WHO
Regional Committee for South-East Asia

Report of the Sixtieth Session
Thimphu, Bhutan, 31 August – 3 September 2007
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Report of the Regional Committee*

* Originally issued as Draft Report of the Sixtieth Session of the Regional Committee for South-East Asia (document SEA/RC60/27 dated 3 September 2007)
1. The Sixtieth Session of the WHO Regional Committee for South-East Asia was held in Thimphu, Bhutan, from 31 August – 3 September 2007. It was attended by representatives of all the 11 Member States of the Region, UN and other agencies, nongovernmental organizations having official relations with WHO, as well as observers.

2. A joint inauguration of the Sixtieth Session of the Regional Committee and the Twenty-fifth Meeting of Ministers of Health was held on 31 August 2007. H.E. Lyonpo Kinzang Dorji, Prime Minister of Bhutan, delivered the inaugural address.

3. The Committee elected H.E. Lyonpo Thinley Gyamtsho (Bhutan) as Chairman and H.E. Dr Abdul Azeez Yoosuf (Maldives) as Vice-Chairman of the session.

4. The Committee reviewed the report of the Regional Director on the Work of WHO in the South-East Asia Region covering the period 1 July 2006 to 30 June 2007.

5. The Director-General of WHO, Dr Margaret Chan, addressed the business session of the Committee on 1 September 2007.

6. The Committee decided to hold its Sixty-first session in 2008 in the Regional Office in New Delhi.

7. A drafting group on resolutions and the Draft Report of the Regional Committee, comprising a representative from each of the Member States, was constituted with Dr I. Nyoman Kandun (Indonesia) as Convener. During the session, the Committee adopted 10 resolutions.
8. Inaugurating the Joint session of the Twenty-fifth Meeting of Ministers of Health and the Sixtieth Session of the Regional Committee for South-East Asia in Thimphu on 31 August 2007, H.E. Lyonpo Kinzang Dorji, Prime Minister of Bhutan, conveyed the warm greetings and best wishes of His Majesty Jigme Khesar Wangchuck, the King of Bhutan, for the success of the meeting. The Prime Minister referred to the historic and unprecedented changes witnessed by Bhutan in recent years, and stated that three major historical events will be celebrated in 2008, namely Bhutan’s unique transition to parliamentary democracy; celebration of 100 glorious years of monarchy; and the coronation of His Majesty the Fifth King. Speaking about “Gross National Happiness”, the Prime Minister clarified that the principle was introduced as a development philosophy which strove to balance spiritual well-being of people with socio-
economic development. The principle of “Gross National Happiness” was reflected in the health sector through integration of traditional medicine into the modern medical system. Realizing that health is essential for happiness, the Constitution guaranteed free general health services to all citizens.

9. The Prime Minister emphasized that one of the major challenges for Bhutan will be sustaining its past accomplishments in view of the present financial constraints. Shortage of human resources was another major difficulty in the context of expanding health care services, difficult geographical terrain and scattered population (for full text of the address, see Annex 1).

10. In his address, Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia (SEA) Region, thanked the Royal Government of Bhutan for hosting the meeting, and His Excellency, Prime Minister Lyonpo Kinzang Dorji, for inaugurating the joint session. He noted that under the guidance of His Majesty the King, Bhutan had achieved a “quantum leap” in health development over the past few decades, developing its health infrastructure almost from scratch into a complete and functional health system. Health indices of the Bhutanese population had shown remarkable improvement in almost all sectors. In view of these achievements, he said, Bhutan was a model for health development from which many countries might learn.

11. The Regional Director stated that the past year had been another significant step on the road to progress in health development in the South-East Asia Region. However, many health challenges remained and called for more enhanced and energetic intercountry collaboration. Among the challenges were that polio was yet to be eradicated; avian influenza was endemic in several countries and posed the potential for an influenza pandemic; and HIV infection was still spreading. In addition, the Region faced emerging public health problems due to noncommunicable diseases such as diabetes, cancer and
cardiovascular ailments, and global warming was causing more frequent and severe natural disasters.

12. Dr Samlee said that serious efforts would be required to ensure that all health-related targets of the Millennium Development Goals by all Member States in South-East Asia were met by the year 2015. Among the strategies he mentioned were strengthening health systems based on the primary health care approach and the development of public health infrastructure. WHO would continue working closely and harmoniously with other international governmental and nongovernmental organizations, he said, to ensure the best support to Member States (for full text, see Annex 2).

13. In her address, WHO Director-General Dr Margaret Chan referred to key health challenges for the Region, and noted that some were related to geography, while others stemmed from the size of populations and the sheer numbers of people to be reached. At the same time, she noted the Member countries’ shared assets – namely, their commitment to poverty reduction and determination to achieve universal coverage with essential interventions. She commended Bhutan’s commitment to Gross National Happiness as the best measure of true progress in development, and said there could hardly be another objective that so closely aligns with the comprehensive definition of health set out in the WHO constitution. The Director-General praised the political courage displayed by the Member countries in the face of a challenge magnified many times in this most populous region in the world.

14. Earlier, in his welcome address on behalf of the Ministry of Health, Royal Government of Bhutan, Cabinet Minister Lyonpo Thinley Gyamtsho briefly highlighted the status of the Bhutanese health services, noting that it had made tremendous achievements over the last four decades due to the highest political commitment accorded to the social sector by the Royal Government of Bhutan. He stated that health-care services were provided free of cost to all citizens; that through the primary health care approach, many of the vital health indices had seen dramatic improvement; and some of the health Millennium Development Goals (MDGs) had already been achieved.

15. He also said that health security was being approached through a multisectoral strategy and that Bhutan was fully committed to collaborating on the issue of international health security. He expressed his appreciation to development partners and solicited their continued support.
16. On behalf of the Health Ministers and distinguished delegates, His Excellency Mr Nimal Siripala de Silva, Minister of Healthcare and Nutrition, Sri Lanka, proposed a vote of thanks, and expressed gratitude to the Royal Government of Bhutan. He observed that political changes were taking place in Bhutan and that democratization was being undertaken at the insistence of the leader in power. He praised Bhutan’s philosophy of Gross National Happiness and the Royal Government’s commitment to ensure free general health services to all its citizens, as enshrined in its constitution. As the health of people was crucial for a country’s economic development, it was important that it was fully protected.
Part III

Business session

Opening of the session

17. In the absence of the Chairman and Vice-Chairman of the Fifty-ninth Session of the Regional Committee, the Regional Director, Dr Samlee Plianbangchang, opened the session as per Rule 12 of the Rules of Procedure of the WHO Regional Committee for South-East Asia.

Business session

Sub-committee on credentials

(Agenda item 2.1)

18. A Sub-committee on Credentials, comprising representatives from Bangladesh, India and Timor-Leste, was appointed. The Sub-committee met under the chairmanship of the representative of Bangladesh and examined the credentials submitted by Bangladesh, Bhutan, DPR Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste. The credentials submitted by all Member countries were found to be in order, thus entitling the representatives to take part in the work of the Regional Committee.

Election of office-bearers

(Agenda item 3)

19. H.E. Lyonpo Thinley Gyamtsho, Cabinet Minister, Royal Government of Bhutan, was elected Chairman, and Dr Abdul Azeez Yoosuf, Deputy Minister of Health, Republic of Maldives, as Vice-Chairman. H.E. Lyonpo Thinley Gyamtsho 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 the support of the Regional Director and his team.
Adoption of the Agenda

(Agenda item 4, document SEA/RC60/1 (Rev.1))

20. The Committee adopted the Agenda as contained in document SEA/RC60/1 (Rev. 1) with the amendment that in Agenda item 16, the sub-item on “International migration of health personnel: a challenge for health systems in developing countries”, be taken up first (Annex 3).

List of participants

21. The list of participants is at Annex 4.

Drafting group

22. The Committee constituted a drafting group on resolutions and on the draft final report of the Regional Committee, comprising one representative from each Member country. Dr. I. Nyoman Kandun (Indonesia) was nominated as the Convener of the Drafting Group (for names of members of the drafting group, see Annex 5).

List of official documents

23. The list of official documents is at Annex 6.
Introduction to the Regional Director’s Annual Report on the Work of WHO in the South-East Asia Region covering the period 1 July 2006 to 30 June 2007

(Agenda item 5, document SEA/RC60/2)

24. Introducing his report, the Regional Director, Dr Samlee Plianbangchang, stated that the South-East Asia Region carried a double burden of both communicable and noncommunicable diseases. These challenges needed to be addressed through improved intercountry and interregional cooperation. Effective implementation of the International Health Regulations (2005) was essential to prevent the spread of infectious diseases internationally. Equally important was strengthening the capacity of national public health systems.

25. A meeting of health and agriculture ministers of nine Member countries of the SEA Region and two from other regions was hosted by the Government of India in July 2006 to prepare the modalities of ensuring a multisectoral response to endemic outbreaks of avian influenza. The meeting adopted the “Delhi Declaration” calling for WHO’s support to Member countries in the battle against avian influenza. WHO had established two regional subunits in Bangkok and New Delhi to provide timely support to countries in the Region in surveillance, outbreak alert and response to communicable diseases.

26. Prompted by the rapid spread of dengue to new areas, the Regional Strategy for Dengue Prevention and Control had been revised and the Asia-Pacific Dengue Partnership formed. Support was also provided to affected countries in the prevention and control of chikungunya.

27. Malaria being a major health problem, the revised Regional Strategy for Malaria Control – advocating community-based prevention and multisectoral intervention – was endorsed by the Health Ministers of the Region during their annual meeting in 2006.

28. The Region continued to bear the highest burden of tuberculosis in the world with five million cases and half a million deaths annually. The HIV epidemic had also impacted TB control, with nearly three million estimated TB/HIV co-infected cases in the Region. However, with a treatment success rate of 87%, the Region was well placed to achieve the target for TB-related Millennium Development Goals (MDGs).

29. Nine countries in the Region had attained the goal of elimination of leprosy, while the remaining two were expected to reach it by the end of 2007.
30. The implementation of the Global Strategy for “Universal Access” with regard to HIV/AIDS had received priority attention with antiretroviral treatment coverage rising tenfold – from 18 000 patients to 180 000 – between 2003 and 2006. However, the coverage of preventive services for STIs and HIV infections, such as the promotion of condom use, was at a low of 20%.

31. Despite encouraging success in several Member countries, polio eradication remained a major challenge. Notwithstanding the unwavering commitment of Member countries, more than 10 million children remained unimmunized annually. Consequently, WHO had focused on intensifying routine immunization with rational use of new vaccines.

32. The Region also carried a disproportionate burden of the neglected tropical diseases (NTDs) including lymphatic filariasis, kala-azar and yaws, which were targeted for elimination by 2015.

33. Noncommunicable diseases (NCDs), including cardiovascular disease, cancer and diabetes, accounted for 54% of all deaths in the Region. Efforts at integrated prevention and control of noncommunicable diseases through networking of programmes and activities had been scaled up. Progress had also been made in the implementation of national strategies and plans of action on diet and physical activity.

34. Member countries carried a very high burden of tobacco-related illnesses – 1.2 million of the 5 million annual global deaths due to tobacco use occur in the SEA Region. Ten Member countries had ratified the WHO Framework Convention on Tobacco Control, and the Bloomberg Global Tobacco-Free Initiative was launched in six of them in November 2006.

35. Community-based mental health services as part of national health-care systems were developed through regional consultations. Multisectoral approaches to mental health promotion had been pursued through community-based organizations.

36. Maternal and newborn mortality continued to be an important public health concern with a third of the global maternal and newborn deaths occurring in this Region. Five Member countries conducted studies on interventions to reduce maternal mortality through improved referral systems and organized workshops to develop guidelines on newborn health. Family planning services, particularly with regard to unsafe abortion, received due and continued attention.
37. The Region was on course for achieving the MDG targets for water supply. Sanitation coverage, however, lagged behind, with only 16% of the rural population covered. Excessive concentration of arsenic and fluoride in drinking water remained a source of concern in some countries despite the introduction of water safety monitoring and surveillance and the setting up of new national water quality standards.

38. The adverse health impacts of global warming evoked grave and widespread concern. WHO supported countries in preparing national plans in response to global warming, in coordination with other international agencies.

39. While the “Dhaka Declaration” – reflecting the commitment of Member States to the strengthening of the health workforce – was adopted at the 24th Health Ministers’ Meeting in 2006, the Regional Office had taken the lead to develop a Regional Strategic Plan for Health Workforce Development.

40. Natural disasters were frequent during the period 1996-2005 and the SEA Region suffered 58% of all deaths due to natural disasters across the globe during this decade. WHO further intensified its efforts in strengthening country capacities in emergency management through multisectoral training programmes (for full text of the Regional Director’s introductory remarks, see Annex 7).

41. The Committee reviewed the Report of the Regional Director in toto and made the following observations after comprehensive deliberations:

42. The Committee commended the comprehensive report and acknowledged the technical support received by countries from WHO. It was, however, felt that some areas such as international health security, climate change and its impact on health, health information systems, geographical information system (GIS) and expenditure-tracking systems were not addressed adequately. National Health Accounts (NHAs), vital for planning and implementation, also deserved greater attention.

43. The Committee noted that areas needing further strengthening in the countries included public health infrastructure, prevention and control of noncommunicable diseases, health-care services at all levels, health systems development (HSD), human resources for health (HRH), strengthening country capacities in public health, pandemic preparedness and intersectoral collaboration.

44. The Committee noted that by adopting a multisectoral approach to deal with major health issues instead of competing with other sectors, the health
sector in some countries had been able to secure a considerably higher resource allocation. This example was considered worth following by other countries as well. The successful scheme of offering incentives to encourage pregnant women to avail themselves of health facilities for childbirth which significantly reduce maternal and child mortality was cited.

45. While effective tobacco control programmes were in place in some countries of the Region, it continued to remain a major cause for concern for others in the face of aggressive campaigns mounted by the tobacco industry to enlist more consumers. WHO’s technical assistance and support was sought by the Committee to curb the burgeoning growth in the number of tobacco users in some Member countries.

46. The Committee observed that remarkable progress was made, despite constraints, in the polio eradication programme and countries reporting fresh cases were striving to achieve the goal of eradication.

47. The Committee, while noting that many Member countries were able to check the spread of HIV/AIDS, stressed the importance of intercountry collaboration, particularly in the context of challenges posed by cross-border migration. WHO was requested to facilitate intercountry/interregional workshops to address these issues.

48. The Committee expressed concern about the accuracy, reliability and quality of health data included in the report. It presumed that some information was based on figures obtained from surveillance sites and felt that it was desirable to include health indicators in it.

49. The Committee was informed that WHO did not provide accreditation per se to any educational institution. The information contained in WHO’s World Directory of Medical Schools was compiled based on inputs provided by the respective countries.

50. The Committee urged WHO to review the proportion of funds allocated for meeting running costs of country offices in relation to health development activities, especially those with relatively small country budgets.

51. The Committee was assured of WHO’s cooperation to strengthen national health information systems, especially through Health Metrics Network. Realizing the importance of this subject, a new cluster on Information, Evidence and Research (IER) had been set up in WHO Headquarters.
52. The Committee was informed that some countries were also working in close collaboration with other UN agencies, and that public-private partnership and community participation was crucial for successful implementation of several health initiatives.

53. The Committee was informed that to support countries in capacity-building endeavours, the Regional Office had encouraged Regional Office staff to visit Member countries to facilitate/organize national-level training courses in various subjects such as epidemiology, clinical case management and surveillance and outbreak investigation.

54. The Committee, after deliberating the Report, noted with satisfaction the progress made during the period under review in WHO’s collaborative programmes in the Region.

Statements by representatives of nongovernmental organizations (NGOs)

55. Dr A.K. Mukherjee (Rehabilitation International) highlighted issues of concern related to disability and the provisions of the UN Convention on Persons with Disabilities adopted by the General Assembly in December 2006 and ratified by more than 100 countries including many in the South-East Asia Region. Three out of 68 Articles of the Convention directly related to health, rehabilitation and international cooperation regarding persons with disabilities, urging Member countries to focus on health-related rehabilitation programmes. He stated that a resolution on disability was adopted by the Fifty-eighth World Health Assembly and that WHO was preparing a World Report on Disability and Rehabilitation. He called upon WHO to define the terms “disability” and “rehabilitation” in the face of current developments and to organize a regional consultation on issues arising out of the UN Convention.

56. Professor Emeritus Khunying Kobchitt Limpaphayom (World Federation for Medical Education, WFME) spoke about WFME’s working relations with WHO and other UN agencies including United Nations Children’s Fund (UNICEF), United Nations Educational, Scientific and Cultural Organizaton (UNESCO), United Naitions Development Programme (UNDP) and the World Bank. The South-East Asia Regional Association for Medical Education (SEARME) operated under the aegis of WFME as an official partner and shared a commitment with WHO to improve the quality and standards of medical education to raise health-care levels.
57. She said that in 2004 the WHO-WFME Strategic Partnership to improve medical education set up an international task force on accreditation. Based on the recommendations of this task force the strategic partnership had formulated a set of guidelines for accreditation of basic medical education institutions and programmes.

58. Mr K. Banerjee (Rotary International) highlighted the commitment of the millions of Rotarians to complete the job of polio eradication. Since the launch of the Global Polio Eradication Initiative, polio cases had been reduced by more than 99%. The joint efforts of governments, private organizations and agencies of the United Nations were an example of what could be achieved through positive collaboration. Mr Banerjee, however, cautioned that “having come this far, we cannot allow the window of opportunity to be closed for completing the work of polio eradication”.

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

59. Dr Margaret Chan, Director-General, drew attention to challenges being faced by public health worldwide on three main fronts: holding the microbial world at bay, changing human behaviours, and gaining attention and resources.

60. Noting that routine health functions took on monumental dimensions in the South-East Asia Region because of the sheer numbers of people inhabiting it, Dr Chan expressed her admiration for the commitment of health leaders of all Member countries to poverty reduction; commitment to universal access; and their responsiveness to the desires of their citizens, right down to the grassroots level.

61. Commending the Region for pioneering the adoption of rational approaches to the provision of essential care on a massive scale, the Director-General highlighted some of the notable
achievements, such as maximizing population-wide protection from preventable threats; stretching resources so that benefits reached the largest possible number of people; using lists of essential medicines as part of national drug policies; and using health legislation to great strategic advantage by using natural resources to extend access to essential care.

62. Dr Chan noted with appreciation that many countries in the Region had adopted the WHO strategy for the Integrated Management of Childhood Illness. The strategy recognizes that most childhood deaths result from a handful of causes that can be prevented by a handful of cost-effective interventions.

63. Referring to the SEA Region as the ancestral home for some of humanity’s oldest diseases, including leprosy and cholera, Dr Chan noted that these and other neglected tropical diseases were closely associated with extreme poverty. Hence, control was clearly a poverty-reduction strategy.

64. The tremendous progress made in controlling these diseases was another sign of the Region’s commitment to tackle the diseases of poverty, even when the people affected were largely hidden in remote areas and had little political voice.

65. The Director-General lauded the Member States for launching microfinancing schemes that were helping to lift millions of people out of poverty and that showed, in particular, that income opportunities for women gave them a chance to realize their potential as agents of change.

66. There was an urgent need for continued efforts to maintain the fragile detente between microbes and their human hosts. In this context, the Director-General recalled how the world community had failed to stop HIV/AIDS from spreading internationally and becoming endemic. It will pay the enormous price of this failure for decades to come. SARS was stopped dead in its tracks in July 2003; but five months later, human deaths from H5N1 avian influenza were confirmed. “And the world continues to live under the looming threat of an influenza pandemic ever since,” she added.

67. Behavioural change had tremendous preventive power, but it was one of the hardest tasks faced by all. Prospects for behavioural change improved in an overall environment that made healthy choices the easy choices.

68. Expressing concern at the way in which the international spread of disease and the disruption it caused had been amplified in today’s highly mobile, interdependent and interconnected world, Dr Chan cautioned the health community against lowering its guard.
69. Lifestyle changes were causing a dramatic rise in chronic diseases in the Region. As a result, it was witnessing this new burden at a time when most countries were still struggling to bring infectious diseases under control. Faced with this trend, the best strategy for public health was population-wide prevention.

70. The Millennium Declaration and its Goals represented the most ambitious commitment ever made by the international community. Recognizing that poverty had multiple and interacting causes, the goals aimed at tackling these causes at their roots. They also championed the role of health as a key driver of socioeconomic progress.

71. Referring to the existing situation in the Region, the Director-General drew the Committee’s attention to three major concerns: financial protection for the poor; the unfinished business of polio eradication; and the need to reassess progress made towards accomplishing the Millennium Development Goals.

72. Acknowledging the tremendous challenges being faced by the Region, Dr Chan however expressed her full faith in the health leaders’ commitment to fairness and social justice, and the determination to see that progress made in health development reached all segments of the vast populations.

73. In response to the Director-General’s address, the Committee stressed the need to increase the South-East Asia Region’s representation on the Executive Board so that the problems facing the Region could be better addressed. Since the Region represented 25% of the global population and carried a disproportionately high burden of diseases, it was imperative for allocated resources to be increased, and this would be possible only with increased representation on important committees.

74. The Committee urged for continued support from WHO in ongoing efforts to eradicate/eliminate diseases in the Region. Further support in achieving the Millennium Development Goals was also requested.

75. The Committee emphasized the urgent need to strengthen health systems in order to reduce the disease burden of countries.

76. The Committee was informed that the issue of social determinants also needs to be taken up, especially in the light of changing trends – the communicable disease burden being on the decline while the noncommunicable diseases are on the ascent.
77. The importance of developing geographical information systems was stressed to strengthen the collection and compilation of health data.

78. The Director-General commended the leaders for their commitment in striving to achieve the health goals. She, however, cautioned against being complacent in this regard, and stressed the importance of collecting evidence and accurate reporting.

79. She also clarified that WHO is a technical agency, with the mandate to support the efforts of Member States by providing technical support and assistance. However, health systems needed to be developed by Member States themselves. She advised the Health Ministers to cooperate with ministers in other departments/ministries, thereby moving health issues up to the cabinet level, and impressing upon decision-makers the importance of health policy. This change in strategy, she felt, would ensure cooperation from all sectors.

80. Responding to the Committee’s suggestion of international collaboration and solidarity, the Director-General cautioned the countries to be wary of the rapid spread of diseases across borders, especially in the light of increased international travel and trade.

81. The Director-General announced a new initiative being launched in September 2007, in collaboration with the governments of Norway, Canada and Germany, and DFID to mobilize additional resources for MDGs 4, 5 and 6 (for full text, see Annex 8).

**Statements by representatives of UN and specialized agencies**

82. Dr Gepke Hingst (UNICEF) welcomed the continuing progress made in immunization, thereby addressing vaccine-preventable diseases. She stated that much more remains to be done and for this, improvements in health systems were a prerequisite. With regard to nutrition, she expressed UNICEF’s concern at the high level of malnutrition, exacerbated by the lack of access to safe sanitation. She commended UNICEF and WHO’s collaboration to promote and support effective national programmes to address all factors contributing to childhood malnutrition. She reiterated UNICEF’s commitment to work with WHO to address issues of maternal and neonatal mortality. The success of the “Accelerating Child Survival and Development” programme in Africa was a shining example of the tremendous progress that can be achieved when partners combine political will, technical expertise and financial resources.
Matters relating to Programme Development and Management (Agenda item 7)

83. The Committee was informed that the World Health Assembly had approved the budgets for the South-East Asia Region for 2008-2009 biennium, in terms of 13 Strategic Objectives, and noted the increase in the Region’s budget by 50.2% for Voluntary Contributions (VC) and 4.6% in Assessed Contributions (AC) compared to the 2006-2007 biennium. The Committee was apprised that the Joint Meeting of the Health Secretaries (HSM) and the Consultative Committee for Programme Development and Management (CCPDM) held in July 2007 reviewed the 2008-2009 budget approved by the Sixtieth World Health Assembly for the SEA Region. The Joint Meeting recommended that a Senior Working Group (SWG) be convened to recommend measures regarding the use of the additional AC funding available to the Region.

84. The Committee noted with satisfaction that Member countries and the Regional Office had undertaken a process of joint planning to prepare the 2008-2009 Programme Budget draft workplans, which were reviewed by the Joint Meeting. The Joint Meeting had also discussed the proposal of the High-level Consultation (HLC), held in May 2007, to merge the HSM and the CCPDM meeting. The Joint Meeting recommended that this proposal be reviewed by the Committee.

85. The Committee adopted a resolution (SEA/RC60/R2) on the subject.

Review of the detailed workplans for Programme Budget 2008-2009 (Agenda item 7.1, document SEA/RC60/3)

86. The Committee noted the four recommendations made at the Joint Meeting: (i) Member countries and WHO must pay increased attention to the role of VCs in WHO collaborative programmes and endeavour that VC funding was received in line with the needs and priorities of Member countries; (ii) the Regional Office and country offices should strive to align the workplans with the approved budget for each Strategic Objective; (iii) WHO should provide information on implementation of multicountry activities (MCAs) and propose steps to strengthen MCAs in the 2008-2009 biennium; and (iv) SWG should determine the distribution of additional AC funding for 2008-2009 to the Region.

87. The Committee was informed that the Regional Director had convened a meeting of the SWG on allocation of increased AC for the SEA Region for PB 2008-2009, and noted the recommendations made by the SWG. The SWG recommended that, out of the increase in AC funds, US$ 1 million were to be
allocated to the proposed South-East Asia Regional Health Emergency Fund (SEARHEF); from the balance, 25% of the funds should be allocated for the Regional Office and 75% to countries on a pro rata basis, based on the 2006-2007 country allocations; and whenever possible, priority should be given to countries with greatest needs/small budgets in distributing unspecified VC funding to support country workplans. Efforts should also be enhanced to mobilize additional VC funding for those country workplans.

88. The Committee urged that Member countries be given full authority to allocate financial resources in implementing MCAs. The Committee was informed that MCAs should only be conducted between countries within the Region since activities with countries outside must be coordinated by SEARO.

89. The Committee urged WHO to support efforts to further increase AC because these were predictable and could be used for any country programme. Regarding distribution of additional allocation, the Committee accepted the pro rata basis for distribution but noted that this might not be appropriate for future AC increases. The Committee stressed the need for evolving a formula that would be scientific instead of ad hoc. It was also suggested that the same formula be used by the SEA Region for getting maximum funds as well as for distributing these funds within the Region. India expressed its willingness to voluntarily distribute a portion of the additional allocation to other countries in the Region with the greatest needs. A number of countries also offered to provide technical assistance as requested. The Committee expressed its appreciation for these offers.

90. Regarding VC funding, the Committee was informed that the Region’s 2006-2007 target of US$ 257.9 million had already been achieved, and that the VC funding was likely to reach US$ 300 million by the end of 2007. Funds raised by countries and the Regional Office are usually specified project/programme-related funds and afford very little flexibility of redistribution to other areas. It was because of this that the distribution of VC funding across different Areas of Work (AoW) varied. The Committee requested more details about the specific distribution of VC funds to countries and programmes and requested that the information be shared at each Regional Committee meeting. The Committee was informed that these funds were being regularly reviewed. Underfunded programmes deserve priority in the distribution of Core Voluntary Contributions (CVC). In addition, the Committee noted WHO’s efforts towards resource mobilization and commitment to intensify them in line with the specific needs of Member countries.
Merging of Meeting of the Consultative Committee for Programme Development and Management (CCPDM) and Meeting of Health Secretaries (HSM) of the South-East Asia Region (Agenda item 7.2, document SEA/RC60/4)

91. The Committee noted the suggestion made by the 11th Meeting of Health Secretaries held in June 2006 that the HSM and the CCPDM meetings be merged. This proposal was discussed at the High-level Consultation (HLC) with SEAR Member States on WHO Programme Development and Management held in May 2007, where the HLC endorsed this proposal.

92. The Committee noted the decision of the Twenty-fifth Meeting of Health Ministers of the South-East Asia Region that the meetings of the CCPDM and HSM be merged and reiterated support for the streamlining of the two meetings. The Committee also sought to advance the governance aspects of the meetings by proposing the establishment of a sub-committee under Rule 15 of the Rules of Procedure of the WHO Regional Committee for South-East Asia.

93. At the request of the Committee, clarifications were provided on both the functional and administrative practices of other WHO regions in the establishment of similar bodies. It was further clarified that specific authority on administrative issues (e.g. reimbursement of travel expenses, etc.) was governed by relevant World Health Assembly resolutions for the three constitutional bodies (World Health Assembly, Executive Board and the Regional Committee). For the Regional Committee, the World Health Assembly resolution WHA34.4, as updated in resolution WHA52.9, governs the reimbursement of travel expenses for attendance at Regional Committees and therefore also applies to any sub-committee established under Rule 15 of the Rules of Procedure of the WHO Regional Committee for South-East Asia.

94. After further deliberation, the Committee decided to use an administrative formula similar to that currently being used by the back-to-back meetings of the HMM and RC. Specifically, the Committee decided to replace the CCPDM through the establishment of a sub-committee on policy and programme development and management (SPPDM) under Rule 15 of the Rules of Procedure of the WHO Regional Committee for South-East Asia. It also requested the Regional Director to continue to convene meetings of the HSM with the two meetings being held back-to-back so as to increase participation, in particular by the least developed countries in the Region.

95. The Committee adopted a resolution SEA/RC60R2 on the subject.
Consideration of the recommendations arising out of the Technical Discussions on ‘Nutrition and Food Safety’

(Agenda item 8.1, document SEA/RC60/5)

96. The Committee was informed that the Technical Discussions on Nutrition and Food Safety were held from 11 to 13 April 2007 at the Regional Office in New Delhi, to which representatives from nutrition and food safety sectors from all Member countries were invited. International and regional experts in related fields, and attendees from WHO Collaborating Centres on Nutrition and Food Safety in the Region, civil society and partner UN and international agencies also participated in the discussions. It was recommended that Member countries should ensure incorporation of appropriate nutrition and food safety measures for all segments of the population with special emphasis on women and children, based on the Right to Food guidelines. Countries should also follow up on implementation of the relevant World Health Assembly and Regional Committee resolutions, taking into account the current status with respect to the MDGs, thereby ensuring timely implementation of national plans of action.

97. The Committee noted with concern the persisting nutritional disorders and the problem of food-borne diseases. In spite of improvements having been recorded in nutrition levels in recent years, Member countries still suffered from a considerable burden of nutritional disorders and food-borne diseases and their contribution in raising mortality levels in women and children.

98. The Committee was informed that the Technical Discussions culminated with nine specific recommendations for Member countries and seven for WHO. All Member countries of the Region had started implementing the recommendations relevant to them.

99. The Committee noted that countries were undertaking multisectoral initiatives to establish, strengthen and utilize monitoring and/or surveillance systems and regulatory mechanisms focusing on diet, nutrition and food safety. Furthermore, national guidelines for consumer protection and education were being developed. Several programmes and initiatives for schoolchildren, adolescents and women had been initiated in line with the recommendations emanating from the Technical Discussions.

100. The Committee noted the need for Member countries to share relevant information in order to address certain complicated issues related to malnutrition, food standards and food safety, iodine deficiency disorders and anaemia, etc.
101. The Committee urged Member countries to establish better surveillance systems for food-borne diseases and nutrition to obtain more evidence-based data to prioritize action. WHO was requested to support countries in conducting studies aimed at estimation of the burden of disease attributable to malnutrition and food-borne diseases.

102. The Committee noted with concern the lack of regional mechanisms to share information on food safety and called for establishment of information networks to address food-related emergencies and outbreaks. Urgent need was expressed for availability of data and information exchange regarding the presence and potential adverse health impacts of toxic residues, such as carcinogenic agents present in food items.

103. The Committee endorsed the report and recommendations of the Technical Discussions as contained in document SEA/RC60/5 with added information from representatives. It recommended adoption of a resolution on the subject.

104. The Committee adopted a resolution (SEA/RC60/R3) on the subject.

Selection of a subject for the Technical Discussions to be held prior to the Sixty-first Session of the Regional Committee (Agenda item 8.2)

105. Acknowledging the importance of promoting primary health care (PHC) in countries of the SEA Region, the Committee unanimously decided on “Revitalizing Primary Health Care” as the subject for Technical Discussions to be held prior to the Sixty-first Session of the Regional Committee in 2008.

Scaling-up prevention and control of chronic noncommunicable diseases in the South-East Asia Region (Agenda item 9)

106. The Committee was informed that chronic noncommunicable diseases (NCDs) were assuming alarming proportions in the SEA Region. It was projected that almost half of the 89 million NCD-related deaths in the Region during the next 10 years will be premature. The Committee expressed concern over the high incidence of NCD-related deaths in the Region and that these diseases are responsible for more than half of all annual deaths in some Member countries. Significant reduction in NCDs can be achieved by Member countries by the introduction of simple public health interventions addressing major NCD risk factors and their socioeconomic determinants. An important step in this direction
would be initiating national policies, plans and programmes, as well as by strengthening the public health response.

107. The Committee was invited to consider the Regional Framework for Prevention and Control of NCDs, endorsed by the Joint Meeting of Health Secretaries and the CCPDM held on 2-6 July 2007, and to provide guidance on strategies for its implementation. The Joint Meeting had recommended that the Member States should set up mechanisms to promote evidence-based and cost-effective interventions for the prevention and control of NCDs. The Meeting had further recommended that integration of NCD programmes should correspond to the stage of epidemiological transition and existing health infrastructure.

108. The Committee emphasized the importance of behavioural change as an approach to address the problem of NCDs. It was vital to recognize that individual approaches to tackle NCDs were less effective than interventions at the national level.

109. The Committee recognized the fact that treatment of NCDs was, very often, more expensive than that of communicable diseases because NCDs could be life-long ailments. As a result, it was strongly felt that prevention was always better than cure. In this regard, increasing the levels of understanding and awareness among the population assumes significance. A clear understanding of the risk factors of NCDs and their management would make it possible to prevent them. The Committee discussed the efficacy of national health
information campaigns in combating NCDs. It was recognized that the WHO Framework for Prevention and Control of NCDs was a very important initiative to facilitate information sharing.

110. The Committee noted with concern the rising burden of chronic NCDs including cardiovascular diseases, diseases associated with tobacco consumption, stress-related mental disorders and diabetes. It emphasized that information sharing alone was not sufficient; it was also important to strengthen capacity.

111. The Committee was informed of various success stories in the countries of the Region, including such examples as a total ban on tobacco use and initiatives to curb alcohol consumption.

112. The Committee adopted a resolution (SEA/RC60/R4) on the subject.

**Tuberculosis Control: Progress and plans for implementing the new Stop TB Strategy (Agenda item 10)**

113. The Committee noted the magnitude of the problem of tuberculosis in the Region, the progress made in TB control and the key issues to be addressed in further reducing the burden of the disease.

114. The Committee was informed that the Regional Office, in consultation with national programmes, had developed a Regional Strategic Plan for TB Control 2006-2015.

115. The Committee requested technical assistance from WHO in dealing with the problem of multidrug resistant (MDR) TB, procurement of rapid diagnostic kits and the strengthening of laboratory capacity. The importance of international aid on a long-term basis was emphasized to ensure financial sustainability.

116. The Committee expressed concern at the increasing incidence of HIV-associated TB and the potential for emergence of TB drug resistance, which threatened to reverse hard-won gains in TB control. It was vital to build up laboratory capacity for culture and drug-susceptibility testing, and ensure sustainability and quality of implementation of directly observed treatment, short-course (DOTS).

117. The Committee expressed satisfaction that the SEA Region as a whole had achieved a case detection rate of 64% in 2005, while treatment success rates in excess of 85% had consistently been achieved since 2003. However, it was noted that there was a long way to go for TB elimination. In this regard, it was
vital to ensure continued supply of anti-TB drugs, including from the Global Drug Facility.

118. The Committee also requested WHO to take appropriate action to restore Global Fund support to countries currently not being supported.

119. It was essential to take steps to enhance the performance of TB programmes through the strengthening of health care systems. The Committee endorsed the new Stop TB Strategy, with a view to reversing globally the alarming rise in the number of cases of MDR-TB and extensively drug resistant TB (XDR-TB) as well as HIV-associated TB cases. There was the need to improve community awareness and build adequate human resources to deliver effective TB services.

120. The Committee was informed that efforts were underway to improve facilities for drug-susceptibility testing with two supranational laboratories already in place in Thailand and India.

121. The Committee adopted a resolution (SEA/RC60/R5) on the subject.

**Revised Malaria Control Strategy: Focusing on a new paradigm** (Agenda item 11, document SEA/RC60/9)

122. The Committee was informed that the rapidly changing epidemiological, socioeconomic and ecological situation has led to formulation of the Revised Malaria Control Strategy (RMCS). The RMCS was endorsed by the Health Ministers’ Meeting in 2006, as well as by the Joint Meeting of Health Secretaries and the Consultative Committee for Programme Development and Management (CCPDM), held in the Regional Office in July 2007.

123. The Committee noted with satisfaction that Member countries had started developing and implementing national malaria control programmes in line with the RMCS through measures such as controlling cross-border malaria within the framework of multicountry activities; strengthening surveillance and assessment mechanisms; initiating multisectoral malaria control activities; and articulating and advocating malaria control at national and international forums.

124. The Committee noted the strong involvement of malaria programme managers, experts, partners and donor agencies in developing the RMCS, and stressed that programme management and capacity building be improved, in particular to address the problem of inadequate human resources in many countries of the Region.
125. The Committee urged Member countries to strengthen cross-border collaboration among themselves and requested the Regional Director to facilitate similar collaboration with the Western Pacific Region. The urgent need for adopting integrated vector management and control measures was stressed. This would, in turn, require specialized training for relevant health personnel, especially in the area of entomology, because of the strong impact of climate change.

126. Taking note of the various constraints/challenges being faced by malaria containment/ control programmes, such as under-reporting of cases/deaths; risks associated with drug-resistant malaria; and lack of sustained supply of antimalaria drugs, the Committee urged WHO to provide assistance to countries to enable them get financial support from the Global Fund to fight HIV/AIDS, TB and Malaria (GFATM).

127. The Committee appreciated the progress achieved by some countries in reducing mortality and morbidity from malaria and urged others to keep working towards integrated vector control in order to overcome the twin challenges posed by malaria and dengue.

128. The Committee adopted a resolution (SEA/RC60/R6) on the subject.

**South-East Asia Regional Health Emergency Fund**

(*Agenda item 12, document SEA/RC60/10*)

129. The Committee was informed that in view of the vulnerability of the Region to emergencies, the establishment of an emergency fund for the South-East Asia Region had been requested by Member countries. To accomplish that objective, the Emergency and Humanitarian Action unit (EHA) in the Regional Office was asked to develop the details of the proposed regional emergency fund. The proposals were submitted and deliberated upon at the meeting of WHO Representatives held in November 2006, at the Regional Consultation for the South-East Asia Regional Health Emergency Fund (SEARHEF) held on 12-13 April 2007, and at the SEARHEF Working Group meeting comprising representatives from Member countries, held in Bangkok in June 2007. The Joint Meeting of Health Secretaries (HSM) and Consultative Committee for Programme Development and Management (CCPDM), held during 2-6 July 2007, provided recommendations for incorporation in the policy paper developed through the various consultations. The joint meeting also recommended Member countries to support SEARHEF.
130. The Committee was informed that after elaborate deliberations, the purpose of the fund, its governance, the criteria for release of funds, guiding principles for the fund, estimates and funding, building the corpus, its management and processes for requests and reporting were outlined. The fund is designed to provide financial support in the immediate aftermath of emergencies, whether natural or man-made, in Member countries, to meet needs and fill in critical gaps.

131. The Committee noted that a Working Group would be established consisting of one representative from each Member country to govern the fund, and would conduct parallel meetings in conjunction with statutory meetings of WHO SEA Region. The EHA unit in the Regional Office would act as the Secretariat to the Working Group.

132. The guiding principles for the utilization of SEARHEF would be equitable use, adequacy and replenishment, transparency and accountability, promptness and ability to mobilize resources. The main expenditure would include items and services such as procurement of essential medicines and supplies, logistics support, public health interventions, operational field presence, and staff and technical support to national and sub-national authorities. The SEARHEF would act as much as possible as a revolving fund composed of Assessed Contributions (AC) and Voluntary Contributions (VC). The principles, policies, and guidelines of the fund could be modified and refined during the course of implementation of the fund.

133. All countries expressed full support for the creation of SEARHEF. The Committee endorsed the creation of the Working Group composed of one representative each from Member States as the governance mechanism for the fund.

134. The Committee was informed that carry-over of the AC part of the fund for the 2008-2009 biennium was not possible because the appropriations resolution had already been adopted in the last World Health Assembly. However, such a carry-over facility could be pursued during the programme budget development process for the next biennium (2010-2011). It was suggested that in managing the funds, the AC portion of the fund could be used first. For the VC portion, donor agreements that would allow for carry-over would be encouraged.

135. The Committee noted that there were several issues, e.g. procedures to ensure flexibility, transparency, accountability, and ceilings for releases that need proper consideration by the Working Group for SEARHEF.
136. The Committee was assured that there would be built-in checks in the processes because the fund would be governed by WHO’s financial rules, systems of accounting and audit.

137. The Committee was apprised that a mechanism to spend any left over AC portion of the fund near the end of a biennium could be created to use such resources for operational readiness (e.g. stockpiling and pre-positioning of emergency health kits). The Working Group for SEARHEF could work out the details of such a mechanism.

138. The Committee adopted a resolution (SEA/RC60/R7) on the subject.

**Membership of the South-East Asia Region on the Executive Board** *(Agenda item 13, document SEA/RC60/11)*

139. The Committee was informed that the issue of expansion of membership of the South-East Asia Region on the Executive Board was discussed at the High-Level Consultation (HLC) with SEA Region Member countries on WHO Programme Development and Management held in New Delhi in May 2007. The HLC agreed that with its high disease burden and large population the SEA Region should strive to have a larger number of seats on the Executive Board.

140. The Committee also noted that a Regional Expert Group Meeting on the Representation of the SEA Region on the WHO Executive Board was organized on 12-13 August 2007 in Bangkok in order to take ahead the action points recommended by the HLC. The meeting had the objective of reviewing options and scenarios on health metrics related to the regional membership on the WHO Executive Board and recommending the most appropriate approach and method to use in support of the proposal to increase membership from the Region on the Board.

141. The Committee reviewed in detail the work of the expert group and its salient outputs including guiding principles and two preferred options to be considered. During the discussion it was emphasized that population and disease burden are indeed valid factors in reference to ‘equitable geographic distribution’ in Article 24 of the WHO Constitution. The Committee also agreed that the formula which took into consideration population, DALYs, as well as any other factor deemed appropriate, in addition to the number of Member States in each region best reflected its views.

142. Understanding that the constitutional procedure involved in changing the membership of the Executive Board could be very long, the Committee
reiterated the importance of current Board Members being active and fully briefed in order to ensure that views of the Region are heard. The Committee also noted the importance of gathering virtually unanimous support from Member States outside the Region to ensure success of the proposed change in the Executive Board membership in order to pass both approval of the World Health Assembly and individual government ratification with a two-thirds majority. The Committee appreciated the opportunity to apprise the Director-General of this issue, while acknowledging her neutral role in this Governing Body matter. It also appreciated the Regional Director’s offer of continued support of the Regional Office in helping the Member States take the issue forward. Furthermore the Committee urged Member States to actively support this process, both through their participation in the work of the Executive Board and through their diplomatic missions in Geneva.

143. It was decided by the Committee that the work already done on the issue formed a strong basis to take the effort forward by seeking inclusion of the item on the agenda of the upcoming 122nd Session of the Executive Board. The Committee decided to draft a resolution requesting the Director-General, through the Regional Director, to propose inclusion of the item entitled “Equitable geographical distribution of the membership of the Executive Board” in the provisional agenda of the 122nd Session of the Executive Board. The current Executive Board members from the Region were requested to advocate strongly on the issue in the upcoming session of the Executive Board.

144. The Committee adopted a resolution (SEA/RC60/R10) on the subject.

**Avian and pandemic influenza preparedness in the context of International Health Regulations (2005)**

*(Agenda item 14.1 document SEA/RC60/12)*

145. The Committee was informed that the WHO Regional Office for South-East Asia accorded high priority to avian and pandemic influenza preparedness, and that there had been considerable progress in mobilizing political commitment and engaging various partners. The Conference of Ministers of Health and Agriculture/Livestock held in New Delhi in July 2006 had adopted the Delhi Declaration on Avian Influenza.

146. The Committee noted that a task force was constituted by the Regional Director to oversee progress of the implementation of recommendations outlined in the Delhi Declaration. With technical assistance from WHO, all Member countries in the Region had developed National Influenza Pandemic
Preparedness Plans (NIPPP); surveillance and outbreak response capacities in all Member countries had been strengthened through training of rapid response teams and table-top exercises, networking of FETP graduates, etc.; laboratories and facilities had been strengthened through networking, training and upgrading; and two laboratories in the Region had been accredited to identify the H5N1 virus.

147. The Committee noted that the CSR unit in the Regional Office including two subunits in Delhi and Bangkok would continue stockpiling of antiviral, personal protection equipment and pre-pandemic vaccines (if available in future) and would support communicable disease surveillance and response activities.

148. The Committee was informed of the discussions of the Interdisciplinary Working Group’s meeting held in Singapore, particularly the suggestion to give custodianship/ownership of virus samples to WHO, and to make WHO responsible for sharing of the samples. However, the discussions did not lead to agreement among participants and remained deadlocked, notably on the issue of benefit-sharing due to differences of opinion between developed and developing countries.

149. Member countries were urged to participate actively in the intergovernmental meeting mandated by World Health Assembly resolution WHA60.28 and scheduled to be held in Geneva in November 2007.

150. The Committee was informed that Indonesia had sent virus samples from Bali human avian influenza cases to the Centers for Disease Control (CDC), which is a WHO collaborating centre. However, the final phase (phase III) would be conducted in Indonesia. It was also informed that no formal agreement or contract had been signed but progress was being made in the area.

151. The Committee noted that surveillance systems had been strengthened in some Member countries and the capacity of laboratories was being enhanced. In this regard, the Committee also noted India’s offer to assist other Member countries.

152. The Committee was informed that capacity building in veterinary public health is an important activity.

Public health, innovation and intellectual property rights: An update (Agenda item 14.2 document SEA/RC60/13)

153. The Committee was presented with an update on public health, innovation and intellectual property rights (IPRs). It noted that an Intergovernmental Working
Group (IGWG) on Public Health, Innovation and IPRs had been created vide World Health Assembly resolution WHA59.24 in response to the need for more research and development for diseases that mostly affect the poor.

154. The key task of the IGWG is to draw up a global strategy and plan of action that aim at, inter alia, securing an enhanced and sustainable basis for needs-driven, essential health research and development relevant to diseases that disproportionately affect developing countries.

155. The Committee was informed that the working text for the second IGWG had been released on 31 July 2007. Member countries noted that the process was now in the critical stage. Some Member countries were currently examining the working document. They were consolidating views through national consultations with the aim of forming a national position.

156. The Committee noted that the Third Regional Consultation on Public Health, Innovation and Intellectual Property Rights would be held on 24-25 October 2007 in Maldives. A request was made that, wherever possible, national positions and inputs be made available to all participants in the consultation beforehand, in order to make efficient use of the available time during the consultation. Several Member countries stressed the need to speak with one voice. India, in its capacity as co-chair of the IGWG, offered to host further consultations after the meeting in Maldives, if Member countries require more time.

WHO and reforms of the UN System: Impact at country level (Agenda item 14.3 document SEA/RC60/14)

157. The Committee was informed that although UN reform was not a new subject of discussion, it had attracted public and media attention in the past few years. The health sector had gained significantly from the reform process both politically and financially, e.g. health is both a major component of the MDGs and beneficiary of numerous UN resolutions. UN reforms had also had an impact on the work of WHO at country level.

158. The Committee noted that Member countries would continue to discuss the topic of UN reform at meetings of the UN General Assembly, United Nations Economic and Social Council (ECOSOC) and Governing Bodies of Specialized Agencies. Considering that Member countries were represented by different people on these UN decision-making bodies, it was crucial for health officials to sensitize their colleagues from other ministries and/or bodies on the implications of UN reform on their work.
159. The Committee was presented with highlights of WHO’s policy directions on UN reform; the current status of some UN reforms as contained in the Report of the High-Level Panel on UN System-wide Coherence; the “One UN” Pilot initiative and the latest Triennial Comprehensive Policy Review (TCPR) of Operational Activities of the United Nations Development System (2007); and other regional activities and initiatives of interest.

160. The Committee noted that WHO will shortly be organizing a meeting involving officials from the Ministry of Health and the Ministry of Foreign Affairs in order to facilitate mutual dialogue and information exchange. This will enable officials from the Ministry of Foreign Affairs and the Ministry of Health to get appropriately sensitized on health aspects of UN reforms.

161. Commending the commitment of Member countries to UN reform, the Committee emphasized that WHO as a specialized agency for health should work closely with countries and provide them with technical expertise in public health. Such collaboration should not only be maintained but further strengthened. The need for a continuing dialogue and information exchange between the Ministry of Health and the Ministry of Foreign Affairs was stressed.

162. The Committee urged Member States to participate actively in the forthcoming regional meeting planned by WHO, and to propose to the WHO Executive Board to set up a Working Group to study the implications of UN reform on the work of WHO.

**Review of the decisions and resolutions of the Sixtieth World Health Assembly and the 120th and 121st sessions of the WHO Executive Board** (*Agenda item 15.1, document SEA/RC60/15*)

163. The Committee noted the decisions and resolutions of the Sixtieth World Health Assembly and the 120th and 121st Sessions of the WHO Executive Board that were reviewed by the Joint Meeting of Health Secretaries and the Consultative Committee on Programme Development and Management. The Committee noted that the joint meeting had emphasized follow-up action in the countries to monitor progress in the rational use of medicines and better medicines for children. Follow-up action by Member States and WHO would be included in the Country Workplans of 2008-2009. A Regional Workshop on Essential Medicines is scheduled to be held in October 2007 to coincide with the 30th anniversary of the Essential Medicines List.

164. The Committee noted the joint meeting’s recommendations that WHO review and synthesize the current situation regarding workers’ occupational
health in Member States in pursuance of World Health Assembly resolution WHA60.26. This agenda item was planned to be discussed at the Sixty-first Session of the Regional Committee.

165. The Committee noted that World Health Assembly resolution WHA60.15 was on the issue of the obligation of Member States to spend 2% of their total health expenditure and 5% of development programme funds on health research and capacity building. Member States were encouraged to participate at the Bamako Ministerial Meeting on Health Research in 2008. The Committee noted the discussions and recommendations arising out of the joint meeting.

**Review of the draft provisional agendas of the 122nd Session of the WHO Executive Board and the Sixty-first World Health Assembly** *(Agenda item 15.2, document SEA/RC60/16)*

166. The Committee reviewed the provisional agendas of the 122nd Session of the WHO Executive Board and the Sixty-first World Health Assembly. As per Rule 8 of the Rules of Procedure of the Executive Board, proposals for inclusion of any additional agenda items were required to be submitted to the Director-General before 13 September 2007. These draft provisional agendas were also reviewed at the Joint Meeting of HSM and CCPDM; based on their deliberations and recommendations, the subject of “International migration of health personnel: a challenge for health systems in developing countries” had been included in the agenda (as Agenda item 16.6) of the Sixtieth Session of the Regional Committee. The Committee reviewed and noted the draft provisional agenda of the 122nd Session of the Executive Board, as well as the proposal to include in it the item entitled “Equitable geographical distribution of the membership of the Executive Board”.

**Iodine Deficiency Disorders in the South-East Asia Region** *(Agenda item 16.1, document SEA/RC/17)*

167. The Committee was informed about the results of the implementation of the resolution on Iodine Deficiency Disorders (IDDs) in the Region that was adopted in 2004. The progress made in curbing IDD in the Region from 2004 to 2007 was assessed on the basis of WHO/UNICEF/ICCIDD guidelines. The Expert Consultative Meeting held in June 2007 had reviewed and verified this assessment. Though Member countries had made considerable progress in eliminating IDD, many challenges remained. The Committee proposed that WHO should facilitate making iodized salt affordable; develop quality control protocols for production of iodized salt; support measures to tackle cross-border
IDD; bolster the availability of IDD data for policy analysis; and establish IDD sentinel surveillance.

168. The Committee noted that Bhutan had achieved universal salt iodization. Though some Member countries were able to reduce the levels of IDD prevalence in varying degrees, it continued to be a public health problem, particularly among pregnant women and young children, in many other countries. Sensitization of the population was crucial to elimination of IDD. All Member countries had strived to achieve IDD elimination through a high level of political commitment, consumer awareness and a good monitoring system.

169. The Committee noted the willingness of Member countries to further implement the Regional Committee resolution SEA/RC57/R4 despite certain difficulties. WHO was urged to continue its collaboration with other organizations and partners and develop a regional mechanism to help countries achieve and maintain USI.

Promoting patient safety in health care

(Agenda item 16.2, document SEA/RC/60/18)

170. The Committee recalled that in 2006 the Regional Committee had adopted a resolution on the subject of promoting patient safety in health care to galvanize key stakeholders. Since then, two regional patient safety workshops had been held focusing on “clean care is safer care”. The first workshop in Bangkok focused on building capacity to prevent health-care-associated infections and hand hygiene. The second, in Jakarta, highlighted the need for engaging patients and consumers as partners in all aspects of quality and safety. This was followed by the Jakarta Declaration on “Patients for Patient Safety in Countries of the South-East Asia Region” (available as document SEA/RC60/18 Add), which called for honest communication between patients and health-care professionals to ensure that “no patient suffered preventable harm”. The Committee endorsed the Jakarta Declaration and asked WHO to support Member countries in the implementation of programme activities on promoting patient safety in health care; to develop a minimal set of data on patient safety indicators; and to document and share the experiences of Member countries.

171. The Committee noted that WHO and the World Alliance on Patient Safety had formulated a series of “Global Patient Safety Challenges”, and that this year’s theme, “Clean Care is Safer Care”, focused on the reduction of health-
care-associated infections. Five countries had already signed a national pledge on this subject and others were urged to follow.

172. The Committee noted that some countries had introduced a systems approach and standardized safe health-care delivery in order to assure patients about standard procedures. Other countries could also follow this example and establish a quality assurance system to ensure delivery of safe services. Investment in good sanitary and safety measures at health-care facilities would automatically result in greater patient safety.

173. The Committee noted that some countries had established national committees on patient safety and infection control committees in hospitals.

174. The Committee also observed that the safety of health-care workers was also of considerable importance. Countries should prioritize aspects of patient safety that deserved special attention according to their special needs. The Committee emphasized the need for Member countries to put in place appropriate safety measures regarding health service delivery.

**Strengthening the health workforce in South-East Asia**

*(Agenda item 16.3)*

175. The Committee acknowledged the importance of an adequate, competent and motivated health workforce which was a key component of health systems strengthening. The Committee noted that WHO had finalized the “Regional Strategic Plan for Health Workforce Development in the South-East Asia Region”. It agreed that a dedicated workforce was essential for social and economic development. It was also imperative to maintain the quality of training of health-care workers at all levels. In this regard, the Committee appreciated the positive inter-country cooperation and collaboration taking place in the Region with regard to providing quality training to health-care workers and efforts in mobilizing medical councils in formation of regional networks.

176. Considering that “Revitalizing Primary Health Care” had been selected as the subject for Technical Discussions to be held prior to its Sixty-first Session, the Committee felt that the focus of training should be on various categories of health workers, rather than providing training in clinical fields. The shortage in workforce could be overcome by making health workers skilled in multi-tasking.

177. However, a multipronged approach towards human resources development was needed to translate the regional strategic plan on health workforce development into action by Member countries.
Health information system development relating to Millennium Development Goals (MDGs) and Health Metrics Network (HMN) (Agenda item 16.4)

178. The Committee urged Member countries to use the Health Metrics Network tool for health information systems assessment and the Regional Strategic Plan to track progress of the MDGs.

179. Health information systems needed to be operationalized as part of the core strategy to strengthen national health systems. This, in turn, would generate reliable evidence for taking effective policy decisions. The Committee noted with concern that health information systems of countries needed to be strengthened in order to effectively respond to their health needs. It urged that information systems comprising disaggregated and evidence-based health information should be instituted for formulating policies and initiating effective interventions, particularly at subnational levels.

180. The Committee commended WHO in bringing out the very informative publication “11 Health Questions about 11 SEAR Countries” which contained useful information on the health situation and trends in the Region. The need to build country capacity in collection, analysis and dissemination of data was also reiterated.

Challenges in polio eradication (Agenda item 16.5)

181. The Committee considered the recommendations made by the Joint Meeting of Health Secretaries and the CCPDM held in Delhi in July 2007 and stressed the importance of strengthening routine immunization and for introducing new vaccines and technologies. It acknowledged the notable progress made in eradicating poliomyelitis in the Region.

182. In a spirit of regional solidarity, Member countries that had achieved success in eradicating and controlling polio offered their expertise to others who needed support. The Committee emphasized that the gains achieved in polio eradication efforts could only be maintained by the highest level of surveillance and sustained routine immunization coverage. It also urged Member countries to continue efforts at maintaining their polio-free status. The Committee requested WHO to constitute a technical working group to review strategies as well as device ways to introduce new techniques and vaccines to prevent importation of polio from endemic to non-endemic countries.

183. The Committee adopted a resolution (SEA/RC60/R8) on the subject.
184. The Committee noted the scope, magnitude and various aspects of the growing problem of international migration of trained health professionals from developing to developed countries and the challenge it posed for the health systems in the source countries. The issue of this “brain drain” was also discussed at the South-East Asia Conference on Postgraduate Medical Education held in Sri Lanka in August 2005. A special issue of the Regional Health Forum also extensively featured this issue. The Dhaka Declaration on “Strengthening Health Workforce in Countries of the South-East Asia Region” made at the Health Ministers’ Meeting held in Dhaka in 2006 focused on actions needed to address this problem in line with the World Health Assembly resolution on the subject of international migration of health personnel.

185. The Committee noted the constraints faced by countries in providing an encouraging environment to their health personnel in order to retain their services and check their emigration. Many Member countries were also trying to cope with domestic migration of trained health workers from rural to urban areas, and from the public to private sectors. In view of the complexity of the issue and the inevitability of globalization, the Committee urged WHO to support Member States in establishing and maintaining a database of all health workers migrating internationally to monitor such movement. Bilateral agreements between the source and recipient countries could be made with a view to regulate temporary and permanent movement. Support was also sought to strengthen planning mechanisms in the countries.

186. The Committee also noted that such international migration of health personnel benefited certain countries that had an adverse doctor/nurse – patient ratio. The issue also had to be viewed from a holistic perspective, taking into consideration the movement of patients from developed countries for treatment in certain countries of the Region having specialized health-care services and facilities.

187. The Committee adopted a resolution (SEA/RC60/R9) on the subject.

Nomination of a Member State to the Joint Coordinating Board (JCB) of the Special Programme for Research and Training in Tropical Diseases (Agenda item 17.1)

188. The Committee noted that the representative from Bangladesh reported the salient points of the 30th JCB meeting at the Joint Meeting of Health
Secretaries and the CCPDM held in the Regional Office, New Delhi, in July 2007.

189. The Committee nominated Bhutan as a member of the JCB for a period of three years effective 1 January 2008 and requested the Regional Director to inform WHO headquarters accordingly.

Nomination of a Member State to the Policy and Coordination Committee (PCC) of the WHO Special Programme for Research, Development and Research Training in Human Reproduction (Agenda item 17.2, document SEA/RC60/23)

190. The Committee was informed that representatives from Bangladesh, Myanmar and Thailand attended the twentieth meeting of PCC held in Geneva in June 2007. It noted that the report of attendance of representatives at the PCC meeting was presented to the Joint Meeting of Health Secretaries and the CCPDM held in the Regional Office, New Delhi, in July 2007.

191. The Committee nominated Indonesia as a member of the PCC for a period of three years effective 1 January 2008 and requested the Regional Director to inform WHO headquarters accordingly.

Time and place of future sessions of the Regional Committee (Agenda item 18, document SEA/RC60/24)

192. The Committee decided to hold its Sixty-first Session in the Regional Office, New Delhi, during the week beginning 8 September 2008. The exact dates will be confirmed later.

193. The Committee noted that Nepal having reconfirmed to host the Regional Committee session in 2009, the Sixty-second Session of the Committee would be held in Kathmandu in 2009.

Adoption of resolutions

194. The Committee adopted the following resolutions:

1. Resolution of thanks
2. Matters relating to programme development and management
3. Nutrition and food safety in the South-East Asia Region
4. Scaling up prevention and control of chronic noncommunicable diseases in the South-East Asia Region
5. The New Stop TB Strategy and its implementation
6. Revised Malaria Control Strategy: Focusing on a new paradigm
7. South-East Asia Regional Health Emergency Fund
8. Challenges in polio eradication
9. International migration of health personnel: A challenge for health systems in developing countries
10. Equitable geographical distribution of the membership of the Executive Board.

**Adoption of the report of the Sixtieth Session of the Regional Committee** *(Agenda item 19, document SEA/RC60/27)*

195. The Committee adopted the draft report of the Sixtieth Session, as contained in document SEA/RC60/27, with minor modifications.

**Closure of the session** *(Agenda item 20)*

196. Representatives of Member countries participating in the Sixtieth Session of the Regional Committee congratulated the Chairman and Vice-Chairman for the smooth and successful conduct of the meeting. They were unanimous in their
expression of thanks to the Royal Government of Bhutan and the Ministry of Health for their warm hospitality and excellent arrangements made for the session.

197. The representatives also expressed gratitude for the stimulating presence and active participation of Dr Margaret Chan, Director-General of WHO. They also conveyed their deep appreciation to the Regional Director, Dr Samlee Plianbangchang, for his dynamic leadership, and complimented the WHO team comprising staff from the Regional Office as well from the Bhutan Country Office for its contribution in the overall success of the meeting.

198. The representatives paid rich tributes to the Prime Minister of Bhutan, H.E. Lyonpo Kinzang Dorji, for his inspiring address at the Joint Inauguration of the Twenty-fifth Health Ministers’ Meeting and Sixtieth Session of the Regional Committee. The presence and active participation of representatives from other UN agencies and local as well as international NGOs was also appreciated.

199. The representatives expressed great satisfaction in the successful conduct of deliberations on subjects of crucial importance to the Region. They desired that resolutions adopted and/or recommendations made during the session be actively pursued and implemented.

200. The host representative from Bhutan expressed his pleasure in having been able to ensure a smooth conduct of the meeting to the satisfaction of all. He felt particularly proud to have the name of Bhutan’s capital associated with the landmark “Thimphu Declaration” on Health Security passed by the Committee which, according to him, would benefit not only the Region but countries outside it as well.

201. The Regional Director thanked the Royal Government of Bhutan for hosting the session of the Regional Committee, and reiterated WHO’s commitment to strengthen the country health systems towards ensuring long-term, sustainable health development in Member countries. The Regional Director also conveyed WHO’s appreciation to the Royal Thai Government for their donation to the South-East Asia Regional Health Emergency Fund. He assured the representatives that WHO, in the SEA Region, will continue to provide unwavering and intensified support for health development.

202. The Chairman declared the session closed.
Resolutions

**SEA/RC60/R1 Resolution of thanks**

The Regional Committee,

Having brought its Sixtieth Session to a successful conclusion,

1. **THANKS** His Excellency, Lyonpo Kinzang Dorji, Prime Minister, Royal Government of Bhutan, for graciously inaugurating the session and for his thought-provoking address;

2. **THANKS** the WHO Director-General, Dr Margaret Chan, for her inspiring address and participation;

3. **CONVEYS** its gratitude to the Royal Government of Bhutan for hosting the session, and thanks the members of the National Organizing Committee and other national authorities for making the session a success, and

4. **CONGRATULATES** the Regional Director for his lucid and comprehensive report on The Work of WHO in the South-East Asia Region covering the period 1 July 2006 to 30 June 2007.

**SEA/RC60/R2 Matters relating to Programme Development and Management**

The Regional Committee,

Having considered document SEA/RC/60/4 on the merging of meeting of Consultative Committee for Programme Development and Management (CCPDM) and Meeting of Health Secretaries (HSM) of the South-East Asia Region,
Recalling the establishment of the CCPDM and its terms of reference, as summarized in document SEA/RC/60/4/Inf. Doc.,

Noting the decision of the 25th Meeting of Health Ministers of the South-East Asia Region that the meetings of the CCPDM and the HSM should be merged,

Recognizing that the Programme Budget 2008–2009 covers the first biennium of the Medium-term Strategic Plan for 2008–2013 and 13 Strategic Objectives,

Noting that the Programme Budget 2008–2009 has increased the budgetary allocation to the SEA Region by 37.6% compared to the Programme Budget 2006–2007, of which 4.6% consists of an increase in Assessed Contributions and 50.2% of an increase in Voluntary Contributions,

Recognizing that the distribution of the regional budget among the 13 Strategic Objectives is based on joint planning undertaken by countries and the Regional Office and which was reviewed in September 2006 by the Senior Working Group established on the recommendation of the Fifty-ninth Session of the Regional Committee, and

Considering the recommendations of the Senior Working Group on Allocation of the Increased Assessed Contributions for the SEA Region for Programme Budget 2008–2009,

1. ESTABLISHES a sub-committee on policy and programme development and management (SPPDM) under Rule 15 of the Rules of Procedure of the WHO Regional Committee for South-East Asia;

2. DECIDES that the SPPDM shall replace the CCPDM and shall be composed of representatives from each Member State of the Region;

3. DECIDES FURTHER that the SPPDM shall provide its views and recommendations to the Regional Committee on the following:

   (a) The proposed operational plans (workplans) of the country offices and the Regional Office;

   (b) Implementation status of the Regional Programme Budget and workplans;

   (c) Resource mobilization efforts and status of funding of the Regional Programme Budget;
(d) Performance Assessment of the previous biennium workplans and Regional Programme Budget, as well as other programme evaluations, and

(e) Documents and subjects to be discussed at the Regional Committee, such as the proposed agenda, regional implications of the Decisions and Resolutions of the World Health Assembly and Executive Board to be considered, the proposed Regional Programme Budget, the General Programme of Work and the Medium-term Strategic Plan and other policy and programme issues at the request of the Regional Committee;

4. THANKS the Director-General for the increase in the Programme Budget 2008–2009 for the SEA Region;

5. ENDORSES the recommendation to allocate the increased Assessed Contributions of US$ 4.687 million to the SEA Region as follows:

   (a) US$ 1 million to the South-East Asia Regional Health Emergency Fund (SEARHEF);

   (b) The remaining balance of US$ 3.687 million to be divided among the Regional Office (25%), and US$ 2.765 million (75%) to countries, and

   (c) The amount of US$ 2.765 million to be distributed, pro rata, among the 11 Member countries on the basis of allocation of Assessed Contributions for the 2006–2007 biennium, and

6. REQUESTS the Regional Director:

   (a) to convene meetings of the Health Secretaries’ Meeting (HSM) as far as possible back-to-back with meetings of the SPPDM, so as to increase the participation of the Member States of the Region, in particular least developed countries;

   (b) to give priority, to the extent possible, to countries with the greatest need/small budgets in distributing funding in the form of unspecified Voluntary Contributions and enhance efforts to mobilize additional Voluntary Contributions for these countries;

   (c) to strengthen resource mobilization efforts involving donors in the Region and with headquarters to obtain adequate Voluntary Contributions to implement the workplans, and
(d) to develop an appropriate scientific formula for the distribution of resources, including assessed contributions and core voluntary contributions.

**SEA/RC60/R3 Nutrition and food safety in the South-East Asia Region**

The Regional Committee,

Recalling World Health Assembly resolutions WHA33.32, WHA49.13, WHA52.24, and WHA57.17 and other resolutions on infant and young child nutrition, appropriate feeding practices and related questions, and particularly resolution WHA53.15 on food safety, which urges integration of food safety into the essential public health and public nutrition functions,

Also recalling its own resolution SEA/RC57/R4 on Iodine Deficiency Disorders in the South-East Asia Region, SEA/RC56/R8 on Water, Sanitation and Hygiene Determinants of Health and SEA/RC53/R7 on Food Safety,

Recognizing that the simultaneous presence of both malnutrition and infection results in an interaction that has more serious consequences for the host than the additive effect would be if the two worked independently,

Concerned that nutritional disorders and foodborne diseases remain a major threat to the health and development of populations in the South-East Asia Region, and by recent foodborne disease outbreaks, both globally and in the Region,

Recognizing that both malnutrition and unsafe food are a major challenge to the attainment of MDGs in the Region, and

Having considered the report and recommendations of the Technical Discussions on Nutrition and Food Safety in the South-East Asia Region, held in New Delhi during 11-13 April 2007,

1. **ENDORSES** the recommendations contained in the report (SEA/RC60/5 and SEA/RC60/5 Inf. Doc.);

2. **URGES** Member States to implement the recommendations of the Technical Discussions; and

3. **REQUESTS** the Regional Director:
(a) to support Member States in further strengthening efforts in the area of nutrition and food safety, and

(b) to support monitoring and reporting of progress in implementation and on the status of National Nutrition and Food Safety Policy and Plans of Action in the Region to the Sixty-third Session of the Regional Committee in 2010.

**SEA/RC60/R4 Scaling up prevention and control of chronic noncommunicable diseases in the South-East Asia Region**

The Regional Committee,

Recalling World Health Assembly resolutions WHA53.17, WHA56.1, WHA57.17 and WHA60.23, and its own resolutions SEA/RC52/R7 and SEA/RC53/R10 relating to the prevention and control of noncommunicable diseases (NCDs),

Realizing that the countries in the WHO South-East Asia Region experience an increasing burden (in health, social and economic status) being imposed by major NCDs such as cardiovascular diseases, diabetes, cancers and chronic respiratory diseases, and concerned that noncommunicable diseases are increasingly becoming common among the poor and marginalized population groups,

Aware of the rapidity of epidemiological transition and globalization which will escalate these burdens over the next decades if appropriate public health action is not taken,

Acknowledging that effective, efficient and affordable interventions are available to modify the common risk factors of NCDs, such as unhealthy diet, physical inactivity, alcohol and tobacco consumption, and of their socioeconomic determinants that lie outside the domain of the health sector,

Recognizing the role of a “life course” approach which emphasizes the need of utilizing available health promotion and disease prevention strategies to minimize the risk of NCDs at each stage of life and the complementarities of a “population-based” and “individual-centred” intervention in achieving this,

Appreciating the growing commitment of Member States towards integrated prevention and control of NCDs and the considerable progress achieved in this regard, and
Having considered the recommendations of the Joint Meeting of Health Secretaries and the Consultative Committee for Programme Development and Management (CCPDM), held in the Regional Office in New Delhi, 2–6 July 2007,

1. **ENDORSES** the Regional Framework for Prevention and Control of Noncommunicable Diseases;

2. **URGES** Member States:
   
   (a) to initiate appropriate steps based on the Regional Framework to formulate, update and strengthen national policies, strategies and programmes for integrated prevention and control of NCDs;
   
   (b) to establish suitable infrastructure and appropriate funding mechanisms for this purpose, and
   
   (c) to set up mechanisms to promote multilateral, multisectoral, multidisciplinary and multilevel collaboration for integrated prevention and control of NCDs and, in particular, to facilitate the establishment of national and regional networks for NCD prevention and control (SEANET-NCD), and

3. **REQUESTS** the Regional Director:

   (a) to provide technical assistance to Member States, and to mobilize necessary resources for developing the capacity to implement national policies, strategies and programmes for integrated prevention and control of NCDs, and to facilitate and coordinate international support of development partners, and

   (b) to report to the Sixty-third Session of the Regional Committee in 2010 on the progress achieved in implementing the Regional Framework.

**SEA/RC60/R5 The new Stop TB Strategy and its implementation**

The Regional Committee,

Recalling World Health Assembly resolutions WHA58.14 and WHA 60.19 relating to tuberculosis control,

Reaffirming WHO’s commitment to the global goal of eliminating TB as a public health problem,
Recognizing that substantial progress has been made in the South-East Asia Region towards the achievement of the goals set by the World Health Assembly in 2000 of 70% case detection and 85% treatment success among all smear-positive TB cases by 2005,

Noting with concern the continuing and unacceptably high burden of tuberculosis in the Region, the emergence of drug resistance and the adverse impact of the HIV epidemic on tuberculosis control efforts in the Region,

Affirming that effective tuberculosis control will result in a significant decrease in morbidity and mortality among adults in the most productive age groups, and to the achievement of TB-related Millennium Development Goals,

Acknowledging that many challenges require to be overcome in order to extend equitable access to a minimum standard of care to all TB patients, including the poor and the marginalized, and

Having considered the paper and discussions on “TB control: Progress and plans for implementing the new Stop TB Strategy” (SEA/RC60/8),

1. ENDORSES the actions contained therein;

2. URGES Member States:
   
   (a) to fully implement the national plans for TB control, in line with the New Stop TB Strategy which should include innovative approaches to improve both the quality as well as equity of delivery;

   (b) to develop and sustain adequate human resources and infrastructure to further strengthen delivery of services including TB services, in the context of health systems strengthening;

   (c) to improve intersectoral collaboration, particularly with private health-care providers to widen the reach of standardized services to all TB patients;

   (d) to ensure effective collaboration between national TB and HIV/AIDS programmes to establish effective interventions for those affected by both TB and HIV;

   (e) to ensure implementation of interventions to effectively address multi-drug-resistant and extensively drug-resistant TB;

   (f) to enhance communication and social mobilization approaches to increase community awareness, utilization and user-friendliness of services and to reduce stigma;
(g) to improve surveillance and monitoring mechanisms to better measure the progress, and impact of interventions;

(h) to support the development of innovative approaches for better service delivery and utilization and contribute to global initiatives in developing new diagnostics, drugs and vaccines which will improve early detection and treatment and prevention of TB, and

(i) to mobilize financial resources in a sustainable manner to allow full implementation of all envisaged interventions, particularly in countries that do not benefit from significant external financing, and

3. REQUESTS the Regional Director:

(a) to advocate for the highest political support and increased funding from national and international sources to support TB control efforts in the Region;

(b) to enhance technical support to Member States to review and revise their national TB policies, strategies and plans and to assist them in implementation of the new TB strategy in the Region, and

(c) to assist Member States in strengthening health systems and developing human resources to ensure effective implementation of all planned interventions under the new strategy towards reaching the Millennium Development Goals.

**SEA/RC60/R6 Revised Malaria Control Strategy: Focusing on a new paradigm**

The Regional Committee,

Recalling World Health Assembly resolution WHA60.18 on Malaria as well as United Nations General Assembly Resolution 59/256 entitled “2001-2010: Decade to Roll Back Malaria in Developing Countries, particularly in Africa”,

Concerned about the large burden of malaria and its unacceptable toll on health and development and with the emergence of drug resistance in Asia,

Adequate that malaria particularly affects the poor and “hard-to-reach” populations living in remote, hilly areas,

Understanding that ecological, environmental and behavioural determinants lead to frequent malaria epidemics,
Calling attention to the fact that the disease is both treatable and preventable, and that newer technologies such as long-lasting insecticidal nets (LLIN) and artemisinin-based combination therapy (ACT) are available,

Realizing that malaria is not only a public health problem but the disease is related to socioeconomic development,

Supporting the Regional Director’s concept of implementing malaria control as a part of healthy public policies, through a strong multisectoral approach,

Recognizing the Regional Director’s initiative and the efforts made by WHO, malaria programme managers and development partners in revising the proposed malaria control strategy for the SEA Region for 2006-2010, to fit with socioeconomic conditions and the needs of SEA countries,

Appreciating recommendations made by the Twenty-fourth Meeting of Health Ministers which endorsed the Revised Malaria Control Strategy for the South-East Asia Region, and

Having considered the report and recommendations of the Twenty-fourth Meeting of Ministers of Health of Countries of the South-East Asia Region and the Joint Meeting of Health Secretaries of Countries of WHO South-East Asia Region (HSM) and Consultative Committee for Programme Development and Management (CCPDM) held during 2-6 July 2007,

1. **ENDORSES** the Revised Malaria Control Strategy for the South-East Asia Region 2006-2010;

2. **URGES** Member States:
   
   (a) to revise national strategies based on the Revised Malaria Control Strategy;
   
   (b) to adapt, as relevant, key elements of the Revised Malaria Control Strategy for SEA Region for application at national level;
   
   (c) to build up capacity and strengthen infrastructure;
   
   (d) to adopt a broad multisectoral approach for malaria and mosquito control;
   
   (e) to mobilize sufficient resource for malaria control;
   
   (f) to articulate and advocate for “malaria control in Asia” in national and international forums;
(g) to allocate appropriate financial support for malaria control, and
(h) to consider observing “malaria day” on 25 April or “malaria week”, or when appropriate, and

3. REQUESTS the Regional Director:

(a) to provide technical support to Member States to strengthen malaria control in the Region;
(b) to facilitate mobilization of financial resources for malaria control, and
(c) to coordinate and assist Member States in the observance of World Malaria Day/s on 25 April of each year, or when appropriate, to raise public awareness of malaria in the Region as a major public health problem and for countries to assess progress in malaria control throughout the Region.

SEA/RC60/R7 South-East Asia Regional Health Emergency Fund

The Regional Committee,

Recalling World Health Assembly resolutions WHA58.1 and WHA59.22, and its own resolutions SEA/RC57/3 and SEA/RC58/3, all of which called for improved investments of resources, systems and expertise for emergency preparedness and response,

Further recalling the recommendations made at the Regional Consultation for Emergency Preparedness and Response (June 2006), at which the Bali Declaration called for setting up a Regional Emergency Fund, and the Twenty-fourth Health Ministers’ Meeting, at which it was recommended that the Regional Office take steps to set up a Regional Emergency Fund,

Confirming that emergencies are a priority in the Region, with 58% of the total number of people killed in natural disasters during the decade 1996–2005 from countries of the South-East Asia Region; that the Organization has prioritized emergency preparedness and response, and that a dedicated Strategic Objective has been developed and Health Action in Crises has become a full-fledged cluster in WHO headquarters,

Noting that steps have been taken to create the Fund with a Working Group based in the Regional Office and a series of consultations conducted with WHO Representatives and representatives of Member countries,
Acknowledging the establishment of the South-East Asia Regional Health Emergency Fund (SEARHEF) as contained in the “Thimphu Declaration on International Health Security in the South-East Asia Region”,

Appreciating the contribution of US$100,000 of the Royal Thai Government to the Fund, and

Having considered the recommendations made by the Joint Meeting of Health Secretaries of countries of the WHO South-East Asia Region and the Consultative Committee for Programme Development and Management, held during 2-6 July 2007,

1. **URGES** Member States:
   (a) to contribute 1% of their WHO Regular Budget allocation to the SEARHEF;
   (b) to support proper use and management of the Fund to address immediate needs in any emergency, and
   (c) to actively participate in the management and utilization of SEARHEF through its Working Group, and

2. **REQUESTS** the Regional Director:
   (a) to lead in the efficient implementation of the Fund so that financial support is provided for immediate needs in countries affected by events;
   (b) to support further resource mobilization for the Fund;
   (c) to have a transparent mechanism for the distribution of the Fund;
   (d) to facilitate linking the SEARHEF with planning and activities for Strategic Objective 5, and
   (e) to report annually to Member States at the Regional Committee on the status of the Fund usage.

**SEA/RC60/R8 Challenges in polio eradication**

The Regional Committee,

Recalling its resolution SEA/RC58/R6,

Reaffirming WHO’s commitment to the goal of eradication of poliomyelitis,
Recognizing that substantial progress has been made in the Region towards the achievement of the goal of polio eradication in 2006, despite minor setbacks,

Encouraged by the high commitment of the Director-General of WHO to finish the job of polio eradication, coupled also with the strong commitment by Member States still endemic to polio to achieve the goal of eradication of poliomyelitis at any cost,

Further bolstered by the effectiveness of new tools such as the use of monovalent OPV (mOPV) and new strategies such as those outlined in the 2006 World Health Assembly resolution WHA59.1, to combat outbreaks of wild polioviruses or appearance of vaccine-derived polioviruses (VDPV),

Re-affirming that poliomyelitis eradication will result in far-reaching humanitarian and economic benefits to all countries, and

Realizing that sustainable polio eradication is only possible with a strong routine immunization programme that reaches all children with all routine antigens,

1. URGES Member States to strengthen the Expanded Programme on Immunization in order to maintain the highest surveillance levels and high routine immunization coverage as the best means to control the spread of polio virus and the outbreaks in the Region, and

2. REQUESTS the Regional Director:

   (a) to support/facilitate a thorough review of the status of routine immunization in Member countries to strengthen polio eradication efforts and to maintain polio-free status in those countries where polio is eradicated;

   (b) to convene a technical working group to evaluate the various options to prevent the spread of polio in the Region;

   (c) to seek and facilitate mobilization of financial resources for supporting the polio and routine immunization programme of Member States;

   (d) to support and facilitate Member States to maintain the highest surveillance levels and high routine immunization coverage as the best means to control the spread of polio virus and outbreaks in the Region;
(e) to work with international agencies and the private sector so that newly developed polio vaccines are available at an affordable price, and

(f) to report on the progress made in polio eradication to the Regional Committee on an annual basis until polio-free status is achieved in the Region.

**SEA/RC60/R9  International migration of health personnel: A challenge for health systems in developing countries**

The Regional Committee,

Recalling World Health Assembly resolutions WHA57.19, WHA59.23 and United Nations General Assembly resolution 58/208 on international migration and development, and the decision therein that, in 2006, the General Assembly will devote a high-level dialogue to international migration and development,

Taking note of the Commonwealth Code of Practice for the International Recruitment of Health Workers, which was adopted at the meeting of Commonwealth health ministers in Geneva in 2003,

Noting the work in progress on international labour migration in the International Organization for Migration, the Global Commission on International Migration, and in other international bodies,

Recalling its own resolutions SEA/RC29/R6, SEA/RC29/R9, SEA/RC38/R10, SEA/RC42/R5, SEA/RC45/R5, SEA/RC56/R7 and SEA/RC/59/R6 relating to human resources for health,

Welcoming the Dhaka Declaration by the Health Ministers of Member countries of the WHO South-East Asia Region on strengthening the health workforce in countries of the South-East Asia Region to achieve an effective and well-motivated health workforce, and which emphasized the need to mitigate the adverse impacts of international migration of health personnel,

Mindful of the fact that effective and efficient management of existing health workforce, which is one of the most precious and important resources of the health system infrastructure, would lead to effective programme delivery and significant improvements in health system performance,
Noting with concern the continued international migration of health personnel, attributed to unacceptable shortages, and geographical and skill-mix imbalances in health workforce in many countries of the Region,

Being aware that highly trained and skilled health personnel from many countries in the Region continue to migrate at an increasing rate to certain countries, which weakens health systems in the countries of origin, and

Noting further that many countries in the Region are not yet technically equipped to assess adequately the magnitude and characteristics of the outflow of their health personnel,

1. **URGES Member States:**
   (a) to intensify efforts to identify the magnitude and impact of international migration of health personnel in respective countries;
   (b) to strengthen human and institutional capacity to monitor the magnitude and impact of migration;
   (c) to develop appropriate strategies to mitigate the adverse effects of international migration of health personnel, as well as from rural and urban areas and from the public to private sector;
   (d) to frame and implement policies and strategies that could enhance effective retention of health personnel, and
   (e) to use government-to-government agreements to set up health-personnel exchange programmes as a mechanism for managing their migration, and

2. **REQUESTS** the Director-General, through the Regional Director to propose the inclusion of an agenda item entitled “International migration of health personnel: a challenge for health systems in developing countries” in the provisional agenda of the 122nd session of the Executive Board;

3. **REQUESTS** the Regional Director:
   (a) to support, establish and maintain, in collaboration with relevant countries, information systems that will enable the monitoring of international movement of human resources for health;
   (b) to carry out research on international migration of health personnel in cooperation with global and regional networks of health workforce development within their respective mandates, in order to determine
the adverse effects of such migration and the possible options to address them;

(c) to support Member States in strengthening their planning mechanisms and processes to develop appropriate policies and strategies to mitigate the adverse effects of international migration of health personnel;

(d) to support efforts of countries by facilitating dialogue and raising awareness at the highest national and international levels and between stakeholders about migration of health personnel and its effects;

(e) to propose the inclusion of international migration of health personnel as a priority programme area in WHO’s Regular Budget for the 2010-2011 biennium, and

(f) to report on implementation of this resolution to the Sixty-first Regional Committee.

SEA/RC60/R10  Equitable geographical distribution of the membership of the Executive Board

The Regional Committee,

Having considered documents SEA/RC60/11 and SEA/RC60/11/Inf. Doc.,

Noting that Article 24 of the WHO Constitution provides that the Health Assembly shall take into account an equitable geographic distribution in electing the Members entitled to designate a person to serve on the Board,

Commending the constructive considerations put forward by the High Level Consultation (Delhi, May 2007) and the Regional Expert Group (Bangkok, August 2007),

Concluding that a geographic distribution based solely on the number of Member States per region does not adequately reflect the principle of equitable geographic distribution and does not take into account other possible parameters that reflect the constitutional mandate and mission of WHO, and

Concluding further that, on the basis of such alternative parameters, the South-East Asia Region appears to be underrepresented in the Executive Board,

1. AGREES that the criteria by which seats in the Executive Board are allocated to the regions should be revised to better reflect current realities as well as the mandate and mission of WHO, and should include parameters such as
population, disability-adjusted life years (DALYs), as well as any other factor deemed appropriate, in addition to the number of Member States in each region;

2. CONSIDERS that the application of the additional criteria should lead to an increased and more equitable allocation of seats to the South-East Asia Region;

3. URGES Member States to actively support this process, both through their participation in the work of the Executive Board and through their diplomatic missions in Geneva;

4. REQUESTS the Director-General, through the Regional Director, to propose the inclusion of an item entitled “Equitable geographical distribution of the membership of the Executive Board” in the provisional agenda of the 122nd session of the Executive Board, and

5. REQUESTS the Regional Director

(a) to support Member States, in particular those that are Members of the Executive Board, in building their capacity to effectively participate and represent the interests of the Region in the deliberations of the governing bodies of WHO;

(b) to facilitate inter-regional consultations and to report to the Sixty-first session of the Regional Committee on progress in the implementation of the present resolution.

**Decisions**

**SEA/RC60(1) Merging of Meeting of Consultative Committee for Programme Development and Management (CCPDM) and Meeting of Health Secretaries (HSM) of the South-East Asia Region**

The Committee decided to use an administrative formula similar to that currently being used by the back-to-back meetings of the HMM and RC. Specifically, the Committee decided to replace the CCPDM through the establishment of a sub-committee on policy and programme development and management (SPPDM) under Rule 15 of the Rules of Procedure of the WHO Regional Committee for South-East Asia. It also requested the Regional Director to continue to convene meetings of the HSM with the two meetings being held
back-to-back so as to increase participation, in particular by the least developed countries in the Region.

**SEA/RC60(2) Technical Discussions: Selection of a subject for the Technical Discussions to be held prior to the Sixty-first Session of the Regional Committee**

The Committee **decided** on “Revitalizing Primary Health Care” as the subject for Technical Discussions to be held prior to the Sixty-first Session of the Regional Committee in 2008.

**SEA/RC60(3) Nomination of a Member State to the Joint Coordinating Board (JCB) of the Special Programme for Research and Training in Tropical Diseases**

The Committee **nominated** Bhutan as a member of the JCB for a period of three years effective 1 January 2008 and requested the Regional Director to inform WHO headquarters accordingly.

**SEA/RC60(4) Nomination of a Member State to the Policy and Coordination Committee (PCC) of the WHO Special Programme for Research, Development and Research Training in Human Reproduction**

The Committee **nominated** Indonesia as a member of the PCC for a period of three years effective 1 January 2008 and requested the Regional Director to inform WHO headquarters accordingly.

**SEA/RC60(5) Time and place of future sessions of the Regional Committee**

The Committee **decided** to hold its Sixty-first Session in the Regional Office, New Delhi during the week beginning 8 September 2008. The exact dates will be confirmed later.
Annexes
Annex 1

Text of address by the Prime Minister of Bhutan

At the outset, I have the great honour to convey the warm greetings and best wishes of His Majesty Jigme Khesar Namgyel Wangchuk, the King of Bhutan for the success of the Twenty-fifth Meeting of the Ministers of Health and the Sixtieth Session of the Regional Committee of WHO’s South-East Asia Region.

I am deeply honoured to be here today among all the visiting dignitaries and distinguished participants at this joint inaugural session of these two very important meetings being held here in our capital city of Thimphu. It is indeed a privilege for Bhutan to host a meeting of this stature.

On behalf of the people and the Government of Bhutan and, on my own behalf, I would like to extend a very warm welcome to all the distinguished delegates. I hope you will have a pleasant and comfortable stay in our country.

Bhutan has witnessed historic and unprecedented changes in recent years, and the year 2008 will culminate in the celebration of three major historical events. These events include Bhutan’s unique transition to parliamentary democracy, celebration of 100 glorious years of monarchy and the Coronation of his Majesty the Fifth King. It will be the year when we will celebrate the unique introduction of parliamentary democracy in the country which is a gift from the Golden Throne. It will be the year, when our people will pay tribute to a dynasty that has brought unprecedented peace, stability and progress through extraordinary and selfless leadership. Above all, it will be the year when we will celebrate the formal coronation of our Fifth Druk Gyalpo, His Majesty Jigme Khesar Namgyel Wangchuck, with great jubilation, and look forward to a bright and prosperous future under his reign.

When we look at Bhutan’s history, it will be seen that our successive monarchs have steered the kingdom on a path of enormous socio-economic development and have brought about peace and stability in the country. The successive generations of our beloved kings have consolidated and crystallized
the foundations of our country, lifted the veil of isolation, and led the country forward as a confident, forward-looking, dynamic and modern nation-state against a global background. In particular, the reign of His Majesty the Fourth Druk Gyalpo, Jigme Singye Wangchuck, will go down in the history of Bhutan as a singularly momentous period in the all-round development of our country. It was under the visionary guidance of the His Majesty the Fourth King that “Gross National Happiness” was introduced as the development philosophy, which strives to balance spiritual well-being of the people with that of socio-economic development.

This principle of Gross National Happiness is reflected in the health sector through integration of the traditional medicine with that of the modern medical system. Realizing health as a major component for happiness, the Constitution also guarantees free general health services to all the citizens. To this end, our government has allocated 10 to 15% of its annual budget to the health sector for the last four decades.

The Bhutanese health sector is honoured to have the continuous support of Her Majesty Ashi Sangay Choden Wangchuck, the Queen of Bhutan and UNFPA Goodwill Ambassador to Bhutan. Her Majesty’s earnest, enduring and continuous campaigns for advocating and raising health awareness have contributed significantly towards the improvement of health of our people, particularly in rural areas.

Recognizing the importance of improving health care for addressing poverty issues, and given its very inter-related nature, health has become one of the agenda in many global, regional and national forums. The emerging and re-emerging diseases such as SARS, avian influenza, MDR TB, etc. do not respect national boundaries, posing a threat to our collective health security. Further, the change in world climate has started to pose a serious threat to global health. Here I would like to commend the WHO in bringing out the revised International Health Regulations (2005), to which Bhutan commits fully. I believe such regulations would contribute towards promoting international cooperation and partnerships.

In this context, the Royal Government of Bhutan also whole-heartedly welcomes the establishment of the South-East Asia Regional Health Emergency Fund. I hope this will go a long way in providing the necessary financial support to unfortunate victims of disasters.

The primary health care approach has been instrumental in attaining public health achievements in Bhutan, with some of them being:
• Polio cases not reported since 1986
• Leprosy eliminated since 1997
• Universal child immunization achieved since 1991
• Iodine deficiency disorders eliminated since 2003
• Rural water supply coverage is 89%
• Basic health care service coverage over 90%

One of the major challenges for Bhutan will be sustaining the above accomplishments in view of the financial constraints. Shortage of human resources is another major difficulty in the light of the expanding health care services, difficult geographical terrain and scattered population.

I believe all our countries in the region face similar problems, but of varying degrees. As rightly stated in the World health report, the region has only around four health workers for every 1 000 population against the global health workforce of around nine. The same report states that the region has 25% of the world’s population to provide health services with only 17% medical institutes to produce doctors, and 3% public health institutes. In addition, the region has a huge disparity in distribution of medical institutes. For instance, Bhutan continues to depend on the region to train its doctors and other health workforce since there is only one institute for training paramedical personnel. We would like to thank you for the support that you provided to Bhutan in its efforts to improve its health services and to have a good health system in place.

The need to sustain and expand primary health care services, the growing demand for quality health-care services, and emerging international threats are increasingly adding pressure on our already limited financial and human resources, especially, the health workforce. Therefore, Bhutan would like to seek continuous support of the region for training our health workforce, especially at the postgraduate level.

I am confident that the signing of ‘Thimphu Declaration on International Health Security in the South-East Asia Region’ will go a long way in reducing the vulnerability of people in the region and the world to a host of health-related risks and disasters. In this regard, I would like to commend the initiative and efforts of WHO and its member countries and wish them success in their future endeavours.
I understand that you will be busy with the meetings over the next four days. Nevertheless, I hope you will find time to familiarize yourselves with our country, culture and way of life.

I am confident that your fruitful deliberations will lead to common vision in minimizing threats to our collective health security.

I now declare the Twenty-fifth Session of the Meeting of the Health Ministers and Sixtieth Session of the Regional Committee of WHO South-East Asia Region opened.

Thank you & tashi delek.
Annex 2

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

It is indeed my privilege to welcome you all to the joint inauguration of the Twenty-fifth Meeting of the Health Ministers of countries of the WHO South-East Asia Region, and the Sixtieth Session of the World Health Organization’s Regional Committee for South-East Asia.

At the outset, I would like to gratefully thank the Royal Government of Bhutan for hosting the meetings in this beautiful and serene city of Thimphu.

I sincerely thank His Excellency Lyonpo Kinzang Dorji for consenting to inaugurate this joint opening session. I also take this opportunity to thank the Honourable Ministers and distinguished representatives for sparing their valuable time to be here, inspite of their very busy schedules.

We must be pleased to be here in Bhutan. Under the guidance of His Majesty the King, the country has achieved a quantum leap in health development over the past few decades.

Bhutan has developed its health infrastructure almost from scratch into a complete and functional health system. Health indices of the Bhutanese population have remarkably improved in almost all sectors. Bhutanese people look much healthier today. Bhutan is really a model for health development, from which many countries may learn.

During the course of these meetings, the Honourable Ministers and distinguished representatives will review the progress of health development in the South-East Asia Region; and, in particular, review the work of WHO during the past year.

The last year was another significant step on the road to progress in health development in the South-East Asia Region. However, many health challenges still prevail, and call for more enhanced and energetic intercountry collaboration.
Polio is yet to be eradicated from the Region. Avian influenza is endemic in several countries and it really poses a potential for an influenza pandemic. HIV infection is still spreading. In addition, the Region is facing emerging public health problems due to noncommunicable diseases such as diabetes, cancer and cardiovascular ailments. These are some of the prevalent issues and challenges which we have to tackle with concerted efforts in the coming year.

Serious efforts will have to continue to be made to ensure reaching all targets of health-related Millennium Development Goals by all Member States in South-East Asia by 2015. At the same time, Member countries have to prepare to face new health challenges such as global warming; the phenomenon that leads to more frequent and more severe natural disasters such as floods and cyclones.

Very importantly, to ensure our own collective health security, we have to vigorously implement the International Health Regulations (2005). These efforts will contribute to the effective prevention of the global spread of infectious pathogens.

For all our efforts, we have to aim towards achieving sustainable development in the long term. Strengthening health systems based on the primary healthcare approach has to be our key strategy in this regard. In particular, special attention has to be paid to the development of public health infrastructure, in order to ensure effective primary prevention, reaching the unreached and achieve universal coverage.

As always, WHO on its part will leave no stone unturned in supporting Member States in their efforts towards sustainable development of health for all their people. The bond of collaboration between Member States and WHO will certainly be further strengthened in the years to come. WHO will continue working closely and harmoniously with other international governmental and nongovernmental organizations to ensure the best support to Member States.

I finally wish the Honourable Ministers and distinguished representatives all success in their deliberations during the course of the two meetings.

Thank you.
Annex 3

Agenda*

1. Opening of the session

2. Sub-committee on Credentials: SEA/RC60/28
   2.1 Appointment of the Sub-committee on
   Credentials
   2.2 Approval of the report of the Sub-committee
   on Credentials

3. Election of Office-bearers

4. Adoption of the Agenda SEA/RC60/1 Rev.1

5. Introduction to the Regional Director’s Annual
   SEA/RC60/2,
   Report on the Work of WHO in the South-East
   SEA/RC60/2
   Asia Region covering the period
   Inf. Doc.1
   1 July 2006 to 30 June 2007
   Rev., Inf. Doc.2 and
   SEA/RC60/2 Corr.

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

7. Matters relating to Programme Development and
   Management
   SEA/RC60/3 and
   7.1 Review of the detailed workplans for
   Programme Budget 2008-2009
   SEA/RC60/3 Add.
   7.2 Merging of Meeting of the Consultative
   Committee for Programme Development
   and Management (CCPDM) and Meeting of
   Health Secretaries (HSM) of the South-East
   Asia Region
   SEA/RC60/4,
   SEA/RC60/4 Inf. Doc.

8. Technical Discussions:
   SEA/RC60/5 and
   8.1 Consideration of the recommendations
   arising out of the Technical Discussions on
   ‘Nutrition and Food Safety’
   SEA/RC60/5 Inf. Doc.

*Originally issued as document SEA/RC60/1 (Rev.1) dated 3 September 2007
8.2 Selection of a subject for the Technical Discussions to be held prior to the Sixty-first Session of the Regional Committee

9. Scaling up prevention and control of chronic noncommunicable diseases in the South-East Asia Region

10. Tuberculosis control: Progress and plans for implementing the new Stop TB Strategy

11. Revised Malaria Control Strategy: Focusing on a new paradigm

12. South-East Asia Regional Health Emergency Fund

13. Membership of the South-East Asia Region on the Executive Board

14. Progress reports requested by Member States:
   14.1 Avian and pandemic influenza preparedness in the context of International Health Regulations (2005)
   14.2 Public health, innovation and intellectual property rights: An update
   14.3 WHO and Reforms of the UN System: Impact at country level

15. Governing Bodies:
   15.1 Review of the decisions and resolutions of the Sixtieth World Health Assembly and the 120th and 121st Sessions of the WHO Executive Board
   15.2 Review of the draft provisional agendas of the 122nd Session of the WHO Executive Board and the Sixty-first World Health Assembly*

16. Follow-up action on selected resolutions/decisions of the last three years:
   16.1 Iodine deficiency disorders in the South-East Asia Region
16.2 Promoting patient safety in health care
SEA/RC60/18 and
SEA/RC60/18 Add.

16.3 Strengthening the health workforce in South-East Asia
SEA/RC60/19

16.4 Health information system development relating to Millennium Development Goals (MDGs) and Health Metrics Network (HMN)
SEA/RC60/20

16.5 Challenges in polio eradication
SEA/RC60/21

16.6 International migration of health personnel: a challenge for health systems in developing countries
SEA/RC60/25

17. Special Programmes:

17.1 Nomination of a Member State to the Joint Coordinating Board (JCB) of the Special Programme for Research and Training in Tropical Diseases
SEA/RC60/22

17.2 Nomination of a Member State to the Policy and Coordination Committee (PCC) of the WHO Special Programme for Research, Development and Research Training in Human Reproduction
SEA/RC60/23
Annex 4

List of participants*

1. Representatives, Alternates and Advisers

Bangladesh

Representative
Mr A.K.M. Zafar Ullah Khan
Secretary
Ministry of Health and Family Welfare

Alternate
Mr Md. Jahangir
Joint Secretary
Ministry of Health and Family Welfare

Bhutan

Representative
Lyonpo Thinley Gyamtsho
Cabinet Minister

Alternate
Dasho (Dr) Gado Tshering
Secretary
Ministry of Health

Dr Rinchen Chophel
Executive Director
National Commission for Women and Children

Advisers
Dr Ugen Dophu
Director
Department of Public Health
Ministry of Health

Mr Thinlay Dorji
Chief Planning Officer
Ministry of Health

Ms Tshering Lhadn
Desk Officer
Department of Multilateral Affairs
Ministry of Foreign Affairs

*Originally issued as document SEA/RC60/26 (Rev.) dated 11 September 2007
DPR Korea

Representative  
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Alternates  
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Ministry of Foreign Affairs

Dr Sok Yong Guk  
Official, Department of External Affairs  
Ministry of Public Health

Mr Choe Yong Su  
Official, Department of External Affairs  
Ministry of Public Health

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Representative  
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Secretary  
Ministry of Health and Family Welfare

Alternates  
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Joint Secretary (International Health)  
Ministry of Health and Family Welfare

Mr Amit Mohan Prasad  
Director (International Health)  
Ministry of Health and Family Welfare

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Representative  
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Minister of Health

Alternates  
Dr I. Nyoman Kandun  
Director-General of Disease Control and Environmental Health  
Ministry of Health

Dr Budihardja  
Chief of Bureau of Planning and Budgeting  
Ministry of Health

Ms Murti Utami  
Chief of Administration and Protocol Division  
Ministry of Health
Mr Abdul Halim
Chief of Sub-Division of Technical Cooperation and International Agreement
Ministry of Health

Mr Bobby Suryowibowo
Staff of Administration and Protocol Division
Ministry of Health

**Maldives**

*Representative*
H.E. Mr Ilyas Ibrahim
Minister of Health

*Alternates*
H.E. Dr Abdul Azeez Yoosuf
Deputy Minister of Health

Ms Aminath Shenalin
Assistant Director
Ministry of Health

**Myanmar**

*Representative*
H.E. Professor Paing Soe
Deputy Minister
Ministry of Health

*Alternates*
Dr San Shway Wynn
Deputy Director-General
Department of Health

Dr Ko Ko Naing
Deputy Director
International Health Division
Ministry of Health

**Nepal**

*Representative*
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Minister of Health and Population

*Alternates*
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Chief Specialist
Policy, Planning and International Cooperation Division
Ministry of Health and Population
Dr Mahesh Kumar Maskey  
Chairman  
Nepal Health Research Council  

Dr Sharad Raj Onta  
Member Secretary  
Nepal Health Research Council  

Sri Lanka  

*Representative*  
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Minister of Healthcare and Nutrition  

*Alternates*  
Dr H.A.P. Kahandaliyanage  
Secretary  
Ministry of Healthcare and Nutrition  

Dr S. M. Samarage  
Deputy Director-General (Planning)  
Ministry of Healthcare and Nutrition  

Dr Palitha Abeykoon  
Adviser to the Hon. Minister of Healthcare and Nutrition  
Ministry of Healthcare and Nutrition  

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*Representative*  
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International Health Policy Programme  
Bureau of Policy and Strategy  
Office of the Permanent Secretary  
Ministry of Public Health  

*Alternates*  
Dr Niphon Popattanachai  
Deputy Secretary-General  
Food and Drug Administration  
Ministry of Public Health  

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Ministry of Public Health  

Dr Sopida Chavanichkul  
Director, Bureau of International Health  
Office of the Permanent Secretary  
Ministry of Public Health
Dr Wanna Hanshaoworakul  
Medical Officer  
Bureau of Epidemiology  
Department of Disease Control  
Ministry of Public Health  

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International Health Policy Programme  
Bureau of Policy and Strategy  
Office of the Permanent Secretary  
Ministry of Public Health  

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Foreign Relations Officer  
Bureau of International Health  
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Ministry of Public Health  

Mr Rachid Janta  
Assistant Researcher  
International Health Policy Programme  
Bureau of Policy and Strategy  
Office of the Permanent Secretary  
Ministry of Public Health  

Timor-Leste  

_Representative_  Mr Marcelo Amaral  
Head, Department of Planning  
Ministry of Health  

2. Representatives from Embassies, United Nations and other Specialized Agencies

_United Nations_  Dr Gepke Hingst  
Children’s Fund  UNICEF Representative  
Bhutan  

_United Nations_  Dr Marc Derveeuw  
Population Fund  Deputy Representative  
Asia and Pacific Division  
55 Lodi Estate  
New Delhi 110003, India
### 3. Representatives from International Nongovernmental Organizations

<table>
<thead>
<tr>
<th>Organization</th>
<th>Name</th>
<th>Position/Role</th>
<th>Organization/Address</th>
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<tbody>
<tr>
<td><em>International Diabetes Federation</em></td>
<td>Dr Dhrubal Lall Singh</td>
<td>Regional Chair-Elect for the IDF SEA Region Nepal</td>
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<tr>
<td><em>International Epidemiological Association (IEA)</em></td>
<td>Dr Babu L. Verma</td>
<td>EA Councillor of SEA Division Division of Biostatistics</td>
<td>Maharani Laxmi Bai Medical College and Hospital Jhansi 284128, India</td>
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<td></td>
<td></td>
<td>Department of Social and Preventive Medicine</td>
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<tr>
<td><em>International Federation of Pharmaceutical Manufacturers and Associations</em></td>
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<td><em>International Planned Parenthood Federation</em></td>
<td>Ms Vandana Sharma</td>
<td>Senior Programme Officer South Asia Regional Office</td>
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<td><em>Medical Women’s International Association</em></td>
<td>Dr Pattariya Jarutat</td>
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<tr>
<td><em>Rehabilitation International</em></td>
<td>Dr A.K. Mukherjee</td>
<td>Director-General</td>
<td>Indian Spinal Injuries Centre Sector C, Vasant Kunj New Delhi 110070, India</td>
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<tr>
<td><em>The Rotary International (PolioPlus Division)</em></td>
<td>Mr Kalyan Banerjee</td>
<td>Past Rotary International Director and Trustee and current IPPC Member</td>
<td>C/o United Phosphorous Limited “Uniphos House” CD Marg, 11th Road, Madhu Park, Khar (West) Mumbai 400052, India</td>
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</table>
World Federation of Medical Education
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5. Observer

International Support and Partnership for Health
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Professor and Chairman
Department of International Affairs and Tropical Medicine
Tokyo Women’s Medical University
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Annex 5

Members of drafting group

Dr I. Nyoman Kandun (Indonesia), Convener
Mr Md. Jahangir (Bangladesh)
Dasho (Dr) Gado Tshering (Bhutan)
Dr Sok Yong Guk (DPR Korea)
Ms Aradhana Johri (India)
H.E. Dr Abdul Azeez Yoosuf (Maldives)
Dr Ko Ko Naing (Myanmar)
Dr Nirakar Man Shrestha (Nepal)
Dr S.M. Samarage (Sri Lanka)
Dr Viroj Tangcharoensathien (Thailand)
Mr Marcelo Amaral (Timor-Leste)
### Annex 6

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*Originally issued as document SEA/RC60/30 dated 12 September 2007*
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<td>SEA/RC60/7 Inf. Doc. 1</td>
<td>Scaling up prevention and control of chronic noncommunicable diseases in the South-East Asia Region: Capacity for noncommunicable disease prevention and control in countries of the South-East Asia Region, Results of a 2006-2007 survey</td>
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Annex 7

Text of Regional Director’s introductory remarks on his Annual Report

My report on the Work of WHO in the South-East Asia Region for the period 1 July 2006 to 30 June 2007 (as contained in Document SEA/RC60/2) has already been distributed. I will, therefore, confine my remarks to some of the salient features in the report.

The South-East Asia Region carries a double burden of disease – communicable and noncommunicable. Noncommunicable disease normally comes insidiously, not attracting immediate public attention. On the other hand, communicable diseases, many a time, occur suddenly and create an emergency that requires prompt action. Therefore, during the period under review, a lot of our efforts and resources had to be devoted to the prevention and control of prevailing communicable diseases.

The South-East Asia Region continued to face repeated threats from newly emerging pathogens, and from the occurrence of disease outbreaks. These were the challenges that needed to be addressed through improved intercountry and interregional cooperation.

Very important is the implementation of International Health Regulations (2005) to prevent the international spread of infectious diseases. And equally important, strengthening the capacity of country public health systems to meet these challenges successfully had been given priority attention.

Among newly emerging infectious diseases, avian influenza had become endemic in several countries of the Region, and had become a global concern. To ensure a multisectoral response to its outbreaks, a meeting of health and agriculture ministers was hosted by the Government of India in July last year.

The meeting adopted the “Delhi Declaration” that created a firm basis for WHO to support Member States in the prevention and control of avian influenza. An exercise to test the readiness of the National Avian Influenza Pandemic Preparedness Plans had been undertaken in most countries of the Region.
To provide timely support to Member States in the area of communicable disease control, WHO has established two regional subunits – one in Bangkok and the other in New Delhi. These sub-units had rendered rapid technical service to countries in surveillance, as well as in outbreak alert and response (CSR).

Dengue had been rapidly spreading to new areas in the Region with more frequent outbreaks, and in a more explosive manner. The Regional Strategy for Dengue Prevention and Control had been revised and the Asia-Pacific Partnership for Dengue Control was formed. Support had also been provided to affected countries in the prevention and control of Chikungunya, another debilitating disease.

Malaria continued to be a major health problem in the South-East Asia Region with approximately 1.3 billion people at risk. The coverage of malaria preventive interventions – such as the use of insecticide-impregnated nets – remained very low; between 10 to 20 per cent of the population at risk.

In view of the changing scenario, the Regional Strategy for Malaria Control was revised in order to lay more emphasis on community-based prevention and multisectoral interventions. The Revised Strategy was endorsed by the Health Ministers of the Region during their annual meeting last year.

As far as tuberculosis is concerned, the Region continued to bear the highest burden in the world, with nearly five million cases and a half million deaths annually. TB control had also been hampered significantly by the HIV epidemic. There were nearly three million estimated TB/HIV co-infected cases in South-East Asia.

The TB case detection rate had increased to 64%; and treatment success rates to 87%. The Region is on the right track towards achieving the target for TB-related Millennium Development Goals (MDGs).

Regarding leprosy, all but two countries in the Region had attained the elimination goal. The remaining two were expected to meet the goal by next year.

Efforts continued to further reduce the leprosy burden through ensuring reaching the unreached, improved quality of care, and integration of leprosy services into the general health services.
With regard to HIV/AIDS, the implementation of the Global Strategy for “Universal Access” continued to receive priority attention. Between 2003 and 2006 coverage with antiretroviral treatment had increased tenfold, from 18,000 to 180,000 patients.

The coverage of preventive services for STIs and HIV infections, such as promotion of condom use, was still low at only 20 per cent. To ensure rapid and sustained scaling up of such services, vigorous efforts had been made to strengthen the related components of country health systems.

Despite encouraging success in several Member States, polio eradication remained a major challenge. Nevertheless, the countries continued their unwavering commitment, and devoted all their efforts to the eradication of the disease from the Region. More than 10 million children in the Region remained unimmunized annually. WHO’s focus in this area, therefore, had been on intensification of routine immunization. Among others, Member States had been supported to further rationalize the use of new vaccines in their routine immunization.

The South-East Asia Region carried a disproportionate burden of neglected tropical diseases, including lymphatic filariasis, kala-azar and yaws. These diseases had been targeted for elimination or eradication in the Region by 2015.

During the period under review, regional partnership meetings had been convened twice for awareness building and resource mobilization.

Noncommunicable diseases (NCD) including cardiovascular disease, cancer and diabetes accounted for 54% of all deaths in the Region. Efforts had been intensified to scale up the integrated prevention and control of noncommunicable diseases in countries through networking of programmes and activities.

Multidisciplinary interventions at the community level had been particularly emphasized. Progress had also been made in the implementation of National Strategies and Plans of Action on Diet and Physical Activity.

In the area of health promotion, support to countries in furthering various health promotion initiatives had been accelerated. Several countries had implemented national programmes on school health promotion.
WHO had actively encouraged the integration of health promotion activities in all other public health programmes. Countries in the South-East Asia Region carried a very high burden of tobacco-related illnesses. Out of five million global deaths due to tobacco use, 1.2 million were in this Region.

All but one country had ratified the WHO Framework Convention on Tobacco Control. In November last year, the Bloomberg Global Tobacco-Free Initiative was launched in six countries of the Region.

Through a series of regional consultations, community-based mental health services as part of national health care systems had been developed. Multisectoral approaches to mental health promotion had been pursued through schools and community-based organizations.

Several countries conducted community-based studies on alcohol use to assess its extent and harmful effects. Information packages to promote the reduction of harmful use of alcohol had been produced and disseminated.

Maternal and newborn mortality continued to be a priority public health concern. Approximately a third of the global maternal and newborn deaths occurred in the SEA Region. Evidence-based guidelines for investigation of maternal deaths were developed for use by the countries.

Studies on interventions to reduce maternal mortality through improved referral systems had been pursued. A series of workshops to develop guidelines for strengthening evidence-based programming for newborn health were organized in five Member countries. The quality of family planning services, particularly unsafe abortion, continued to be given due attention.

Evidence-based guidelines for providing quality reproductive health care were developed. Through inter-programme workshops, linkages between reproductive health and prevention of STIs/HIV infections had been encouraged.

With regard to environmental health, the Region was on track for achieving the MDG targets for water supply. However, sanitation coverage was lagging far behind, with only 16 per cent of the rural population covered.

Furthermore, excessive concentration of arsenic and fluoride in drinking water continued to cause serious concern in some countries. Several countries had introduced water safety monitoring and surveillance and had set national water quality standards as well.
According to WHO’s estimate in 2000, most countries in the Region experienced the highest burden of occupational diseases. During the period under review, WHO’s focus in this area was on disease surveillance as the basis for strengthening occupational health services. In addition, one more WHO Collaborating Centre for Occupational Health in India was designated.

Annually, about 1.3 million people in the Region suffered accidental poisonings and attempted suicides. Guidelines were developed for training of multidisciplinary groups of country staff to deal with the problems more effectively. A Regional Poison Control Training and Research Centre had been established in Chennai, India, to provide technical support in this area.

During the past year, grave concern with the adverse health impact of global warming had been widely expressed. In coordination with other international agencies, WHO supported countries in preparing national plans for responding to the impact. Plans included vulnerability assessments and strengthening of countries’ sectoral programmes to address effectively the climate-sensitive health impacts. A regional meeting had been planned for the end of this year to create awareness among policy makers and planners.

At the 24th Health Ministers’ Meeting, the Dhaka Declaration was adopted to reflect continued commitment of Member States to the strengthening of the health workforce.

The Regional Office had taken the lead in developing the Regional Strategic Plan for Health Workforce Development. A Regional Meeting on Revisiting Community-based Health Workers and Community Health Volunteers had been planned for October this year.

In the area of essential medicines, two monographs on the Role of Education and the Role of Ethics in Rational Use of Medicines were published and disseminated. A Regional Meeting on the Role of Education in Rational Use of Medicines had been planned for December this year.

As regards country health information, a publication “11 Health Questions about the 11 SEAR Countries” was produced and disseminated.

To face today’s health challenges in a more effective manner, greater investment in health systems strengthening was considered an overriding priority. The Regional Strategic Framework on Health Systems Strengthening Based on Primary Health Care Approach was developed through a regional consultation.
A training programme on developing National Health Accounts (NHA) had been prepared through a bi-regional workshop. Several Member countries had initiated the development of their National Health Accounts.

As far as patient safety is concerned, a number of meetings had been organized, at both regional and country levels, to build awareness and partnerships. Regional guidelines had been developed for multidisciplinary training of country staff to ensure patient safety in health-care institutions.

According to the World disasters report 2006, around 58% of deaths due to natural disasters during 1996-2005 were in this Region. Through multisectoral training programmes, WHO had further intensified its efforts in strengthening country capacity in emergency management. In such efforts, emphasis was also placed on developing community resilience at the grassroots levels.

Steps had been under way to establish a South-East Asia Regional Health Emergency Fund to ensure availability of resources to deal adequately with the emergency during its early phase.

WHO in the SEA Region continued to work closely with the UN, and other international organizations; including NGOs, the private sector and other partners. This Region needs resource inputs from the outside. Building partnerships with these organizations is one of our strategic approaches in resource mobilization.

Until this month, US$ 270 million had been mobilized for WHO execution. This amount is well beyond the planned target set for regional voluntary contribution for the 2006-2007 biennium. In this connection, 110 agreements and memorandums of understanding were signed with external partners.

In all areas of collaboration with Member States, WHO is aiming towards strengthening and increasing country capacity, especially the capacity of their public health systems, the capacity that can ensure long-term sustainable development and self-reliance in health.

Today, with strong public health systems in place in countries, health development challenges will certainly be tackled in a more efficient and effective manner. During the period under review, the development of a number of public health education programmes; including schools and institutes of public health, had been initiated in several countries of the Region. This situation was never witnessed before in the Region.
There had been a clear indication of commitments in countries to such developments in the coming year. WHO in the South-East Asia Region will continue to ensure its full support to the strengthening of public health systems and public health infrastructure in Member countries.

I now come to the end of my introductory remarks on the work of WHO in South-East Asia Region for the period 1 July 2006 – 30 June 2007. While thanking you all for your kind attention, I wish again to place on record WHO’s unwavering commitment and support to Member States in their efforts towards better health of all people.

Thank you.
I am well aware that I am standing before a group of ministers and other leaders responsible for health in some of the most densely populated countries in the world.

Worldwide, public health is engaged in basically the same struggles on three main fronts. We struggle to hold the microbial world at bay. We struggle to change human behaviours. And we struggle to gain attention and resources. But the challenges in South-East Asia have distinct dimensions.

I am aware of the heavy responsibility on your shoulders. Routine health functions take on monumental dimensions because of the sheer numbers of people you must reach.

This part of the world has the largest number of children missed by immunization services. It has the highest number of deaths from measles, and the highest number of deaths from complications of pregnancy and childbirth. South-East Asia has the highest number of unsafe abortions. Problems like malnutrition in children, and anaemia in pregnant women, persist. You have so many mouths to feed, so many babies to deliver safely. You have my full appreciation for the magnitude of challenges you face. You also have my full admiration.

At a time when social justice and fairness are driving the development agenda, I believe you have three golden assets at the policy level. I am referring to your commitment to poverty reduction, your commitment to universal access, and your responsiveness to the desires of your citizens, right down to the grassroots level. I see these policy commitments, time and time again, in your national health plans and long-term objectives. Many of these objectives are visionary. It is not surprising that this Region has pioneered the adoption of rational approaches to the provision of essential care, on a massive scale. You have shown the world how to maximize population-wide protection from preventable threats. Above all, your efforts are lessons in how to stretch resources so that benefits reach the largest possible number of people. This Region leads
the world in the use of lists of essential medicines as part of national drug policies. The use of the WHO Model List goes hand-in-hand with policies promoting rational drug use. To protect health, you use health legislation to great strategic advantage. Health-promoting regulations in this Region range from mandated latrines in households, to child protection legislation, to control of the safety and quality of medicinal products, including blood safety. Your legislation also provides a model for using a natural resource to extend access to essential care. I am referring here to the Region’s rich heritage of traditional medicine and the wealth of knowledge and wisdom preserved by its practitioners. Traditional medicine is especially well-regulated in this Region. In many countries, modern and traditional systems co-exist in harmony, and benefit from mutual referral. This is, once again, a rational way to use existing resources to reach more people.

Health leaders in South-East Asia take advantage of regional and global strategies, especially those that increase operational efficiency. For childhood illness, many countries have adopted the WHO strategy for the Integrated Management of Childhood Illness. This approach recognizes that most childhood deaths result from a handful of causes that can be prevented by a handful of cost-effective interventions. It attacks these causes, including malnutrition, in an integrated way, using standardized treatment protocols. For the Stop TB strategy, experts agree: progress in this Region is driving progress globally. As another example, you have on your agenda a proposed regional framework for the prevention and control of chronic diseases. Again, a population-wide collaborative approach is the most rational way to counter this growing threat.

As we all know, South-East Asia is the ancestral home for some of humanity’s oldest diseases, including leprosy and cholera. Today, these and other neglected tropical diseases are closely associated with extreme poverty. Their control is clearly a poverty-reduction strategy. The tremendous progress in controlling these diseases is another sign of your commitment to tackle the diseases of poverty, even when the people affected are largely hidden in remote areas and have little political voice. As just one example, nine countries in this Region have reached the target for elimination of leprosy as a public health problem. Apart from being the ancestral home of some ancient diseases, this Region is also the birthplace for some newer and better things. I am referring here to microfinancing schemes that are helping to lift millions of people out of poverty. These schemes are now being used worldwide. They show, in particular, that income opportunities for women give them a chance to realize their potential as agents of change. As mounting evidence tells us: the benefits for the health of households and communities are immense.
As I have said, women are not just a vulnerable group, and not just a free source for health care. They are agents of change, and a tremendous resource for poverty reduction and sustainable development. Allow me to put some of these challenges and achievements in perspective. As I mentioned, all of us working in public health are engaged in common struggles on three fronts. First, we struggle against the constantly changing microbial world. We have some rare victories, when we eradicate or eliminate a disease. But for the most part, we struggle to hold these diseases at bay, to maintain the fragile detente between microbes and their human hosts. And the struggle is, indeed, constant. Research develops drugs. Microbes develop resistance. We triumphed over smallpox in 1979. Just a few years later, HIV/AIDS was on the scene. We failed to stop this new disease from spreading internationally and becoming endemic. We will pay the enormous price of this failure for decades to come. We stopped SARS dead in its tracks in July 2003. Five months later, human deaths from H5N1 avian influenza were confirmed. And we have lived under the looming threat of an influenza pandemic all the long years since.

We struggle on a second front: to change human behaviour. On the surface, it sounds so easy. Use a condom. Sleep under a bednet. Don’t smoke. Eat a healthy diet. Get plenty of exercise. And finish the course of TB pills. As we all know, behavioural change has tremendous preventive power, but it is one of the hardest tasks we face. Prospects for behavioural change improve in an overall environment that makes healthy choices the easy choices. National policies and legislation can provide critical support, especially when they shape activities in other sectors – like agriculture or environmental sanitation – with an impact on health.

This brings me to the third struggle. Public health is constantly fighting to gain attention and resources. Many of the mechanisms and infrastructures that safeguard public health on a daily basis go unnoticed until something dramatic goes wrong. The need to invest may come into view only when the food or water supply is contaminated, hospital beds are full, substandard or counterfeit drugs enter the market, or surveillance misses the start of an outbreak. Although the consequences of such failures are costly and disruptive, public health still struggles to persuade governments to invest in basic infrastructures and services – before something dramatic goes wrong. None of this is new, of course. Public health has struggled on these three fronts virtually since the beginning. But the struggles have become much more complex, sometimes ominously so.

Changes over just the past few decades have reshaped the landscape of public health, introducing a host of new challenges. First, that fragile detente
with the microbial world is increasingly tense. Changes in the way humanity inhabits the planet have disrupted the natural equilibrium of the microbial world. Population growth, urbanization, intensive farming practices, the misuse of antibiotics, environmental degradation, and incursion into previously uninhabited areas have exerted enormous pressure on pathogens. As a result, new diseases are emerging at an historically unprecedented rate. Old diseases are resurging, or spreading to new areas. Resistance to mainstream antimicrobials is occurring at a rate that outpaces the development of replacement drugs.

Simultaneously, emerging and epidemic-prone diseases have become a much larger menace under the unique conditions of the 21st century. The international spread of disease, and the disruption it causes, have been greatly amplified in our highly mobile, interdependent, and interconnected world. As just one obvious example, the World Bank estimates of global economic loses during the first year of an influenza pandemic have ranged from US$ 800 billion to more than US$ 2 trillion, depending on the virulence of the virus. After almost four years of intensive control efforts, the H5N1 avian influenza virus remains stubbornly present in birds in large parts of the world, including some countries in this Region. We do not know whether this virus will cause the next pandemic or not. But influenza pandemics are recurring events, and we are long overdue. We dare not let down our guard. The struggle to promote healthy behaviours has also become more complex. The forces of globalization have democratized several lifestyle factors. The food and beverage supply is globalized. Advertising and marketing, also for tobacco products, have a global reach.

Confronted by these trends, developing countries are losing two of their most important natural assets: healthy traditional diets, and healthy lifestyles. In this part of the world, lifestyle changes join demographic trends to cause a dramatic rise in chronic diseases. This new burden comes at a time when most countries are still struggling to bring infectious diseases under control. Health systems can often manage the intermittent emergencies caused by infectious diseases. The patient either survives or dies. Health systems have a much more difficult time managing chronic conditions. For households, the costs of chronic care can be catastrophic. Faced with this trend, the best strategy for public health is population-wide prevention. Fortunately, chronic diseases are largely caused by a small number of shared risk factors: improper diet, inadequate physical activity, tobacco use, and excessive alcohol consumption. We return, again, to that difficult struggle to change human behaviour.

On the third front – the struggle for attention and resources – the situation looks far more optimistic, especially at the international level. In just the past
decade, health has received unprecedented support from a growing number of partnerships, implementing agencies, foundations, and funding mechanisms. Although there will always be unmet needs, health has never before received such attention, or enjoyed such wealth.

The Millennium Declaration and its Goals represent the most ambitious commitment ever made by the international community. They tackle one of the biggest problems facing health development in this Region: poverty. The goals recognize that poverty has multiple, interacting causes, and they tackle these causes at their roots. They champion the role of health as a key driver of socioeconomic progress. The health sector has been arguing for this kind of recognition and intersectoral action since the Declaration of Alma Ata, almost 30 years ago. Like the Health for All movement, the Millennium Development Goals are all about social justice and fairness. People should not be denied the opportunity to realize their human potential for unfair reasons, including those with economic or social causes. Again, we see the importance of this Region’s commitment to poverty reduction, social justice, and universal access to essential care.

Returning to the situation in South-East Asia, I want to draw your attention to what I believe are three major concerns. The first is financial protection for the poor. Out-of-pocket expenditure is the main financing mechanism in most countries of this Region. This Region has some of the highest levels of out-of-pocket spending in the world. The concern is obvious. If we want better health to work as a poverty reduction strategy, we cannot let the costs of health care drive impoverished households even deeper into poverty. I know the need for more equitable health financing is fully recognized in your national health strategies. This need is also increasingly recognized by the international aid community. A country’s decision to abolish user fees, in the interest of equitable access, needs to be matched by a guarantee of long-term, predictable compensatory funds.

A second concern pertains to unfinished business. I am referring here to polio eradication. The past 12 months have seen a revolution in the tools and tactics being used to finish the job of eradicating polio, once and for all, from South-East Asia. The global eradication effort is already reaping the benefits of your re-invigorated efforts. In Myanmar, the very rapid response to a new outbreak is saving hundreds of children from paralysis. In India, western Uttar Pradesh has been the most entrenched reservoir of polio in history. In this area, no child has been paralysed by Type 1 polio virus for more than six months. This progress has put us in the homestretch for polio eradication.
As a final area of concern, we are near the midpoint in the countdown to 2015, the year given so much significance by the Millennium Development Goals. Malaria is a major problem in this part of the world, but you have good control strategies, and many countries are on track to meet the target. South-East Asia has seen remarkable progress in improving detection and cure rates for tuberculosis. The recent emergence of extensively drug-resistant tuberculosis is of great concern, as it could render this disease, once again, virtually untreatable. Again, we must never let down our guard.

In many countries in this Region, the HIV/AIDS epidemic remains largely confined to groups with high-risk behaviours. It would be extremely unwise to assume that this situation will remain stable. The stakes are too high for such a gamble. Countries in South-East Asia must get the upper hand on this disease, before it gets out of hand. This Region has long been considered a potential powder keg for explosive spread, partly because of high population density, but also because of the high prevalence of sexually transmitted diseases. Worldwide, we are still running far behind this deadly, devastating epidemic. For every person placed on antiretroviral therapy, another six people will become newly infected within a year. We must do a better job of prevention, and a better job of expanding access to treatment. Above all, we must do a better job in that age-old struggle to change human behaviours.

For this Region, indicators suggest that achieving the goals for maternal and child health will be a major challenge. Expanded childhood immunization, and implementation of the strategy for integrated management of childhood illness hold great promise for accelerated progress. But too many babies are still dying within their first few weeks of life. Globally, the numbers of maternal deaths have remained stubbornly high despite two decades of efforts. To address this problem, the need for better health systems and service delivery is absolute. We will not see a substantial reduction in maternal deaths until skilled birth attendants are present at more deliveries, and more women have access to emergency obstetric care. Improved access to sexual and reproductive health services is a vital preventive strategy.

As I conclude, let me return, briefly, to those three classic struggles. The conditions of this 21st century increasingly call for shared responsibility and global solidarity, especially when vulnerability to a threat is universal. In our collective struggle to hold the microbial world at bay, we now have the greatly strengthened International Health Regulations, which came into force in June of this year. The revised Regulations move away from the previous focus on
passive barriers at national borders, to a strategy of pro-active risk management. This strategy aims to detect an event early and stop it at source, before it has an opportunity to become an international threat. The strategy greatly strengthens our collective security, and raises the preventive power of these Regulations to new heights. We must never again allow a disease such as HIV/AIDS to slip through our surveillance and control networks. In our struggle to change human behaviour, we have the Framework Convention for Tobacco Control. This Convention has become one of the most widely embraced treaties in the history of the United Nations. This is preventive medicine, on a global scale, at its best.

Next year, the Commission on Social Determinants of Health will issue its report. This will be another powerful tool as we seek to address the complex social factors that influence health. In our struggle for attention and resources, we have the Millennium Development Goals. We have unprecedented momentum, political commitment, new partnerships, global initiatives, and funds from innovative sources. This, in turn, has increased the responsibility on the health sector to use these resources and enthusiasm wisely, and in ways that have a maximum impact on health outcomes.

While the challenges in this most densely populated Region are great, your leadership has the qualities that count the most: a commitment to fairness and social justice, and a determination to see that progress in health development reaches all segments of your vast populations.

I commend your courage, and wish you every success in this noble endeavour.

Thank you.
Annex 9

Report of the Joint Meeting of Health Secretaries of Countries of WHO SEA Region (HSM) and Consultative Committee for Programme Development and Management (CCPDM)*

Introduction

The Joint Meeting of Health Secretaries of Countries of the WHO SEA Region (HSM) and Consultative Committee for Programme Development and Management (CCPDM) was held at the WHO Regional Office for South-East Asia (SEARO), New Delhi, from 2 to 6 July 2007. Senior government representatives from Member States of the SEA Region participated in the meeting. The Agenda and List of Participants are attached as Annexures 1 and 2 respectively.

1. Inaugural session (Agenda 1)

Opening Remarks by the Regional Director

Welcoming the distinguished delegates, Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region, stated that the main purpose of this meeting is to thoroughly prepare for the forthcoming session of the Regional Committee and for the 25th Health Ministers’ Meeting.

A few issues worth considerations, Dr Samlee noted, were the Regional Health Emergency Fund (agenda 9), the expansion of membership of the SEAR on the Executive Board (agenda 10), the use of additional assessed contribution in 2008-2009 (Agenda 4.2) for the health emergency fund and other priorities. He wished the delegations success and active participation by all.

The full text of the Regional Director’s Opening Remarks is attached to the report as Annexure 3.

Nomination of Chairperson, Rapporteur and Drafting Group

Dr H.A.P. Kahandaliyange, Secretary, Ministry of Healthcare and Nutrition, Sri Lanka, was nominated as Chairperson, and Mr Ramchandra Man Singh,

*Originally issued as document SEA-PDM-10, August 2007
Secretary, Ministry of Health and Population, Nepal, was nominated as Co Chairperson.

Dr Gado Tshering, Secretary, Ministry of Health, Bhutan, was nominated as Rapporteur, while Mr A.P. Singh (India), Mr Abdurachman (Indonesia), Dr Ko Ko Naing (Myanmar), Dr Viroj Tangcharoensathien (Thailand), and Mr Basilio Martins Pinto (Timor-Leste) were nominated as members of the drafting group.

2. International Health Security (Agenda item 2)

Introduction

The Secretariat introduced the topic by emphasizing that International Health Security (IHS) was a broad subject focusing on two priority interventions: International Health Regulations 2005 (IHR 2005) and Emergency Preparedness and Response (EPR). The Region has several vulnerabilities, hazards and risks such as HIV-AIDS, SARS, Avian Influenza, effects of climate change and various emergencies. Multisectoral coordination and cooperation across borders is needed to address them. Two areas of intervention identified were: (1) action towards full enforcement of IHR 2005 and (2) action towards systematic Emergency Preparedness and Response through EPR benchmarks, standards and indicators.

The draft Thimphu Declaration was presented.

Discussion points

- There were detailed discussions of various health issues such as HIV/ AIDS, H5N1, chemical and radioactive hazards, man-made and natural disasters and the core capacity for implementing IHR (2005). This indicates a strong need for a common instrument to ensure international/ regional health security.

- Health security can be viewed beyond disease control, looking at financing healthcare in order to prevent catastrophic health expenditure that results in impoverishment. Proper financial protection of the poor and improved access to services would improve the health security of households at the micro-level.

- Problems of the capacities of Member States in implementing IHR (2005) and Emergency Preparedness and Response systems were highlighted. These require short- and long-term capacity building. This should cover not only public but also the private sectors.
• It was emphasized that the concept of International Health Security goes beyond country and regional borders. It was suggested that SEARO should look into working closely with Regional Offices of Eastern Mediterranean and Western Pacific.

• It was suggested that there must be follow-up with declarations, resolutions and suggestions, including Regional Strategy for International Health Security and/or short-term action plans for the IHS.

• It was explained that the EPR benchmarks, standards and indicators have already been established for all countries in the Region. The progress report of the assessment of the achievement of the 12 EPR benchmarks, as discussed in June 2006 in Bali, was presented and later shared with the participants. It was recommended that these results be widely circulated. Activities relating to these should also be included in the 2008-2009 workplans.

• An update on the status of regional stockpiling was discussed. The Regional Director apprised the group that the Regional Office is putting together procedures for a regional stockpile with a practical, well-monitored and inventoried system. It was emphasized that the stockpile should be one that is “living”—i.e. replenished and monitored regularly.

• The importance of International Health Security (IHS) was underscored and that cooperation among countries is essential to achieve International Health Security. Participants reviewed and gave useful opinions on the improvement of the draft Thimphu Declaration and recommended endorsement at the ministerial meeting. It was suggested that participation of the private sector be included in the Thimphu Declaration. A short-term Plan of Action should be prepared for endorsement in the Thimphu Declaration (Annexure 4).

**Recommendations**

**Action by Member States**

(1) Implement the short-term action plan in coordination with partners at country level and WHO as part of the commitment to the Thimphu Declaration and legal obligation to IHR 2005.

(2) In coordination with WHO, continue to work on strengthening core capacities for IHR and addressing benchmarks, standards and indicators for EPR.
Action by WHO-SEARO


(2) Provide continued technical support for building core capacities for IHR and achieving the benchmarks, standards and indicators for emergency preparedness and response

(3) Facilitate intercountry and interregional cooperation for issues relating to International Health Security.

3. Climate change and health (Agenda item 3)

Introduction

The Secretariat introduced the issue of the impact of climate changes on the health of the population. Ample evidence indicates a serious impact on health as a result of climate changes. For example, dengue haemorrhagic fever emerges in countries previously free from dengue and malaria flares up due to warm climate. Another major concern is the serious impact on agriculture production due to droughts and floods, affecting food security and finally nutritional status of the population. The emission of greenhouse gases (including \( CO_2 \) from the use of fossil, \( CH_4 \) and \( N_2O \)) results in greenhouse effect and global warming.

WHO focuses on responding to the consequences of climate change, as there are many other key players, such as UNEP, UNDP and intergovernmental panels focussing on its causes.

Discussion points

- Climate change will exacerbate existing vector-borne diseases, malnutrition and diarrhoeal diseases which are prevalent, to a variable extent, in all SEAR countries. Himalayan countries like Bhutan and Nepal face threats from melting of glaciers leading to flash floods and bursting glacier lakes, and later on from the drying of the rivers. Maldives and Bangladesh face a menace from rising sea levels.

- The health effects of climate change are already perceived in many Member countries. For example, Nepal and Bhutan are experiencing the spread of vector-borne diseases like malaria, Japanese encephalitis and dengue hemorrhagic fever at previously unreported higher altitudes.
• Action to mitigate climate change effects is required at the global, regional, national and individual levels. Climate change can lead to the spread of many vector-borne diseases from developing countries to developed countries. International regulations should be respected by all and effective national legislation and its enforcement are required. Governments should consider enforcing a ban on the use of equipment containing chlorofluorocarbon compounds. A suggestion was made to make climate change a World Health Day theme to focus global action.

• The concerned health sector should take a lead role in mitigation of effects of climate change which should include consideration of population densities and advocacy for better lifestyles and food habits that are in harmony with nature. It should also prepare multisectoral high-level disaster response teams and action plans for emergency preparedness and response.

• Advocacy and awareness should be increased among political leadership with involvement of other sectors and effective coordination among different population groups. Preserving the environment should be part of the school curriculum. Advocacy material and relevant documentation for sensitizing people on the public health effects of climate change should be shared with Member States.

• The concern for the preservation of natural environment as well as the prevention of environmental pollution by chemicals and industrial pollutants should be recognized. International regulations should be enforced to prevent transboundary movements of hazardous chemicals.

• Several countries in SEAR have already taken action. For example, the National Climate Change Committee was established in 1993 by the Royal Thai Government, the Inter-Ministerial Committee on Climate Change was established in Sri Lanka, the Prime Minister of India created the Council on Climate Change and Bhutan has prepared plans to carry out concrete actions in priority areas. All SEAR countries have preparedness and response plans for early warning systems based on forecasting information, which can be used to meet the challenges posed by climate change.

Recommendations

Action by Member States
(1) The Health sector should take the lead in putting forward health arguments for the mitigation of climate change in line with the policies of other sectors.

(2) The health sector should prepare for mitigation of anticipated effects of climate change on health, i.e. emergency preparedness for disasters and measures for prevention and control of vector-borne diseases, diarrhoeal diseases and malnutrition.

(3) The countries should monitor and document health effects from climate change.

Action by WHO-SEARO

(1) Support capacity enhancement of the health sector to take a leadership role in providing strong arguments on the health impact of climate change.

(2) Enhance global, regional and subregional collaboration for joint action for conducting research on the health effects of climate change and strengthen institutional capacity leading to evidence-based policy and action.

(3) Provide and share advocacy and educational material and documentation with Member countries for sensitizing political leaders, policy-makers and the community on the public health effects of climate change, particularly on vulnerable population groups.

(4) Observe Health and Climate Change as one of the future World Health Day themes to call for global and national action.

4. Matters relating to Programme Development and Management (Agenda item 4)

4.1 Review of WHO collaborative programmes implemented during 2006-2007 biennium (Agenda item 4.1)

Introduction

The secretariat introduced the outcome of 2006-2007 implementation as of 30 June 2007.

Of the total regular budget available in the biennium, US$ 44.2 million, US$ 23.25 million was disbursed, US$ 10.24 million was un-liquidated obligation. The obligation rate was 76% while 24% were uncommitted. The
spending rate varied from 61% to 93% across 11 Member States. Noted with concern was the intercountry, uncommitted rate of 53%.

The performance in terms of voluntary contribution is lower than the regular budget. The obligation rate was 73% for country operation, 56% for intercountry and 69% for the whole Region. That leaves 31% of funds uncommitted, especially the intercountry which has the highest rate of uncommitted funds at 44%.

**Discussion points**

- It was noted that in many cases, 2006-2007 quality of expenditure in terms of adherence to rules and procedures was in general good. However, it was pointed out that the changes in the financial rules call for activities to be implemented sooner rather than later so as to ensure full disbursement before the end of the biennium. Review missions would continue to focus on quality of expenditure, especially in the area of procurement.

- Issues associated with the implementation of multicountry activities (MCAs) were discussed. Applying lessons learned during 2006-2007 implementation and the principle of working together at country level as much as possible were stressed.

- The participants noted with concern the high proportion and magnitude of voluntary contributions, which are mostly earmarked, leaving less than 2% unspecified. Efforts are underway to improve the situation by increasing the unspecified proportion, but the Regional Office has less say than WHO Headquarters. Implementation of the uncommitted funds should be accelerated so that the surrendered amount in 2006-2007 would be minimized.

**Recommendations to Member States and Regional Office**

(1) The Regional Office and Member States will continue the efforts to ensure the quality of delivery and accelerate the implementation of the programme budget 2006-2007.

(2) To improve the performance of MCAs to ensure that they are driven from the country level, new initiatives should be taken by the countries to develop and implement these activities. The Regional Office would not control MCAs but rather facilitate and support them as and when requested.
(3) To establish a regional working group to address the issues of the high proportion of voluntary contributions.

4.2 Review of the detailed workplans for Programme Budget 2008-2009 (Agenda item 4.2)

Introduction

The secretariat introduced the PB2008-2009, with close participation through the application of Country Cooperation Strategies and the Country Days. The total budget increase in 2008-2009 compared to 2006-2007 was 37.6% (regular budget increase by 4.6%, and voluntary contribution increase by 50.2%). The total resources available in 2008-2009 would be US$ 491.5 million, distributed into 13 Strategic Objectives. The ongoing work plan would be finalized based on comments provided by the joint meeting.

Discussion points

- With 78.9% of the PB 2008-2009 budget funded from Voluntary Contributions (VCs), this presents the Region with several growing issues. First, there is a danger that donors are determining the priorities of WHO work in countries by funding projects in line with their own priorities. Second, although the Region has been successful in mobilizing funds for VCs, there is an imbalance between countries and programme areas. Some countries are not receiving adequate VC funding, whereas other countries have exceeded their planned work. In the same way, donors have funded certain programme areas (especially polio, HIV/AIDS, tuberculosis and avian influenza) but have not supported funding for maternal and child health, International Health Regulations (2005), health systems and noncommunicable diseases. In order to ensure that the work of WHO is in line with country needs and priorities, more proactive resource mobilization is needed. Countries should develop workplans representing their needs and priorities and more should be done to mobilize donor funds to support this work. The use of unspecified VC funds (core voluntary contributions or CVCs) potentially could help fund those programmes not usually supported by donors, but there were still concerns about the mobilization and distribution of CVC funds.

- The recently approved budget reflects the changing priorities of WHO’s work in the Region. There were large increases in Strategic Objectives (SOs) for maternal and child health (SO4), nutrition and food safety
(SO9), health and environment (SO8) and health systems (SO10). Although there was support for these new priorities, some members questioned the absorptive capacities of these funds and the absorptive capacity to implement these large increases. There was strong support for the priority of increasing WHO work in maternal and child health (SO4) and nutrition and food safety (SO9) because these are closely related to the achievement of the Millennium Development Goals (MDGs). Some members felt that WHO should strengthen its technical support to countries and develop capacity as quickly as possible.

- The total for draft workplans as of June 2007 in both the Regional Office and countries exceeds the budget by US$ 42.7 million. In addition, there was an imbalance between SOs, with workplans in some SOs (SO1 and SO2) above the budget and other SOs (SO4, SO9 and SO10) well below the budgets. In finalizing the workplans, more must be done to align workplans with the approved budget.

- Multicountry Activities (MCAs) were first introduced in 2006-2007; lessons learnt should be applied to improve the performance of MCAs in PB 2008-2009.

- The increase in Assessed Contributions (AC) funds for the Region was a positive development. There was a consensus that these funds should be used to support the SEA Regional Health Emergency Fund, although there was no agreement on the amount to allocate to this fund. Some felt that $1 million should be allocated for the fund, while others wanted a greater amount, possibly the entire increase of $4.687 million. However, there was a request that any remaining balance in the fund be carried over to the subsequent biennium. At present, WHO financial rules do not allow AC funds to be carried over. More clarification on the regulations was being sought from Headquarters so that action could be taken to allow the funds to be carried over.

- The balance not used by the Regional Health Emergency Fund should be divided into 75% to countries and 25% to the Regional Office for intercountry work. Countries express the desire to use the additional funds in line with their own needs through application of Country Cooperation Strategies. There was also a suggestion that the 75% be (a) divided pro rata among the countries, based on 2006-2007 AC funding levels; or (b) divided in favour of countries with greatest need.
Recommendations to Member States and Regional Office

(1) Countries and the Regional Office must increase attention to the role of Voluntary Contributions in determining the work of WHO in the Region to ensure that VC funding received is in line with the needs and priorities of countries.

(2) The Regional and Country Offices should continue their efforts to ensure that the workplans are aligned with the approved budgets for each Strategic Objective.

(3) The Regional Office should provide more detailed information about the implementation of Multicountry Activities and propose steps to strengthen MCAs in the next biennium.

(4) Two options are proposed for the use of additional Assessed Contributions for PB 2008-2009 to the Region:

   (i) The entire increase of $4.687 million would be allocated to the SEAR Health Emergency Fund, on the condition that any balance can be carried over to the subsequent biennium; or

   (ii) $1 million would be allocated to the SEAR Health Emergency Fund on the condition that any balance can be carried over to the subsequent biennium and the remainder of the AC increase would be allocated 25% to the Regional Office and 75% to countries. This 75% will be allocated to countries based on: (a) pro rata distribution to Member countries based on 2006-2007 AC funding levels; (b) in favour of countries with greatest need; or (c) equally distributed to all Member countries. The country allocation would observe the country priorities in-line with Country Cooperation Strategies.

A Working Group of Member Countries would be convened prior to the 60th Session of the Regional Committee to provide recommendations regarding (4).

5. Technical Discussions: Selection of a subject for the technical discussions to be held prior to the Sixty-first Session of the Regional Committee (Agenda item 5)

Introduction

The secretariat put forward six topics for discussion:

(1) Education and ethics in rational use of medicine
(2) Injury prevention and safety promotion
(3) Tobacco control: meeting the obligations of WHO FCTC
(4) Intersectoral collaboration for control of zoonotic diseases
(5) Health effects of climate changes
(6) Revitalizing routine immunization and addition of new vaccines to national immunization programmes in the SEA Region

**Discussion points**

- The delegation from Bhutan proposed the topic of revitalizing routine immunization and insertion of new vaccines into the immunization portfolio. This is because of the important role of expanded programme of immunization (EPI) in averting vaccine-preventable diseases and in the light of new vaccines being introduced in the market, which require prudent decisions. The proposed topic was supported by two Member States.

- The delegate from DPR Korea asked if the joint meeting could discuss topics outside the six items proposed by the secretariat. The Secretariat responded positively.

- The delegation from Myanmar proposed to revisit Primary Health Care (PHC) in the light of the 30-year celebration of the Alma Ata Declaration (1978) and 60-year anniversary of WHO in 2008. In addition, in 2008, the World Health Report would be on PHC. The proposal was supported by eight other Member States in the Region.

- Discussions continued on justifying the proposed topic on PHC for the 61st Regional Committee. PHC is one of the most concerning issues for countries in this Region in the context of realizing the Millennium Development Goals (MDGs). Elements considered in the PHC approaches like health education, nutrition, maternal and child health and water and sanitation should be given more emphasis. The importance of tertiary care was acknowledged but it was mentioned that more stress should be given to primary health care. In addition, there are several global initiatives supporting PHC through strengthened health systems supported by GAVI, the Global Fund and the 10-year policy of the World Bank’s Health, Population and Nutrition Division. PHC, based on the concepts of equity, universality, community participation and intersectoral partnership, is one of the main instruments in achieving MDGs, especially through MCH programmes,
health promotion and control of communicable and chronic noncommunicable diseases. PHC also plays a vital role in improving EPI coverage. PHC is in line with WHO programme activities to revisit and revise the role of PHC.

**Recommendations to the Regional Committee**

1. The meeting reached an agreement on the topic of “Revitalizing PHC”, to be discussed prior to 61st RC in 2008. In addition, a common protocol would be developed in order to compile country experiences on what has been achieved, what is the current situation and current and future challenges in the context of changing demographics and health needs. Country experiences would be compiled and the way forward for countries and the Region would be provided for the technical discussion, in order to endorse an evidence-based PHC movement in the future.

2. The joint meeting recommends the 60th RC endorse the topic on PHC as a subject for technical discussion to be held prior to 61st Session for RC.

6. Scaling up Prevention and control of chronic noncommunicable diseases in the SEA Region *(Agenda item 6)*

**Introduction**

Noncommunicable diseases (NCDs) are assuming alarming proportions in the South-East Asia Region. Almost half of the 89 million NCD-related deaths projected in the Region during the next 10 years will occur prematurely. Evidence shows that important reduction in NCDs can be achieved by the introduction of simple public health interventions.

The WHO Regional Framework for Prevention and Control of NCDs, formulated in early 2006, is intended to facilitate further development, updating and strengthening of national policies, plans and programmes for integrated prevention and control of NCDs.

Building on the momentum generated by the national networks, the South-East Asia Network for NCD Prevention ad Control (SEANET-NCD) was initiated in order to facilitate information sharing, capacity building, advocacy, policy development and research.

The scope of the NCD problem, including the recent evidence on the risk factors for NCDs generated through surveys using the WHO-promoted STEPS
approach as well as information on the capacity for prevention and control of NCDs compiled by the regional survey, were presented. Priorities for future action have been proposed.

**Discussion points**

- The delegates appreciated the working paper and information documents prepared by the Secretariat and endorsed the Regional Framework for Prevention and Control of NCDs.
- All Member countries of SEA Region are experiencing the growing burden of NCDs. They are committed to further strengthening national capacity to address NCDs.
- Many Member countries have/or are in the process of developing national policies, plans and programmes for prevention and control of NCDs. Important progress has been achieved in this regard in several countries. There is a need to strengthen human resources, and infrastructure and establish appropriate funding mechanisms, such as earmarking taxes from health-hazardous products (for example tobacco and alcohol).
- The integrated approach to prevention and control of NCDs is an important guiding principle. The integration should focus on identifying and managing common risk factors for NCDs such as tobacco and alcohol consumption, unhealthy diet, physical inactivity, stress, etc. at all levels (population, family, individual).
- Legislation and regulation are important intervention tools in prevention and control of NCDs.
- There is a need to strengthen surveillance systems as well as capacity for prevention and control of NCDs, in particular at Primary Health Care level.
- The delegates commended the efforts to establish the SEANET-NCD. Bhutan and Nepal will further review and provide additional comments, through respective WHO Country Offices, on the Information Document 3 related to establishing the network.

**Recommendations**

**Action by Member States**

(1) To setup mechanisms promoting multilateral, multisectoral, multidisciplinary and multilevel collaboration in applying evidence-
based and cost-effective interventions for prevention and control of NCDs by Member States.

(2) To ensure that the integration of NCD programmes should correspond to the stage of epidemiological transition, existing health infrastructure and the health needs of their population.

Action by WHO-SEARO

(1) The Regional Office should submit to the RC 60 the draft resolution on Regional Framework for Prevention and Control of Noncommunicable Diseases, identifying priorities for its implementation.

(2) The Regional Office is to support establishment of the Regional NCD Network (SEANET-NCD).

7. Tuberculosis control: Progress and plans for implementing the new Stop TB Strategy (Agenda item 7)

Introduction

The Secretariat reported that new regional estimates indicate that TB prevalence decreased by 30% and mortality declined 22% since 1990. Case detection reached 64% and targets relating to successful treatments have been achieved in the Region since 2003. However, given the close link of TB with poverty and new health challenges such as HIV and drug resistance, new interventions are needed. Key challenges and uncertainties are financial and operational resources, limited technical and management capacity and weak laboratory networks and surveillance mechanisms. All countries require adequate technical and managerial capacity, quality-assured laboratory networks, intersectoral partnerships and social mobilization approaches. The new Stop TB Strategy and Regional Strategy (2006-2015) focus on sustaining and enhancing directly observed treatment, short-course (DOTS), establishing interventions to address TB/HIV and MDR-TB, forging partnerships and strengthening health systems. Effective implementation of TB control in the Region requires adequate financial support from national budgets and from international donor partners.

Discussion points

- TB control is making good progress in all countries as highlighted by the presentation. However, to reflect the progress appropriately, up-to-date and accurate data, particularly at the national and sub-national
levels, are very important for planning and monitoring to improve programme implementation.

- TB still poses a major problem in the South-East Asia Region: 34% of the global burden is in our Region. Introduction of DOTS has been instrumental in terms of progressing towards global targets of 70% case detection and 85% cure rate. Some members expressed concern over the 15% who are not cured. Implementing DOTS–PLUS should be decided with care. It can be introduced in certain conditions where the TB programme is strong but must ensure that resources are not diverted from routine TB programmes. To sustain the achievements so far and make further progress strengthening health systems is crucial. There is a very close link between TB control activities and the existence of good laboratory services, procurement systems, health infrastructure and human resources.

- TB control in the Region has been fortunate to have the management structures put in place. However, the management is complex, given the involvement of many partners and issues. Therefore, there is a need to strengthen management capacity through training.

- Private sector involvement is very important in TB control. There are very good examples of private-public partnerships and community involvement. Such partnerships should be strengthened and expanded in all our member countries. TB prevention and detection must be in the curriculum of all relevant institutes and the standard treatment guidelines followed by all involved. Ensuring quality of DOTS implementation, in particular adherence to standard treatment, is also very important in preventing MDR and XDR-TB.

- The HIV epidemic is having a great impact on TB control. Though HIV-TB collaboration has been initiated, progress is slow. There is an urgent need to strengthen the collaboration between HIV and TB programmes.

- The Region is concerned about the growing threat of rising MDR and XDR. Though MDR-TB prevalence is still low, in terms of actual numbers they are considerable given the TB prevalence base. Initiatives in building the laboratory capacity are appreciated. XDR-TB is also an international health security issue. Cases have been reported in some member countries such as Thailand and there is an urgent need for WHO to convene a working group to discuss issues and recommend how to monitor and contain XDR-TB.
• The Global Drug Facility is playing a crucial role and support has been provided to nine countries in the Region. The continuation of the Global Drug Facility is particularly important in Myanmar and DPRK, where Global Fund grants are not available. WHO is requested to facilitate the continuation of the arrangements in these two countries. Countries may also include management of MDR-TB in the proposals to be sent to the Global Fund.

• Sustainability of TB control programmes and their financing are big issues. There is a need to allocate additional resources (both domestic as well as external) to achieve the global target of case detection and cure rate.

**Recommendations**

**Action by Member States**

(1) To fully implement National TB programmes in line with Regional Strategic Plan 2006-2015 in order to achieve the goal of halving TB prevalence and mortality by 2010 and reaching the MDGs by 2015.

(2) Build adequate human resources and infrastructure to deliver effective TB services, including laboratory services under primary health care systems, and take into account the pivotal role of private sector in service provision.

(3) Collect, analyze and use data at the sub-national level for planning and implementing appropriate interventions.

(4) Carry out operations research in order to devise appropriate strategies and effective intervention and to improve programme effectiveness.

(5) Mobilize additional resources, both domestic as well as external, to sustain the achievements and to expand services such as HIV-TB and DOTS Plus, to ensure no diversion of financial resources from the routine to new services.

**Action by WHO-SEARO**

(1) To mobilize additional resources required for implementing and strengthening TB programmes in the Region.

(2) To facilitate continued support of the Global Drug Facility to countries, particularly to DPR Korea and Myanmar where Global Fund support is not available.
(3) To convene a working group to urgently assess the XDR-TB situation in order to recommend mechanisms to monitor and contain it.

8. Revised strategy for malaria control: Focusing on a new paradigm (Agenda item 8)

Introduction

The Secretariat presented the malaria situation and problems in the Region and rationale for the Revised Malaria Control Strategies (RMCS). The process of developing the revised strategy and progress made were summarized. The current global malaria context and resolutions of 60th WHA pertaining to malaria were presented.

Discussion points

- Member States fully supported the Revised Strategy and thanked WHO for developing the revised strategy through a participatory process with strong involvement of Malaria Programme Managers, partners and donor agencies.

- It was noticed that the goal set in the Revised Strategy is ambitious (50% reduction of mortality and morbidity in 10 years). However, the regional trend shows 30% reduction in mortality and less than 10% reduction in morbidity over the past five to six years. Therefore, this goal is not unrealistic given the fact that it is expected that there will be greater impact on mortality than on morbidity because countries are moving towards more effective therapies such as artemisinin-based combination therapy (ACT). At the same time, current coverage of preventive activities such as impregnated bed nets and indoor residual spraying coverage is low.

- There is no appreciable decline in morbidity, highlighting the need for scaling up prevention.

- Member States agreed with the new WHO policy on banning artemisinin monotherapy and raised concerns about the unaffordable cost of ACT and unavailability of paediatric formulations of ACT. Rational use of drugs needs to be established for malaria and other diseases, especially in the private sector.

- Malaria is a problem at several international borders and this issue was not clearly articulated in the RMCS. Member States cannot solve this problem without collaboration of neighbouring countries and
effective coordination of WHO. Multicountry Activities should be applied for the control of border malaria control.

- Inadequate human and financial resources for malaria control were discussed, and health sector capacity building in particular, to address inadequate human resource in many countries.

- Operations research is very important for malaria control. It is one of the activities proposed as a key element of the Revised Strategy. Some areas (such as vector bionomics) which are related to ecological changes require operations research.

- The Secretariat clarified that DDT has never been banned by WHO for malaria control as it is effective for indoor residual spraying in some countries where prevention of environmental contamination is in place.

- It is fully agreed that surveillance systems and programme management need strengthening. As malaria epidemiology varies, a stratification approach for malaria control is crucial.

- It was agreed that behavioural change communication is crucial for scaling up prevention and treatment interventions.

**Recommendations**

**Action by Member States**

1. To develop and implement national malaria control programmes in line with Revised Regional Strategy for Malaria Control, taking into account the private sector role and substantial financial resources from the Global Fund grant emphasizing the improvement of health system capacity, including human resources.

2. To control cross-border malaria with the application of Multi Country Activities (MCA).

3. To continue to strengthen surveillance and assess the burden of disease in the countries.

4. To mobilize other sectors to implement malaria control as a part of healthy public policies.

5. To articulate and advocate malaria control in the national and international fora.

6. To consider observing 25th April as National Malaria Day to advocate malaria control in the country.
Action by WHO-SEARO

(1) To provide technical support and facilitate the mobilization of financial resources to strengthen malaria control programmes in the Region.

(2) To include operations research as one of the priorities under the Revised Strategy, and to support Member Countries to conduct and use research for programme purposes.

(3) To share useful information and country experiences with Member States.

9. South-East Asia Regional Health Emergency Fund (Agenda item 9)

Introduction

The Secretariat provided an overview of the SEARHEF, explaining that it was requested by Member States through various meetings including the 24th Health Ministers Meeting in Dhaka on 20-21 August 2006. SEARO held several regional consultations and established the SEARHEF Working Group composed of representatives from Member States. The paper presented here was reviewed by the SEARHEF Working Group at a meeting held in Bangkok, 11-12 June 2007.

The paper clarifies that the purpose of the Fund is to respond to needs of Member States during the first three months of an emergency. The principles of the Fund were then described as follows: equitable use, adequacy and replenishment, transparency and accountability, promptness and ability to mobilize resources. The SEARHEF Working Group would provide oversight and guidance to the management of the Fund. The SEARO EHA unit will act as secretariat to the Working Group and WHO Representatives will process funding requests through existing WHO channels.

Discussion points

- All the countries who participated in the discussions welcomed the initiative taken by WHO to set up the South-East Asia Regional Health Emergency Fund (SEARHEF).

- Numerical criteria were not applied due to variability of factors, e.g. size of population, vulnerability, etc. The criteria proposed in the paper were accepted by the participants. However, it was felt that this can
be further refined and fine-tuned during the course of management and implementation of the funds.

- For optimal management of the Fund, effective coordination with Member countries through the Working Group would be required. It was agreed that all 11 Member countries will have a representative in the SEARHEF Working Group.

- In view of its emergency nature, it was agreed that the turn-around time from request to release of a first installment should be done not later than 24 hours.

- Considering the magnitude of needs during an emergency, it was pointed out that the current suggested corpus will not be sufficient. It was suggested that advocacy should be undertaken for resource mobilization with donors and Member countries to voluntarily contribute to the SEARHEF.

- The Secretariat was requested to revisit the current estimates of funding and review ceilings of allocations/requests accordingly.

- Participants pointed out that the establishment of SEARHEF should be integral part of the proposed Thimphu Declaration.

- The Secretariat clarified that it is committed to mobilizing VC resources systematically, as stated in the paper. The SEARHEF has been identified as a key activity for implementing Health Emergency (SO5) for the Region and an important programme component identified for priority funding.

- It was also suggested by DRD that unspecified voluntary contributions received may also be used as part of SEARHEF.

- Regarding the concern expressed on the carry forward of the AC portion of the Fund, DAF apprised the group that communications with HQ are ongoing regarding this issue.

- It is agreed that AC components will be utilized first and then the VC part of the Fund can be used.

- While efforts to explore exemption for carry-over of AC is being done, the Fund will be managed according to WHO Financial Rules.

- It was explained why the first installment was limited to US$ 40,000. As needs assessments are conducted in the course of an emergency,
the second request with a ceiling of US$ 160,000 can then be made. Some members expressed the view that the total of US$ 200,000 was too low and proposed US$ 350,000, with the initial release of 50% in view of immediate response to emergency.

- It was reiterated by many of the participants that these guidelines are not cast in stone. They should remain flexible and should be regularly reviewed and revised as necessary during the course of implementation of the Fund.

**Recommendations**

**Action by Member States**

1. To support the development of the South-East Asia Regional Health Emergency Fund (SEARHEF), and consider contributing on a voluntary basis to the Fund.
2. To actively participate in the Fund management through the SEARHEF Working Group.

**Action by WHO-SEARO**

1. To consider raising the total amount of support up to US$ 350,000 and the initial release would be up to 50% in view of adequacy of response.
2. To revise the guidelines, principle and policy as discussed in the Joint Meeting.
3. To actively advocate and mobilize resources for SEARHEF, and take the opportunity of the Thimphu Declaration to mobilize VC by Member States in SEAR.
4. To include the establishment of SEARHEF as one of the main components in the proposed Thimphu Declaration.

**10. Expansion of membership of the South-East Asia Region on the Executive Board** *(Agenda item 10)*

**Introduction**

This issue, expansion of membership of the Southeast Asia Region on the Executive Board, was originally raised at RC59 in Dhaka last year to analyse various options and approaches.
As a response, SEARO contracted Mr Tom Topping, former WHO Legal Counsel, to perform an independent review of the subject. The result of his work is presented in document SEA/HSM-CCPDM/10-infdoc. This paper formed the background for discussion of this issue at the High Level Consultation with SEAR Member States on WHO Programme Development and Management in May 2007.

During that meeting (which 11 current participants attended), the legal, procedural and political considerations related to a possible expansion of regional representation on the EB were discussed. There was agreement that with its high disease burden and large population base, the South-East Asia Region should strive to have a larger number of seats on the Executive Board.

And even though it was understood from the presentation by LEGAL/HQ during the meeting that an attempt to change the composition of the EB would be politically sensitive, require strong lobbying of Member States outside the Region and could take many years, the High Level Committee recommended that SEARO constitute a group of experts from both Member States and WHO to agree on a formula that most clearly represents their position and to report to RC60 on the progress.

In order to fulfill the action recommended by the High Level Consultation, a Regional Expert Group Meeting on this subject is being organized from 13 to 14 August in Bangkok. Preparatory work is currently under way and is being led by Dr. Anton Fric, SEARO Regional Advisor for Evidence and Health Information, under the technical direction of DPM.

The objectives of the expert group meeting are 1) to present, review and elaborate options and scenarios on health metrics related to regional membership in the WHO Executive Board and 2) to recommend the most appropriate approach and method to use in support of the proposal to increase the membership from SEAR countries in the WHO Executive Board.

The meeting will include experts from the regional office and Member States. The recommendations emanating from this meeting will be presented to RC60 in Thimphu, Bhutan for consideration. The RC will then have an opportunity to discuss how it wants to proceed on the issue.

This short introduction is provided as an update on where we are in the process. Specific outcomes from the expert group will be presented at the upcoming Regional Committee.
Discussion points

- SEAR should lobby and negotiate with other regions on the increase of EB membership. Some of the members expressed that the criteria of population, burden of disease and contribution to the Assessed Contribution must be emphasized.

- Some of the members suggested that an increase in SEARO EB membership could be accompanied by equal increases in AFRO and EMRO.

- The members proposed that the results of the upcoming expert group meeting be presented to the 60th Regional Committee.

Recommendations

Action by WHO-SEARO

1. The expert group should provide input to the 60th RC using the most favourable criteria/formulation of factors including population, disease burden and assessed contribution.

11. Progress reports requested by Member States

(Agenda item 11)

11.1 Avian and pandemic influenza preparedness in the context of International Health Regulations (2005) (Agenda item 11.1)

Introduction

Avian influenza (AI) H5N1 has expanded its outbreaks in 5 out of 11 Member countries in South-East Asia Region. The National Influenza Pandemic Preparedness Plan (NIPPP) existing in all countries requires capacity building. With the IHR 2005 entered into force on 15 June 2007, it provided a good opportunity for countries to strengthen the surveillance system as well as response to the threat. In SEAR, progress has been made in two strategic areas: (1) Multisectoral pandemic preparedness to mobilize political commitment and engage partners and stakeholders; and (2) Following the Health and Agriculture Ministers meeting, the Delhi Declaration has served as framework for AI prevention and control. A task force was established to follow up progress made as a result of recommendations.
**Discussion points**

- Most of the Member countries shared information regarding their preparedness through adoption and implementation of the NIPPP. Assessment of the plan brought out the need for better coordination at the national level and expanding the number of Rapid Response Teams for enhanced mobility and response. Risk communication and networking of experts in the Region would help better facilitate and coordinate outbreak response.

- A matrix has been developed to identify gaps in core capacities in each country and efforts required for strengthening them. Laboratory capacity, in particular, will be strengthened with the establishment of two reference laboratories in the Region by the end of 2007. In this regard, a mission was fielded by SEARO in April 2007 to assess the laboratory capacity in Indonesia, namely the National Institute of Health Research and Development (NIHRD) and Eijkman laboratory, which resulted in acceptance by WHO of national laboratory results as confirmation of Human Avian Influenza diagnosis. A similar assessment mission is planned in September 2007 in the National Institute of Virology in Pune, India.

- WHO has been involved in short- and long-term measures to build capacity. The short-term efforts include protection from transmission of AI to humans through risk communication, prevention of transmission by employing other public health interventions and reduction of mortality through better case management. Long-term measures for eliminating the virus from animals as well as humans include use of vaccines.

- Both the SEARO CSR subunits, at Bangkok and Delhi, have become fully operational. Together with the SEARO Communicable Disease, Surveillance and Response (CSR) unit, they have been assisting Member countries in surveillance and outbreak response.

- Field epidemiology training has been ongoing in the Region for over two decades, focused on increasing the number of trained epidemiologists. A three-month intercountry short-term course is being developed by the Regional Office in collaboration with existing Field Epidemiology Training Programs (FETPs). The first training course will start in the National Institute of Communicable Disease (NICD), Delhi in September 2007; this will be followed by country level FETPs.
Recommendations

Action by Member States

(1) To strengthen veterinary public health as a part of an integrated multi-sectoral pandemic preparedness plan. The human health sector should take an active role to prevent infection from poultry to human beings, and minimise case fatality.

(2) To apply non-pharmaceutical interventions such as risk communication and social distancing in addition to the use of vaccines and antiviral drugs during human pandemic phase.

(3) To develop guidelines on the major components of NIPPP and conduct training in order to build up capacity in the implementation of NIPPP.

(4) To develop / strengthen the core capacities as required by International Health Regulations (IHR) 2005 and the implementation of NIPPP, to cover capacities in both public and private sectors.

(5) To foster public and private partnership in concerted effort in the implementation of NIPPP, including resource mobilization.

Action by WHO-SEARO

(1) To continue to support Member States in the region in the implementation of NIPPP, capacity building and strengthening of the National Regulatory Authority (NRA) and to ensure that influenza vaccination is part of the NIPPP.

(2) To operate the CSR unit in SEARO and two CSR subunits in Delhi and Bangkok, including resource mobilization and stockpiling of antiviral, personal protection equipment and pre-pandemic vaccines if available in future.

(3) To report the progress on the implementation of a Avian and Pandemic Influenza preparedness plan in the context of IHR 2005 in the 61st to 65th sessions of the Regional Committee.

11.2 Public health, innovation and intellectual property rights: An update (Agenda item 11.2)

Introduction

Resolution WHA 59.25 of May 2006 established an intergovernmental working group (IGWG) on public health, innovation and intellectual property rights.
The IGWG seeks to address the fact that insufficient research and development (R&D) is taking place for diseases that disproportionately affect the poor. The SEA region has actively been involved in and contributed to the process through regional consultations, participation in the first IGWG as well as national and regional submissions. The contributions and proposals from the SEA Region focus on three broad themes:

- IPR should be managed in a way that protects access to medicines;
- alternative mechanisms for promoting innovation should be discussed and explored;
- capacity building for R&D and technology transfer are to be encouraged.

All these are included in the elements of the draft plan of action, which however has not yet been agreed. Moreover, while within the Region there is considerable agreement on these matters, globally views are diverging, including among developing countries. This may pose challenges in the upcoming negotiations to finalize the global strategy and plan of action.

Meanwhile, resolution WHA 60.30, adopted in May 2007, calls on Member States to actively participate in the IGWG process, and on WHO to support the process, among other things via regional consultations. A key feature that distinguishes this resolution from prior resolutions on the same topic is that there is an explicit request for WHO to support Member States, upon request, in making use of the “TRIPS flexibilities” in the operative paragraph of the resolution.

**Discussion points**

- SEA countries reaffirmed that they want WHO to take a lead role with regard to access to medicines, and that this should include the relationship between intellectual property rights and access to medicines.
- There is a need to further strengthen countries’ capacity to understand and manage intellectual property rights and the implications for public health. This could be done via case studies and a training course.
- Countries noted with satisfaction that a third regional consultation is envisaged, in order to prepare for the second IGWG meeting. The forum discussed that the possible dates for the meeting could be in
October or November 2007, before the second IGWG meeting to be held in Geneva.

- Countries in the Region are keen to see the “zero draft” negotiating text for the second IGWG that is currently being prepared by the IGWG Secretariat as soon as possible.
- Reference was made to the high cost of medical/pharmaceutical R&D. It was pointed out that, while R&D is indeed expensive, some of the figures that are circulating appear to be exaggerated. Moreover, the public sector is also contributing significantly, especially to basic research.

**Recommendations**

**Action by Member States**

- To strengthen policy and multi-sectoral administrative arrangements to deal with public health, innovation and IPRs so as optimally to benefit from the capacity building initiatives of WHO and other expert bodies.
- To actively participate in the third regional consultation on IGWG and the second meeting of IGWG.

**Action by WHO-SEARO**

1. To support/facilitate Member States to participate in the third regional consultation and the second IGWG meeting.
2. To draw experience and lessons from the implementation of compulsory licensing as a case study from the region.
3. To prepare an action plan to strengthen capacity in the management of intellectual property rights (IPR) in the context of public health/access to medicines in the Region. This regional plan can be harmonized with the action matrix generated from IGWG to be endorsed by WHA 2008.
4. To develop in-depth training programmes, including a training program of two to three months to build capacity on intellectual property rights and public health/access to medicines for both health officials and representatives from relevant sectors.
11.3 WHO and reform of the UN system: Impact at country level

(Agenda item 11.3)

Introduction

Since the early days of its formation, the United Nations has taken various reform initiatives, but the recent efforts have attracted a lot of attention. These reforms have recognized the importance of health and given it prominence (e.g. the Millennium Declaration, the 2005 World Summit Outcome). Moreover, UN reform also affects health and development cooperation and WHO’s work and collaboration at the country level.

Three processes are underway that would influence UN reform at the country level: (1) the UN Secretary-General’s High Level Panel on UN System-wide Coherence (HLP-SWC) report; (2) the evaluation of “One UN” Pilot programmes; and (3) the Triennial Comprehensive Policy Review of Operational Activities of the United Nations Development System (TCPR) in 2007. Member States would discuss these three issues at the United Nations Economic and Social Council (UN ECOSOC) and governing bodies of Specialized Agencies over the coming year. Intergovernmental, interagency and stakeholders’ negotiations are still ongoing. The recommendations of the HLP-SWC have sharply divided developed and developing countries as well as UN agencies and stakeholders.

WHO supports UN reform and it is currently defining its policies and directions. It is also actively participating in the eight “One UN” Pilot countries. The meeting was briefed on these policies and directions as well as the lessons drawn from WHO’s participation in the pilot countries. They were also informed that there was a move from “One UN” to a “Delivering as One” concept that focuses on result rather than structure.

The presentation emphasized that to ensure coherent direction and guidance from the various UN governing bodies, dialogue between the different ministries representing Member States at the various UN decision-making bodies is crucial.

Discussion points

- Member States emphasized that WHO, as a specialized agency, works very closely with Member States, where it provides not only normative functions but also technical cooperation in public health with each ministry of health. This relationship should be maintained and strengthened.
• The relationship of the UN with specialized agencies is governed by legal agreements and for UN reforms to be successful revision of these basic legal documents is essential. Such amendments to the basic documents are difficult to achieve.

• Member States pointed out that WHO focuses on a country’s priorities and respects a country’s leadership. It is in this light that WHO presents its country cooperation strategy as a contribution to the CCA/UNDAF process.

• Member States also pointed out that the United Nations contributes best to national development and reforms when its work is led by and contributes toward national priorities, processes and actions like the National Poverty Reduction Strategy (NPRSP), Sector-Wide Approach (SWAP) and sector reform.

• Member States supported the idea of holding a WHO regional meeting on UN reforms that will also involve ministries of health and ministries of foreign affairs to facilitate dialogue on this important subject.

• Concerns were raised that no country from the SEA Region participated in the “One UN” Pilots programme, and Member States were also keen to know when the assessment of the pilot project would be done and whether any country from the Region would be included in the pilot in the near future.

Recommendations

Action by Member States

1) To actively participate in the regional meeting planned by SEARO in October 2007 with the aim of facilitating dialogue between health officials and foreign affairs officials and contributing to the UN reform debates.

2) To propose to set up a WHO EB Working Group to investigate the implications of UN reform and the work of WHO, and provide recommendations through the EB agenda on UN reform.

Action by WHO-SEARO

1) To facilitate the capacity building in the Member States in understanding and actively participating in UN reform and its implications on health.
(2) To communicate to the Member States on the progress made and lessons learnt from UN reform including the report from eight pilot countries and the work of WHO.

12. Governing bodies (Agenda item 12)

12.1 Review of the decisions and resolutions of the Sixtieth World Health Assembly and the 120th and 121st sessions of the WHO Executive Board (Agenda item 12.1)

Introduction

Introducing the agenda item, the Deputy Regional Director stated that the working paper highlights the following most significant and relevant decisions and resolutions emanating from the Sixtieth World Health Assembly, as well as the 120th and 121st sessions of the Executive Board:

- WHA60.13: Control of Leishmaniasis
- WHA60.15: WHO’s role and responsibilities in health research
- WHA60.16: Progress in rational use of medicines and WHA60.20: better medicines for children
- WHA60.24: Health promotion in a globalize world
- WHA60.26: Worker’s health: Global Plan of Action
- WHA60.28: Pandemic influenza preparedness
- WHA60.30: Public health, innovation and intellectual property

The objective of this agenda item is to inform the Joint Meeting of those decisions and resolutions, for review in the regional perspectives. These decisions and resolutions are particularly relevant to the South-East Asia Region, have obvious and immediate implications for the Region and would merit follow-up action, both by Member States of the Region as well as WHO at the Regional Office and country levels.

Highlights from the operative paragraphs of selected decisions/resolutions, as well as the regional implications of each decision or resolution, and actions proposed for Member States and WHO were presented. All the resolutions adopted and decisions taken by the 120th and 121st sessions of the Executive Board and the Sixtieth World Health Assembly were also provided. DRD also
The Joint Meeting then considered the resolutions/decisions and made the following observations and recommendations:

**Discussion points**

- The Joint Meeting noted the regional implications and actions taken and proposed as contained in the working paper.
- Regarding resolution WHO60.16 and WHA60.20, the Joint Meeting stressed that there should be follow up in the countries. This was particularly important with regard to work plans and national multidisciplinary bodies being established in the countries. In paediatric essential medicines, it was important to include medicines that are necessary during the neonatal period. A Regional Workshop in Essential Medicines will be held in late October to coincide with the thirtieth anniversary of the Essential Medicines List. The activities appropriate to these resolutions will be included in the country work plans of 2008-2009.
- With regard to resolution WHA60.26 on workers’ health, the members of the Joint Meeting showed concern that the work in the occupational health area in WHO has been sporadic in the past, and thus there is the need to be more comprehensive and consistent. Increasing use of asbestos and high incidence of hepatitis B infections in the Region are also of concern. There is also a need to provide health insurance to the workers of the informal sector. Some members requested the Secretariat to review and synthesize the current situation of worker health in Member States to be discussed in the agenda item of the 61st Regional Committee.
- With regard to resolution WHA 60.15, concerns were raised on the obligation by Member States to spend 2% of the total health expenditure and 5% of development programmes on health research and capacity building. Resource tracking on health research should be established Member states should propose participation at the Bamako Ministerial Meeting on Health Research in 2008.
- Regarding WHA 60.28 and WHA 60.30, the discussions are reflected in agenda items 11.1 and 11.2, respectively.
Recommendations

Action by WHO-SEARO

(1) To review and synthesize the current situation of workers’ health in Member States, to be discussed in the agenda item of 61st Session of the Regional Committee.

(2) The review of these WHA resolutions is to be submitted to the 60th Session of the Regional Committee for their consideration and noting as appropriate.

12.2 Review of the draft provisional agendas of the 122nd Session of the WHO Executive Board and the Sixty-first World Health Assembly (Agenda item 12.2)

Introduction

The Deputy Regional Director introduced the draft provisional agenda of the 122nd Session of the EB. This will further be submitted to the forthcoming 60th Session of the Regional Committee to note that Member States may propose the inclusion of any additional item to the agenda of EB 122 which will be held from 21 to 26 January 2008. The provisional agenda of the Board will be dispatched to Member States with the letter of convocation eight weeks before the commencement of the session. The agenda of the 61st WHA will only be discussed during the 122nd Session of the EB in coming January.

As per Rule 8 of the Rules of Procedure of the Executive Board, as amended by the Board at its 121st Session, any proposal from a Member State 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 EB, whichever is earlier. The proposals should therefore reach the Director-General by 13 September 2007.

The joint meeting noted the draft provisional agenda of 122nd Session of the Executive Board.

Discussion points

- In view of the internationally significant problem of migration of health workforce as referred to in WHA 57.19 and WHA 58.17, some members proposed that the “International Migration of Health
Personnel: a challenge for health systems in developing countries”, be included in the agenda of 60th RC and 122nd EB in January 2008. The RD clarified the procedural issue and that it is possible to include it in the RC, and that the EB member from SEAR will have to ensure that it be inserted in the EB agenda.

**Recommendations**

**Action by Member States**

(1) To propose the agenda on “International Migration of Health Personnel: a challenge for health systems in developing countries”, to be discussed in the 60th RC.

13. Follow-up on selected resolutions/decisions of the last three years (Agenda item 13)

13.1 Iodine deficiency disorders in the South-East Asia Region (Agenda item 13.1)

**Introduction**

The Secretariat presented the progress report on the elimination of iodine deficiency disorders in South East Asia Region as follow-up to the regional resolution SEA/RC57/R4. The report was prepared based on the assessment of the reported information made according to the guidelines by WHO/UNICEF/ICCIDD and has been updated and verified in the expert consultative meeting on 25-26 June 2007 at Bangkok. Considerable progress has been recorded in the Region. The population with insufficient iodine intake declined from 556 million in 2004 to 443 million in 2006. Sri Lanka reported achieving IDD elimination in 2007. In 2004, only Bhutan had achieved IDD elimination. The number of countries having a national intersectoral coordinating body increased to 10 in 2006 from 8 in 2004. The number of countries that had salt iodization legislation in place reached eight in 2006, while the remaining three countries from the Region have advanced towards the process of achieving it. Nine countries now have laboratory facilities for monitoring salt quality and programmes compare with seven that had these facilities in 2004. In spite of the remarkable progress made, the report also highlighted the need to maintain and enhance commitment among stakeholders, sustain the gains made, strengthen existing national bodies and bolster implementation of effective regulation on universal salt iodization. It also stresses the need for strengthening regular monitoring of Urinary Iodine Excretion (UIE) and assessment of the iodized salt production and distribution process.
Discussion points

- Access to regional sources for potassium-iodate or iodine supply;

  His Excellency the Deputy Minister from Myanmar and the distinguished delegate from Thailand highlighted the importance of the availability of potassium-iodate (or its precursor iodine), which is the major vehicle for universal salt iodization. The difficulty of procuring and transporting Potassium-iodate became a major obstacle and a drastic drawback for IDD elimination in Myanmar, which had reached the stage of almost achieving the goals of IDD elimination in 2005. The availability from regional sources will help to solve this issue.

- Quality control protocols for monitoring the iodized salt at the production level;

  The distinguished delegate from Thailand pointed out the need to establish protocols for quality control measures at salt production level. Bangladesh, Bhutan, India, Myanmar, Nepal and Sri Lanka also shared their experience in the importance of quality control for iodized salt.

- Issues of cross-border trades of iodized salt;

  Distinguished delegates from Nepal and Bhutan discussed the issue of cross-border trading of low-quality iodized and non-iodized salt in their remote border areas. The Secretariat said that this issue has been discussed in the expert consultative meeting in Bangkok on 25-26 June this year, concerned countries being Bhutan, Bangladesh, India, Myanmar and Nepal.

- Issues of monitoring for sustainability of results achieved;

  Distinguished delegates from Bhutan and Thailand called attention to the importance of maintaining efforts to sustain the elimination of IDD. They shared their experiences in deviation of priorities from IDD elimination after encouraging achievements. Because IDD cannot be eradicated like some diseases but can only be eliminated, thus requiring a continuous process of maintaining the goals, they pointed out the necessity of regular monitoring for sustainability. Distinguished delegates from Bangladesh, India, Myanmar, Nepal, and Sri Lanka shared their commitments to IDD elimination and experiences in monitoring. They highlighted the importance of data/information for policy and programme analysis. DPM noted the importance of monitoring for sustainability and suggested sentinel surveillance with
most sensitive indicators. He also pointed out the need for sub-analysis of national data to identify areas with excess and insufficient iodine intake. DPM assured the meeting that WHO’s technical assistance in these areas in collaboration with WHO Collaborating Centres would continue.

**Recommendations**

**Action by Member States**

(1) To revitalize and strengthen IDD programmes to ensure sustainable elimination of IDD problems, monitor progress through the application of urinary iodine excretion tests and ensure access to adequately iodised salt.

**Action by WHO-SEARO**

(1) To facilitate the access to affordable potassium-iodate or iodine from the regional sources in collaboration with other partners.

(2) To support Member States in development of quality control protocols for production of iodized salt in collaboration with the other partners and WHO Collaborating Centers (WHO–CC).

(3) To support, through the application of MCA to Member States, tackling of the cross-border IDD, including quality control of iodized salt.

(4) To support the Member States by:
   (a) Strengthening the availability of data related to IDD for policy and programme analysis.
   (b) Establishing IDD sentinel surveillance by using most sensitive indicators.
   (c) Sub-analysis of the data from national surveys to identify the areas of excess and insufficient iodine intake.

**13.2 Promoting patient safety in health care (Agenda item 13.2)**

**Introduction**

One of the main issues for governments is to galvanize commitment and action among the key stakeholders to improve the quality and safety in health care. To assist countries in this important area, the WHO World Alliance on Patient Safety has formulated a series of “Global Patient Safety Challenges”.
This year’s Challenge has the theme “Clean Care is Safer Care” and focuses on the reduction of health care associated infections. All Member States have been invited to sign the pledge to “Clean Care is Safer Care”. To date, India, Bangladesh, Bhutan and Thailand have signed the pledge at high-level national events. Indonesia has committed to do so later this month.

A series of three regional patient safety workshops have been organized to date. These workshops build on the recommendations of the first Regional Workshop on Patient Safety which took place a year ago in New Delhi. Each workshop develops regional capacity in a key aspect of patient safety. In addition to capacity building, these regional workshops have been designed to facilitate collaboration and exchange of information and best practices between countries as spelled out in the resolution. Each workshop is part of an inclusive consultative process – each providing clear directives to identify priority areas of work, action points for Member States and clear directives regarding how WHO can support these.

Thus, each workshop represents a building block in the development of a regional strategy and a package of interventions and tools to promote quality and safety in health care in our Region.

**Discussion points**

- Myanmar delegates pointed out that Myanmar has started a patient safety initiative in the SEA region in January 2006, and it needs to be reflected when reporting the progress of the Region.

- Representatives of Bangladesh, Bhutan, DPR Korea, India, Maldives, Nepal, Sri Lanka and Thailand shared country initiatives in relation to patient safety and reiterated the need to strengthen efforts on patient safety and pledged their support.

- Thailand delegates emphasized the need to focus on clinical waste management, extend the initiative to cover the private health sector and the need to agree upon a set of patient safety indicators; they emphasized the need to develop medium-term plans with a view to institutionalizing the initiative.

- The DPR Korea delegates emphasized the need to develop clinical protocols and guidelines with a view to standardizing the service delivery.

- DPM in his final remarks emphasized the need to strengthen the internal collaboration as patient safety is a cross-cutting issue. The
need to document the rich country experiences and the need to develop a set of patient safety indicators were reiterated.

**Recommendations**

**Action by Member States**

1. To implement programme activities as stipulated in SEA/RC59/R3 on promoting patient safety in health care.
2. To develop/strengthen programmes on patient safety through intra- and inter-sectoral collaboration, including private sector.

**Action by WHO-SEARO**

1. To support/facilitate Member States in the implementation of programme activities as stipulated in SEA/RC 59/R3 on promoting patient safety in health care, including South–South Collaborations.
2. To develop a minimal data set of patient safety indicators for the Region, in close collaboration with Member States.
3. To document and share the rich country experiences from the Member States.

**13.3. Strengthening the health workforce in the South-East Asia Region and follow-up on the Dhaka declaration** (*Agenda item 13.3*)

**Introduction**

Introducing the topic of discussion, the Secretariat stated that the Dhaka Declaration and Resolution SEA/RC59/R6 had been landmark events. She stated that the declaration and the resolution emphasize the need of Member countries to pay attention to effective health workforce planning and deployment, production, competency, health workforce management and increasing the investment in health workforce development. The resolution specifies the need to revitalize the role of community health workers.

Outlining the ten months’ progress of SEARO in implementing the activities spelled out in the declaration and the resolution, it was noted that the Regional Strategic Plan for Health Workforce Development has been formulated and is being disseminated. SEARO is in the process of actively assisting Bhutan, Sri Lanka and DPR Korea to develop national HRH strategic plans. While collaborating with other regional and global alliances in HRH development
activities, SEARO is in the process of organizing a Regional Consultation on Revisiting Community-Based Health Workforce, which is scheduled to be held in 3-5 October 2007.

Further, with the objective of strengthening the quality and regulation process of health practitioners, a Regional Network of medical Councils has been established, and currently SEARO is functioning as the network secretariat.

**Discussion points**

- The Member States applauded SEARO’s initiatives in relation to HRH development, especially the development of the Regional HRH Strategic Plan for Health Workforce Development to guide the work of WHO and Member countries over the next four years.

- Representatives of Member States shared the challenges faced by their respective countries and emphasized the need to accelerate activities in relation to HRH development.

- The need to facilitate or strengthen the ongoing intercountry cooperation and collaboration was emphasized. DPR Korea delegates requested WHO to facilitate exchange of competencies, which is their special need.

- Thailand delegates proposed to include “International Migration of Health Personnel: a challenge for Health System in Developing Countries”, as an agenda item in the 60th Regional Committee to be held in Bhutan.

**Recommendations**

Action by Member States

1. To propose the agenda on “International Migration of Health Personnel: a challenge for health system in developing countries”, to be discussed in the 60th RC.

Action by WHO-SEARO

1. To take steps to intensify the intercountry cooperation and collaboration among Member countries in support of strengthening the health workforce among Member States in the Region.
13.4 Health Information System Development relating to Millennium Development Goals (MDG) and Health Metrics Network (HMN)

(Agenda item 13.4)

Introduction

Follow-up actions after the RC 59 on the resolution related to Health Information System (HIS) Strengthening relating to the MDG and Health Metrics Network started immediately with printing and dissemination of the Regional Strategy for Strengthening HIS. It recommends different options for countries on how to focus their health information system strengthening. The Health Metrics Framework (HMN) assessment tool may be used, and six SEAR countries have been supported by the HMN. In this context, a Regional Consultation on Mortality Statistics was organized in April 2007 to recommend potential avenues that could be pursued by countries to improve the availability and utility of mortality data. Responding to the mandate of WHO to analyse and disseminate information on health situation and trends in the Region, two publications (“11 Health Questions about 11 SEAR Countries” and “Health in Asia and the Pacific, Edition 2007”) have been or are being finalized. Two regional activities (Workshop for Trainers on International Classifications and Workshop on Health Statistics Reporting) are planned for September 2007, with the purpose of enhancing data quality and capabilities of the countries in data analysis at the sub-national level. Tracking progress in MDG has drawn attention to strengthening HIS. Monitoring of MDGs, particularly at the sub-national level, may be used as a good platform for strengthening HIS, and its implementation would facilitate prioritization of interventions and evidence-based decisions at the sub-national level. Disaggregation of the data to lower levels, its analysis and targeting of the interventions are crucial for making progress in achieving the MDGs.

Discussion points

- The need to collect evidence-based, disaggregated information in monitoring MDGs was highlighted.
- The usefulness of documenting much of the work carried out in the Region in relation to achieving MDGs was highlighted by the Bangladesh representatives.
- The Health Metrics Framework has been identified by the Member countries as an important partnership mechanism for the national health information system development.
• The Member countries sought SEARO’s proactive assistance to support their efforts to strengthen national Health Information Systems.

• The need to strengthen information collection, analysis and utilization at the sub-national levels was emphasized by the DPM.

• The Health Metrics Framework has been identified by the Member countries as an important funding mechanism for national health information system development.

Recommendations

Action by Member States

(1) To build information systems that include disaggregated and evidence-based health information for policy formulation and effective interventions, particularly at the sub-national levels.

Action by WHO-SEARO

(1) To proactively support Member countries to strengthen national health information systems and to build countries’ capacity in collection, analysis and dissemination of the data, particularly at the sub-national levels.

13.5 Challenges in polio eradication (Agenda item 13.5)

Introduction

The committee on polio eradication presented an update to the Joint Meeting of the HSM and the CCPM highlighting the achievements so far in implementing the strategies outlined in the WHO/UNICEF Global Immunization Vision and Strategies (GIVS). One of the key strategic directions of the the GIVS framework is to increase access to existing antigens as well as to newer antigens. In this regard all countries have made tremendous progress in strengthening routine immunization by conducting evaluation of their National Immunization Programmes, data quality improvement, strengthened surveillance for vaccine-preventable diseases and capacity improvement for vaccine management and programme implementation. All GAVI-eligible countries also have developed fully costed multiyear plans with clear strategies for resource mobilization needed for sustaining the achievement in immunization. Further, all countries except Timor-Leste have introduced hepatitis B vaccine, and several other countries are on their way to add Haemophilus influenzae type b (Hib).
On the polio front, the Regional Office continues to support the strengthening of Acute Flaccid Paralysis (AFP) Surveillance through regular assessment of AFP Surveillance as well as EPI programmes in Member countries. Also, all countries either endemic or that have recently faced importation of polioviruses have put in plan emergency response plans consistent with World Health Assembly Resolution WHA59.1. Intensified Supplemental Immunization Activities (SIA) have been carried out in all countries either endemic or facing potential importation of polioviruses.

It was highlighted that while tremendous achievements have been made in the Global Polio Eradication Initiative (GPEI), the global polio eradication programme is now at a critical juncture. It is so close to finishing the job and yet, at the same time, it is at a most vulnerable period in the eradication efforts. The greatest challenge faced by GPEI is the lack of sufficient funding to complete the job. By July 2007 the GPEI will have a negative cash flow, which, if not addressed, will require an immediate reduction in planned polio eradication activities in the remaining infected countries. Even a temporary cutback would result in the reinfection of polio-free areas, delays in outbreak response, a surge in polio-paralyzed children and an increase in overall costs. Despite these, the Director General of WHO remains highly committed to finish the job of polio eradication and will spare no efforts to liaise closely with all potential donors to ensure their urgent attention to closing the funding gap for 2007-2008 activities.

**Discussion points**

- While many countries have achieved high standards of surveillance, in some countries there is some decline in the quality of surveillance. No country is safe until polio is eradicated from all countries of the Region, and eventually, from the entire world. Therefore, to continue to maintain the highest quality of AFP surveillance is a must.

- Routine immunization, within the context of the WHA-adopted Global Immunization Vision and Strategies (GIVS) document is important for the SEA Region. While many countries of the SEA Region attain and maintain high levels of coverage, there are also several countries where routine immunization coverage has been falling. Of the 27 million or so children globally who do not get routine immunization, almost 50% are estimated to be in the SEA Region. While high-quality SIA must be implemented, it is equally important to ensure that high routine coverage with polio vaccine is achieved to prevent any importation or outbreak within a particular country.
• Both in the countries that are still endemic as well as where recent importations have been seen, ensuring the highest quality possible for SIAs is essential.

• International spread of polio is a concern because no country is safe as long as any country in the world continues to have wild polio. A discussion is continuing on how best to fit the requirements for the prevention of the international spread of polio within the context of IHR without imposing undue restrictions on Member countries to tackle the problem at hand, which is to eradicate polio and prevent importation.

• The unprecedented effort of the Government of India to eradicate the circulation of the polio virus, adopting comprehensive evidence-based strategies in consultation and close collaboration with the WHO and other expert agencies, was appreciated by the Member States. It was felt that these measures would enable India to achieve polio-free status as early as possible.

• The delegate of India also highlighted the quality of AFP surveillance in India and its adherence to the highest global standards. The Secretariat emphasized the need for both exporting as well as importing countries to maintain the highest surveillance levels and high routine immunization coverage as the best means to control the spread of polio virus and the outbreaks in the Region.

• Globally, only four countries are now endemic to polio: Afghanistan, India, Nigeria and Pakistan. With new tactics and intensified efforts, by this time there is cautious optimism that P1 virus transmission can perhaps be halted in Western Uttar Pradesh. The high commitment of the Government of India and the huge domestic financial resources that the Government is putting in to complete the job of polio eradication is highly commendable and appreciated by WHO and partners for polio eradication.

• One Member State considered a reference by another Member State to the constitutional and structural features of the polity of another Member State to be an aberration and emphasized the need for all Member States to conduct discussions within established norms of propriety so as to maintain the dignity of the forum.

• Although the risk is considered minimal, Bhutan requested WHO’s support to conduct supplemental immunization in high-risk areas to
Recommendations

Action by Member States

(1) To strengthen the EPI programme in order to maintain the highest surveillance levels and high routine immunization coverage as the best means to control the spread of polio virus and the outbreaks in the Region.

Action by WHO-SEARO

(1) To support/facilitate a thorough review of the status of routine immunization in the Member countries to strengthen polio eradication efforts and to maintain polio free status in those countries where polio is eradicated.

(2) To convene the technical working group to evaluate the various options to prevent the spread of polio in the Region.

(3) To seek and facilitate mobilization of financial resources for supporting the polio and routine immunization programme of the Member States.

(4) To support and facilitate the Member States to maintain the highest surveillance levels and high routine immunization coverage as the best means to control the spread of polio virus and the outbreaks in the Region.

(5) To report the progress towards polio eradication to the Regional Committee on an annual basis until polio-free status is achieved in the Region.

14. Reports by country representatives on their attendance at the meetings of the coordinating bodies of WHO’s global programmes (Agenda item 14)

14.1 UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases: Joint Coordinating Board (JCB) (Agenda item 14.1)

Introduction

The Thirtyeth meeting of the Joint Coordinating Board (JCB) was held in Geneva, from 19-21 June 2007. Representatives from the three Member countries of
the South-East Asia (SEA) Region, namely Bangladesh, India and Thailand, attended the meeting.

Dr Md Shahjahan Biswas, representative from Bangladesh, presented the report on the deliberations of the JCB meeting on behalf of representatives from the SEA Region.

The Joint Meeting of Health Secretaries and CCPDM noted the report.

14.2 WHO Special Programme for Research, Development and Research Training in Human Reproduction: Policy and Coordination Committee (PCC) (Agenda item 1.2)

Introduction

The Twentieth Meeting of the Policy and Coordination Committee of the UNDP/UNFPA/WHO/World Bank Special Programme for Research, Development and Research Training in Human Reproduction (“the Programme”) was held in Geneva on 28-29 June 2007. Representatives from three Member countries of the South-East Asia (SEA) Region, namely Bangladesh, Myanmar and Thailand, attended the meeting.

Dr Ko Ko Naing, representative from Myanmar, presented the report on the deliberations of the Policy Coordination Committee (PCC) meeting on behalf of representatives from the SEA Region.

The Joint Meeting of Health Secretaries and CCPDM noted the report.

15. Adoption of report

The Joint Meeting of Health Secretaries and CCPDM reviewed the draft report of the meeting agenda by agenda, concentrating on the discussions and observations made by Members, and the recommendations arrived at on each agenda item, and adopted it with some modifications.

16. Closure

Dr Samlee Plianbangchang, Regional Director, in his concluding remarks, thanked all the distinguished participants for their deliberations. He expressed his particular appreciation to the Chairperson, Dr H.A.P. Kahandaliyange, and the Co Chairperson, Dr Ram Chandra Man Singh, for the effective manner in which they chaired the meeting. Dr Samlee also thanked Dr Gado Tshering and other members of the drafting group for their excellent report. He
appreciated the practical recommendations made by the Committee and assured the members that the Regional Office would take urgent action to implement all the recommendations made by the Committee.

The Co-Chairperson, Dr Ram Chandra Man Singh, thanked all the distinguished participants for their deliberations and active participation in the meeting. He then declared the meeting closed.
Annexure 1

Agenda

1. Opening Session
2. International Health Security
3. Climate Change and Health
4. Matters relating to Programme Development and Management
   4.1 Review of WHO collaborative programmes implemented during 2006-2007 biennium
   4.2 Review of the detailed workplans for Programme Budget 2008-2009
5. Technical Discussions: Selection of a subject for the Technical Discussions to be held prior to the Sixty-first Session of the Regional Committee
6. Scaling up Prevention and Control of Chronic Noncommunicable Diseases in the SEA Region
7. Tuberculosis Control: Progress and plans for implementing the new Stop TB Strategy
8. Revised Strategy for Malaria Control: focusing on a new paradigm
9. South-East Asia Regional Health Emergency Fund
10. Expansion of Membership of the South-East Asia Region on the Executive Board
11. Progress reports requested by Member States:
   11.1 Avian and pandemic influenza preparedness in the context of International Health Regulations (2005)
   11.2 Public Health, Innovation and Intellectual Property Rights: An Update
   11.3 WHO and Reform of the UN System: Impact at country level
12. Governing Bodies:
   12.1 Review of the decisions and resolutions of the Sixtieth World Health Assembly and the 120th and 121st sessions of the WHO Executive Board
12.2 Review of the draft provisional agendas of the 122nd Session of the WHO Executive Board and the Sixty-first World Health Assembly

13. Follow-up on selected resolutions/decisions of the last three years:

13.1 Iodine Deficiency Disorders in the South-East Asia Region
13.2 Promoting Patient Safety in Health Care
13.3 Strengthening the Health Workforce in the South-East Asia Region and Follow-up on the Dhaka Declaration
13.4 Health Information System Development relating to Millennium Development Goals (MDG) and Health Metrics Network (HMN)
13.5 Challenges in Polio Eradication

14. Reports by country representatives on their attendance at the meeting of the coordinating bodies of WHO’s global programmes, i.e.

14.1 UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases: Joint Coordinating Board (JCB).

15. Closing
Annexure 2

List of participants

**Bangladesh**
Dr Md Shahjahan Biswas  
Director-General  
Directorate General of Health Services  
Ministry of Health and Family Welfare  
Mr Md Jahangir  
Joint Secretary (PH & WHO)  
Ministry of Health and Family Welfare

**Bhutan**
Dr Gado Tshering  
Secretary  
Ministry of Health  
Mr Thinlay Dorji  
Chief Planning Officer  
Policy and Planning Division  
Ministry of Health  
Ms Sangay Wangmo  
Planning Officer  
Policy and Planning Division  
Ministry of Health

**DPR Korea**
Dr Pak Jong Min  
Director  
Department of External Affairs  
Ministry of Public Health  
Mr Choe Yong Su  
Official  
Department of External Affairs  
Ministry of Public Health

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Ministry of Health & Family Welfare

**Indonesia**
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Senior Advisor for the Minister of Health on Community financing and Empowerment  
Ministry of Health  
Mr Abdurachman  
Chief  
Centre for Analysis Health Development  
Secretariat General  
Ministry of Health  
Ms Nurlina Supartini  
Staff  
International Cooperation Division  
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Ministry of Health  
Ms Aminath Shenalin  
Assistant Director  
Ministry of Health

**Myanmar**
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Deputy Minister  
Ministry of Health
Dr Ko Ko Naing
Deputy Director
International Health Division
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Secretary
Ministry of Health and Population

Dr Sarala Malla
Director
National Public Health Laboratory
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Ministry of Healthcare & Nutrition

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The Permanent Secretary of Health
Ministry of Health

Mr Basilio Martins Pinto
Director
Policy and Planning Directorate
Ministry of Health

WHO Secretariat
Dr Poonam Khetrapal Singh
Deputy Regional Director

Dr Myint Htwe
Director, Programme Management

Mr J.J. Kobza
Director, Administration and Finance

Dr Than Sein
Director
Department of Non-communicable Diseases and Mental Health

Dr Abdul Sattar Yoosuf
Director
Department of Sustainable Development & Healthy Environment

Dr Jai P Narain
Director
Department of Communicable Diseases
Dr Sultana Khanum  
Director  
Department of Health Systems Development

Dr Sudhansh Malhotra  
Ag. Director  
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Dr William L. Aldis  
Coordinator, Health Policy and Research

Dr Sangay Thinley  
Coordinator, HIV/AIDS, Tuberculosis and Other Communicable Diseases

Dr Chusak Prasittisuk  
Coordinator, Communicable Diseases Control

Dr R.M. Brooks  
Coordinator, Programme Planning and Coordination

Dr Lin Aung  
Programme Development Officer  
Programme Planning and Coordination

Dr Yonas Tegegn  
Technical Officer  
Strategic Alliance and Partnerships

Dr Rui Paulo De Jesus  
Sustainable Health Policy Officer

Mr John M Kennedy  
Budget and Finance Officer

Mr R.K. Arora  
Programme Planning and Coordination Unit
Annexure 3

Opening remarks of the Regional Director

Your Excellency, Professor Mya Oo, Deputy Minister of Health, Myanmar; Honourable Health Secretaries; Distinguished Members of the Consultative Committee for Programme Development and Management; Distinguished participants; Colleagues; Ladies and gentlemen;

I warmly welcome you all to this joint meeting. I especially welcome H.E. Prof. Mya Oo, Deputy Minister of Health, Myanmar. First of all, I would like to thank the participants for sparing their valuable time to attend this important meeting.

The main purpose of the meeting is to thoroughly prepare for the forthcoming session of the Regional Committee (RC) and for the 25th Health Ministers’ Meeting (HMM).

As we are all aware, we will have only four days for the two meetings to be held at the end of August and the beginning of September. At the same time, the agenda of the RC session is very long, containing many important issues for our consideration.

To ensure that the RC and the HMM will be able to complete their agendas in the most efficient and effective manner, this joint meeting is, therefore, convened to make thorough preparations for the two meetings. The agenda of the joint meeting contains all the substantive items of the Regional Committee and Health Ministers’ meetings. It is hoped that for all those substantive items, the joint meeting will review them carefully and come out with suggested conclusions and recommendations. These conclusions and recommendations will be submitted for consideration of the RC and the Health Ministers’ Meeting.

In this connection, there are a few things that I would like to specifically touch upon at this stage. First, on the issue of Regular Budget increase. We have a 4% increase in the RB for the 2008-2009 biennium. For SEAR, we are getting about 4.6 million US$ from this increase.

We have to agree at this joint meeting on how to distribute this 4.6 million US$.

As we are aware, a Regional Health Emergency Fund is being established. We have to decide whether a part of this RB increase will go to this Fund. If yes, how much - we have to decide.
And, as has been practised, 25% of the RB increase will be used for supporting Regional Office and Intercountry programmes; 75% will go to the countries.

This meeting has to advise the secretariat on how to divide the 75% among countries. It is important to decide on this distribution now; so that we can have the complete budget figures for the RC session.

Also, during this joint meeting, there will be a special meeting on the Global Fund. This will be on Tuesday, 3 July in the afternoon. There is a separate agenda and programme prepared for this special meeting on the Global Fund. Global Fund is the main source of funds for supporting HIV/AIDS, Tb and Malaria Control. We have to work closely together to ensure that SEAR will get its fair share from this source of funding.

Another subject that I would like to mention is on TDR. At the last meeting of TDR/JCB, the Board made a number of important recommendations. Those recommendations, if fully implemented, will have a far reaching implication on TDR policy, strategy and direction.

The countries that attended the last session of the JCB will present the recommendations for our deliberations during this joint meeting.

Furthermore, at the last session of the RC, two other important decisions were made. The decisions that need our particular attention at this stage.

Firstly, the SEA Regional Health Emergency Fund which I mentioned earlier. We have to make sure that operational modalities which are realistic and practical are ready for submission to RC.

Another important issue is Expansion of Membership of SEAR in the WHO Executive Board. The issue is highly sensitive. We need to provide the best advice to RC on how to move forward.

This joint meeting will work on the draft working papers prepared for the RC session and the HMM. Therefore, the meeting is invited to advice on the improvement of those working papers, in terms of form and format, so, that we can have working papers of high quality for consideration of the Regional Committee.

Since we have many items on the agenda of this joint meeting, and these items cover very important issues of our concern, we have, therefore, planned the meeting programme for the entire week, 2-6 July.
I hope that this arrangement will not be too tiring for us. It will be excellent, if we can finish the meeting earlier.

We have a strong group of secretariat. Please call for help whenever required.

Let me also remind that the RC session is the meeting of Member States. It is the only WHO constitutional body in the Region. It is the Member States’ forum. WHO staff members are facilitating and providing secretariat back up, as required.

Therefore, we have to make sure by working hard together now; so that our RC session will be conducted successfully.

Once again, I thank the participants for their valuable time and contribution to the outcome of the meeting.

Finally, I wish this joint meeting all success. And I wish the Health Secretaries and members of the CCPDM an enjoyable stay in Delhi.

Thank you.
Thimphu Declaration on International Health Security in the South-East Asia Region

We, the Health Ministers of Member States of the World Health Organization’s South-East Asia Region participating in the Twenty-fifth Health Ministers’ Meeting in Thimphu, recognize that in the concept of International Health Security lies the realization that there is a need to reduce the vulnerability of people around the world to the escalation of existing, new, acute or rapidly spreading risks to health, particularly those that threaten to transcend international borders.

We also recognize that rapid globalization with easy, frequent travel as well as large-scale trade gives an ample opportunity for communicable diseases to spread across borders quickly and with ease.

We are aware that the world climate is changing. Temperatures are rising; tropical storms are increasing in frequency and intensity; polar ice caps and permafrost regions are melting. The acute impact of climate change-related events may be local, but their causes are global.

We are also concerned that no single institution, sector or country has all the capacities needed to respond to international public health emergencies caused by epidemics, natural disasters, and humanitarian or environmental emergencies.

We are of the view that the impact of the above threats on human health has serious implications to morbidity and mortality; and will delay internationally agreed upon development goals.

We reiterate our commitment to the World Health Assembly Resolutions related to Emergency Preparedness and Response and International Health Regulations (IHR) 2005.

We note the efforts of WHO’s Regional Office for South-East Asia to:

(1) Systematize and measure emergency preparedness and response in health systems through benchmarks, standards and indicators

(2) Systematically support countries in the full implementation of the International Health Regulations (IHR) 2005 strengthening core capacities
(3) To support the short term strategies in stockpiling anti-virals, personal protective devices and pre-pandemic vaccines as well as long term strategies to increase influenza vaccine production capacity in the region; and

(4) To mobilize adequate resources to support these activities

To achieve effective solutions to address issues related to International Health Security, we are committed to:

(5) Take further action to improve emergency preparedness and response in line with the World Health Assembly and Regional Committee Resolutions WHA 58.1, WHA 59.22, SEA/RC 57/3, and SEA/RC 58/3;

(6) Take further action to implement the International Health Regulations (IHR) 2005 in line with World Health Assembly and Regional Committee Resolutions WHA 58.3 and WHA 59.2, and SEA/RC 58/7.

(7) Develop and systematically implement medium and long-term National Emergency Preparedness Plans taking into account the significant role of private health providers based on country-specific priority benchmarks and indicators within one year and to revisit the plans regularly;

(8) Develop and implement action plans towards strengthening core capacities for countries for International Health Regulations (IHR) 2005; and

(9) Mobilize adequate resources for these initiatives and participate actively in developing and maintaining partnerships related to improving these areas of health.

We, the Health Ministers of WHO’s South-East Asia Region fully support the establishment of South-East Asia Regional Health Emergency Fund and commit to the function of the Working Group as well as efforts towards resource mobilization.

We, the Health Ministers of WHO’s South-East Asia Region, urge all Member States as well as the WHO Director-General and the Regional Director for the South-East Asia Region to continue to provide leadership and technical support in building partnerships between governments, United Nations and bilateral agencies, members of academia, professional bodies, NGOs, the private sector, and the media and civil society, and to jointly advocate effective follow-up on all aspects of this Thimphu Declaration on International Health Security in the South-East Asia Region.
Annex 10

Consideration of the recommendations arising out of the Technical Discussions on “Nutrition and Food Safety”*

Introduction

1. At the Fifty-ninth Session of the Regional Committee held in Dhaka in 2006, the distinguished country delegates proposed the subject of ‘Nutrition and Food Safety’ for Technical Discussions to be held prior to the Sixtieth Session of the Committee. Technical Discussions on the subject were held in the WHO Regional Office for South-East Asia (SEA) from 11 to 13 April 2007. Representatives from all 11 Member countries of the Region covering the Nutrition and Food Safety sectors were invited along with experts from both Member countries and WHO collaborating centres in the Region. The working paper for Technical Discussions has been widely shared and consulted, in its preparatory phase, among country participants, experts in the Region, partners and relevant staff in headquarters and the Regional Office.

2. Those who participated in the Technical Discussions included 13 representatives from seven Member countries, 12 experts from the countries and WHO collaborating centres in the Region, one international expert, five participants from partner agencies, two participants from WHO headquarters, one each from India and Indonesia country offices, and seven participants from the Regional Office.

3. Professor Dr Ir. Dedi Fardiaz, representative of the National Agency of Drug and Food Control from Indonesia, and Dr Chanin Charoenpong, Senior Expert in Food Standards, Food and Drug Administration, Ministry of Public Health, Thailand, were elected as Chairperson and Co-chairperson respectively. Dr Htin Lin, Senior Medical Officer, National Nutrition Centre, Ministry of Health, Myanmar, was elected Rapporteur.

*Originally issued as document SEA/RC60/5 dated 13 July 2007
4. Participants discussed the Working Paper on Nutrition and Food Safety in detail in groups and in plenary sessions. The Technical Discussions concluded with corpus of recommendations, 10 action points for Member countries and seven activities for the Regional Office as future actions. The Technical Discussions Group also proposed that the Sixtieth Session of the Regional Committee may consider adopting a resolution on the subject drawing from these recommendations.

**Key issues**

5. There has been growing concern in the Region over persisting nutritional disorders and their links with food-borne diseases, in the context of recent global events, and the emergence of food-borne disease outbreaks, and the increasing resistance of some food-borne bacteria to common therapies. The simultaneous presence of both malnutrition and infection results in an interaction that has more serious consequences for the host than the additive effect would be if the two worked independently.

6. The SEA Region, with its inhabitants accounting for a quarter of the global population has high infant and young child mortality. Although some improvement in nutrition levels was recorded in recent years, a substantial magnitude of several nutritional disorders, their interaction with food-borne diseases and impact on morbidity and mortality in women and children are still observed in variable degrees among the Member countries. There are 3.1 million annual child deaths in the Region of which 14.7 per cent are attributed to diarrhoea and compounded with malnutrition.

7. Emerging situations such as concurrent existence of over-and under-nutrition among members of the same population poses the double burden of malnutrition. Double burden of malnutrition in developing countries emerges as the “Nutrition Transition” which is characterized by rapidity of changes, coexistence of obesity, over-weight people and cases of under-nutrition within the same population, and effect on people from all socioeconomic groups. It was also noted that growth retardation in fetal life and during infancy leads to nutrition-related chronic diseases in later life. The changing nature of global food supply, easier access to foods high on fats and sugar, increasing reliance on fast food of the rapidly growing urban population and a sedentary lifestyle is contributing to the problem of over-nutrition in developing countries, including many from the SEA Region.

8. WHO has responded to the issues in the form of various World Health Assembly (WHA) resolutions on Infant and Young Child Feeding, Food Standard and Food Safety, Sustainable Elimination of Iodine Deficiency Disorders, Diet,
Physical Activity and Health, and Nutrition and HIV/AIDS. Globally, WHO has responded with strategies on Nutrition for Health and Development, Global Strategy for Food Safety, and the Global Strategy on Diet, Physical Activity and Health. In the SEA Region, WHO has responded with region-specific strategies on nutrition and food safety.

**Technical Discussions**

9. The consensuses reached upon key strategic issues are highlighted below.

10. All Member countries reached a consensus on the need to integrate food safety into the overall nutrition development agenda and address with the life cycle approach – with emphasis on the most vulnerable and affected groups – issues related to women and children, focusing on human and national development.

11. All partners attending the discussion agreed on close and intense collaboration. Food and Agriculture Organization (FAO), WHO and United Nations International Children’s Emergency Fund (UNICEF), expressed commitments in collaborative activities such as playing key advocacy roles and capacity building. FAO committed itself to extending support in food-borne disease surveillance and laboratory activities for food safety.

12. The nutrition and food safety workforce in countries should be strengthened and placed as an integral part of the primary health care system. Community participation and empowerment is required at the grass-roots level to carry out the interventions on nutrition and food safety.

13. Food-borne diseases surveillance which can promote strategic formulation should address microbial as well as chemical contamination from food ingredients, food additives, etc. Focus should be given to food for consumer and food-borne diseases.

14. Compliance with Codex or national food standards and regulations, and harmonizing with Codex are necessary steps to be taken by Member countries. Programmes should also advocate, communicate with and encourage the food industry on ethical marketing.

15. It was noted that Member countries should place the development/revision of the National Nutrition Policy and Plan of Action by adopting a sector-wise approach on the priority agenda. This would ensure conformity with the common agenda for nutrition and food safety and enable the effective implementation of World Health Assembly (WHA) and other regional resolutions. WHO should support Member States in developing a National Food and
Nutrition Policy and Plan of Action, adopting evidence-based programming, preparing Standards, Norms and Guidelines, and in ensuring adequate resources.

16. The Technical Discussions concluded with the following recommendations:

**For Member countries**

17. It is recommended that Member countries should:

   (1) Review/revise or develop as necessary a National Nutrition and Food Safety Policy and Plan of Action, to focus on integrated actions emphasizing multi-sectoral effort and sector-wise approach, ensuring incorporation of appropriate nutrition and food safety for all segments of the population with special emphasis on women and children, based on the Right to Food guidelines, ensuring follow-up implementation of relevant WHA and regional resolutions in accordance with global and regional strategic guidelines, taking into account the current status with respect to MDGs, to ensure timely implementation of National Plan of Actions.

   (2) Initiate and support action oriented research and studies to further strengthen evidence-based programme development and implementation in nutrition and food safety.

   (3) Establish/strengthen and utilize monitoring and/or surveillance systems that focus on diet, nutrition and food safety.

   (4) Prioritize, revitalize and/or strengthen community-based programmes based on the primary health-care approach to ensure appropriate, adequate nutrition and safe food, including safe water and sanitation for all, particularly women and children, throughout their life course.

   (5) Strengthen and sustain prevention, control and elimination of micronutrient deficiency disorders as appropriate.

   (6) Strengthen regulatory action and mechanisms to enforce regulations for universal salt iodization and a code for marketing of breast milk substitutes, to follow Codex standards and guidelines as appropriate, and to develop national guidelines for consumer protection and education.

   (7) Implement health promotion strategy in education on appropriate nutrition and safe food for appropriate target groups and stakeholders.

   (8) Develop a preparedness plan on nutrition and food safety in response to natural and man-made emergency
(9) Combat emerging issues such as over-nutrition and nutrition in cases HIV/AIDS by determining prevalence rates and undertaking suitable actions.

(10) Ensure adequate resources for sustaining of nutrition and food safety programmes.

For WHO

18. It is recommended that WHO should:

(1) Provide support and technical leadership to Member States for development of National Policy and Plan of Action for Nutrition and Food Safety and to ensure effective programming by way of following up on relevant WHA and regional resolutions.

(2) Assist Member States in developing evidence-base programme actions, assessment, and monitoring and surveillance of problems and programmes on nutrition and food safety, through information sharing, consultation and training.

(3) Provide assistance to Member countries in estimating the economic burden caused by malnutrition and food-borne diseases to encourage policy development on nutrition and food safety.

(4) Establish an information networking and sharing mechanism on nutrition and food safety in the Region through SEA Nutrition Research-Cum Action Network and INFOSAN, by working closely in collaboration with international, inter-sectoral and other partners.

(5) Support, and obtain assistance from, global development of evidence-based standards, norms and guidelines for appropriate diet, nutrition and food safety.

(6) Assist and support Member States to ensure adequate resources for sustainable nutrition and food safety programmes through programme planning, budgeting, and preparing proposals in collaboration with WHO/HQ and potential donors.

(7) Monitor and report on the progress of implementation and status of trends in the Region.

19. The Technical Discussions Group proposed that the Sixtieth Session of the Regional Committee may consider adopting a resolution on the subject based on the recommendations made.
Report of the Sixtieth Session
Thimphu, Bhutan, 31 August – 3 September 2007