challenges faced due to climate change and rapid urbanization,

Concerned that the Region faces an increasing burden of noncommunicable diseases including mental health problems, accidents and injuries; while controlling communicable diseases and addressing maternal and child health needs requires continued attention,

Acknowledging that the community-based health workforce (particularly community health workers and volunteers) is the backbone of a PHC-based health system,

Recognizing that a well-trained, well-equipped and well-supported community-based health workforce will help in achieving universal coverage, health equity, multisectoral collaboration, and community participation, and has the potential for improving efficiency and
effectiveness of the health system and contributing towards the achievement of health-related MDGs and other national and international health goals,

Noting the country initiatives in implementing the recommendations of the “Strategic directions for strengthening community-based health workers and community health volunteers in the South-East Asia Region” (SEA/HSD/311) and the opportunities and challenges for further strengthening the community-based health workforce,

Recognizing further that additional policy support is required for strengthening the community-based health workforce, and

Having considered the report and recommendations of the Technical Discussions on “Strengthening of the community-based health workforce in the context of revitalizing primary health care” (document SEA/RC64/6),

1. ENDORSES the recommendations contained in the report;
2. URGES Member States:
   (a) to review and further strengthen national health policies, including policies with specific reference to community-based health workforce and to redefine its roles to effectively address the epidemiological and demographic challenges within the socio-cultural context of the countries;
   (b) to further strengthen the skills of frontline health workers for providing comprehensive (preventive, promotive, curative and rehabilitative) health care to the community for existing and emerging health problems; and to give additional focus on building capacity to enable them to effectively function as “change agents” with emphasis on skills building for empowering the community for self-care, health promotion and disease prevention;
   (c) to urgently institute policy measures to address issues related to the management of the community-based health workforce including adoption of appropriate selection criteria; strengthening supportive supervision;
rationalization of its distribution in remote as well as urban areas; incentives for retention of workers especially in remote and difficult areas; administrative and legal support; career progression and strengthening co-ordination with community-based workers of other sectors, and

(d) to generate evidence and conduct operational research to formulate and strengthen evidence-based policy to further enhance the efficiency and effectiveness of the community-based health workforce, and

3. REQUESTS the Regional Director:

(a) to advocate strengthening of national health policies, including human resources for health policies for strengthening the community-based health workforce, and support the Member States to develop appropriate mechanisms for monitoring and implementation of such policies;

(b) to facilitate exchange of information, experiences and best practices for strengthening the community-based health workforce and support collaboration and networking among Member States and institutions, and

(c) to support evidence generation, operational research and development of appropriate models to inform policy for strengthening of the community-based health workforce in the context of revitalization of PHC.

SEA/RC64/R3 2012: Year of Intensification of routine immunization in the South-East Asia Region: Framework for increasing and sustaining coverage

The Regional Committee,

Recalling World Health Assembly resolutions WHA53.12 on immunization as a major factor in promoting child health and WHA58.15 on Global Immunization Vision and Strategy,
Recalling the target adopted at the United Nations General Assembly’s Twenty-seventh special session on children (S-27/2, 2002) to ensure full immunization of children under one year of age, at 90% coverage nationally, with at least 80% coverage in every district or equivalent administrative unit,

Recognizing the progress made in the Region in protecting children from vaccine-preventable diseases through close partnerships with Member States, development agencies and other stakeholders,

Concerned that globally over 40% of the children who do not receive DPT 3 in their first year of life live in the South-East Asia Region,

Taking pride in the milestones achieved in the Region on polio eradication and reduction of measles mortality,

Considering that most Member States have recognized immunization as a public good, basic human right and a valuable tool in accelerating progress towards achieving the Millennium Development Goal of reducing by two-thirds by 2015, the under-five mortality rate,

Reiterating that high-level advocacy and intense social mobilization contribute to increased demand for immunization services and appropriately informed populations,

Cognizant that decentralized health systems and certain health reforms may affect immunization programmes,

Concerned with inadequate allocation of resources in national and sub-national health budgets to implement the necessary activities, and

Having considered “2012: Year of Intensification of Routine Immunization in the South-East Asia Region: Framework for increasing and sustaining immunization coverage” (SEA/RC64/8 Inf.Doc.),
1. **URGES Member States:**

(a) to declare 2012 as the Year of Intensification of Routine Immunization while agreeing to implement, and mobilize and allocate the needed resources to successfully overcome the challenges identified in the Framework for increasing coverage in the South-East Asia Region;

(b) to support organizing an annual regional immunization week in April as one of the major advocacy activities in regional intensification of routine immunization in 2012 and as part of a growing global and multi-regional movement designed to raise awareness of the benefits of immunization by increasing access and demand while targeting underserved populations and cross-border collaboration;

(c) to ensure that routine immunization remains a priority on the national health agenda and is supported by systematic planning, implementation, monitoring and evaluation and long-term financial commitment through establishment of a specific budget line for immunization in national budgets;

(d) to develop national and sub-national level plans of action based on risk analysis to intensify routine immunization coverage in line with agreed immunization targets expressed in the United Nations General Assembly special session on children, and targets in the Framework for increasing and sustaining coverage;

(e) to encourage and inform senior policy makers and stakeholders of the benefits of improving and sustaining immunization programmes, and

(f) to continue to collaborate with development partners to explore the introduction of new vaccines in expanded programmes for immunization through evidence-based disease burden studies, cost-effectiveness analysis and sustainability, and
2. REQUESTS the Regional Director:
   (a) to officially launch 2012 as the Year of Intensification of Routine Immunization in South-East Asia and support and promote major advocacy activities in regional intensification of routine immunization in 2012;
   (b) to mobilize resources from donors and development partners and support Member States in resource mobilization and implementation of the Framework, to further intensify technical support to Member States to strengthen their capacity to increase and sustain immunization coverage within the framework of primary health care and health system strengthening by focusing on high-priority and low-coverage areas;
   (c) to pursue a multisectoral approach to ensure collaboration between Member States, development partners and technical agencies and to mobilize adequate resources to intensify routine immunization coverage in the Region;
   (d) to facilitate purchase of quality vaccines at affordable rates, especially for countries with limited capacity for negotiation with suppliers, and sharing of experiences between Member States, and
   (e) to report annually to the Regional Committee on the progress towards achievement of the immunization targets adopted in the Framework.

**SEA/RC64/R4 Regional Nutrition Strategy: addressing malnutrition and micronutrient deficiencies**

The Regional Committee,

Recalling World Health Assembly resolutions WHA33.32, WHA52.24, WHA57.17, WHA58.32 and other resolutions on infant and young child nutrition, appropriate feeding practices, including but not limited to, exclusive breastfeeding for six months and starting
complementary foods along with breastfeeding thereafter, and related questions, and particularly resolution WHA53.15 on food safety, which urges integration of food safety into essential public health and nutrition functions,

Recognizing the simultaneous presence of both macro- and micronutrient under-nutrition among women and children in particular, as well as the ‘double burden’ of malnutrition: the presence of under-nutrition along with rapid increase of overweight/obesity in children and possible increasing diet-related chronic diseases in adults,

Recognizing further that global food shortage, with consequent rising food prices, and the impact of climate change may further aggravate the problem of under-nutrition,

Acknowledging that effective, efficient and affordable promotive, preventive and management interventions are available to mitigate negative consequences and improve the health and survival of the population,

Recognizing that nutrition has strong linkages with noncommunicable diseases,

Appreciating the growing commitment of Member States and their concerted efforts to implement national policies and multisectoral actions, and

Having considered the Regional Nutrition Strategy: Addressing Malnutrition and Micro-Nutrient Deficiencies (SEA/RC64/9 Inf. Doc.),

1. URGES Member States:

(a) to endorse the Regional Nutrition Strategy in addressing malnutrition and micro- nutrient deficiencies;

(b) to take further action to make nutrition an integral part of a multisectoral national development agenda, including:

   (i) reinforcing existing national nutrition policies, programmes and interventions;
developing specific advocacy tools to raise decision-makers’ awareness of the urgency and steps needed for intensified multisectoral actions including promotion, prevention, treatment and care programmes, and

(iii) coordinating with other international agencies in addressing malnutrition;

(c) to provide support and expand existing interventions for improving nutrition and managing severe malnutrition in women, infants and young children by:

(i) implementing fully the global strategy for infant and young child feeding, with its approach to feeding in exceptionally difficult circumstances, and

(ii) building the capability of hospitals and community-based health workforce, mothers, family members and other caregivers in order to improve the care of the severely malnourished, and

2. REQUESTS the Regional Director:

(a) to provide technical guidance and support to Member States for implementation of the Regional Nutrition Strategy;

(b) to strengthen technical guidance to Member States for incorporating nutrition and food safety policies and programmes;

(c) to provide support for the development of advocacy tools to raise decision-makers’ awareness of the urgency and the need to include nutrition as a priority in health, social security and national development agenda;

(d) to provide priority support to development and dissemination of science-based recommendations, guidelines and tools on nutritional care and support;

(e) to continue to promote research relative to nutrition and to address gaps in knowledge and operational issues;

(f) to provide support for development of appropriate indicators for monitoring progress and impact of nutrition
interventions and conduct regional-level monitoring of implementation, and

(g) to ensure collaboration between all concerned parties in this area so that progress may be made by building on each other’s achievements.

**SEA/RC64/R5 National essential drug policy including the rational use of medicines**

The Regional Committee,

Recalling World Health Assembly Resolution WHA60.16 on Progress in the Rational Use of Medicines as well as its own resolutions SEA/RC55/R4 on Accessibility to Essential Medicines and SEA/RC63/R4 on Prevention and Containment of Antimicrobial Resistance,

Concerned that irrational use of medicines continues to be an extremely serious and widespread problem in both the public and private sectors and aware that there is a lack of investment in monitoring use of medicines and promoting rational use of medicines,

Knowing that irrational use of medicines is wasteful for both patients and governments and has serious consequences in terms of poor patient outcome, increasing antimicrobial resistance, increased frequency of adverse drug reactions and events and the spread of blood-borne diseases through unsterile injections,

Wishing to promote rational use of medicines by prescribers, manufacturers and consumers,

Recognizing that the causes of irrational use of medicines are multi-factorial and may include perverse financial incentives and that a coordinated, comprehensive, national, health systems approach to promoting rational use of medicines is needed,

Aware that many Member States lack comprehensive national programmes, nor a stringent drug regulatory authority, and dedicated
department/division/unit within the Ministry of Health to promote rational use of medicines, and

Noting that implementation of interventions and drug policies known to be associated with improved use of medicines is sub-optimal, and convinced that it is time for governments, health professionals, civil society, the private sector and international partners to pledge resources and act to promote rational use of medicines,

1. URGES Member States:

   (a) to provide adequate human and financial resources to implement national strategies to promote rational use of medicines;

   (b) to establish or strengthen a dedicated department/division/unit in the government/MoH, guided by a broad-based, independent, long-term, steering committee involving all relevant stakeholders, to monitor medicines use and coordinate strategies to promote rational use of medicines;

   (c) to develop a national strategy and roadmap for action that takes the health system and local context into account, based on a situational analysis, to promote rational use of medicines which should include: monitoring medicines use including adverse drug reaction through a pharmacovigilance programme; using updated national clinical guidelines, essential medicines lists and formularies in all pre- and in-service training of prescribers; conducting regular government-funded continuing medical education; providing independent medicines information; establishing functional drug and therapeutic committees in all hospitals and districts; and carrying out public education on medicines use;

   (d) to strengthen drug regulatory authorities particularly with regard to enforcing measures to ban unethical and misleading promotion of medicines and prevent over-the-counter sales of certain prescription-only medicines,
including selected newer generation and/or other antibiotics;

(e) to develop mechanisms to minimize incentives for irrational use of medicines in the health system, such as incorporation of an Essential Medicines List into the benefit package of existing or new insurance schemes, and

(f) to develop appropriate mechanisms for weeding out irrational, fixed-dose combinations, and

2. REQUESTS the Regional Director:

(a) to develop and update a regional strategy to promote rational use of medicines;

(b) to advocate for, and facilitate the creation of, a department/division/unit for rational use of medicines in the ministries of health and the establishment of a broad-based steering committee to guide the department/division/unit;

(c) to include a component on promoting rational use of medicines in all Country Cooperation Strategies;

(d) to support Member States in mobilizing resources to promote rational use of medicine;

(e) to develop a model protocol or tool, with indicators, for undertaking a situational analysis in countries; pilot it; and adapt it so that countries may monitor their progress using the protocol or tool;

(f) to collect, share and analyze reports from the region on medicines use and drug policy to use for advocacy, and in order to monitor progress on the rational use of medicines;

(g) to provide technical support to Member States on monitoring use of medicines and implementing drug policies, and to facilitate the establishment of functional regional fora for sharing experiences and expertise on promoting rational use of medicines, for example, through meetings, training programmes, and websites, and
(h) to report biennially to Member States at the Regional Committee on progress achieved, problems encountered and further actions proposed to promote rational use of medicines.

**SEA/RC64/R6 Regional Health Sector Strategy on HIV, 2011–2015**

The Regional Committee,

Recalling World Health Assembly resolutions WHA53.14, WHA56.30, WHA59.12 and WHA59.19, relating and building on previous WHO HIV/AIDS strategies and plans endorsed by several Health Assemblies, and welcoming adoption by the World Health Assembly of resolutions WHA63.19 requesting the Director-General to develop a WHO HIV/AIDS strategy for 2011-2015, and resolution WHA64.14 which unanimously endorsed the global health sector strategy on HIV/AIDS, 2011-2015,

Mindful that after sub-Saharan Africa, the South-East Asia Region has the second highest burden of HIV in the world with 3.5 million people living with HIV, and that the type and quality of HIV interventions delivered in many settings do not adequately focus on populations at highest risk for HIV infection such as people who inject drugs, sex workers and men who have sex with men, and these interventions should be based on characteristic epidemiological features of HIV in South-East Asia,

Taking note that the Global Health Sector Strategy on HIV/AIDS 2011-2015 recommends to Member States to strengthen targeted prevention measures and achieve universal access to antiretroviral treatment, within a framework of respect for human rights, gender equality, and the reduction of stigma and discrimination, in national context,

Aware that the framework for the regional strategy has been developed in consultation with the national HIV/AIDS programmes as
well as with experts in the Region and is based on the Global Health Sector Strategy for HIV 2011–2015 which has been endorsed by the Sixty-fourth session of the World Health Assembly,

Recognizing that HIV prevention should continue as a core focus area in the Region, and

Mindful of the enormous challenges faced by the Member States in terms of building the necessary core capacity, including human resources and health systems development essential for the implementation of global commitments made on MDGs and universal access,

1. **URGES** Member States:

   (a) to incorporate, based on national contexts, the policies, strategies, programmes and interventions and tools recommended by WHO in order to implement effective HIV prevention measures, early diagnosis, treatment and care; and take further steps towards minimizing stigma and discrimination which hamper access to prevention, treatment and care;

   (b) to take forward new WHO priorities, including revitalization of primary health care, integrated service delivery, and equitable access to health services, selectively integrating HIV interventions in different health services;

   (c) to strengthen links between HIV; tuberculosis; sexual and reproductive health; maternal, newborn and child health; and other programmes and services in order to ensure sustainability and maximize efficiency and effectiveness;

   (d) to strengthen surveillance systems and generation of quality data for setting programme priorities;

   (e) to address migration, including cross border migration, as a factor in emerging epidemics, based on principles of dignity and respect in accordance with international norms;

   (f) to have a multisectoral and multistakeholder response for social protection;
(g) to work towards adequate fund provision for HIV programmes including allocation for prevention, treatment and care, and
(h) to fulfill all administrative and resource requirements that may be necessary for effective implementation of the Regional Health Sector Strategy on HIV 2011-2015, and

2. REQUESTS the Regional Director:
   (a) to provide technical support to Member States in implementation, monitoring and evaluation of the Regional Health Sector Strategy on HIV 2011-2015;
   (b) to facilitate resource mobilization for implementation of the Strategy in all Member States through multisectoral response and by advocating innovative health-financing options;
   (c) to promote intercountry and interregional collaboration through sharing of experiences, strategies and best practices in prevention and control of HIV, and
   (d) to review progress made and report to the Sixty-seventh session of the Regional Committee.

**SEA/RC64/R7 Resolution of Thanks**

The Regional Committee,

Having brought its Sixty-fourth session to a successful conclusion,

1. THANKS His Excellency, Mr Ghulam Nabi Azad, Union Minister of Health and Family Welfare, Government of India, for graciously inaugurating the session and for his thought-provoking speech;

2. THANKS the Director-General of the World Health Organization, Dr Margaret Chan, for her inspiring address and participation;
3. CONVEYS its gratitude to His Excellency, Mr Ghulam Nabi Azad, staff of the Ministry of Health and Family Welfare and other national authorities of the Government of India for organizing and hosting the Regional Committee in India;

4. CONVEYS further its gratitude to His Excellency, Mr Ashok Gehlot, Chief Minister, Government of Rajasthan and the staff of the Government of Rajasthan;

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

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

SEA/RC64(1)  Introduction to the Regional Director’s Annual Report on the Work of WHO in the South-East Asia Region covering the period 1 January - 31 December 2010

The Committee endorsed the Regional Director’s report on the Work of WHO in the South-East Asia Region during 2010 and agreed that it was well organized, comprehensive and covered all areas.

SEA/RC64(2)  Technical Discussions: Selection of a subject for the Technical Discussions to be held prior to the Sixty-fifth Session of the Regional Committee

The Committee decided on “Noncommunicable diseases, including mental health and neurological disorders” as the subject for Technical Discussions to be held prior to the Sixty-fifth Session of the Regional Committee in 2011.

SEA/RC64(3)  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 Bangladesh as member of the PCC for a three-year term starting 1 January 2012, and requested the Regional Director to inform WHO headquarters accordingly.

SEA/RC64(4)  Time and place of future sessions of the Regional Committee

The Committee decided to hold its Sixty-fifth Session in Indonesia in September 2012.
Annexes
Honourable Colleague Health Ministers from South-East Asia Region,

Honourable Chief Minister of Rajasthan, Shri Ashok Gehlot,

Madam Director-General, WHO, Dr Margaret Chan,

Regional Director, Dr Samlee Plianbangchang,

Secretary to Government of India, Department of Health Research, Dr V.M. Katoch,

Principal Secretary to Government of Rajasthan, Deptt of Health, Shri B.N. Sharma,

Distinguished Ambassadors,

Representatives from UN Agencies, Donor Partners, Distinguished delegates from South-East Asia Region Member States, Non-Governmental Organizations, Media, Ladies and Gentlemen,

It is my privilege to welcome all of you to the 29th Health Ministers’ Meeting and the 64th Regional Committee Session of the South East Asian Region of the World Health Organisation, being held in India. I am particularly happy that the venue of these meetings is Rajasthan, which is famous around the world for its rich culture, history and hospitality.
Two years ago, in Kathmandu, I had made a request to all the members of the SEAR region to allow India to host these meetings. I would like to thank all of you for having graciously accepted my invitation. Incidentally, before the 2000 meeting in New Delhi, India had hosted the Regional Committee Meeting in Srinagar in 1976. At that time too the Union Health Minister was from my State - Jammu & Kashmir, Mr Karan Singh, so the tradition of hospitality is all pervasive in India from Jammu & Kashmir to Rajasthan! The historic and lovely city of Jaipur, renowned as the “Pink City” has picked up the baton from Srinagar.

Though the South-East Asia Region countries, as a group, are only eleven in number, we are extremely significant on the world stage because of our population size, disease burdens and public health challenges. The region has almost one quarter of the world population and is witnessing rapid economic growth. Therefore, it is important that we continue to find solutions specific to problems affecting the health of our people.

I am glad that the theme for this year’s Health Minister’s meeting is Anti Microbial Resistance.

Besides many other factors affecting health, the emergence and spread of antimicrobial resistance is negating the achievements made in protecting human life and health from communicable diseases. As you are aware, the most important driver of antimicrobial resistance is irrational use of antimicrobial agents.

It is also a matter of great concern that, despite technological advancements in the field of health there has been negligible development in the field of new anti microbial agents.

Lack of attention to this problem has the potential to become a critical impediment in the attainment of the Millennium Development Goals (MDGs).

I am happy to state that the Regional Committee would be discussing some very crucial issues like:
“2012: Year of intensification of routine immunization in the South-East Asia Region”

“Addressing malnutrition and micro nutrient deficiencies”

“National essential drug policy including rational use of medicines”

“Regional health sector strategy on HIV, 2011-2015” and

“Recommendations arising out of the technical discussions on strengthening of the community-based health workforce in the context of revitalization of primary health care”

The reform of the WHO as well as its future financing is another important topic being taken up for discussion in the 64th Session of the Regional Committee. These reforms, as proposed by the DG, WHO, have a crucial bearing on how this organisation will function in the future.

The economic crisis and its impact on the WHO budget is now telling, with revenues substantially less than the expenditures. Attention will have to be paid on the state of finances, for all of us to continue to get assistance in the areas of technical and innovative inputs.

In fact, immediately after Jaipur meetings, the heads of states and governments, including health ministers, will assemble in New York to discuss another major public health challenge facing the world – Non Communicable Diseases (Cardio-Vascular Diseases, Diabetes, Cancer and Stroke being the four major Non-Communicable Diseases) - on the UN General Assembly platform.

Developing countries like ours face a multiplicity of concerns. While not yet having been able to fully control communicable diseases, we are facing the mounting challenge of Non-Communicable Diseases and new & re-emerging infections.

In order to work towards the highest attainable standards of physical and mental health, we need to institute effective measures
to prevent, control and manage Non-Communicable Diseases since they are now the main causes of mortality and disability at global and national levels. In countries like ours, they are the major cause of premature deaths, which strike the poor the hardest.

Non-Communicable Diseases are not only a health issue but also a development issue as they impact the productivity and also impoverish the society due to high health expenditures. Recognizing this, we have launched a national programme under which a nation-wide screening for Diabetes and Hyper-tension is currently underway, ahead of the UN General Assembly discussion.

The Government of India is fully committed to provide adequate resources for the health sector. The Prime Minister of India, Dr Manmohan Singh, said during his speech to the nation on the 65th Independence Day, "I have often referred to the 11th Five Year Plan as an education plan. We will lay the same emphasis on health in the 12th plan as we laid on education in the 11th plan. I will propose to the National Development Council that the 12th plan should be specially focused on health". Unquote.

We in the health Ministry are in the process of drafting our recommendations for the 12th Plan where we will substantially scale up our investment in the health sector. I hope that, in the coming years, we will be in a much better position to reach those who need care.

I am glad to share with you our achievement in controlling polio. We are now at the end of the peak season and have had just one case this year, as against 741 cases in 2009 and 42 cases in 2010. Though this gives us a lot of hope, we are not letting our guard down and remain ever vigilant. I can assure you that we will not spare any effort to eradicate polio from the country.

Before I conclude, I once again welcome Honourable Ministers of Health from South-East Asia Region and Director-General, WHO for attending these meetings. The Health Ministers’ and Regional
Committee meetings are a unique platform where countries from different cultural, linguistic, ethnic, religious and economic backgrounds sit together to find common solutions to the health problems of the Region.

I would like to thank the Hon’ble Chief Minister and Government of Rajasthan for extending all cooperation and assistance in organizing these meetings. I hope the arrangements will be to your satisfaction and will lead to fruitful deliberations and successful outcomes.

I would like to request the WHO Regional and Country Offices and officers of my Ministry to give you reasonable time off to enjoy the rich culture, sight-seeing and shopping in this wonderful and globally famous city of Jaipur.

I am sure that these meetings, over the next four days will become events to be recalled with much joy and nostalgia in the years to come by all of us.

Thank you and all the best!
Annex 2

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

Excellency, Mr Ghulam Nabi Azad, Minister of Health and Family Welfare, the Government of India; Excellencies, Ministers of Health from Countries of WHO SEAR; Distinguished country representatives; Dr Margaret Chan, Director-General, World Health Organization; Dr V.M. Katoch, Secretary (HR), Ministry of Health and Family Welfare, Government of India; Mr B.N. Sharma, Principal Secretary (HFW), Government of Rajasthan;

Honorable guests; Ladies and gentlemen;

On behalf of WHO/SEAR, it is my privilege to warmly welcome you all to the 29th Meeting of Health Ministers of Health and the 64th Session of the WHO Regional Committee for South-East Asia. I sincerely thank the Government of India for hosting these two important meetings in this beautiful city of Jaipur.

As a dynamic member of WHO and as host of the WHO Regional Office for South-East Asia, India has consistently demonstrated unwavering commitment to the mandate of the Organization in promoting the attainment by all peoples of the highest possible level of health. The National Rural Health Mission launched in 2005 to revitalize the primary health care approach in the country is another shining example of this commitment. I wish to put on record WHO’s deep appreciation of India’s long-standing involvement in the work of the Organization.
The current key health indicators provide clear evidence of significant progress in health development in SEAR. Among other achievements, all countries have reached the leprosy elimination targets. HIV and Tb prevalence are showing a downward trend in many countries. And we are very close to achieving the goal of polio eradication. However, in the area of maternal, newborn and child health, a few countries are facing formidable challenges in their efforts towards MDGs 4 and 5.

There are also troublesome trends which need our urgent attention. It is evident that the burden of chronic noncommunicable diseases in the Region is expected to rise steeply during the coming decade. These also include among others injuries; disabilities; and mental disorders.

Mortality due to NCDs has already surpassed that of communicable diseases.

This situation reflects the inability of our health systems to mainstream health promotion along with disease prevention through a population-based primary health care approach.

Most chronic noncommunicable diseases need long-term, or even life-long medical treatment, a situation that creates an additional “economic burden” for individuals and families. This trend will significantly contribute to increasing or even skyrocketing health care cost. We need to do much more in “primary prevention” of NCDs through the efforts of multiple stakeholders and partners; the efforts that can be efficiently coordinated by robust health systems. I hope that Your Excellencies, when attending the UN NCD Summit in New York later this month would voice our regional concerns in this regard.

Antimicrobial resistance was the theme of this year’s World Health Day.

WHO has been continually advocating “rational use of medicines”, including antibiotics. In order to effectively control microbial resistance to antibiotics and in order not to allow “superbugs” to develop in our
Region we need to exert much more efforts in advocating the “rational use of antibiotics”. Environmental threats to health due to rapid population growth and urbanization are becoming critical challenges to the majority of countries in the Region.

And climate change will certainly exacerbate the already heavy burden on our over-stretched health systems. We need to effectively mitigate the health impact of climate change through urgently strengthening our public health programmes.

Immunization is the most cost-effective public health intervention to prevent infectious diseases among children. Compared with other WHO Regions; SEA has a relatively low coverage of routine immunization. Concerted action is urgently required to intensify our efforts on routine immunization. We have the most rational reason to agree that 2012 be the Year of Intensification of Routine Immunization in SEAR.

Public health interventions place health promotion and disease prevention at their core; these interventions are vital in controlling and reducing disease burden be it communicable or noncommunicable diseases. For this to happen, we need to strengthen our public health systems for effective support to the implementation of PHC principle.

And, critically important, public health work has to be given due emphasis in national health policies and in allocation of national health resources. We need to ensure that public health work will not lag behind in our national health development endeavours.

Ladies and gentlemen, I wish the Honorable Health Ministers and distinguished country representatives very fruitful deliberations during the course of their meetings.

I sincerely thank the local organizing committee for the excellent arrangements made for the two meetings.

And I wish you all an enjoyable stay in Jaipur.

Thank you.
### 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 Work**
   - 2.1 Introduction to the Regional Director’s Annual Report on the Work of WHO in the South-East Asia Region covering the period 1 January - 31 December 2010
   - 2.2 Address by the Director-General of the World Health Organization

3. **Programme of Reform for WHO**
   - 3.1 Future of financing and programme of reform for WHO

4. **Programme Budget Matters**
   - 4.1 Implementation of Programme Budget 2010-2011
   - 4.2 Proposed Programme Budget 2012-2013
5. Technical Matters

5.1 Consideration of the recommendations arising out of the Technical Discussions on “Strengthening of the community-based health workforce in the context of revitalization of primary health care” SEA/RC64/6

5.2 Selection of a subject for the Technical Discussions to be held prior to the Sixty-fifth Session of the Regional Committee SEA/RC64/7

5.3 2012: Year of Intensification of Routine Immunization in the South-East Asia Region: Framework for increasing and sustaining coverage SEA/RC64/8

5.4 Regional Nutrition Strategy: Addressing malnutrition and micronutrient deficiencies SEA/RC64/9

5.5 National essential drug policy including rational use of medicines SEA/RC64/10

5.6 Regional Health Sector Strategy on HIV, 2011-2015 SEA/RC64/11

6. Governing Body Matters

6.1 Key issues and challenges arising out of the Sixty-fourth World Health Assembly and the 128th and 129th sessions of the WHO Executive Board SEA/RC64/12

6.2 Review of the draft provisional agenda of the 130th session of the WHO Executive Board SEA/RC64/13
6.3 Follow-up action on pending issues and selected Regional Committee resolutions:

6.3.1 Regional Strategy for Universal Health Coverage (SEA/RC63/R5)

6.3.2 Challenges in Polio Eradication (SEA/RC60/R8)

6.3.3 Utilization of South-East Asia Regional Health Emergency Fund (SEA/RC60/R7)

7. Special Programmes


8. Closure of the Session

8.1 Time and place of future sessions of the Regional Committee

8.2 Adoption of Resolutions

8.3 Adoption of the report of the Sixty-fourth Session of the Regional Committee

8.4 Closing of the Session
Annex 4

List of participants

1. Representatives, Alternates and Advisers

Bangladesh

Representative  H.E. Dr AFM Ruhal Haque
Minister of Health & Family Welfare

Alternate  H.E. Dr Capt (Rtd) Mozibur Rahman Fakir
State Minister for Health & Family Welfare

Advisers  Prof Mohammad Abul Kalam Azad
Additional Director-General (Development and Planning) and Line Director (MIS)
Directorate-General of Health Services

Mr Md Azam-e-Sadat
Deputy Secretary (WHO)
Ministry of Health & Family Welfare

Bhutan

Representative  *H.E. Zangley Dukpa
Health Minister
Ministry of Health

Alternate  Dr Kezang Namgyel
Medical Specialist
Mongar Eastern Regional Referral Hospital
Mongar

Adviser  Mr Jayendra Sharma
Planning Officer
Planning and Policy Division
Ministry of Health

*did not attend
DPR Korea

Representative  
H.E. Mr Choe Chang Sik  
Minister of Public Health  
Ministry of Public Health

Alternates  
Mr Pak Jong Min  
Director  
Department of External Affairs  
Ministry of Public Health

Mr Kim Jae Hon  
Senior Official  
Department of International Organizations  
Ministry of Foreign Affairs

Adviser  
Mr Choe Yong Su  
Official  
Ministry of Public Health

India

Representative  
H.E. Mr Ghulam Nabi Azad  
Union Minister of Health and Family Welfare  
Ministry of Health and Family Welfare  
Government of India

Alternates  
*H.E. Mr S. Gandhiselvan  
Minister of State for Health and Family Welfare  
Ministry of Health and Family Welfare  
Government of India

*H.E. Mr Sudip Bandyopadhyay  
Minister of State for Health and Family Welfare  
Ministry of Health and Family Welfare  
Government of India

*H.E. Mr Ashok Gehlot  
Chief Minister  
Government of Rajasthan

*did not attend
Mr Aimaduddin Duru Miyan  
Minister of Medical & Health, Family Welfare, Ayurveda and Medical Education  
Government of Rajasthan

Mr Shalauddin Ahmed  
Chief Secretary  
Government of Rajasthan

Dr VM Katoch  
Director-General  
Indian Council of Medical Research and Secretary,  
Department of Health Research  
Ansari Nagar  
Post Box 4507  
New Delhi – 110029

Dr NK Ganguly  
President  
Jawaharlal Institute of Postgraduate Medical Education and Research  
Dhanvantri Nagar  
Puducherry – 605006

Dr RK Srivastava  
Director-General of Health Services  
Ministry of Health and Family Welfare  
Government of India

Mr PK Pradhan  
Special Secretary & Director, National Rural Health Mission  
Ministry of Health and Family Welfare  
Government of India

Mr Keshav Desiraju  
Additional Secretary  
Ministry of Health and Family Welfare  
Government of India

Ms Aradhana Johri  
Additional Secretary  
Department of AIDS Control  
Ministry of Health and Family Welfare  
Government of India
Mr Partha Satpathy  
Minister  
Permanent Mission of India  
Geneva

Mrs Anuradha Gupta  
Joint Secretary (RCH)  
Ministry of Health and Family Welfare  
Government of India

Dr BK Tiwari  
Adviser (Nutrition)  
Directorate-General of Health Services  
Ministry of Health and Family Welfare  
Government of India

Dr D Bachani  
Deputy Director-General (NCD)  
Directorate-General of Health Services  
Ministry of Health and Family Welfare  
Government of India

Mr Sanjay Prasad  
Director (International Health)  
Ministry of Health and Family Welfare  
Government of India

Advisers

Dr Sharat Chauhan  
PS to Hon’ble Health Minister  
Ministry of Health and Family Welfare  
Government of India

Ms Mandeep Kaur  
Additional Private Secretary to HFM  
Ministry of Health and Family Welfare  
Government of India

Indonesia

Representative  
Dr Supriyantoro  
Director-General of Health Effort Care  
Ministry of Health

Alternates

Ms Lily Sriwahyuni Sulistyowati  
Chief  
Center of Health Promotion  
Ministry of Health
Dr Bambang Sardjono
Director of Primary Health Effort Care
Ministry of Health

Ms Niniek K Naryatie
Chief
Center of International Cooperation
Ministry of Health

Dr (Ms) Ekowati Rahajeng
Director of Noncommunicable Disease Control
Directorate-General of Communicable Disease
Control and Environmental Health
Ministry of Health

Dr (Ms) Widiyarti
Head
Division of Bilateral and Multilateral
Center of International Cooperation
Ministry of Health

Advisers
Ms Andi Sari Bunga Untung
Head
Sub Division Advocation
Center of Health Promotion
Ministry of Health

Dr (Ms) Sri Wahyuni
Head
Sub Division Multilateral
Center of International Cooperation
Ministry of Health

Dr (Ms) Bernadette Eka Wahyoeni
Head
Subdirectorate of Referral Health Care Service
at Teaching Hospital
Directorate of Referral Health Effort Care
Directorate-General of Health Effort Care
Ministry of Health

Maldives

Representative
H.E. Dr (Ms) Aminath Jameel
Minister of Health and Family
Ministry of Health and Family
Alternates
H.E. Mr Abdul Bari Abdulla
Minister of State for Health and Family
Ministry of Health and Family

Ms Aishath Samiya
Deputy Director
Ministry of Health and Family

Adviser
Ms Aminath Shaina Abdulla
Senior Social Service Officer
Ministry of Health and Family

Myanmar

Representative
H.E. Prof Pe Thet Khin
Union Minister for Health
Ministry of Health

Alternates
Dr Htun Naing Oo
Director-General
Department of Health
Ministry of Health

Dr Min Than Nyunt
Deputy Director-General
Department of Health
Ministry of Health

Dr Ko Ko Naing
Director
International Health Division
Ministry of Health

Dr Nyi Nyi Latt
Assistant Director
Ministry of Health

Nepal

Representative
Dr BK Suvedi
Chief
Policy, Planning and International Cooperation Division
Ministry of Health and Population
Alternates
Dr PB Chand
Chief
Public Health Administration, Monitoring & Evaluation Division
Ministry of Health and Population

Sri Lanka

Representative
H.E. Mr Lalith C.B. Dissanayake
Deputy Minister of Health
Ministry of Health

Alternates
Dr PG Mahipala
Additional Secretary (Medical Services)
Ministry of Health

Dr R Wimal Jayantha
Deputy Director-General of Health Services (Planning)
Ministry of Health

Thailand

Representative
Dr Suriya Wongkongkathep
Inspector-General (Region 5)
Office of the Inspector-General
Office of the Permanent Secretary
Ministry of Public Health

Alternates
Dr Phusit Prakongsai
Director
International Health Policy Programme
Office of the Permanent Secretary
Ministry of Public Health

Dr (Ms) Nipunporn Voramongkol
Medical Officer, Advisory Level (Health Promotion)
Bureau of Technical Advisor
Department of Health
Ministry of Public Health
Dr (Mrs) Attaya Limwattanayingyong
Medical Officer, Senior Professional Level
National Vaccine Committee Office
Department of Disease Control
Ministry of Public Health

Mrs Naphaporn Puripunyavanich
Pharmacist, Professional Level
Bureau of Drug Control
Food and Drug Administration
Ministry of Public Health

Miss Orratai Waleewong
Pharmacist, Practitioner Level
International Health Policy Programme
Office of the Permanent Secretary
Ministry of Public Health

Mr Nipat Suksaensamran
Pharmacist, Practitioner Level
Bureau of Drug Control
Food and Drug Administration
Ministry of Public Health

Miss Cholluedee Sootsukon
Foreign Relations Officer, Practitioner Level
Bureau of International Health
Office of the Permanent Secretary
Ministry of Public Health

Mr Kitti Sukantho
Pharmacist
Bureau of Drug Control
Food and Drug Administration
Ministry of Public Health

**Timor-Leste**

*Representative*

Dr (Mrs) Odete Maria Freitas Belo
Deputy Director for External Funds
Ministry of Health
Alternates

Dr (Mrs) Floriati Octaviana Dolores Fernandes
Do Rego
Minister
Dentist Medical in CHC
Ministry of Health

Adviser

Ms Manuel Maria Martins
Personal Assistant to the Minister of Health
Ministry of Health

2. Representatives from United Nations Specialized Agencies and donors

UNDP

Ms Alka Narang
Head
HIV & Development Unit
55 Lodi Estate
New Delhi – 110003
India

UNFPA

Ms Frederika Meijer
UNFPA Representative
55, Lodi Estate
New Delhi – 110003

Mr Sunil Jacob Thomas
State Prog. Coordinator
29 Shrirampura Colony
Civil Lines
Jaipur – 302006

UNICEF

Mr Sam Mawunganidze
Chief
B-9, Bhawani Singh Lane
C Scheme
Opp Nehru Sahkar Bhawan
Jaipur – 302001
India

Dr Anil Agarwal
Health Officer
B-9, Bhawani Singh Lane
C Scheme
Opp Nehru Sahkar Bhawan
Jaipur – 302001
India
Dr Avtar Singh Dua  
Health Specialist  
B-9, Bhawani Singh Lane  
C Scheme  
Opp Nehru Sahkar Bhawan  
Jaipur – 302001  
India

Ms Neelam Bhatnagar  
Nutrition Officer  
B-9, Bhawani Singh Lane  
C Scheme  
Opp Nehru Sahkar Bhawan  
Jaipur – 302001  
India

3. Representatives from Intergovernmental Organizations

World Organization for Animal Health (OIE)  
Dr Chantanee Buranathai  
Regional Technical Assistant  
Food Science Building 5F  
University of Tokyo  
1-1-1 Yayoi  
Bunkyo-ku  
Tokyo 113-8657  
JAPAN

4. Representatives from Nongovernmental Organizations

Alzheimer’s Disease International (ADI)  
Dr K Jacob Roy Kuriakose  
Chairman  
Post Box No. 53  
Guruvayur Road,  
Kunnamkulam - 680 503  
Thrissur Dist  
Kerala  
India

Framework Convention Alliance on Tobacco Control (FCATC)  
Mr Shailesh Vaite  
Regional Coordinator (South-East Asia)  
196, Harmony Apartment, Pocket 1  
Sector 4, Dwarka  
New Delhi – 110078  
India
<table>
<thead>
<tr>
<th>Organization</th>
<th>Contact Person</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>International Council for Control of Iodine Deficiency Disorders (ICCIDD)</td>
<td>Dr CS Pandav</td>
<td>Regional Coordinator for ICCIDD Centre for Community Medicine All India Institute of Medical Sciences Ansari Nagar New Delhi – 110029 India</td>
</tr>
<tr>
<td>International Federation of Medical Students’ Associations (IFMSA)</td>
<td>Mr Salahuddin Mohammad</td>
<td>Bangladesh Medical College Dhaka University Dhaka Bangladesh</td>
</tr>
<tr>
<td>International Federation of Pharmaceutical Manufacturers and Associations (IFPMA)</td>
<td>Mr Amitabh Baxi</td>
<td>Ch. Louis-Dunant 15 PO Box 195 1211 Geneva 20 Switzerland</td>
</tr>
<tr>
<td>World Federation of Medical Education (WFME)</td>
<td>Prof Khunying Kobchitt Limpaphayom</td>
<td>Professor Emeritus Department of Obstetrics and Gynaecology Faculty of Medicine Chulalongkorn University Bangkok Thailand</td>
</tr>
<tr>
<td>World Federation of Public Health Associations (WFPHA)</td>
<td>Dr CS Pandav</td>
<td>President Indian Public Health Association Centre for Community Medicine All India Institute of Medical Sciences Ansari Nagar New Delhi – 110029 India</td>
</tr>
<tr>
<td>World Heart Federation (WHF)</td>
<td>Ms Shalini Bassi</td>
<td>Head (Programmes) HRIDAY C-1/52, Third floor, Safdarjung Development Area New Delhi – 110016 India</td>
</tr>
</tbody>
</table>
5. Observers

Global Alliance for Vaccines and Immunization (GAVI)

Dr (Ms) Ranjana Kumar
Senior Programme Officer
GAVI Alliance
2 Chemin des Mines
1202 Geneva
Switzerland

International Federation of Red Cross and Red Crescent Societies (IFRC)

Dr (Ms) Laura Elena Pacifici
Regional Health and Care Coordinator
South Asia Regional Delegation
1, Red Cross Road
New Delhi – 110001
India

International Federation of Red Cross and Red Crescent Societies (IFRC)

Mr Ahyan Shandilya
Regional Health Information Officer
South Asia Regional Delegation
1, Red Cross Road
New Delhi – 110001
India

Indian Institute of Health Management Research (IIHMR)

Dr S.D. Gupta
Director
1, Prabhu Dayal Marg
Sanganer,
Jaipur – 302011
India

International Special Dietary Foods Industries (ISDI)

Ms Anshu Gupta
Manager (Corporate Affairs)
International Infant Food Manufacturers Association
Chemin Louis Dunant 7-9
1211 Geneva 20
Switzerland

Ministry of Health, Labour and Welfare, Government of Japan

H.E. Dr Masato Mugitani
Assistant Minister for Global Health
Ministry of Health, Labour and Welfare
Government of Japan
1-2-2 Kasumigaseki
Chiyoda-ku
Tokyo 100-8916
Japan
Mobility India (MI)  
Ms Albina Shankar  
Director  
1st & 1st “A” Cross, JP Nagar, Second Phase  
Bangalore - 560078  
Karnataka  
India

PATH  
Dr Sanjay Gandhi  
351, Solitaire Corporate Park  
151, M Vasanji Road  
Chakala, Andheri (E)  
Mumbai – 400093  
Maharashtra  
India

Third World Network (TWN)  
Mr KM Gopakumar  
Legal Advisor and Senior Researcher  
Third World Network  
C-236, First Floor, Defence Colony  
New Delhi 110024  
India

Voluntary Health Association of India (VHAI)  
Mr Alok Mukhopadhyay  
Chief Executive  
B-40, Qutab Institutional Area  
New Delhi – 110002  
India
## Annex 5

### List of official documents

<table>
<thead>
<tr>
<th>Document Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEA/RC64/1 Rev. 2</td>
<td>Agenda</td>
</tr>
<tr>
<td>SEA/RC64/2 and Inf. Doc.</td>
<td>Introduction to the Regional Director’s Annual Report on the Work of WHO in the South-East Asia Region covering the period 1 January - 31 December 2010</td>
</tr>
<tr>
<td>SEA/RC64/4 Rev. 1</td>
<td>Implementation of Programme Budget 2010-2011</td>
</tr>
<tr>
<td>SEA/RC64/5 Rev. 1 and Inf.Doc.</td>
<td>Proposed Programme Budget 2012-2013</td>
</tr>
<tr>
<td>SEA/RC64/6 and Inf. Doc.</td>
<td>Consideration of the recommendations arising out of the Technical Discussions on “Strengthening of the community-based health workforce in the context of revitalization of primary health care”</td>
</tr>
<tr>
<td>SEA/RC64/7 Rev. 1</td>
<td>Selection of a subject for the Technical Discussions to be held prior to the Sixty-fifth Session of the Regional Committee</td>
</tr>
<tr>
<td>SEA/RC64/8 and Inf. Doc.</td>
<td>2012: Year of Intensification of Routine Immunization in the South-East Asia Region: Framework for increasing and sustaining coverage</td>
</tr>
<tr>
<td>SEA/RC64/9 Rev. 2, Rev. 2 Inf. Doc</td>
<td>Regional Nutrition Strategy: Addressing malnutrition and micronutrient deficiencies</td>
</tr>
</tbody>
</table>
Mr Chairman,

Please allow me to present my Annual Report on the Work of WHO in the South-East Asia Region. The report covers the period from 1 January to 31 December 2010. Since the full report (document SEA/RC64/2) has already been distributed, I will only touch on some of its salient features.

Mr Chairman,

I am happy to mention that the WHO South-East Asia (SEA) Region continues to advance steadily towards the goal of reducing the burden of communicable diseases.

The campaign against polio is in the last stages. In the year 2010, only 24 cases of type 1 wildpolio virus were detected in India. But, till date, in 2011, the country has reported only one case of wildpolio virus type 1. A polio-free status can soon be achieved for the SEA Region. However, among other important activities in connection with polio eradication, sensitive surveillance, and high-quality immunization have to be maintained and even further improved. This is in order to ensure complete interruption of the remaining chains of transmission of wild poliovirus.
Mr Chairman,

In the year 2010, the world moved into the post-pandemic phase of influenza (H1N1). Because of extensive preparedness by countries and the generous support from the international community, early detection and prompt management of cases were greatly facilitated in countries of the SEA Region. Such experience will be useful in future in continuing effective influenza surveillance, as well as in responding to the outbreaks of other emerging infectious diseases. Also, five countries in the Region have further developed and implemented national action plans to build up their core capacities for surveillance and response to outbreaks of emerging diseases. This is to ensure effective implementation of International Health Regulations (2005). Laboratory support networks for disease surveillance and outbreak investigations are operational to serve all countries in the SEA Region.

Mr Chairman,

The Region achieved the target set for leprosy elimination at the end of the year 2010. Sri Lanka and Maldives have reached the point of elimination of lymphatic filariasis. Plans for elimination of soil-transmitted helminthiasis, kala-azar and yaws are actively implemented in some countries of the Region.

Mr Chairman,

Substantial progress continues to be made in combating HIV/AIDS, tuberculosis, malaria, and other communicable diseases. Although the HIV epidemic is generally on the decline, 3.5 million people in South-East Asia are still living with HIV/AIDS. The new HIV infections among children are now being targeted for elimination from the Region.

Mr Chairman,

All countries have made steady progress in tuberculosis control. Prevalence rates of TB have declined by 25% in the Region since 1990. Major achievements during 2010 include the scaling-up of
interventions against TB-HIV coinfection and against multidrug-resistant TB. Public-private partnerships for provision of services to TB patients have been further expanded in most countries in the Region.

Significant progress was also made in malaria control. Thirty per cent of population at risk were covered with longlasting insecticide nets and indoor residual spraying. However, this coverage is still very low; much more needs to be done. Regarding malaria control, collaboration among countries was maintained through cross-border consultations and meetings. The implementation of the South-East Asia/Western Pacific bi-regional project on containment of artemisinin-resistant malaria continued with more support from partners.

Mr Chairman,

Noncommunicable diseases, including mental health and injuries, are emerging as important public health concerns in the SEA Region. Most countries have a national integrated policy on prevention and control of NCDs. As regards prevention and control of injuries and violence, commitment on the part of Member States has increased significantly. All countries are actively raising awareness on road traffic injuries and many countries have developed national action plans for implementation of the Decade for Action on Road Safety, 2011-2020.

Mr Chairman,

Several countries in the Region are paying more attention to the promotion of mental health and mental well-being at community level. The basic health service facilities at primary-care level are being supported to deliver essential mental health care to people. Harm from alcohol use has been recognized as a significant public health problem. With WHO’s support, Member States are attempting to reduce harm from alcohol by developing strategies that would suit the individual country-specific situation.
Several Member States, including Bhutan, DPR Korea and Maldives have recently enacted comprehensive tobacco control legislation. This is in line with the WHO Framework Convention on Tobacco Control.

Mr Chairman,

Rising food prices compromise food security. The situation has led to unsatisfactory food safety practices and to a high proportion of undernutrition among the most vulnerable population groups in South-East Asia. The rate of exclusive breastfeeding in infants up to the age of six months remains far from optimal in the Region, in spite of the fact that International Code for Infant Feeding has been adopted in all countries in the Region.

The main constraints are inadequate enforcement of the Code and aggressive marketing of breast-milk substitutes by the commercial sector. The proportion of under-five children in the Region who are underweight ranges from 4% to 44%. This is a composite indicator of long- and short-term nutrition challenges for the Region. Stunting, which is an evidence of chronic malnutrition, ranges from 15.7% to 55% for the same age group.

With regard to the overall achievement of MDGs 4 and 5, the SEA Region is lagging behind. In order to accelerate progress towards these goals, Member States continue to make concerted efforts to strengthen partnerships and collaboration with UN agencies and other actors to develop home-based newborn care, and in management of the sick child at the community level. WHO is also intensifying its technical back-up to the Integrated Management of Childhood Illnesses (IMCI).

Mr Chairman,

The Region is particularly prone to natural disasters. According to the World Disaster Report, from 2000 to 2009, the SEA Region accounted for 62% of global deaths due to natural disasters. The South-East Asia Regional Health Emergency Fund (SEARHEF) continues to be the key mechanism for supporting relief operations in these events.
Mr Chairman,

Subsequent to the recommendations of the WHO Commission on Social Determinants of Health there has been increased focus on actions at the country level. National studies on social disparities and health have resulted in the development of multisectoral partnerships at the country level. Gender-based analysis of health programmes has been pursued in many countries in the Region. Regional and country factsheets on “gender-based violence” were prepared and disseminated during the reporting period. The WHO Regional Office for South-East Asia has been actively promoting the mainstreaming of Social Determinants of Health, and Gender and Women’s Health into all health programmes.

WHO is also providing support to help strengthen the capacity of countries in intellectual property, as well as in trade and public health. The support has been mainly through regional consultations, meetings and training of national staff.

To improve workers’ health, strategies were developed by countries for implementation of the Global Plan of Action on Occupational Health.

In the area of environmental health, strategic approaches to the management of chemicals were also reviewed and strengthened in most countries.

National action plans to address the health impact of climate change are in place in most countries. Water safety plans were developed and implemented in Bangladesh, Bhutan, India and Nepal. Appropriate technologies for sanitation were piloted in several other countries. Some milestones in the area of environmental health during the year 2010 include: the World Health Day campaign on 1000 cities and 1000 lives; the Parliamentarians’ Conference on Protection of Human Health from Climate Change; and the High-level Preparatory Meeting of Health and Environment sectors for preparations for the COP16 meeting in Mexico.
Mr Chairman,

Strong PHC-based health systems are the foundation on which public health interventions can be implemented effectively. The South-East Asia PHC Innovations Network (SEAPIN) was established last year to provide a platform for information exchange, evidence generation and intensification of advocacy for PHC-based health system strengthening.

The Regional Office has developed Rapid Health Systems Assessment Guidelines. These guidelines should be used to assist countries in identifying health systems gaps and assess needs that could be included in the proposals to GAVI; the Global Fund, and other relevant funding agencies for their support to health system strengthening in countries. With the help of WHO’s support for training of national staff, countries further strengthened their national health information systems particularly in the areas of vital registration; data/information management; and use of health information in health planning and management. In addition, observatories on Health Care Financing and Human Resources for Health were established in the Region.

Mr Chairman,

As far as human resources for health are concerned, special emphasis during the review period was placed on strengthening of public health workforce. Notable among others, was the support provided to Bhutan in launching the Bachelor’s Degree Programme in Public Health. This will not only enhance the professional capacity of health assistants working at the village level, but will also provide them with career enhancement opportunities.

Mr Chairman,

Health care financing is an area that received renewed attention during the review period. Catastrophic expenditures on health contribute significantly to impoverishment. The Region records the highest out-of-pocket expenditures on health and most countries in
the Region are yet to achieve the recommended 5% allocation from GDP for health. In order to move forward more effectively in this important area, the Regional Offices for South-East Asia and the Western Pacific regions jointly developed a Health Financing Strategy for Asia and the Pacific, 2010-2015.

Mr Chairman,

In the area of essential medicines, the SEA Region continues to face daunting challenges: high prices; lack of availability; low or lack of quality; and irrational use. Likewise, many drug regulatory authorities are weak due to various reasons. Antibiotics continue to be overused or misused and antimicrobial resistance is increasing. To address the issue relating to traditional medicine, WHO is providing advisory support, particularly with regard to safety, efficacy and quality, with emphasis on the use of herbal remedies, as well as for information exchange among countries through Herbalnet, which was developed by the WHO Regional Office for South-East Asia.

Though nine Member States now have a National Blood Safety Policy or Act in place, unsafe blood transfusions continue in some countries. WHO enhanced its support to strengthen national blood banks and services mostly through training of national staff, and promoting intercountry cooperation.

With regard to immunization, the vaccine producing countries such as India, Indonesia and Thailand have functional national regulatory authorities. These countries may now apply for the WHO pre-qualification of their vaccines for procurement through the United Nations procurement system. This development will also help in intensification of the routine immunization in the Region.

Mr Chairman,

I have outlined a number of vexing health challenges. These challenges have been compounded in recent years by the unprecedented situation beyond the control of the health sector, such as the skyrocketing of food and fuel prices; the effects of
climate change; and consequences of the 2008 global financial crisis. This highlights the fact that, for public health programmes to be effective, they must always embody multisectoral approaches in their development and implementation. WHO has always been promoting multisectoral actions in national public health systems.

Finally, Mr Chairman, as you are aware, under the leadership of the Director-General, Dr Margaret Chan, WHO has embarked on a programme of reform. This is aimed at making the Organization more effective and efficient in responding to the needs of Member States. And this response, we must ensure, is within the context of the rapidly changing global health landscape. In this connection, I should like to underscore my commitment to steer the WHO SEA Region through this period of reform so that WHO emerges as a stronger, and more effective partner of Member States not only in this Region but globally too.
Honourable ministers, distinguished guests, Dr Samlee, ladies and gentlemen,

Let me join others in thanking India for hosting this session of the Regional Committee for South-East Asia. I will be commenting on some of your agenda items tomorrow.

The twenty-ninth Health Ministers Meeting will discuss the follow up to the Bangkok Declaration on Urbanization and Health, strategies for combating antimicrobial resistance, and preparations for the high-level meeting on noncommunicable diseases to be held shortly during the UN General Assembly.

All three topics are distinctly 21st century challenges to health. And solutions for all three of these challenges depend on policies and actions in multiple sectors of government, not just health.

Policies in the international systems that govern how this world works are especially important for the prevention of chronic noncommunicable diseases. Worldwide, diseases like heart disease, stroke, diabetes, and cancers are already the world’s biggest killers.

These diseases, especially diabetes and stroke, are already responsible for half of all disabilities worldwide.
Future trends are ominous, especially for developing countries undergoing rapid modernization, as seen in many parts of this region. Most noncommunicable disease develop slowly. But the forces that drive the rise of these diseases are spreading with a stunning speed and sweep.

These forces are nearly universal, powerful, and difficult to reverse. Namely: population ageing, rapid unplanned urbanization, and the globalization of unhealthy lifestyles.

We all hope that the high-level meeting will be a wakeup call. And I do not mean for the health sector. We are already wide awake to the magnitude of the problem, with its multiple and heavy costs to health, societies, and economies.

And these burdens are frightening, especially in the many countries that are still fighting to control high-mortality infectious diseases.

In my view, the meeting needs to be a wake-up call right up to the level of heads of state. They need to be confronted with the facts right now, and how things will look very soon if the right actions are not taken immediately.

They need to understand the costs. These are the diseases that break the bank. In some countries, for example, care for diabetes alone consumes as much as 15% of the national health care budget.

Estimates from the USA indicate that diagnosed diabetes costs the country $174 billion a year, of which $116 billion goes for direct medical costs. That is a huge pile of money for a largely preventable disease.

To put it bluntly, these disease have the capacity to literally devour the benefits of rapid modernization and economic growth.

We need to emphasize population-wide preventive measures as well as cost-effective treatments, ideally delivered at the community level through primary health care.
The right actions need to be broad-based, including high-level government policies touching multiple sectors, and engaging industries, civil society organizations, medical associations, and patients’ groups.

Without question, full implementation of the WHO Framework Convention on Tobacco Control would bring the single biggest boost to the prevention of these diseases.

Ladies and gentlemen,

The Regional Committee, which starts tomorrow, has an outstanding report on national essential drug policies, including the rational use of medicines.

As the report notes, most efforts in the region to promote the rational use of medicines have been educational in nature, small-scale, and fragmented, with very limited impact. I can readily confirm that this observation holds true at the global level as well.

Combating antimicrobial resistance was the theme for this year’s World Health Day, under the slogan: No action today means no cure tomorrow.

This is the stark reality the world faces. We have taken antibiotics and other antimicrobials for granted. And we have failed to handle these precious, yet fragile medicines with appropriate care. The message is clear. The world is on the brink of losing its miracle cures.

As clearly set out in the document before the Regional Committee, the responsibility for turning this situation around is entirely in our hands. Irrational and inappropriate use of antimicrobials is by far the biggest driver of drug resistance.

This includes overuse, when drugs are dispensed too liberally. Sometimes this occurs because doctors want “to be on the safe side”. Sometimes this occurs in response to patients demands.
The problem includes underuse, especially when economic hardship encourages patients to stop treatment as soon as they feel better.

The problem includes misuse, when drugs are given for the wrong disease, usually in the absence of a diagnostic test.

Region-specific data, prepared for tomorrow’s session, document widespread improper use of antibiotics, especially for childhood killers like diarrhoeal disease and pneumonia, the use of unsterile injections, and the availability of many antibiotics over-the-counter, without any input whatsoever from prescribers.

The problem also includes the massive routine use of antimicrobials, to promote growth and for prophylaxis, in the industrialized production of food. In several parts of the world, more than 50% in tonnage of all antimicrobial production is used in food-producing animals.

Drug resistance costs vast amounts of money, and affects vast numbers of lives. At a time of multiple calamities in the world, we cannot allow the loss of essential medicines, essential cures for many millions of people, to become the next global crisis.

Thank you.
WHO Regional Committee for South-East Asia

Report of the Sixty-fourth Session

Jaipur, India, 6-9 September 2011