WHO Regional Committee for South-East Asia

Report of the 67th session

Dhaka, Bangladesh, 9–12 September 2014
WHO Regional Committee for South-East Asia

Report of the Sixty-seventh Session

Dhaka, Bangladesh
9–12 September 2014
Contents

1 Introduction ...................................................................................................... 1

2 Inaugural session ............................................................................................. 3

Welcome speech by Mr M.M. Neazuddin, Secretary, Ministry of Health and Family Welfare, Government of the People’s Republic of Bangladesh ......................... 3

Address by Dr Poonam Khetrapal Singh, Regional Director, WHO South-East Asia .......... 4

Speech by the outgoing Chairman of the Health Ministers’ Forum, His Excellency Dr Harsh Vardhan, Minister of Health and Family Welfare, Government of India ........................................................................................................ 6

Address by Dr Margaret Chan, Director-General, World Health Organization ............... 7

Address by His Excellency Mr Mohammed Nasim, Minister of Health and Family Welfare, Government of the People’s Republic of Bangladesh ....................... 8

Inaugural Address by Her Excellency Sheikh Hasina, Prime Minister, People’s Republic of Bangladesh ..................................................................................... 9

Vote of Thanks by His Excellency Mr Zahid Maleque, State Minister, Ministry of Health and Family Welfare, Government of the People’s Republic of Bangladesh .... 10

3 Business session ............................................................................................. 14

Opening of the Session .......................................................................................... 14

Appointment of the Subcommittee on Credentials ................................................. 14

Approval of the report of the Subcommittee on Credentials ................................... 14

Election of office-bearers ........................................................................................ 15

Adoption of the Agenda ........................................................................................ 15

Drafting Group on Resolutions ............................................................................... 15

Key addresses and report on the Work of WHO.................................................... 16

   Introduction to the Regional Director’s Biennial Report on the Work of WHO in the South-East Asia Region covering the period 1 January 2012–31 December 2013 .......................................................... 16

   Statements by representatives of United Nations and Specialized Agencies ........ 20

   Address by the Director-General ........................................................................ 22
WHO reform .................................................................................................................. 25
Framework of engagement with non-State actors ....................................................... 25
Follow-up of the Financing Dialogue ........................................................................ 27
Strategic Resource Allocation ..................................................................................... 28
Programme Budget matters ........................................................................................... 30
Programme Budget Performance Assessment: 2012–2013 ......................................... 30
Implementation of the Programme Budget 2014–2015 .............................................. 31
Proposed Programme Budget 2016–2017 .................................................................. 33
Technical matters ........................................................................................................... 35
Consideration of the recommendations arising out of the Technical Discussions on “Covering every birth and death: improving civil registration and vital statistics” ..... 35
Selection of a subject for the Technical Discussions to be held prior to the Sixty-eighth session of the Regional Committee ......................................................... 36
Traditional medicine: Delhi Declaration .................................................................... 38
Strengthening the implementation of the WHO Global Strategy to Reduce the Harmful Use of Alcohol to support the achievement of the regional targets on prevention and control of noncommunicable diseases ........................................... 39
Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage ................................................................. 42
Viral hepatitis .......................................................................................................... 44
Regional strategy on strengthening health workforce education and training .......... 46
Progress reports on selected Regional Committee resolutions ................................. 47
Nutrition and food safety in the South-East Asia Region ........................................... 48
South-East Asia Regional Health Emergency Fund ................................................... 50
Challenges in polio eradication ................................................................................... 51
Injury prevention and safety promotion ...................................................................... 52
2012: Year of intensification of routine immunization in the South-East Asia Region: Framework for increasing and sustaining coverage ........................................ 54
Regional Health Sector Strategy on HIV 2011–2015 .................................................... 56
Consultative Expert Working Group on Research and Development: Financing and Coordination ........................................................................................................ 57
Comprehensive and coordinated efforts for the management of autism spectrum disorders and developmental disabilities .......................................................... 59

Regional action plan and targets for prevention and control of noncommunicable diseases (2013–2020) ........................................................................... 60

Governing body matters ......................................................................................................................... 62

Key issues arising out of the Sixty-seventh World Health Assembly and the 134th and 135th sessions of the WHO Executive Board ................................................................................... 62

Review of the Draft Provisional Agenda of the 136th session of the WHO Executive Board ......................................................................................................................... 63

Special Programmes .......................................................................................................................... 64

UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases: Joint Coordinating Board (JCB) – Report on attendance at JCB in 2014 and nomination of a member in place of Nepal whose term expires on 31 December 2014 ................................................................. 64


Time and place of future sessions of the Regional Committee ...................................................................... 66

Adoption of the report of the Sixty-seventh Session of the Regional Committee ....................................... 66

Closure of the session ................................................................................................................................ 66

4 Resolutions and Decisions .................................................................................................................. 69

Resolutions ............................................................................................................................................. 69

SEA/RC67/R1 Proposed Programme Budget 2016–2017 ........................................................................ 69

SEA/RC67/R2 Covering Every Birth and Death: Improving Civil Registration and Vital Statistics ...................................................................................................................... 71

SEA/RC67/R3 Traditional Medicine: Delhi Declaration ............................................................................. 73

SEA/RC67/R4 South-East Asia Regional Action Plan to Implement Global Strategy to Reduce Harmful Use of Alcohol (2014–2025) ........................................................................ 75

SEA/RC67/R5 Viral Hepatitis .................................................................................................................. 78

SEA/RC67/R6 Strengthening Health Workforce Education and Training in the Region ............................... 81

SEA/RC67/R7 Resolution of Thanks ....................................................................................................... 83
Decisions ........................................................................................................................ 83

SEA/RC67(1) Strategic Budget Space Allocation......................................................... 83
SEA/RC67(2) Framework of engagement with non-State actors............................ 83
SEA/RC67(3) Nomination of a Member State to the Policy and Coordination Committee (PCC) of the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction ......................................................... 84
SEA/RC67(4) Nomination of a Member State to the UNICEF/UNDP/World Bank/WHO Special Programme of Research and Training in Tropical Diseases: Joint Coordinating Board (JCB) ...... 84
SEA/RC67(5) Time and place of future sessions of the Regional Committee..... 84

Annexes

1. Text of welcome speech by the Secretary, Ministry of Health and Family Welfare, Government of Bangladesh ........................................................................................................... 85
2. Text of address by the Regional Director, WHO South-East Asia ......................... 88
3. Text of address by outgoing Chairman of the Health Ministers’ Forum, the Minister of Health and Family Welfare, Government of India ......................................................... 91
4. Text of address by the Director-General, World Health Organization .................. 95
5. Text of address by the Minister of Health and Family Welfare, Government of Bangladesh ................................................................................................................................. 98
6. Text of inaugural speech by the Prime Minister of Bangladesh ............................ 100
7. Agenda ....................................................................................................................... 105
8. List of participants ..................................................................................................... 108
9. List of official documents ........................................................................................ 124

Side events at the Sixty-seventh Session of the WHO Regional Committee for South-East Asia

1. Signing of the MoU on Kala-azar............................................................................. 128
2. Ministerial Round Table on Traditional Medicine................................................ 130
3. Briefing on Ebola Virus Disease by WHO Director-General, Dr Margaret Chan ..... 137
4. Partnerships for innovation and affordable technology for public health ............. 140
5. Addressing autism through partnerships: A round-table discussion for the development of a multifaceted action plan................................................................. 145
INTRODUCTION

1. The Sixty-seventh Session of the WHO Regional Committee for South-East Asia was held in Dhaka, Bangladesh, from 9 to 12 September 2014. It was attended by representatives of all 11 Member States of the Region, UN and other agencies, nongovernmental organizations having official relations with WHO, and observers.

2. The joint inauguration of the Sixty-seventh Session of the WHO Regional Committee for South-East Asia and the Thirty-second Meeting of Ministers of Health of Countries of the WHO South-East Asia Region was held on 9 September 2014. The Honourable Prime Minister of Bangladesh, Her Excellency Sheikh Hasina, delivered the inaugural address.
3. The Regional Committee elected His Excellency Mr Mohammed Nasim, Honourable Minister of Health and Family Welfare of the People’s Republic of Bangladesh, as Chairperson and Her Excellency Dr Thein Thein Htay, Deputy Minister of Health, Republic of the Union of Myanmar, as Vice-Chairperson for the Session.

4. The Committee reviewed the Report of the Regional Director covering the period 1 January 2012 to 31 December 2013.

5. The Committee decided to hold its Sixty-eighth Session in 2015 in Dili, Timor-Leste.

6. A Drafting Group on Resolutions comprising a representative from each of the Member States was constituted with Dr Thaksaphon Thamarangsi, Thailand, as Rapporteur. During the Session, the Committee adopted 7 resolutions.
7. The joint inauguration of the Thirty-second Meeting of Ministers of Health of Countries of the WHO South-East Asia Region and the Sixty-seventh Session of the WHO Regional Committee for South-East Asia was held in Dhaka, Bangladesh, on 9 September 2014.

Welcome speech by Mr M.M. Neazuddin, Secretary, Ministry of Health and Family Welfare, Government of the People’s Republic of Bangladesh

8. In his welcome speech, Mr M.M. Neazuddin, Secretary, Ministry of Health and Family Welfare, People’s Republic of Bangladesh, recalled Bangladesh’s achievements in the health sector over the past few years under the leadership of the Honourable Prime Minister, Her Excellency Sheikh Hasina. He also referred to the series of international awards received by the country for the improvement of health indices.

9. Mr Neazuddin strongly endorsed WHO’s contribution in determining best practices in health and developing appropriate roles for health systems under the leadership of the Director-General, Dr Margaret Chan. He expressed the hope that under the visionary guidance of the new WHO Regional Director for South-East Asia, Dr Poonam Khetrapal Singh, health challenges will be addressed on a fast-track and effective basis.
10. The WHO Regional Director for South-East Asia, Dr Poonam Khetrapal Singh, in her address, welcomed the honourable ministers and other distinguished representatives, and conveyed her grateful thanks to the Government of the People’s Republic of Bangladesh for hosting the meeting in Dhaka. She also expressed her sincere gratitude to Her Excellency Sheikh Hasina, Prime Minister of the People’s Republic of Bangladesh, for consenting to inaugurate the joint session.

11. The Regional Director commended the health advances achieved in Bangladesh under the inspired leadership of the Honourable Prime Minister, especially the steep and sustained reduction in birth rates and mortality. She said that strategies such as improvement of health outcomes by ensuring gender equity and offsetting socioeconomic constraints through direct health interventions were worthy of emulation.

12. Dr Singh said that the polio-free certification of the Region was a defining moment and a cause for celebration. She congratulated the health ministers for their collective political commitment and expressed her appreciation for the untiring efforts of the thousands of unsung health workers who had dedicated themselves to bring about this achievement.

13. The Regional Director cautioned against complacency in the face of mounting challenges posed by noncommunicable diseases that threatened to destabilize the health systems and economies of Member States if not checked. She stressed that intersectoral partnerships were crucial to overcome the numerous challenges posed by noncommunicable diseases (NCDs).

14. Dr Singh reiterated that health equity should be the cornerstone of all policies, in recognition of the inalienable right of all people to health. Universal health coverage can only be achieved by putting people at the centre of health interventions.

15. Recognizing that the hard-won achievements in health could be wiped out by unexpected disasters and calamities, the Regional Director lauded the heroic efforts of the national and international community in combating the unprecedented outbreak of Ebola fever in West Africa that had claimed more than two thousand lives.
16. Dr Singh stressed that health in the twenty-first century required a twenty-first century approach. What we have learned in our fight against tobacco stands us in good stead. We cannot hope to outrun NCDs without action in the many sectors that impact health: finance, trade, agriculture and education. Partnership across all sectors of society is not an add-on in this fight. It is an absolute necessity.

17. The Regional Director reiterated her commitment to the four strategic directions outlined by her that reflected the priorities of Member States and would guide the work of the Region. She highlighted the role that WHO could play in driving policy agendas for delivery of better health to the peoples of the Region and adding value to national health programmes. While noting with appreciation the increase in the number of global players in the health sector and additional spending on health in the Region, she advised the Member States against duplication and fragmentation of programmes that resulted in wasteful use of resources.

18. The Regional Director thanked the Honourable Prime Minister for hosting and inaugurating the meetings and the Ministry of Health and Family Welfare, Government of the People’s Republic of Bangladesh for the excellent arrangements made in this regard. She also welcomed the distinguished participants and conveyed her greetings and good wishes for fruitful and productive deliberations.

(For full text of the address, please see Annex 2.)
Speech by the outgoing Chairman of the Health Ministers’ Forum, His Excellency Dr Harsh Vardhan, Minister of Health and Family Welfare, Government of India

19. His Excellency Dr Harsh Vardhan, Honourable Minister for Health and Family Welfare, Government of India, representing India as the Chairperson of the Health Ministers’ Forum, recalled the historic relationship between Bangladesh and his country and sought the support of the health ministers to work to achieve the highest standard of health in the Region.

20. Recalling the long and arduous road to attain polio-free status for the Region in which he had a pioneering role at the national level, he reiterated that this achievement had infused the people of the Region with new hope and energy.

21. Appreciating the new vision and new leadership in WHO South-East Asia Region, he was sure that this will generate new enthusiasm and vision to take on greater challenges.

22. His Excellency informed the ministers that strong measures had been taken in India to intensify implementation of the WHO Framework Convention for Tobacco Control. This included prohibiting smokeless tobacco use and strengthening primary health care (PHC) systems in a bid to tackle the threat posed by noncommunicable diseases.

23. The Region being home to several vector-borne diseases such as malaria, dengue and lymphatic filariasis, the honourable Minister noted that five countries of the Region were jointly signing an agreement for the prevention, control and elimination of kala-azar and welcomed the Dhaka Declaration on Vector-borne Diseases.

24. Highlighting the important features of the Indian traditional system of medicine, Ayurveda, he noted with satisfaction that it was an important agenda item in the Regional Committee session and a bilateral agreement on traditional medicines was being signed with Bangladesh in this regard.

25. The honourable minister reiterated that investing additional resources into the health system, improving access to essential medicines, harnessing information technology, promoting traditional medicine systems, providing an essential
package of preventive and promotive health services, community participation and partnerships would empower the governments to achieve greater health outcomes.

(For full text of the address, please see Annex 3.)

Address by Dr Margaret Chan, Director-General, World Health Organization

26. The Director-General of the World Health Organization, Dr Margaret Chan, expressed her pleasure to be in Dhaka and thanked the Government of the People’s Republic of Bangladesh, especially the Honorable Prime Minister, Her Excellency Sheikh Hasina, and His Excellency Mr Mohammed Nasim, Minister of Health and Family Welfare, Government of the People’s Republic of Bangladesh, for hosting these important meetings.

27. Commending the significant improvements in the health system of Bangladesh, Dr Chan said that the medical community had witnessed a stunning rise in the overall health status and life expectancy with a woman at the helm.

28. The Director-General congratulated India on its monumental achievement of polio-free status that demonstrated the fact that with commitment and sustained efforts, nothing was impossible.
29. Dr Chan said that in an era of global movement of goods and people, the recent outbreak of Ebola fever in West Africa was a reminder that all countries were endangered. Only sound health systems and heightened vigilance could keep emerging diseases such as Ebola fever at bay.

(For full text of the address, please see Annex 4.)

Address by His Excellency Mr Mohammed Nasim, Minister of Health and Family Welfare, Government of the People’s Republic of Bangladesh

30. His Excellency Mr Mohammed Nasim, Minister of Health and Family Welfare, Government of the People’s Republic of Bangladesh, expressed his gratitude to the Honourable Prime Minister of Bangladesh for gracing the joint inaugural session. He said it was a privilege for Bangladesh to host the Health Ministers’ Meeting in Dhaka. He also thanked the Director-General of WHO and the Regional Director, WHO South-East Asia Region for their leadership in global health.

31. While acknowledging the noteworthy support and guidance being provided by Her Excellency Sheikh Hasina for the all-round health development efforts of Bangladesh, the Honourable Minister commended her vision and commitment to take not only Bangladesh but the whole of the Region forward on the road to
progress. Conversant as she is with all important health issues facing the peoples of Member States of the Region, the Honourable Minister was confident of the Prime Minister leading by example in setting the tone for successfully pursuing the health development goals and thereby providing better and sustainable health to all people.

32. His Excellency stated that he looked forward to receiving positive and useful inputs and feedback from the discussions and deliberations at the Health Ministers’ meeting and the session of the Regional Committee.

(For full text of the address, please see Annex 5)

Inaugural Address by Her Excellency Sheikh Hasina, Prime Minister, People’s Republic of Bangladesh

33. The Honourable Prime Minister of Bangladesh, Her Excellency Sheikh Hasina, shared some of Bangladesh’s success stories in the health sector. The Prime Minister said that since the time of the founding of the country in 1971 by Bangabandhu Sheikh Mujibur Rahman, health had been accorded the highest priority and included in the Constitution as one of the five fundamental rights. She recalled that during the tenure of her government in 1996–2001, 4000 community clinics, 7000 hospital beds and 2000 doctors were added to the infrastructure and the private sector was involved for the first time in health care through a series of incentives. “Today, a total of 13 000 community clinics are operational with internet connectivity, e-health and telemedicine facilities, and a pragmatic health policy is in place,” she said.

34. Bangladesh received the South-South Award in 2011 for its robust health infrastructure, which Her Excellency described as one of the world’s most extensive and equitably distributed with domiciliary care, primary clinics, and primary, secondary, tertiary and specialized hospitals with upward and downward referral linkages. Stressing the importance of the health of women and children in the making of a healthy nation, the Honourable Prime Minister said health policies must incorporate holistic dimensions of social, economic and environmental determinants, including poverty reduction, education, gender equality, women’s empowerment and family planning. Poverty reduction can aid in ensuring food and nutrition security.

35. The Prime Minister said Bangladesh met the targets of MDG 4 three years ahead of the 2015 deadline and is on track to meet the goals of MDG 5 by 2015. While the South-East Asia Region was certified polio-free in March 2014, Bangladesh has
also eliminated leprosy and reduced mortality and morbidity due to tuberculosis, avian influenza, anthrax, Nipah, severe acute respiratory syndrome (SARS), dengue and malaria through its nationwide effective public health measures. Nutrition, noncommunicable disease control, autism and mental health programmes have been mainstreamed with primary health care and screening, identification and follow-up systems strengthened. Bangladesh has a robust pharmaceutical sector that meets 97% of domestic demands and exports medicines to about 87 countries.

36. Her Excellency acknowledged the role of WHO and other development partners in the achievement of these successes, and in sharing global knowledge and best practices. Given that the Member States of the WHO South-East Asia Region share largely similar economic and sociocultural situations and challenges, Her Excellency hoped the meeting of health ministers and the Regional Committee session will provide effective guidance and best solutions to better health.

37. Referring to the “side event” on autism on 11 September 2014, where her daughter and child psychologist, Ms Saima Wazed Hossain, will deliver the keynote address, she hoped that it will help mobilize crucial global support for autism. It is imperative that individuals with autism and other developmental disabilities find easy access to improved diagnosis and services.

38. Her Excellency renewed the commitment to universal health coverage as an essential precondition to ensuring sustainable growth. “Bangladesh has been an active participant in all discussions of WHO and will continue to do so,” she added.

(For full text of the address, please see Annex 6.)

Vote of Thanks by His Excellency Mr Zahid Maleque, State Minister, Ministry of Health and Family Welfare, Government of the People’s Republic of Bangladesh

39. Delivering the vote of thanks, His Excellency Mr Zahid Maleque, State Minister, Ministry of Health and Family Welfare, Government of the People’s Republic of Bangladesh, extended a warm welcome to the Prime Minister of Bangladesh, Her Excellency Sheikh Hasina, honourable health ministers of the WHO South-East Asia Region, WHO Director-General, Dr Margaret Chan, and WHO Regional Director, Dr Poonam Khetrapal Singh, and all other distinguished delegates from the Member States. He welcomed all delegates to Bangladesh,
“the beautiful country of diverse flora and fauna, and with mighty rivers flowing through it”, and wished them a very comfortable and memorable stay in Dhaka.

40. His Excellency extolled the extraordinary leadership and guidance being provided by Her Excellency Sheikh Hasina; it was due to her monumental support and commitment that Bangladesh had made commendable progress in recent years, especially in agriculture and food production. From being a food-deficit country until not too long ago, Bangladesh is now a food-surplus nation. Furthermore, the literacy rate has gone up, road and highway infrastructure has improved, telecommunication and connectivity expanded and child and maternal mortality rates have declined.

41. The honourable minister expressed confidence that the Dhaka Declaration on Vector-borne Diseases would prove to be very beneficial to all tropical countries in the Region, such as Bangladesh, in tackling the growing challenges posed by vector-borne diseases.
Opening of the Session

42. In the absence of the Chairperson, the Vice-Chairperson of the Sixty-sixth Session of the Regional Committee, His Excellency Dr Sergio G.C. Lobo, Honourable Minister of Health, Timor-Leste, opened the Sixty-seventh Session of the Regional Committee for South-East Asia, in accordance with Rule 12 of the Rules of Procedure of the WHO Regional Committee for South-East Asia. His Excellency Dr Lobo acknowledged the role of the Regional Committee in addressing the formidable challenges facing the health sector through enhanced collaboration. He noted that the Committee had important technical agenda items and matters related to WHO reform and Programme Budget to discuss during the current Session.

Appointment of the Subcommittee on Credentials (Agenda item 2.1)

43. A Subcommittee on Credentials, comprising representatives from Bhutan, Nepal and Thailand was appointed.

Approval of the report of the Subcommittee on Credentials (Agenda item 2.2)

44. The Subcommittee nominated the distinguished representative from Bhutan as its Chairperson and examined the credentials submitted by all Member States.
The credentials submitted by the 11 Member States namely, Bangladesh, Bhutan, Democratic People’s Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste were found to be in order, thus entitling the representatives to take part in the proceedings of the Regional Committee Session.

**Election of office-bearers (Agenda item 3)**

45. His Excellency Mr Mohammed Nasim, Minister of Health, Government of the People’s Republic of Bangladesh, was elected Chairperson and Her Excellency Dr Thein Thein Htay, Deputy Minister of Health, Government of the Republic of the Union of Myanmar was elected Vice-Chairperson.

**Adoption of the Agenda**  
*(Agenda item 4: Document number SEA/RC67/1)*

46. The Committee adopted the Agenda as contained in document SEA/RC67/1Rev.4.

**Drafting Group on Resolutions**

47. The Committee constituted a Drafting Group on Resolutions comprising a representative from each of the Member States with Dr Thaksaphon Thamarangsi, Thailand, as Rapporteur.
Key addresses and report on the Work of WHO (Agenda item 5)

Introduction to the Regional Director’s Biennial Report on the Work of WHO in the South-East Asia Region covering the period 1 January 2012–31 December 2013
(Agenda item 5.1: Document number SEA/RC67/2)

48. In her first address to the Regional Committee as Regional Director, Dr Poonam Khetrapal Singh broke from tradition by going beyond providing a synopsis of the biennial report on the Work of WHO in the South-East Asia Region for the period 1 January 2012–31 December 2013, and sharing her vision with the participants.

49. Recalling the broad lessons that can be learned from WHO’s experience of working together with Member States over the last two years, she urged Member States to envision a more intense future role for WHO in this Region. She said that a strategic review of the past can help shape priorities for the future, and influence how the progress of WHO’s work is measured and reported.

50. Stating that the Region recorded health achievements of which all Member States could justifiably be proud, Dr Singh singled out the triumph over polio culminating in the polio-free certification, thanks to unwavering national commitment and the untiring efforts of thousands of frontline workers. She noted that leprosy had also been successfully eliminated at the national level in all Member States. There had also been significant declines in childhood and maternal mortality and in deaths from acquired immunodeficiency syndrome (AIDS), tuberculosis (TB) and malaria. Calling India the “world’s pharmacy” providing medicines and vaccines of certified quality on a global scale, she noted that other countries in the Region are stepping up efforts to acquire self-sufficiency in the manufacture of quality medicines. She added that the Region also had a rich resource in its long history of traditional medicine.

51. Amidst these achievements, the Regional Director also struck a note of caution by reminding participants of the health challenges that Member States continued to face. She said that there was no room for complacency in the face of the real threat of polio importation from currently endemic countries, and therefore strict
vigilance and continued surveillance were of vital importance. The Region also suffers more deaths from natural disasters than any other in the world. Child deaths have declined, but neonatal mortality remains a particular challenge. Nine out of 11 countries have yet to attain adequate core capacities as defined in the International Health Regulations (2005). The Regional Director stressed that NCDs do not just threaten the people and health systems of the countries of the Region, they threatened national economies. On the deadly impact of antibiotic resistance, she said it hampers the control of infectious diseases and dramatically increases the costs of health care.

52. Urging a more holistic approach to health challenges, the Regional Director noted that the major problems of NCDs, antimicrobial resistance, the impact of conflict and instability on the spread of disease and wider access to safe and affordable medicines are as much problems of governance as they are of health alone. Good governance, collective action and inter-ministerial collaboration could help deal with these and success depends on solidarity between countries as they seek the best solutions to common problems. Citing the example of tobacco, she said the fight against its consumption calls for engagement with ministries of finance, trade, agriculture and many others. The same is true for NCDs.

53. She also drew the Committee’s attention to the fact that public health and poverty are intimately linked: the poor are hit first and the hardest in times of disaster; they have less access to services, resulting in worse health outcomes. The geography of poverty has also changed, she said, and two-thirds of the world’s absolute poor now live in middle-income countries. This has major implications for health, for example, reducing health inequity is as critical to better health as it is to fulfil the health targets of the Millennium Development Goals. The theme of inequity of access and outcome is one that should increasingly underpin planning for the future. The Regional Director underscored the role of technology and the creativity of innovators in envisaging Twenty-first century solutions to longstanding health problems. Information systems, new medical tools and products and communications technology empower frontline health workers and health-care managers and civil society on an unforeseen scale.

54. While the global increase in development assistance for health over the first decade of this century has resulted in a proliferation of new initiatives and new partnerships, the Regional Director cautioned against fragmentation and duplication of effort. Reiterating WHO’s real comparative advantage in this context, Dr Singh informed participants about her focus on aligning regional strategic directions with
the global strategy set out in the WHO Twelfth General Programme of Work (GPW), while at the same time, reflecting the priorities expressed by the Member States.

55. Being responsive to a changing world and its emerging challenges was the inspiration for her first strategic direction of “addressing persistent and emerging epidemiological and demographic challenges”. Her second strategic direction, “advancing universal health coverage and robust health systems”, meets the criteria of integrative ways of work, breaking down silos and underscoring the importance of equity and health as a right.

56. In line with the Twelfth General Programme of Work (GPW) that stresses the need to protect lives in times of emergencies, Dr Singh said that her third strategic direction is “strengthening emergency risk management for sustainable development”. Emergency preparedness and response to combat antimicrobial resistance are the flagship areas in this direction.

57. Speaking on WHO reform, Dr Singh said one of its objectives is greater coherence in global health. She was convinced that the Region should have a stronger voice in global health, and “articulating a strong regional voice in the global health agenda” is the fourth strategic direction. The strategic directions define what WHO will do, but it is necessary to be clear not just about what it will do, but also how it will go about it. She said that it was important to not just spend, but spend wisely, using the right people, the right level of resources, deployed in the right places, to do the right things. Better health was not a luxury, but an investment in the future of countries.
58. The Regional Director also informed the Committee about the establishment of a high-level Advisory Committee to provide independent, strategic advice to her. This Committee would bring together a select group of people – the brightest and the best – from a variety of backgrounds and disciplines, from the Region and beyond, to advise on regional health priorities.

59. She informed the Committee of a number of efficiency measures undertaken by her to streamline WHO’s spending for quality rather than quantity, including strengthening country offices with technical manpower and focusing duty travel of technical staff to provide country support as well as aligning meetings around WHO and country priorities.

60. In conclusion, Dr Singh said that even though WHO cannot do everything, what it does must make a difference. WHO can add value by being ready to offer advice and support, based on the best information, best science and the best network of resources globally, regionally and in the Member States of the Region. This requires that WHO embrace change, be proactive in looking outward and be prepared to work with a wide range of partners that shared its vision for a healthier Region and a healthier world.

61. The Committee commended the Regional Director’s Report on the Work of WHO in the South-East Asia Region for the period 1 January 2012–31 December 2013, noting that the report provided a wide-ranging and excellent update on current health perspectives from the Region and issues of significant concern in
the future. The Committee also placed on record its appreciation of the Regional
Director’s vision and endorsed the four strategic directions emanating therefrom.

(For full text see Annex 2.)

Statements by representatives of United Nations and Specialized Agencies

62. Mr Srinivas B. Reddy, Country Director, International Labour Organization
(ILO), Bangladesh, said that safe work was at the heart of ILO’s Decent Work
Agenda and an integral part of ILO’s work. According to the Director-General of
ILO, Mr Guy Rider: “The right to a safe and healthy workplace is a basic human right
– a right to be respected at every level of development and in different economic
conditions. Respecting this human right is an obligation – as well as a condition
for sustainable economic development.” Though the right to life is fundamental,
globally, about 2.2 million women and men succumb to work-related accidents and
diseases every year. It is ironic that work claims more victims around the globe than
war. It is the poorest — the least protected, informed and trained workers, including
women, children, people with disabilities, migrant workers and ethnic minorities
who are the most vulnerable. In this context, it is necessary to focus attention on
social protection, education and training by integrating occupational safety and
health within vocational training courses. Key stakeholders and employers must
understand that better educated and healthier workers carrying out decent work in
safe surroundings will drive growth, not hinder it. This can be achieved by fostering
a culture of intolerance towards risks at work, which would reduce the incidence
of work-related accidents. He called for establishment of a permanent culture of
health and safety at the workplace.

63. Dr Douglas Noble, Regional Health Adviser, UNICEF Regional Office for South
Asia (ROSA), Kathmandu, underlined the importance of ensuring the survival and
protecting the health of children as the twenty-fifth anniversary of the Convention
on the Rights of the Child approached. Noting that nutrition and birth registration
figuring on the agenda of the Regional Committee session had serious implications
for children, he said that it was important to break the intergenerational cycle of
undernutrition by improving the quality of food and feeding practices including
breastfeeding. Birth registration was the first formal recognition of a child’s existence
without which the child would be denied access to health services to thrive and
survive.
64. Dr Noble said that UNICEF had two key health priorities for South Asia – neonatal mortality and immunization. The death of a newborn baby in the first month of life is a tragedy, but sadly enough, this was a common occurrence in South Asia, accounting for more than half of all child mortality. He hoped that the World Health Assembly resolution WHA67.10 on newborn health action plan ratified at the Sixty-seventh World Health Assembly in May 2014 would be implemented through a tripartite partnership between UNICEF, WHO and Member States. He informed participants that recognizing immunization as one of the most cost-effective and life-saving health interventions for children, UNICEF had actively contributed to improvement of the cold chain in Member States. In order to raise awareness of communities and families on the role of vaccination in protecting children from diseases, UNICEF developed and disseminated key messages and information materials in the Region. Dr Noble concluded with a plea to keep in mind the wider social determinants of health such as reducing child poverty and improving access to education.

65. In her intervention on behalf of the World Meteorological Organization (WMO), Ms Mahnaz Khan, Deputy Director, Bangladesh Meteorological Department, highlighted the impact of climate on human health. Extreme weather events were an increasing concern for the health sector, affecting not only people’s mental and physical well-being, but causing disruption to critical health services and threatening the integrity of essential health facilities, and water and sanitation infrastructure. In this scenario, improving the joint capacity of WHO and WMO to develop actionable climate and weather knowledge and community-level protection to proactively address climate- and weather-related health risks was essential.
66. The Third World Climate Conference held in Geneva in 2009 established the Global Framework for Climate Services (GFCS), a partnership of UN and international organizations and other stakeholders aimed at enhancing the production and application of climate services in support of decision-making in four priority areas, of which health is one. A joint office on climate and health between WMO and WHO was established in May this year, which facilitates global coordination of key stakeholders to address priorities identified by the health component of GFCS.

67. The recent WHO Global Conference on Health and Climate held in Geneva from 27–29 August 2014 stressed the need for strengthening collaboration between the health, meteorological and climate communities to better manage climate risks to health. It is necessary that the health sector establishes operational coordination mechanisms at national level with the meteorological and climate sector to promote capacity-building in both sectors and conduct interdisciplinary research to develop integrated epidemiological and environmental monitoring or early warning systems that accurately alert local health authorities about impending weather-related risks for proactive preparedness. She concluded with an appeal to Member States to ensure that national health authorities join forces with the meteorological and health communities under the Global Framework for Climate Services and actively involve themselves in the implementation of the UN Framework Convention for Climate Change for improved health outcomes.

**Address by the Director-General (Agenda item 5.2)**

68. In her address to the Regional Committee, the Director-General, Dr Margaret Chan, commended Bangladesh for championing the cause of good health as a
nation-building strategy, which was an example worthy of emulation. Reaching the community through its vast network of grassroots-level workers was the best way to ensure universal health coverage and withstand shocks from violence or natural calamities.

69. The Director-General appreciated the Regional Director for her creative presentation and astute analysis of common threats facing the Region by underlining the complexities in the new health landscape.

70. She noted that countries of the Region were in a state of high preparedness due to the threat of the deadly and fast-moving Ebola virus and were anxious to keep it out of their borders. She expressed her distress at the deaths and devastation caused by the virus that had decimated villages, orphaned thousands of children, caused food and fuel shortages, demolished health systems infrastructure, immobilized air and road transport and brought health services to a standstill. Little wonder that rumours and panic were spreading faster than Ebola. The whole world was watching how WHO, the UN system and others were working in West Africa to control the Ebola crisis.

71. Dr Chan highlighted the lessons to be learnt from the Ebola outbreak: growing inequalities in societies with fear amplifying social differences; global risk caused by interconnected and interdependent nature of societies; decades of neglect of fundamental health systems catapulting countries into crisis situations; the indifference of a profit-driven industry to investment in research for diseases affecting poor countries, and the poor preparedness of most countries to severe public health emergencies. She urged Member States to continue to push for strengthening health systems as there was compelling evidence that the pressure of outbreaks revealed functional flaws. She also pressed for more accountability by upgrading national systems of civil registration and vital statistics, and engaging more educated, trained and incentivized health manpower.

72. In conclusion, Dr Chan observed that every minister in a government is a health minister, because of the intersectoral nature of health. She urged health ministers to be watchful of the policies of other sectors for any adverse impact on health. She concluded by wishing the honourable ministers and distinguished representatives a constructive meeting.

(For full text of the Director-General’s address see Annex 4.)

73. His Excellency Mr Mohammed Nasim, Honourable Minister of Health and Family Welfare, Government of the People’s Republic of Bangladesh, thanked the
Director-General for recognizing the achievements of his country in the field of health in spite of the challenges of a huge population and regular natural calamities.

74. His Excellency Lyonpo Tandin Wangchuk, Honourable Minister of Health, Royal Government of Bhutan, appreciated the guidance given by the Director-General at global level, which had helped his country to manage its public health emergencies.

75. His Excellency Dr Harsh Vardhan, Honourable Minister of Health and Family Welfare, Government of India, placed on record his appreciation of the work done by the WHO Regional Office and the Regional Director’s vision that would help the Region to achieve perceptible and measurable difference in the health status of the people. The Honourable Minister urged Member States to resolve to convert all the good policies, programmes and directions provided by WHO into vibrant health programmes in countries, so that health care becomes a social movement. His Excellency also called for a whole-of-government approach with the highest commitment from the top leadership and “out-of-box” thinking to address the problems facing the Region in order to ensure that the Region emerges as a leader in health for the rest of the world. India had made a beginning in that direction with a proposal to establish “health cells” in ministries other than health with different roles to play in health. The importance of information, education and communication (IEC) in generating awareness in the population to promote health was highlighted. The Honourable Minister urged WHO to set up a regular monitoring mechanism for collaborative activities.

76. His Excellency Mr Hussain Rasheed, Honourable Minister of State for Health, Republic of Maldives noted that Member States should work together on research for Ebola vaccine, and improve their health systems so as to be able to withstand any natural disaster or outbreak. The Honourable Minister expressed the commitment of his government to work collectively with other countries in the Region to realize the vision of the Regional Director.

77. His Excellency Mr Lalith Dissanayake, Deputy Minister for Health, Democratic Socialist Republic of Sri Lanka, expressed his appreciation to the Director-General for her briefing on Ebola virus and said that a
separate ministry to handle disaster management had been set up in the wake of the tsunami of 2004.

78. Her Excellency Dr Thein Thein Htay, Deputy Minister for Health, Government of the Republic of the Union of Myanmar, congratulated the Director-General for her inspiring address and expressed her appreciation for the Regional Director’s vision. Her Excellency concurred with the suggestion of the Committee that a monitoring mechanism for collaborative activities was needed. It was important to ensure inclusive development and for this, health should be embedded in the work of all sectors, with health-in-all policies and a whole-of-government approach.

79. The Committee congratulated the Director-General for her thought-provoking and inspiring address, and concurred with her views on health-in-all policies.

WHO reform (Agenda item 6)

Framework of engagement with non-State actors
(Agenda item 6.1: Document number SEA/RC67/3, Add.1 and Inf. Doc.1)

80. Today’s health landscape has become more complex in many respects, including the increase in the number of players in global health governance. The Committee acknowledged the major and growing role of non-State actors in all aspects of global health, retiterating that the overall objective of WHO’s engagement with such actors is to work towards the fulfilment of the Organization’s mandate by making better use of resources. As part of WHO reform, the governing bodies had requested the Director-General to develop an overarching framework for engagement with
non-State actors as well as separate policies on WHO’s engagement with different groups of non-State actors.

81. Based on the inputs received from debates at the meetings of the governing bodies and consultations, the WHO Secretariat had submitted to the Sixty-seventh World Health Assembly in May 2014 a draft framework for engagement with non-State actors. The draft overarching framework applies to all engagements of WHO with non-State actors and provides the rationale, principles and boundaries of such engagement.

82. The Committee was informed that the Sixty-seventh World Health Assembly had decided that the regional committees should discuss the draft framework of engagement with non-State actors as well as consider the comprehensive report of the comments made by Member States and the follow-up comments and questions raised, including clarification and response thereon from the Secretariat. It had requested the regional committees to submit a report on their deliberations to the Sixty-eighth World Health Assembly through the Executive Board.

83. The Committee was also informed of the deliberations at the High-Level Preparatory (HLP) meeting held in the Regional Office, New Delhi, from 14–17 July 2014, and the inter-sessional meeting convened in the WHO Regional Office, New Delhi, in August 2014 to prepare for the discussions on the subject at the Regional Committee Session to provide a regional response as requested by the Secretariat.

84. The recommendations of the inter-sessional meeting to the Committee were considered, including the proposed changes by Member States of the Region in the draft framework and associated policies/operational procedures. The chief concern of the Committee was that in its engagement with non-State actors, the integrity and neutrality of WHO should not be compromised. In addition, the Committee sought clarifications concerning definitions, secondments from non-State actors and in relation to donation of medicines.

85. Member States were assured that there were no secondments to WHO from the private sector. Most of the
secondments were from UN agencies, which did not fall under the category of non-State actors, being sister agencies. It was clarified that non-State actors being active in the public health arena, it was important to engage with them, albeit with some boundaries.

86. The Committee was informed that the draft framework was being developed with inputs from Member States, whose concerns were relevant and pertinent. These, along with the comments from other regions of WHO would be compiled by the Secretariat and submitted to the Executive Board in January 2015 for revision of the draft framework on engagement with non-State actors, which would then be placed before the Sixty-eighth World Health Assembly in May 2015.

87. The Committee requested that the report of the inter-sessional meeting held in August 2014 be taken into consideration while revising the draft framework on engagement with non-State actors.

88. With these clarifications, the Committee endorsed the recommendations made by the inter-sessional meeting held in August 2014.

Follow-up of the Financing Dialogue
(Agenda item 6.2: Document number SEA/RC67/4)

89. The Director-General launched WHO’s Financing Dialogue with Member States in June 2013. The Committee was informed that this Financing Dialogue is a mechanism to ensure a match between WHO’s results and deliverables, as agreed in the Member State-approved Programme Budget, and the resources available to finance them, with the ultimate objective of enhancing the quality and effectiveness of WHO’s work. It is designed to improve the alignment, predictability, flexibility and transparency of WHO’s funding and to reduce its vulnerability.

90. The Committee was informed about the recommendations made by the High-Level Preparatory Meeting that urged Member States to continue to engage in the Dialogue, voice opinions and suggest improvements as the process moves forward.

91. The Committee deliberated the Financing Dialogue in detail, observing the aspect of transparency offered by the newly released Programme Budget web portal, and also expressed concern about the financial vulnerability that arises from only 20 contributors providing 80% of WHO’s Voluntary Contributions.

92. Member States also took note of the fact that available and projected funding totalled 85% of the 2014–2015 Programme Budget, and stressed the importance of
extending the Financial Dialogue beyond a narrow, two-year window and aligning it more strongly with the General Programme of Work.

93. Expressing support for the concept of Financing Dialogue, the Committee called it a key component of WHO reform and observed that budgetary support should link with regional health concerns and challenges over donor priorities, and that there should be greater and more flexible core budget funding.

94. The Committee also expressed the need for contributions from the private sector while safeguarding the integrity and independence of WHO in a structured manner based on WHO priorities and the needs of Member States.

95. The Committee urged WHO to share the findings of the independent evaluation of the Financing Dialogue, and noted that it is premature to pass judgment about its long-term implications since it is at a very initial stage. If carefully coordinated and managed, it can lead to positive developments and results through prediction of funds and harmonization of programme budgeting.

96. Expressing concern that the number of donors in the South-East Asia Region is not only limited but also among the lowest in the WHO regions, any reduction in the size of the Programme Budget would threaten the Regional Office’s ability to provide appropriate technical support to Member States. The Committee called for addressing the mismatch between budgets and national health needs and priorities.

97. While all Member States reiterated the importance of priority-based funding on the basis of the needs of the people of the Region as opposed to donor priorities, some Member States also welcomed non-cash contributions from donors such as through deputing in-service experts and hosting activities of WHO, and urged more discussions on the Financing Dialogue. The Committee also called for harmonization between donor funding and WHO priorities.

Strategic Resource Allocation
(Agenda item 6.3: Document number SEA/RC67/5, Add.1, Inf. Doc.1 and Inf. Doc.2)

98. The Committee recalled that at the Sixty-sixth World Health Assembly in May 2013, Member States had requested the Director-General to propose a new Strategic Resource Allocation (SRA) methodology in WHO, starting with the development of the Programme Budget for the 2016–2017 biennium. The 134th Meeting of the Executive Board, held in January 2014, had endorsed the proposal of the Director-General to establish a Working Group on Strategic Resource Allocation to
provide guidance to the Secretariat in further developing the proposal for a new SRA methodology.

99. The Committee was also informed that since then a Working Group comprising Member States (one each representing each of the six regions) was formed to provide guidance to the Secretariat in developing a draft of the proposed new methodology. The Committee also noted that the High-Level Preparatory Meeting, held in July 2014, had reviewed the subject and made recommendations, including a call to Member States for submission of their inputs to Maldives, which was a member on the Working Group from the South-East Asia Region.

100. The Committee recognized that the development of a new Strategic Resource Allocation methodology in WHO is quite complex and interdependent with many other WHO reform initiatives that are currently under way. These include work on “bottom-up” planning, identification and costing of outputs and deliverables, the roles and functions of the three levels of the Organization, and review of the financing of administrative and management costs.

101. The guiding principles of the new Strategic Resource Allocation methodology include need- and evidence-based strategic allocation of resources supporting those countries in greatest need, based on epidemiological data including research findings and scientifically-validated facts, as well as objectively measurable benchmarks that ensure fairness and equity.

102. Member States reiterated the need to revisit the criteria for allocation of strategic resources to address the health needs of Member States of the Region
and also to incorporate the new post-2015 development goals as and when they are formalized. Some Member States underscored the need to have a uniform weighting system to ascertain the health priorities and needs of countries factoring in the unit cost of health care, which is high in some countries on account of factors such as difficult terrain and remote pockets of population, etc.

103. It was also suggested that achievements in financial performance and technical indicators must be considered to improve the quality of output of WHO programmes. While the SRA methodology must be evidence-based, it was also stated that fairness and equity principles must underscore the same. The SRA methodology should address the health concerns and risk factors of Member States, and take an objective look at criteria such as the human development index and the burden of disease, etc.

**Programme Budget matters**
*(Agenda item 7)*

**Programme Budget Performance Assessment: 2012–2013**
*(Agenda item 7.1: Document number SEA/RC67/6, Inf. Doc. 1 and Inf. Doc. 2)*

104. The Committee was informed that the Organization-wide report on the 2012–2013 Programme Budget Performance Assessment (PBPA) had been submitted to the Sixty-seventh World Health Assembly in May 2014 after it was initially reviewed at the Twentieth Meeting of the Programme Budget and Administration Committee (PBAC) of the Executive Board. The PBAC in its report had highlighted the improvement in the level of fully achieved Organization-wide expected results (OWERs), from 54%
during the 2010–2011 biennium to 63% during the 2012–2013 biennium. The Committee also noted the improvement in the level and alignment of financing of the Strategic Objectives (SO) in the major offices. However, it observed that full financial alignment had not yet been achieved.

105. The Committee expressed concern with regard to the slow implementation recorded in the case of some Office-specific expected results (OSERS) for the 2012-2013 biennium, especially the ones that had been indicated as being “in trouble”. It was clarified that the reasons for this were: (i) lack of funding; (ii) lack of dedicated staff; and (iii) absence of donor(s) for such OSERS. The Committee was informed that as a result of sustained monitoring a large number of OSERS that were reported as “at risk” or “in trouble” during mid-term review got converted to “on track” by the end of the second year of the biennium. The Committee was also informed that the Organization was taking rigorous steps in the form of more focused and enhanced monitoring of implementation status of OSERS, as well as through increased resource mobilization efforts.

106. Some Member States felt that they had faced reduction in their respective country budgets in the last biennium. It was explained that this situation had arisen as a result of the overall reduction in the regional Programme Budget for 2014–2015.

107. The Committee noted the reasons why the funding levels were different for different WHO regions such as for the Eastern Mediterranean and the African Regions for the 2014–2015 biennium, as compared with the South-East Asia Region, as mentioned in the working document pertaining to this agenda item SEA/RC67/6 Inf. Doc.1 and Inf. Doc.2.

108. The Committee noted the recommendations made by the Seventh Meeting of the Subcommittee on Policy and Programme Development and Management (SPPDM) held at the Regional Office in July 2014 that had discussed Programme Budget issues.

Implementation of the Programme Budget 2014–2015
(Agenda Item 7.2, Document number SEA/RC67/7)

109. The Committee observed that the Programme Budget 2014–2015 is a transitional budget that responds to the ongoing programmatic and managerial reforms of WHO. It is the first of three biennial budgets to be formulated within the Twelfth General Programme of Work for the period 2014–2019.
110. The attention of the Committee was drawn to the problem of uneven distribution of resources that persists in many Member States as well as across technical areas. Countries such as Bangladesh and the Democratic People’s Republic of Korea had mobilized resources close to 75% of their budgeted figures, whereas Bhutan, Nepal and Thailand, for example, had only managed to mobilize funds to support around 50% of their budgets. The distribution of funds to categories and programme areas also continued to be uneven. It was also highlighted that additional resources would be required for the Region to achieve 75% implementation by the end of 2014.

111. The Committee was further informed of the combined impacts of the regional budget reduction for 2014–2015, implementation of WHO financing reforms (e.g. Financing Dialogue) and the fundamental shift to an integrated budget coupled with the tendency for voluntary funds to be directly allocated to country level, all of which had left the Regional Office with the need for more funds. These forces have resulted in the previous fund allocation practices (e.g. 75-25 allocation of the assessed contribution between countries and the Regional Office) as being obsolete in an integrated budget scenario.

112. The Committee was informed that the Seventh Meeting of the Subcommittee on Policy and Programme Development and Management (SPPDM) had reviewed implementation of the Programme Budget and made recommendations.

113. The Committee underscored the importance of exercising better control and monitoring of programme budget implementation in both country offices and the WHO Regional Office for South-East Asia. This would especially strengthen the case for having flexibility in budget allocation to allow for critical transfer or reallocation of funds to areas of work that might require additional funding because of having achieved good-quality outcomes/products through efficient management practices.

114. The Committee was assured that as the preparation of the Programme Budget encompassed elements of the WHO Reform process, care would be taken to allow for greater flexibility associated with budget space. Programme Budget
assessments would be the basis for analysis of factors to be considered with regard to fair, transparent and flexible distribution of funds between various budget sections and categories.

115. The Committee noted WHO’s limitation in having flexibility with regard to specified Voluntary Contributions as those were targeted only for specified countries or projects.

Proposed Programme Budget 2016–2017
(Agenda Item 7.3, Document number SEA/RC67/8 Add.1 and Inf. Doc.1)

116. The Committee was provided with the latest update on the principles and processes involved in the formulation of the proposed Programme Budget 2016–2017 through a comprehensive and illustrative presentation made by Dr Hans Troedsson, ADG/GMG, WHO headquarters. Dr Troedsson explained that inputs provided by all Member States of the regions through the bottom-up planning process are the critical elements that guided WHO in the preparation as well as during the discussions pertaining to the proposed Programme Budget. He enumerated the salient features of the proposed Programme Budget 2016–2017, within the broader context of WHO reforms, as: (i) robust, bottom-up priority-setting; (ii) clear roles and responsibilities; and (iii) realistic costing of outputs.

117. The starting point for preparation of the proposed Programme Budget 2016–2017 is the 12th General Programme of Work, and it builds on the implementation of the Programme Budget 2014–2015 and continuation of WHO’s commitments. Dr Troedsson also informed the Committee that the Director-General of WHO had decided to have a “stable” budget (around US$ 4 billion). Importantly, the 2016–2017 budget would be a fully funded and “realistic” budget and not an “aspirational” budget as was the case in the past. Thus, such a budget would realistically reflect estimated resources required for achieving priorities across all levels of the Organization. The Director-General, based on realistic projections, may consult the Member States in case the budget needs to go beyond the current level of US$ 4 billion.

118. The Committee also noted that the proposed Programme Budget 2016–2017 would allow for more focused technical cooperation through a bottom-up identification of priorities at the country level. It would also reflect more clearly the roles and responsibilities of each of the three levels of the Organization, thereby leading to better alignment of the work of each of the three levels through “category” and “programme area” networks. Thus, it would eliminate duplication and cross-cutting of activities/functions by enabling all levels of the Organization to
“come together” and “plan together”. Capacity strengthening of the country offices would be carried out to provide quality support to Member States.

119. The Committee acknowledged that WHO was determined to: (i) ensure alignment of bottom-up priorities with the global/regional commitments and targets; (ii) identify, further elaborate and develop means to manage cross-cutting issues such as antimicrobial resistance and gender equity and rights; (iii) refine the output cost estimates based on dedicated staff and activity resources requirements; and (iv) reflect further the programmatic and budgetary implementation of recent World Health Assembly resolutions.

120. The Committee raised concerns regarding the lack of adequate flexibility in fund allocation and the persistent, uneven distribution and mobilization of resources across categories and programme areas. In this regard, the need to upscale resource mobilization efforts towards acquiring additional funds for noncommunicable diseases, was also stressed. Strategic shifts from the technical areas with adequate donor base and capacity to those that require capacity building was discussed.

121. The Committee was reassured that its concern regarding alignment of proposed Programme Budget 2016–2017 with the post-2015 development agenda was valid. However, the post-2015 development agenda was not finalized yet. Also the “unused” or “unimplemented” funds at country level would be reallocated to other areas, as warranted, and thereby used more efficiently and productively.

122. The Committee noted with appreciation that the process of monitoring and evaluation of implementation status in the SEA Region is being further strengthened. It was also informed that the updated draft of proposed Programme Budget 2016–2017 shall be presented to the WHO Executive Board in January 2015, taking into account inputs from all regional committees. The final draft would be presented for approval to the World Health Assembly in May 2015.

123. The Committee noted that the budget cuts experienced by Member States were the result of the overall reduction in the regional Programme Budget and urged WHO to take necessary steps to strengthen country capacity. It welcomed Dr Troedsson’s
assurance that there will not be a budget cut for the SEA Region for the 2016–2017 biennium.

124. The Committee was informed that WHO intends to strengthen monitoring and evaluation of programmes in the Region.

125. The Committee was informed that the Seventh Meeting of the Subcommittee on Policy and Programme Development and Management (SPPDM) had reviewed the developments related to the proposed Programme Budget 2016–2017. The subject was also discussed as part of the inter-sessional meeting held in August 2014.

126. The Committee endorsed the recommendations made by SPPDM and the inter-sessional meeting.


Technical matters (Agenda item 8)

Consideration of the recommendations arising out of the Technical Discussions on “Covering every birth and death: improving civil registration and vital statistics”
(Agenda item 8.1: Document number SEA/RC67/9 and Inf. Doc.1)

128. The Committee noted that comprehensive assessments of civil registration and vital statistics (CRVS) systems were being undertaken by Member States of the WHO South-East Asia Region, using the WHO tool. It however expressed concern regarding inadequate coverage and completeness of birth and death registration; poor quality of cause of death (CoD) data resulting in ill-defined recording of ICD (International Classification of Diseases) codes; lack of quality audits to improve civil registration data quality and its use for generation of vital statistics; and inadequate inter-agency coordination between the key stakeholder ministries responsible for CRVS.

129. At the technical discussions on “Covering every birth and death: Improving civil registration and vital statistics” held in the Regional Office on 16–17 June 2014, the
The draft regional strategy on strengthening the role of the health sector in improving civil registration and vital statistics was finalized. At the HLP meeting held in the Regional Office in New Delhi, from 14–17 July 2014, Member States were urged to undertake comprehensive assessment of CRVS systems and link health services to CRVS to promote registration of births and deaths with technical support from WHO.

130. The Committee also noted that the HLP meeting had endorsed the Draft Regional Strategy on Covering Every Birth and Death: Improving Civil Registration and Vital Statistics.

131. The Committee acknowledged the importance of having good-quality, comprehensive CRVS systems in all Member States of the Region. It underscored the need to establish a universal CRVS model that could be replicated by all countries. Such a model would need to be built by linking its components and elements appropriately with other relevant ministries of governments. Also, such a model will help create positive synergies between the health and other sectors associated with it in this regard.

132. The Committee noted that establishing good-quality CRVS systems would require strong political commitment and intersectoral cooperation and collaboration. Only then could CRVS systems help the health sector make evidence-based policy decisions. It was suggested that a uniform computer software be developed for recording and registration of data to facilitate comparative analyses. Furthermore, the CRVS systems should be linked with national social protection schemes as it is the “fundamental right of every citizen to have his/her birth/death appropriately registered”.

133. The Committee urged WHO to continue to provide technical and financial support to enhance both country capacity and capability to establish sound, effective and comprehensive CRVS systems.

134. The Committee adopted resolution SEA/RC67/R2 “Covering every birth and death: improving civil registration and vital statistics”.

**Selection of a subject for the Technical Discussions to be held prior to the Sixty-eighth session of the Regional Committee**  
(*Agenda item 8.2: Document number SEA/RC67/10*)

135. The Committee was briefed about the discussions of the HLP meeting held in the Regional Office, New Delhi on 14–17 July 2014 to identify a topic for the
Technical Discussions to be held prior to the Sixty-eighth session of the Regional Committee in 2015.

136. Having reviewed the topics presented at all Regional Committee meetings since 2001 and other topics, the Committee endorsed the recommendation of the HLP meeting that “Strengthening community-based health-care services” be the subject for Technical Discussions to be held prior to its Sixty-eighth session in 2015. The good practices in the Member States will be shared further in the technical discussions.

**Traditional medicine: Delhi Declaration**  
*(Agenda item 8.3: Document number SEA/RC67/11)*

137. The Committee was apprised that the South-East Asia Region has a rich history of traditional medicine with almost every country having its own system of traditional medicine. Various Member States are mainstreaming traditional medicine and integrating it into the conventional health care system. The Committee noted details on utilization of traditional medicines by the population, services offered in health care facilities, training of practitioners, and regulation of traditional medicine products, practices and practitioners.

138. The Committee recognized the need for more research to ensure the safety, quality and efficacy of all traditional medicine products and evidence-based practices. Some Member States had developed research agendas and identified research institutions to take this forward, including the provision of training for personnel from other countries of the Region.
139. The Committee acknowledged that adequate regulation of products, practices and practitioners is needed to ensure the safe and effective use of quality traditional medicine and that increased capacity in these areas is needed and requested WHO support for this.

140. The Committee noted that all Member States had adopted the Delhi Declaration in 2013 wherein all countries in the South-East Asia Region agreed to cooperate, collaborate and provide mutual support to each other in all fields of traditional medicine in accordance with their national situation, priorities, legislation and circumstances.

141. The Committee noted that a new WHO Traditional Medicine Strategy 2014–2023 had been endorsed by the World Health Assembly in May 2014. The strategy aims to harness the potential contribution of traditional medicine to health, wellness, people-centred health care and universal health coverage. The strategy also aims to promote best practices in the use of safe and good quality traditional medicine through the regulation, research and integration of traditional medicine products, practices and practitioners into the health system, as appropriate.

142. The Committee was informed that the area of traditional medicine had very limited resources and urged that more resources should be allocated.

143. The Committee adopted resolution SEA/RC67/R3 “Traditional medicine–Delhi Declaration”.

**Strengthening the implementation of the WHO Global Strategy to Reduce the Harmful Use of Alcohol to support the achievement of the regional targets on prevention and control of noncommunicable diseases** *(Agenda item 8.4: Document number SEA/RC67/12)*

144. The harmful use of alcohol causes a huge social, economic and disease burden. Alcohol consumption is increasing in the South-East Asia Region where it is dominated by the consumption of spirits as well as a high degree of unrecorded alcohol consumption.

145. The Committee was informed that globally the harmful use of alcohol causes approximately 3.3 million deaths every year (or 5.9% of all deaths), and that 5.1% of the global burden of diseases is attributable to alcohol consumption. There are causal relationships between alcohol consumption and more than 200 health conditions, most notably alcohol dependence, liver cirrhosis, cancers and injuries.
146. To address this escalating problem, the Sixty-third World Health Assembly in May 2010 adopted resolution WHA63.13 on the Global Strategy to Reduce the Harmful Use of Alcohol. The strategy builds on several WHO initiatives, both global and regional, including World Health Assembly resolution WHA61.14 on prevention and control of noncommunicable diseases: implementation of the global strategy, which was endorsed by the Sixty-first World Health Assembly in 2008.

147. The Committee noted that the harmful use of alcohol is one of the four most common modifiable and preventable risk factors for noncommunicable diseases (NCDs). Reducing the harmful use of alcohol will contribute to a reduction in NCDs in the Region. A 10% relative reduction in the harmful use of alcohol by 2025 measured against a 2010 baseline has been adopted as a voluntary target both globally and regionally. This was endorsed by the governing bodies and also by the United Nations General Assembly.

148. The recommendations of the HLP meeting, held in the Regional Office, New Delhi in July 2014, which extensively discussed the subject included a call to Member States to develop or strengthen a national/sub-national alcohol policy framework to reduce the harmful use of alcohol taking into consideration the global strategy. Member States were also urged to promote linkages between the implementation of the global strategy and efforts on NCD prevention and control. The Regional Office was recommended to provide support to develop a regional action plan linked to
the NCD multisectoral action plans to be adopted at the country level and to build
capacity of Member States to advance the implementation of the global strategy.

149. The Committee was apprised that though the Region has low prevalence
(13.5%) of people who consume alcohol, heavy episodic drinking or binge drinking
is a problem for the Region. There is a gradual increase in consumption of alcohol
among the general population, particularly among adolescents, youth and also
women. The Committee noted with concern the availability of illicit or informally
produced alcohol, which has additional negative consequences due to higher ethanol
content; the poor implementation of the alcohol policy and weak enforcement of
laws regarding surrogate alcohol and the harm caused by illicit alcohol.

150. The Committee reiterated the need for further strengthening of national
and regional capacities including institutional capacities and accelerating the
implementation of the global strategy to reduce the harmful use of alcohol.

151. The Committee noted that the global strategy to reduce the harmful use of
alcohol, which has 10 national targets, has a wide scope, but it is important that
there should be a regional strategy together with a regional action plan to reduce
the harmful use of alcohol.

152. The Committee endorsed the draft resolution, “South-East Asia Regional Action
Plan to Implement Global Strategy to Reduce Harmful Use of Alcohol (2014–2025)”. The
draft resolution emphasizes the implementation of the Global Strategy to Reduce
the Harmful Use of Alcohol to support the achievement of the regional targets on
prevention and control of noncommunicable diseases, in the South-East Asia Region.
The “best buys” in reducing the harmful use of alcohol, like drink driving, use of
taxation, and bans on advertising, etc. were highlighted.

153. The Committee also emphasized the need for establishment of alcohol de-
addiction centres, including drug de-addiction since this is also a major emerging
problem. Instruments to address the alcohol and drug problems should be
established on the lines of tobacco control.

154. The Committee adopted resolution SEA/RC67/R4 “South-East Asia Regional
Action Plan to Implement Global Strategy to Reduce Harmful Use of Alcohol
(2014–2025)”
Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage
(Agenda item 8.5: Document number SEA/RC67/13)

155. The Committee recalled that the Sixty-sixth Session of the Regional Committee had adopted resolution SEA/RC66/R4 on Health Intervention and Technology Assessment in support of universal health coverage (UHC). Universal Health Coverage emphasizes the availability, accessibility, affordability and acceptability of all health services provided within the health-care system.

156. The World Health Report 2008 recognized that surgical care is an integral component of primary health care; yet, it is estimated that more than two billion people in the world lack access to basic surgical care. This is mainly due to lack of basic surgical care services in primary health-care centres and inadequately trained human resources. In addition, the delivery of anaesthesia, which is essential for surgical services, is limited by deficiencies in human resources, skills and equipment, as well as system capacity issues.

157. Surgically-treatable conditions are among the top 15 causes of disability worldwide. Conservative estimates suggest that 11% of the burden of disease in the world can be attributed to health problems that could have been successfully treated with surgery. As local surgical services are not available or are limited in health-care facilities in many low- and middle-income settings, these conditions remain untreated. There is a need to include emergency and essential surgical care and anaesthesia as part of UHC in order to make them accessible and affordable.

158. Strengthening emergency and essential surgical care and anaesthesia services will bolster health services and improve the outcomes of populations who need these services, such as mothers and children as well as populations at risk. The value of incorporating surgical care into health services as a step towards providing UHC has been reiterated in many World Health Assembly resolutions. All 11 Member States endorsed the view that strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage was a pressing need that should be incorporated into their national health policies.
159. The Committee was also informed that the HLP meeting, held in the Regional Office, New Delhi, in July 2014, had urged Member States to develop appropriate health policies, plans and roadmaps to introduce emergency and essential surgical care and anaesthesia services at appropriate levels. It also recommended the conduct of health technology assessments to introduce and establish appropriate, cost-effective health technologies, including emergency and essential surgical care and anaesthesia services with the support of the WHO Regional Office.

160. Many Member States identified the need to strengthen health infrastructure with adequate equipment on a long-term basis to address the problems of providing emergency and essential surgical care. It was also noted that the country capacity must be further developed to address human resources issues in order to provide adequate surgical and anaesthesia facilities in health centres. In addition, Member States emphasized the need to establish good referral systems from lower-level health facilities to provincial and national and specialized facilities supplemented with adequate ambulance services.

161. Member States deliberated on the importance of the use of technology and suggested that it is necessary to conduct health technology assessments (HTA) and identify gaps. The Committee also discussed the importance of introducing tele-medicine, e-health, m-health and digital health repositories to enhance the effectiveness of established surgical facilities at district and sub-district health facilities, since digitalization is inevitable in the days ahead.

162. The Committee noted that establishing support services such as blood transfusion, diagnostic and laboratory facilities will further strengthen and enhance effectiveness of emergency and essential surgical care and anaesthesia. Also, it is necessary to include all essential medication required to provide these services in the National Essential Drugs List and strengthen national drug policies to ensure a safe and continuous supply of these medications and other surgical items.

163. The importance of introducing safe surgery care, prevention of antimicrobial resistance, and prevention of health-care acquired infections, should be incorporated into health-care quality and safety. The need to establish health accreditation systems to ensure quality and safety of services provided to health-care facilities was also reiterated.

164. The Committee also observed that it is necessary to include basic and essential surgical and anaesthetic care in the UHC package that will be offered by health insurance schemes in Member States.
165. Member States requested WHO to provide further technical assistance in the areas of: (i) capacity development with regard to health intervention and technology assessment to identify gaps; (ii) organizing short training courses on emergency surgical care and anaesthesia care; and (iii) developing lists of standard surgical care and anaesthesia services to be implemented at the district and lower-level health facilities.

**Viral hepatitis**  
*(Agenda item 8.6: Document number SEA/RC67/29)*

166. The Committee reiterated the huge global and regional burden of viral hepatitis, a serious public health problem worldwide, as well as for the WHO South-East Asia Region. Hepatitis B and C account for a greater health burden and a higher mortality rate because they can cause chronic infection which, in turn, can lead to hepatic cirrhosis and cancer. Around 500,000 estimated deaths in the WHO South-East Asia Region occur annually due to hepatitis viruses whereas the corresponding global toll is approximately 1.4 million.

167. The Committee noted that the Regional Strategy for the Prevention and Control of Viral Hepatitis (SEA-CD-282) published in 2013 has six strategic pillars: (a) policy, planning and resource mobilization; (b) surveillance; (c) research; (d) prevention and control; (e) education; and (f) medical care and treatment. The regional strategy can be considered for adoption by Member States in their own context and in alignment with their needs and health system requirements.
168. The Committee suggested the consideration of the launch of a coordinated, collaborative and sustained approach for viral hepatitis prevention, education, surveillance, medical care and treatment, research, policy, and planning and resource mobilization that may be aligned with the Regional Strategy on Prevention and Control of Viral Hepatitis of 2013.

169. Noting the observations and views on the subject of viral hepatitis, the Committee expressed concern on the significant morbidity and mortality attributable to viral hepatitis globally and its disproportionate impact on the South-East Asia Region.

170. The Committee acknowledged and appreciated the leadership of WHO at the global level for highlighting the public health burden of viral hepatitis through the two World Health Assembly resolutions in 2010 (WHA 63.18) and 2014 (WHA 67.6). They also acknowledged the initiative by the WHO Regional Office for South-East Asia to develop the regional strategy in line with the Global Strategy on Viral Hepatitis.

171. The Committee raised concerns over the lack of data, surveillance and monitoring of viral hepatitis within the Member States of the Region. It also expressed the need for strengthening the diagnostics and management capacity. The need for a multisectoral and integrated approach to addressing viral hepatitis was emphasized.

172. The Committee stated that most Member States had either developed or were in the process of developing national plans for addressing viral hepatitis. National plans focus on strengthening the prevention, screening, management, surveillance and monitoring of viral hepatitis. All Member States have included hepatitis B vaccination in the expanded immunization programme and are in the process of strengthening the birth dose of hepatitis B. Member States also requested WHO to provide technical assistance to strengthen laboratory capacity, case management and surveillance of viral hepatitis.

173. Dr Charles Gore from the World Hepatitis Alliance, participated in the discussions on viral hepatitis. He drew attention to the long-standing neglect and systematic underfunding of viral hepatitis that has resulted in its high contribution to the morbidity and mortality from communicable diseases. He appreciated the efforts made by Member States and the Regional Office on addressing viral hepatitis at regional and national levels. He suggested that perhaps the WHO South-East Asia Region could think of introducing indicators for monitoring the implementation of
viral hepatitis response similar to that of the WHO Western Pacific Region, with the goal of reducing hepatitis B infection rates to less than 1% by 2017.

174. The Committee adopted resolution SEA/RC67/R5 “Viral hepatitis”.

**Regional strategy on strengthening health workforce education and training (Agenda item 8.7: Document number SEA/RC67/21 Rev. 1)**

175. The Committee discussed the progress made since the World health report 2006 on “Working together for health” and World Health Assembly resolution WHA59.23 on rapid scaling up of the health workforce production. The Committee noted that challenges in human resources for health (HRH) or health workforce (HWF) persist in Member States of the WHO South-East Asia Region. These include critical issues in HWF education and training as a consequence of which health systems and, ultimately, health outcomes are adversely impacted.

176. To address the urgent need to improve the quantity and quality of health workforce in the Region, the Sixty-fifth session of the Regional Committee for South-East Asia adopted the resolution “Strengthening health workforce education and training in the Region”. As a follow-up, the WHO Regional Office also developed a draft Regional Strategy on Strengthening Health Workforce Education and Training in the South-East Asia Region based on the outcome of comprehensive country assessments. The draft was reviewed at the Regional Expert Group Meeting in Bangkok, Thailand, in May 2014.

177. The Committee observed that standard guidelines on HRH need to be contextualized to specific country situations, both with respect to constraints such as geographical challenges of distribution as well as where health outcomes may actually be better in spite of relative “poor” performance on HRH indicators.

178. The Committee underlined that accreditation of educational institutions is important to ensure quality in production of HRH. Member States noted this as an area for WHO’s technical support. Emphasis was also placed on strengthening regional networks to share experiences and develop human resources.
179. The Committee acknowledged that the country assessments undertaken for the regional strategy are the types of information needed to develop appropriate education and training strategies. It also highlighted that platforms for regional cooperation on HRH training have proved very effective for individual countries and WHO has an important role in facilitating this.

180. The Committee flagged the need to design health education to support the retention of HRH in rural areas and at the PHC level, as “gatekeepers” to the health system. Member States cited e-education as an example of a successful innovative approach.

181. The Committee adopted resolution SEA/RC67/R6 “Strengthening health workforce education and training in the Region”.

182. Professor Pratap Narayan Prasad of the World Organization of Family Doctors (WONCA) said his organization believes that it is important that every medical school in the world should have an academic department of family medicine and that every medical student should receive training and experience in family medicine. WONCA advocated that every medical school in the South-East Asia Region should run an undergraduate and postgraduate course in family medicine/general practice/primary care to strengthen the health services in the Region.

183. Ms Wonyun Lee of the International Federation of Medical Students’ Associations (IFMSA) said that IFMSA represented more than a million medical students from 117 countries. One of the main guiding principles of IFMSA is to uphold the highest ethical and professional values of the medical profession. Expressing sincere appreciation for the untiring efforts of WHO and Member States to strengthen health workforce education and training, she said the quality of the training and education ultimately helps define the quality of the health system.

184. In this context, Ms Lee reiterated the importance of maintaining conducive training conditions as a vital component of health education, since it is directly correlated to both quality of training as well as patient safety. The effective enforcement of regulations will only help provide more positive outcomes in the longer run.

**Progress reports on selected Regional Committee resolutions:**

*(Agenda item 9)*

185. The attention of the Committee was drawn to nine progress reports on Regional Committee resolutions that were discussed at the HLP meeting, held in the Regional
Office, New Delhi, in July 2014. The WHO Regional Director for South-East Asia also released a publication entitled “Polio eradication in the South-East Asia Region: The Lesson-It can be done”.

186. These progress reports were on the following nine resolutions:

9.1 Nutrition and food safety in the South-East Asia Region (SEA/RC60/R3);
9.2 South-East Asia Regional Health Emergency Fund (SEA/RC60/R7);
9.3 Challenges in polio eradication (SEA/RC60/R8);
9.4 Injury prevention and safety promotion (SEA/RC63/R2);
9.5 2012: Year of intensification of routine immunization in the South-East Asia Region: Framework for increasing and sustaining coverage (SEA/RC64/R3);
9.6 Regional Health Sector Strategy on HIV 2011–2015 (SEA/RC64/R6);
9.7 Consultative Expert Working Group on Research and Development: Financing and Coordination (SEA/RC65/R3);
9.8 Comprehensive and coordinated efforts for the management of autism spectrum disorders (ASD) and developmental disabilities (SEA/RC65/R8); and

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

187. The Sixtieth session of the Regional Committee for South-East Asia urged Member States to continue sustained efforts to strengthen nutrition and food safety programmes and WHO’s Regional Office to provide necessary support to these programmes, including the national nutrition and food safety policies and plans of action. The Committee’s attention was drawn to the progress report providing information on the status of nutrition and food safety activities in the Region.

188. The Committee observed that most Member States of the Region are “food secure” with relative self-sufficiency in food production and availability, though there are population pockets that encounter food insecurity leading to poor food consumption and therefore undernutrition. Many foodborne diseases are also reported in Member States posing a significant public health burden. In recent years, the close links between food safety and nutrition issues have been recognized, calling for an integrated nutrition and food safety approach.
189. National nutrition policies and plans of action, mostly multisectoral in nature, are in place in all Member States, reflecting increased attention to nutrition and food safety issues. Several Member States have formulated national food-based dietary guidelines and action plans for food safety exist in all. Member States have achieved considerable – though not uniform – reduction in the prevalence of undernutrition and associated morbidity and mortality in children. Anaemia remains the most common nutritional deficiency in the Region. Food legislation in several Member States has been updated and food standards and regulations revised to harmonize with the Codex Alimentarius guidelines. Food control and inspection activities and routine post-marketing food monitoring and control measures now exist in most Member States. All Member States are part of the International Food Safety Authorities Network (INFOSAN).

190. The Committee expressed strong commitment to improve the nutritional status of the population. Wide-ranging multisectoral interventions targeting infants, young children, adolescents and mothers have been introduced in Member States. These comprise promotion of the international code for the marketing of breastmilk substitutes, iron and folic acid supplementation, guidance on healthy diet and lifestyle, as well as strengthening the national food safety authorities. Most Member States have formulated dietary goals and nutrition-related guidelines in keeping with robust global food regulatory systems.

191. Member States sought WHO support in improving national capacity in foodborne disease, surveillance, close collaboration in risk assessment and management and in developing a comprehensive plan for improving the nutrition of infants, young children and mothers. There was discussion on integrated nutrition and food safety activities and aligning nutrition and noncommunicable diseases. Member States were briefed on the status of preparations for the forthcoming International Conference on Nutrition.

192. Dr Kapil Yadav of the International Council for Control of Iodine Deficiency Disorders (ICCIDD) Global Network said severe iodine deficiency leads to irreversible brain damage in children, resulting in the loss of 13.5 IQ points. Iodine
deficiency during the period of pregnancy may lead to recurrent abortion, stillbirth, increased neonatal and infant mortality and irreversible brain damage in children.

193. Universal salt iodization, WHO’s preferred strategy for the elimination of iodine deficiency disorders, has resulted in saving four billion IQ points in children globally. In partnership with national governments, iodized salt producers, civil society organizations and bilateral international agencies, the efforts of the ICCIDD Global Network have led to an increase in global household coverage of adequately iodized salt from only 20% in the 1990s to 76% in 2013.

194. The ICCIDD Global Network has been working in collaboration with the WHO Regional Office for South-East Asia and other partner agencies to strengthen sustainable elimination of iodine deficiency disorders (IDD) in the Region. Elimination of IDDs should be recognized as an essential reproductive and child health intervention.

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

195. The Committee recalled the magnitude and recurrence of natural disasters in the South-East Asia Region over the past few years, such as the annual monsoons, landslides, earthquakes, tsunamis, conflicts and devastating fires. The magnitude of disasters and their effects have had considerable impact on the morbidity and mortality in the Region, which has a quarter of the world’s population but accounted for 37% of the global total annual mortality from natural disasters during the period: 2003-2012.
196. The Committee also took note that since its inception, the South-East Asia Regional Health Emergency Fund (SEAHREF) has provided financial support to 24 disasters in nine Member States of the Region. The first disaster supported by the fund was Cyclone Nargis in Myanmar in 2008 and the latest was the eruption of Mt Sinaburg volcano in Indonesia in 2014.

197. The Committee also expressed its appreciation for the efforts made by the WHO Regional Office to find ways to move funds to a voluntary contribution component so that the balance at the end of the biennium could be transferred to the next biennium. Member States also welcomed the meeting of the SEARHEF Working Group on 2 September 2014 to review the SEARHEF processes and to familiarize the ministries, partners and donors with details of the utilization of the fund.

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

198. The Committee noted the recommendations made by the High-Level Preparatory (HLP) Meeting, held in the Regional Office, in July 2014, for WHO and Member States on Agenda item 9.3, Challenges in Polio Eradication. It noted that the Regional Certification Commission for Polio Eradication (RCCPE) had certified the Region as polio-free. This was an incredible public health feat, considering the immense challenges faced by the programme in this Region, the magnitude of the efforts put in by all the countries, the resilience and strong dedication of health workers and the unflinching support provided by partner agencies, donors and governments, WHO, UNICEF, Rotary and other international partners. Two major challenges remained – firstly, complacency at becoming polio-free; and secondly, the risk of importation and spread of poliovirus from polio-infected countries.

199. The Committee agreed that the regional polio-free certification was the result of concerted efforts of Member States due to strong political commitment and leadership, a tight-knit partnership with WHO and other stakeholders, and focus on high quality. The Committee was further informed that Bangladesh had been polio-free since 2006. However, national immunization was not discontinued. By January 2015, the country planned nationwide introduction of IPV, subject to availability of vaccine in the country. The Member States endorsed the Endgame Strategic Plan 2013–2018 and suggested that the RCCPE and the national certification committees must remain active until global certification in order to assist countries to remain polio-free.

200. Mr Salim Reza of the Rotary International congratulated Member States of the Region on their extraordinary achievement of being certified polio-free. He also affirmed Rotary’s continued commitment to ending polio everywhere and achieving
the shared goal of a polio-free world. The recent certification of the Region as polio-free had helped to set the stage and provided a strong example of how the public health system could work to make a real and lasting difference towards improving the health and well-being of children everywhere. India, where once it was thought impossible to eradicate polio, was a shining example of what could be done when government, civil society and international agencies worked together. He further stated that while moving closer to the goal of a polio-free world, there would be newer challenges, which could be overcome through collective efforts, as evidenced in the South-East Asia Region. Rotary International recognized the need for governments of all countries to take prompt action together with partners, to build on the progress achieved. In conclusion, he said that Rotarians were ready to serve as a network of support and advocacy, reaching out to government officials and community members who can help enforce the need for enhanced engagement by all levels of government.

9.4 Injury prevention and safety promotion (SEA/RC63/R2)

201. The Committee endorsed the way forward and the recommendations contained in the resolution and agreed that the role of trained health professionals would be important and that an injury management unit in the ministry of health with a full-time motivated team would be crucial in moving forward the agenda and achieving substantial progress in combating injuries. The Committee requested WHO to intensify efforts and continue to further help the Member States in identifying national policy and legal gaps, in capacity-building, improving the basic health information systems and establishing financial mechanisms to facilitate multisectoral collaborations, and submit a progress report to its Sixty-ninth Session.

202. The Committee was informed that India had an injury and trauma unit in the health ministry to implement the road safety and injury prevention programme as well as for assistance to set up trauma centres across the country. The unit was also responsible for coordinating with other ministries and sectors, including the ministry of road transport and highways as well as the state governments. Road
safety training of children and parents, policy-makers, lawyers, nongovernmental organizations (NGOs) and journalists is regularly conducted. Besides, capacity-building for developing trauma care facilities in government hospitals on national highways has been initiated to bring down preventable deaths on account of road crashes to 10% by developing a pan-country trauma care network. A web-based national injury surveillance and trauma registry is also proposed in technical collaboration with Australia.

203. During the Twelfth Five-Year Plan, 2012–2017, a National Programme for Prevention and Management of Burn Injuries is being implemented to reduce incidence, mortality, morbidity and disability due to burn injuries, to improve awareness among the general masses and vulnerable groups especially the women, children, industrial and hazardous occupational workers, and to establish adequate infrastructural facility and network for behaviour change communication, burns management and rehabilitation interventions.

204. The Committee noted the recommendations made by the HLP meeting held in the Regional Office, New Delhi, in July 2014, for WHO and Member States on Agenda item 9.4, Injury prevention and safety promotion. The Committee was informed that although a national injury prevention policy had not materialized in Sri Lanka, an accident and emergency policy was in place and injury prevention activities were being implemented under that policy.

205. The Committee was informed that in Bangladesh, 70 000 people die each year due to any kind of injury accounting for 9.3% of total deaths. Injury is attributable to 17% of all disabilities. The most frequent causes of injury-related disabilities are falls, road traffic accidents, falling objects, cuts, burns, animal bites and violence. Injury prevention and promotion of safety have been given due recognition by the Member States of the Region as major public health measures. For better management of injuries along with other emergency medical services, facilities at national, district and sub-district levels were being strengthened with WHO support. Drowning is a major cause of injury-related mortality in children aged one-four years. A simple solution to prevent drowning-induced mortality had been prepared through public–NGO collaboration and WHO was requested to extend technical assistance for national scale-up of this model. The Committee recommended that it was desirable to quantify the economic impact of the various types of injuries on families in order to generate evidence to prioritize injury prevention in national health programmes. The Committee advised WHO to actively coordinate with Member States for timely implementation of resolution SEA/RC63/R2 on injury prevention and safety promotion.
206. The Committee noted the recommendations made by the HLP meeting, held in the Regional Office, in July 2014, for WHO and Member States on Agenda item 9.5, 2012: Year of intensification of routine immunization in the South-East Asia Region: Framework for increasing and sustaining coverage. The Committee observed that Member States have a long history of immunization programmes and are striving hard to strengthen routine immunization services. India has made efforts for convergence of polio with the routine immunization activities. The Committee agreed that more needs to be done to sustain the gains in many countries, especially in the context of the underserved populations, and that continued efforts are needed to mobilize both internal and external support to strengthen and sustain high-quality immunization services. India proposed that the national coverage targets to be achieved should not be generalized across the Region, and that Member States should be given necessary flexibility in this regard. The Committee also noted that the agenda item should be changed to “Progress Report on Regional Immunization goals” in subsequent meetings of the Committee. This would allow the countries to set realistic targets with due consideration to local variables and constraints.

207. The Committee noted that the Bangladesh immunization programme was a success story even in the global context, with a coverage of BCG (99%); Penta3 (92%) and for fully vaccinated children (80.7%). Following the adoption of the Regional Committee resolution, activities for intensification of routine immunization...
in Bangladesh were implemented with the support of GAVI, UNICEF, WHO and NGOs. Thirty-two districts and four city corporations that were lagging behind were selected as priority locations for intervention. The existing government mechanisms for the same purpose supported by GAVI, UNICEF and WHO were also integrated. The Committee noted with satisfaction that ten districts and one city corporation from the list had already achieved more than 80% coverage of vaccinated children. Local pharmaceutical companies have been encouraged to produce vaccines and efforts are on to strengthen national drug regulatory authorities to monitor domestic vaccine production.

208. Ms Hind Khatib-Othman of the **GAVI Alliance** congratulated the Region on the incredible achievement of maintaining a polio-free status since January 2011 and on receiving polio-free certification in 2014. She said that GAVI was fully committed to the polio end-game strategy and will be supporting the introduction of inactivated polio vaccine (IPV). Six countries of the Region had successfully applied to GAVI for IPV and Nepal will be the pioneering country to launch IPV later this month.

209. The Committee was informed that GAVI had supported an unprecedented ramp-up in vaccine implementation over the last year with the launching of 41 new vaccines and campaigns. A major milestone was achieved in July 2014 when the last of the 73 GAVI-eligible countries introduced DTP-HepB-Hib pentavalent vaccine into the routine immunization programmes.

210. GAVI had recently launched a replenishment effort to raise a further US$ 7.5 billion to support its work between 2016–2020. GAVI-supported countries will be at the forefront of this effort to achieve the bold investments needed to secure a healthy and sustainable future.

211. **The International Federation on Ageing (IFA)** in their statement informed that over the course of the last six months, IFA had undertaken significant work through its advocacy and promotion of a life-course approach to immunization. When considering issues such as the eradication of polio and the intensification of routine immunization in the South-East Asia Region and across the world, effective progress cannot be made without viewing these issues through the life-course lens.

212. In its statement, the Federation added that immunization is a core component of the human right to health, a standard element in any effective, preventive, public-health approach, and an individual, community and governmental responsibility. The current advocacy efforts to promote the importance of immunization have focused primarily on children, yet there is a grave lack of awareness about the fact that older people are equally, if not more vulnerable to the spread of infectious diseases.
9.6 Regional Health Sector Strategy on HIV 2011–2015 (SEA/RC64/R6)

213. The Committee noted the recommendations made by the HLP meeting, held in the Regional Office, in July 2014, for WHO and Member States on Agenda item 9.6, Regional Health Sector Strategy on HIV 2011–2015. The Committee was informed that Indonesia had developed the national HIV strategy for 2014–2019 based on WHO guidelines with the focus on the strategic use of antiretrovirals. A policy had been formulated on early diagnosis and immediate treatment for all key populations, seropositive pregnant women, HIV-TB co-infections and HIV-hepatitis B co-infections. To strengthen the adherence and retention in care for those enrolled, a continuum of care programme had been initiated in key districts. The Committee also noted that Indonesia is an active member of the ASEAN Task Force on AIDS focusing on HIV and migrant health. The country had rolled out the universal health care policy and HIV treatment was covered as part of the UHC benefit package. The Committee observed that Sri Lanka had a national strategy for the period 2013–2017 and it continued to be HIV low-prevalence country.

214. The Committee was informed that Bangladesh, although a very low-prevalence country (<1%), had concerns about pockets of concentration of the disease in certain areas, mostly among people who inject drugs. Since the first HIV case in the country in 1989, 3241 cases had been detected until December 2013 with 472 deaths. The estimated number of persons living with HIV is 8000, of which 1000 HIV-positive people with CD4 count more than or equal to 350 are on antiretroviral treatment.

215. The Committee noted that India has made significant progress on the strategic directions outlined in the Regional Health Sector Strategy on HIV/AIDS. During the last decade, the programme succeeded in reducing the number of annual new HIV infections in adults by 57% through scaled-up prevention activities. Wider access to ART has resulted in a decline of the estimated number of people dying due to AIDS-related causes. India is committed to providing universal access to ART to all those who need it.

216. The Committee was informed that the National AIDS Control Programme Phase IV from 2012–2017 aimed to accelerate the process of reversal and further strengthen the epidemic response in India through a cautious and well-defined integration process over five years. India has announced the decision for early initiation of ART at CD4 count of 500 and treating all positive pregnant women with immediate ART. With an estimated adult HIV prevalence of 0.27%, the focus of the programme is on prevention among the key populations and vulnerable groups.
217. Targeted interventions for key populations including prevention form the backbone of India’s fight against HIV. India had also stepped up its domestic budgetary support for the HIV/AIDS response from 12% in its third phase to around 70% over the next few years.

9.7 Consultative Expert Working Group on Research and Development: Financing and Coordination (SEA/RC65/R3)

218. The Committee noted the recommendations made by the HLP meeting, held in the Regional Office, in July 2014, for WHO and Member States on Agenda item 9.7; Consultative Expert Working Group on Research and Development: Financing and Coordination (CEWG).

219. The Committee reviewed the progress made on resolution SEA/RC65/R3. This resolution was the outcome of national and regional consultations on the CEWG report presented to the World Health Assembly in May 2012. The resolution also provided the basis for the draft World Health Assembly resolution formulated during the open-ended meeting of all WHO Member States held from 26 to 28 November 2012 in Geneva. This led to the adoption of World Health Assembly resolution WHA66.22 in May 2013 that focused on new and innovative sources of financing to stimulate research and development (R&D) to promote access to medical products.

220. Resolutions SEA/RC65/R3 and WHA66.22, inter alia, urge Member States and WHO to strengthen health R&D capacities and investments for diseases that disproportionately affect developing countries. The resolutions also request WHO
to establish a global health R&D Observatory to monitor and analyse relevant information on health R&D as well as to promote advisory mechanisms. The progress in this aspect thus takes account of both resolutions at national, regional and global levels.

221. The Committee recommended taking forward the proposal for the Global Health R&D Observatory and explore funding mechanisms for the benefit of Member States in the Region. There is a need to have a network of institutions from Member States of the Region and develop R&D capacities of developing countries. It emphasized that there is a need to improve the monitoring of resource flows, identifying gaps and better coordination in health R&D, as well as setting priorities based on the public health needs of developing countries. Suitable advisory mechanisms should be developed for this purpose.

222. The Committee noted the progress made in the “Regional Consultation for developing a strategic workplan as a follow-up of the Consultative Expert Working Group on Research and Development: Financing and Coordination” on 25–26 July 2013 at Bangkok. They further noted that submission of projects at the global level was facilitated by the “Meeting of Experts on Demonstration Projects”, held at the WHO Regional Office for South-East Asia, New Delhi, India.

223. The Committee urged WHO to expedite the remaining demonstration projects on “multiplexed point-of-care test for acute febrile illness” and “dengue vaccine development”. The analysis of the extent of innovative components being implemented by the projects, including financing, the use of open access models,
multisectoral research platforms, and “delinkage”, among other criteria, needs to be included.

224. The Committee recommended that deliberations be held on a global platform on the classification grid developed in the Region for health R&D for the Global Health R&D Observatory. There is a need to reflect on the national and regional positions during the assessment of the parent resolution WHA61.21 on Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property when this is taken up for discussions at the World Health Assembly.

9.8 Comprehensive and coordinated efforts for the management of autism spectrum disorders (ASD) and developmental disabilities (SEA/RC65/R8)

225. The Committee noted the recommendations made by the HLP meeting, held in the Regional Office, in July 2014, for WHO and Member States on Agenda item 9.8, Comprehensive and coordinated efforts for the management of autism spectrum disorders (ASD) and developmental disabilities. The Committee was apprised that the Member States of the South-East Asia Region are progressively recognizing the need to promote stronger and coordinated actions in the Region and globally for improving access to high-quality care for children with ASD and other developmental disorders.

226. The Committee noted the support provided by the WHO Regional Office for South-East Asia to strengthen national capacities to address ASD and developmental disabilities through the development of training manuals for primary health-care physicians. Simple-to-use tools have been identified to screen for ASD at the primary health-care level. The Committee acknowledged the coordinated actions taken towards improving the access to and quality of health-care services for individuals with ASD through the development of community-based strategies.

227. The Committee was informed that resources have been allocated under the broad heading of ”Strengthening care for mental and neurological disorders” and provisions made for specific allocation of funds for ASD.

228. It noted the support provided by WHO in strengthening national capacities for implementing the mental health gap action programme (mhGAP) launched in some Member States to expand the services for mental and neurological disorders. The mhGAP programme promotes integration of services for mental health care at all levels of the health system, including community settings.
229. The Committee noted that community-based programmes have been implemented to create awareness and provide care in close proximity to homes, giving consideration to the lifelong care and rehabilitation required for people with ASD.

230. In spite of the progress made, the Committee noted that there were challenges to be addressed, including a lack of awareness about ASD, resulting in a paucity of resources for implementing ASD programmes and lack of prioritization of ASD by policy-makers and health planners. The absence of reliable data limits the development of region/country-specific strategies and programmes.

9.9 Regional action plan and targets for prevention and control of noncommunicable diseases (2013–2020) (SEA/RC/66/R6)

231. The Committee noted the recommendations made by the HLP meeting, held in the Regional Office, in July 2014, for WHO and Member States on Agenda item 9.9, Regional action plan and targets for prevention and control of noncommunicable diseases (2013–2020). It acknowledged the rising burden of NCDs, and noted the key initiatives undertaken at the country level highlighted by Member States including fresh rounds of WHO STEPS surveys; expansion of screening services and other essential NCD interventions at the primary health-care level; increased availability of essential NCD medicines including medicines for pain management; strengthening of health systems including two-way referral mechanisms; and development of multisectoral policies and action plans for prevention and control of
NCDs. Underscoring the merits of an integrated approach, the Committee welcomed the inclusion of tobacco, alcohol and oral health into the NCD programme of work. Further recognizing the linkages and synergistic approaches required, the Committee urged WHO to align the nutrition and NCD programmes into one programme for greater efficiency and impact.

232. The Committee recognized the importance of monitoring and evaluation and requested WHO to track key indicators and targets at the regional level and disseminate the results to Member States at regular intervals. WHO was also requested to continue to provide technical support to countries in scaling up cost-effective interventions for prevention and control of noncommunicable diseases.

233. The Committee noted that NCDs were being accorded priority by all the Member States. In India, a national programme for prevention and control of cancer, diabetes, cardiovascular diseases and strokes has been established, and is being expanded to cover all districts of the country by 2017. Under this programme, 55.7 million adults had been screened till 31 March 2014 and during the same period, diabetes and hypertension were detected in 6.14% and 5.12% respectively of the population in selected districts in India. India has also demonstrated success in implementing the WHO FCTC through a multisectoral approach. The country contributed actively to the global events leading to the development and subsequent endorsement of the World Health Assembly resolution WHA66.10. Strong advocacy by India led to inclusion of the term “tobacco use” instead of “tobacco smoking” in the Global Monitoring Framework for the Prevention and Control of NCDs.

234. The Committee was informed that 99% of the adult population in Bangladesh was exposed to at least one NCD risk factor; 51% of adults aged 25 years and above use tobacco in some form or the other; the per capita intake of fruits and vegetable is low, physical activity is low among females and urban dwellers, and 18% of adults have hypertension while 4% have diabetes. The government is aware of the emerging burden of the NCD epidemic and initiatives are being taken to put a multisectoral coordination mechanism in place, and to bring on board non-health actors and the civil society.

235. Dr Kaoru Takahashi of the International Organization for Migration applauded the continuing collaborative efforts of UN and other intergovernmental organizations to support governments in moving forward the commitments made in the UN Political Declaration on NCDs and the implementation of the WHO Global Action Plan on Noncommunicable Diseases 2013–2020 as endorsed by the Sixty-sixth World Health Assembly in 2013.
236. With an estimated one billion migrants worldwide, attention needs to be drawn to NCD-related vulnerabilities and needs of this marginalized and hard-to-reach population. Such an approach was also recommended by the World Health Assembly resolution WHA61.17 on health of migrants, at the Sixty-first World Health Assembly in 2008, highlighting the need to formulate and implement strategies to improve the health of migrants.

237. In line with this resolution, Dr Takahashi underlined that universal health care, and social protection mechanisms and strategies for NCDs should be inclusive of migrants, and that the post-2015 development agenda should not ignore health issues related to migrants.

238. Ms Ranjit Kaur representing the NCD Alliance commended Member States of WHO for concluding the work on global architecture for NCDs at the Sixty-seventh World Health Assembly. She said that together, the Global Coordination Mechanism for NCDs, the Global Monitoring Framework, and the Global NCD Action Plan, reinforced the three pillars of the global NCD architecture – accountability, action and coordination. She congratulated Member States for adopting a concise, action-oriented outcome document at the UN NCD Review and Assessment in New York, in July 2014, signalling an important shift from global dialogue to national action and implementation. She called on Member States to support an overarching outcome-focused health goal of ensuring healthy lives and promoting well-being for all at all ages; a stand-alone target to reduce NCD mortality by 40% by 2030; and health-sensitive indicators across all dimensions of the post-2015 development agenda. Ms Kaur requested that WHO should review and, where appropriate, revise national and local legislation and policies for controlled medicines, with reference to WHO policy guidance, on improving access to and rational use of pain management medicines, in line with the United Nations International Drug Control conventions. Palliative care is an appropriate response for all NCDs, including ischemic heart disease, which is the biggest killer in Bangladesh. “Our preferred indicator is morphine-equivalent consumption of strong opioid analgesics (excluding methadone) per capita consumption”, Ms Kaur concluded.

**Governing body matters (Agenda item 10)**

**Key issues arising out of the Sixty-seventh World Health Assembly and the 134th and 135th sessions of the WHO Executive Board (Agenda item 10.1: Document number SEA/RC67/24)**

239. The Committee noted the significant and relevant resolutions from the perspective of the South-East Asia Region adopted by the Sixty-seventh World Health Assembly.
Assembly and the 134th and 135th Sessions of the WHO Executive Board. These resolutions and decisions relate to health matters as well as Programme Budget and financial matters that were deemed to have significant implications and merited follow-up action by both Member States and WHO in the South-East Asia Region.

240. The **International Society of Physical and Rehabilitation Medicine (ISPRM)** in its statement mentioned that disability is recognized by WHO as a global public health and human rights issue and as a development priority. According to the *World report on disability 2011*, this includes around 15% of the global population. South-East Asia has the second highest prevalence of disability with 16% having moderate or severe disability, of which 2.9% are severely disabled.

241. In May 2014, WHO approved the Global Disability Action Plan 2014–2021: Better health for all people with disability, which has the vision of a world in which all persons with disabilities and their families live in dignity, with equal rights and opportunities, and are able to achieve their full potential. Considering that disability is likely to increase in the Region due to the ageing population and chronic health conditions, and considering the high impact of disability in society as well as the importance of rehabilitation as a set of measures that assist individuals who experience, or are likely to experience, disability, in order to achieve and maintain their optimal functioning in interaction with their environments, ISPRM recommends that rehabilitation be included in the health programmes of countries of the South-East Asia Region.

**Review of the Draft Provisional Agenda of the 136th session of the WHO Executive Board** *(Agenda item 10.2: Document number SEA/RC67/25 Rev.1)*

242. The Committee was informed that the 136th Session of the WHO Executive Board would be held at WHO headquarters in Geneva from 26 January to 3 February 2015. It noted that any proposal from a Member State or Associate Member to include an item on the Agenda should reach the Director-General not later than
12 weeks after circulation of the Draft Provisional Agenda or 10 weeks before the commencement of the session of the Executive Board, whichever is earlier.

243. The Committee also noted that the High-Level Preparatory (HLP) Meeting had reviewed the Draft Provisional Agenda of the 136th Session of the WHO Executive Board and recommended that Bangladesh take the lead in proposing the inclusion of TB and HIV under Agenda item 9.

**Special Programmes (Agenda item 11)**


244. The Joint Coordinating Board (JCB) of the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases Research (TDR) acts as the governing body of the Special Programme and is responsible for its overall policy and strategy. The Committee noted the report of the Thirty-seventh Meeting of the JCB of the Special Programme for Research and Training in TDR that was presented to the HLP meeting in July 2014.

245. At present, there are two Member States from the South-East Asia Region (India and Thailand) that are members of JCB under paragraph 2.2.1 until 31 December 2017. The term of Nepal under paragraph 2.2.2 will expire on 31 December 2014. Currently, there is no representation from the South-East Asia Region for JCB membership under paragraph 2.2.3.

246. The HLP meeting reviewed the report on attendance at the Thirty-seventh meeting of the JCB in 2014 and recommended that the Republic of Maldives be nominated in place of the Federal Democratic Republic of Nepal with effect from 1 January 2015 for the period 2015–2018.

247. The Committee noted the recommendation of the HLP meeting and **nominated** the Republic of Maldives in place of the Federal Democratic Republic of Nepal on the JCB with effect from 1 January 2015 for the period 2015–2018, and requested the Regional Director to inform WHO headquarters accordingly.
248. The Policy and Coordination Committee (PCC) acts as the governing body of the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP). The Committee noted the report of the Twenty-seventh Meeting of the PCC of the Special Programme of Research, Development and Research Training in Human Reproduction, held in Geneva on 26–27 June 2014, that was presented to the HLP meeting in July 2014.

249. At present, three Member States from the WHO South-East Asia Region (Bangladesh, Maldives and Timor-Leste) are members of PCC Category 2, while India continues to be a member of PCC Category 1. Nepal is a member of PCC Category 3.

250. The Committee nominated the Republic of Indonesia in place of the People’s Republic of Bangladesh, whose term expires on 31 December 2014, as a member of the PCC for a three-year term starting 1 January 2015, and requested the Regional Director to inform WHO headquarters accordingly.

251. The Committee also noted Myanmar’s request that it was keen to be nominated from the Region as a member of the PCC of the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction for the term starting 1 January 2015. The Committee requested the Regional Director to convey Myanmar’s request to WHO headquarters.
Time and place of future sessions of the Regional Committee
(Agenda item 12: Document number SEA/RC67/28)

252. The Regional Committee was informed of the invitation by H.E. Dr Sergio G.C. Lobo, Minister of Health of the Democratic Republic of Timor-Leste, made in May 2014, on behalf of the Government of the Democratic Republic of Timor-Leste, to host its Sixty-eighth Session in September 2015 in Timor-Leste.

253. The Committee formally accepted the invitation of the Government of the Democratic Republic of Timor-Leste and decided to hold its Sixty-eighth session in September 2015 in Timor-Leste.

Adoption of the report of the Sixty-seventh Session of the Regional Committee
(Agenda item 14)

254. The Chairperson noted that the draft report had been circulated to all Member States and that it would be finalized after incorporating any comments received. With this guidance, the report was adopted as presented.

255. The Committee adopted seven resolutions and took five decisions.

Closure of the session (Agenda item 15)

256. Representatives of Member States participating in the Sixty-seventh Session of the Regional Committee congratulated the Chairman and Vice-Chair for the smooth and successful conduct of the session. They were unanimous in expressing thanks to the Government of Bangladesh and to its Ministry of Health and Family Welfare for their warm hospitality as well as for the excellent arrangements made for the session.

257. The representatives expressed gratitude for the gracious and encouraging presence of Her Excellency Sheikh Hasina, Honourable Prime Minister of the
Government of Bangladesh at the joint inauguration of the health ministers’ meeting and the Sixty-seventh Session of the Regional Committee. They also conveyed their deep appreciation to Dr Margaret Chan, Director-General of WHO, and to Dr Poonam Khetrapal Singh, Regional Director, WHO South-East Asia, for their dynamic leadership.

258. The Chairman thanked representatives for their active participation and unwavering support. He expressed his deep appreciation of Dr Poonam Khetrapal Singh for her very able and astute stewardship of the WHO South-East Asia Region. The Committee reviewed several important issues and made valuable suggestions, which the Chair hoped would be implemented.

259. The Vice-Chair thanked staff of the Ministry of Health and Family Welfare, Government of Bangladesh, for their hospitality and for making the stay of participants comfortable and their visit memorable. She also complimented the Chair for his efficient conduct of the session.

260. The Regional Director, Dr Poonam Khetrapal Singh, expressed her deep gratitude to Her Excellency Sheikh Hasina, Prime Minister, Government of Bangladesh, for her exceptional personal interest in the Regional Committee session by not only gracing the inaugural ceremony on the first day but also taking time out to attend two important side events during the course of the session. She also thanked the Honourable Ministers and their representatives for their valuable suggestions, comments and inputs. She expressed her appreciation to the Chairman, His Excellency Mr Mohammed Nasim, Honourable Minister of Health and Family Welfare of the People’s Republic of Bangladesh, for the successful conduct of the session, as well as for injecting a touch of humour into otherwise very serious discussions during the session. Dr Singh assured the representatives that WHO would ensure action and extend support to all Member States of the Region with regard to the several resolutions adopted at the session.
261. The Regional Director expressed her gratitude for the Committee having agreed to merge the Senior Advisers’ Meeting (SAM), the Health Ministers’ Meeting (HMM) and the Regional Committee session into a four-and-a-half-day session of the Committee. Dr Singh assured the representatives that she would soon be sharing the details of the revised format of the proposed session with Health Ministers of all Member States of the Region.

262. The Regional Director also thanked the Director-General, WHO, for her thought-provoking address and conveyed her deep appreciation to colleagues from WHO headquarters and staff of the Regional Office for their hard work towards the successful conduct of the session.

263. The representatives expressed great satisfaction at the successful conduct of deliberations on subjects of vital importance to the health of the people of the Region.

264. The Chairman declared the session closed.
Resolutions

SEA/RC67/R1 Proposed Programme Budget 2016–2017

The Regional Committee,

Having considered the Proposed Programme Budget 2016–2017, which builds on the approved Programme Budget 2014–2015; and which is structured according to the categories of work and programme areas outlined in the Twelfth General Programme of Work 2014–2019, providing the overall strategic direction and results chain for the Organization,

Noting that the development of Programme Budget 2016–2017 is very different from that of the previous biennia, since it has followed a need-based, bottom-up prioritization process involving the Member States, in response to their requests to identify a focused number of priorities for technical cooperation and aligning these with the regional and global commitments,

Recognizing that the Programme Budget is the primary instrument to express the full scope of work of the Organization and identify the roles, responsibilities and budgetary allocations of the three levels of the Organization,

Noting the absence of a finalized strategic budget space allocation methodology, and the need for a robust, bottom-up planning and budgeting process for Programme Budget 2016–2017,
Further noting that the budgets for polio-related activities and outbreak, crisis and response (OCR) are considered as flexible budgets and can be reviewed and increased, based on the requirements of the regions,

Recognizing the need for having increased programme budget allocation for identified regional flagship programmes,

Endorsing the recommendations of the Inter-sessional Meeting in August 2014 and the Seventh Meeting of the Sub-Committee on Policy and Programme Development and Management on the Draft Proposed Programme Budget 2016–2017,

1. URGES Member States:

   (a) to ensure more active and enhanced participation in the programme-budget related discussions at the regional and global governing body meetings;

   (b) to further strengthen national programme planning and management capacities with the objective of improving the efficiency and effectiveness of WHO’s programme implementation; and

2. REQUESTS the Regional Director:

   (a) to convey the following views of the Regional Committee to the Director-General for her consideration while finalizing the Proposed Programme Budget 2016–2017:

      (i) the need for a programme budget increase for the South-East Asia Region for the biennium 2016–2017, to address the high disease burden and population of the Region;

      (ii) the health priorities, prevailing health situation and related resource requirements in a country-specific setting should be one of the major considerations for the allocation of resources;

      (iii) the budget estimates arrived through bottom-up planning by countries should be of a flexible nature allowing any subsequent shifts within and across categories and programmes as identified at country level;

      (iv) the Region should get full funding against the programme budget;

   (b) to ensure efficient management of the budget for the Region, through appropriate consultations, in light of the budget allocation, in a manner that aligns the budget with the health needs and priorities identified by the Member States of the Region;
to enhance resource mobilization efforts in the Region, particularly attracting flexible and un-earmarked funds and other voluntary contributions for underfunded categories, priority programme areas and Member States with limited fund mobilization capacity.

SEA/RC67/R2 Covering Every Birth and Death: Improving Civil Registration and Vital Statistics

The Regional Committee,

Recalling World Health Assembly resolution (WHA67.14) on Health in the post-2015 development agenda,

Recognizing the importance of evidence-based decision-making and accountability through regular assessment of progress by strengthening civil registration and vital statistics (CRVS) and health information systems with disaggregated data to monitor health equity,

Noting that reliable data is essential for effective planning and management of health and other sectors, particularly in efforts towards achieving the time-bound health targets,

Emphasizing that CRVS systems are crucial to obtain continuous and compulsory data on births, deaths and causes of death, through cost-effective means,

Concerned with the heavy reliance on expensive and time-consuming surveys to produce health statistics in the absence of more complete civil registration data and the generation of reliable mortality statistics from routine CRVS systems,

Noting the findings of the comprehensive assessment of CRVS, already completed (using the WHO tool) in eight of the 11 Member States of the WHO South-East Asia Region, that have identified the key challenges for CRVS in the countries of the Region to be: inadequate coverage and completeness of birth and death registration; poor quality of cause of death (CoD) data resulting in ill-defined recording of ICD (International Classification of Diseases) codes; lack of quality audits to improve civil registration data quality and its use for generation of vital statistics; and inadequate interagency coordination between the key stakeholder ministries responsible for CRVS,
Considering the commitment of Member States to prioritize CRVS strengthening as a coordinated effort between ministries of health, ministries responsible for civil registration and the national statistics offices,

1. **ENDORSES** the Regional Strategy for Strengthening the Role of the Health Sector in Improving CRVS (2015–2024), hereinafter referred to as the Regional Strategy; and

2. **URGES** Member States:
   
   (a) to undertake key actions for implementing the Regional Strategy:
   
   (b) to establish or strengthen a national CRVS coordination mechanism with representation of all key stakeholders;
   
   (c) to undertake assessment of national CRVS systems and development of costed national plans for improvement of CRVS, including requirements of all stakeholders;
   
   (d) to build national capacity for strengthening of CRVS and mobilize adequate human and financial resources,
   
   (e) to enhance the contributions of health and other sectors to boost the completeness and quality of birth and death registration by creating demand through linking CRVS systems with services;
   
   (f) to support the use of verbal autopsy, as appropriate for deaths occurring particularly in the absence of a trained health-care worker;
   
   (g) to strengthen death certification by trained health-care workers;
   
   (h) to strengthen implementation of ICD coding and generate quality mortality statistics from routine CRVS data; and
   
   (i) to monitor progress and evaluate achievements in strengthening completeness and quality of CRVS systems and institutional capacities on a regular basis aligned with the agreed-upon framework in the Regional Strategy, conducting mid-course corrections where necessary,

3. **REQUESTS** the Regional Director:

   (a) to provide technical support to Member States to implement the Regional Strategy;

   (b) to support knowledge-sharing platforms encompassing a repository of tools and conduct technical consultations for sharing of best practices and lessons learned;
(c) to coordinate and harmonize technical and financial support from different international agencies and development partners at the regional and country levels;

(d) to assist Member States on request in adapting and implementing the standard verbal autopsy tools to strengthen CRVS, in particular in the absence of a trained health-care worker; and

(e) to report progress to the Seventy-first, Seventy-fourth and Seventy-eighth Sessions of the Regional Committee for South-East Asia in 2018, 2021 and 2025.

SEA/RC67/R3 Traditional Medicine: Delhi Declaration

The Regional Committee,

Having considered the Delhi Declaration on Traditional Medicine adopted on 13 February 2013 by the 11 Member States of the WHO South-East Asia Region,

Recalling World Health Assembly resolutions WHA22.54, WHA29.72, WHA30.49, WHA31.33, WHA40.33, WHA41.19, WHA42.43, WHA 44.34, WHA54.11, WHA56.31, WHA61.21 and WHA62.13, and in particular Regional Committee resolution SEA/RC56/R6 on traditional systems of medicine which requested the Regional Director to assist Member States in developing/strengthening national policies, strategies and plans of action on traditional systems of medicine,

Acknowledging the WHO Traditional Medicine Strategy 2014–2023 that was endorsed in World Health Assembly resolution WHA67.18,

Recognizing that traditional medicine and traditional medicine practitioners have substantial potential to contribute to improving health outcomes in Member States of the South-East Asia Region,

Recognizing that some Member States in the South-East Asia Region are poised, within country for specific types of traditional medicine, to pursue a harmonized approach towards education, practice, research, documentation and regulation of traditional medicine, and

Noting that the International Conference on Traditional Medicine for Member States of the South-East Asia Region took place on 12–14 February 2013 and the Delhi Declaration on Traditional Medicine was adopted on 13 February 2013,
1. URGES Member States:

(a) to consider implementing the Delhi Declaration on Traditional Medicine 2013 in accordance with national capacities, priorities, relevant legislation and circumstances, as follows:

(i) promoting national policies, strategies and interventions for equitable development and appropriate use of traditional medicine in the health-care delivery system;

(ii) developing institutionalized mechanisms for exchange of information, expertise and knowledge on traditional medicine with the active cooperation of WHO through workshops, symposia, visits of experts, exchange of literature etc.;

(iii) pursuing a harmonized approach for the education, practice, research, documentation and regulation of traditional medicine and involvement of traditional medicine practitioners in health services;

(iv) exploring the possibility of promoting mutual recognition of educational qualifications awarded by recognized universities, pharmacopoeias, monographs and relevant databases of traditional medicine;

(v) encouraging the development of common reference documents on traditional medicine for Member States of the South-East Asia Region;

(vi) developing regional cooperation for training and capacity-building of traditional medicine experts;

(vii) encouraging sustainable development and resource augmentation of medicinal plants in Member States of the South-East Asia Region;

(viii) establishing regional centres as required for capacity-building and networking in the areas of traditional medicine and medicinal plants, and

(ix) exchanging views, experiences and experts for integration of traditional medicine into national health systems in accordance with national policies and regulations,

(b) to adapt and implement the WHO Traditional Medicine Strategy 2014–2023 taking into account national capacities, priorities and legislation;

(c) to integrate, as appropriate, traditional medicine into the mainstream health-care systems in order to contribute to universal health coverage; and
(d) to strengthen systems, particularly pharmacovigilance systems, to ensure that all available traditional medicine products meet safety, efficacy and quality standards,

2. REQUESTS the Regional Director:

(a) to support Member States, as appropriate, in implementing the Delhi Declaration on Traditional Medicine and the WHO Traditional Medicine Strategy 2014-2023;

(b) to support Member States, as appropriate, to strengthen systems, particularly pharmacovigilance systems, to ensure that all available traditional medicine products meet safety, efficacy and quality standards;

(c) to allocate adequate funds in accordance with the WHO Programme Budget towards implementation of the Delhi Declaration on Traditional Medicine and the WHO Traditional Medicine Strategy 2014–2023 in Member States of the South-East Asia Region;

(d) to provide policy and technical guidance in the promotion of traditional medicine on harmonized lines for each type of traditional medicine in the Region; and

(e) to report on the progress of the implementation of WHO Traditional Medicine Strategy 2014–2023 to the Seventy-second and Seventy-seventh sessions of the Regional Committee for South-East Asia in 2019 and 2024.

**SEA/RC67/R4 South-East Asia Regional Action Plan to Implement Global Strategy to Reduce Harmful Use of Alcohol (2014–2025)**

The Regional Committee,

Noting the report on Strengthening the Implementation of the Global strategy to reduce harmful use of alcohol to support the achievement of the regional targets on noncommunicable diseases (NCDs) prevention and control in the South-East Asia Region,

Recalling the World Health Assembly resolution WHA63.13 on the Global strategy to reduce the harmful use of alcohol, the follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases, particularly in regard to the adoption of
the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 and the global target on the reduction of harmful use of alcohol as one of the nine voluntary targets,

Also recalling Regional Committee resolution SEA/RC66/R6 on the Regional Action Plan and Targets for Prevention and Control of NCDs (2013–2020), that endorsed a regional voluntary target of 10% reduction in the harmful use of alcohol and recommended to Member States to use total adult per capita consumption as the basic indicator,

Further recalling Regional Committee resolutions SEA/RC54/R2 on Mental Health and Substance Abuse, including Alcohol, and SEA/RC59/R8 on Alcohol Consumption Control: Policy Options, which endorsed the Regional Policy Framework, and document SEA/RC59/15 on providing strategic guidance to Member States,

Concerned that there is a gradual increase in consumption of alcohol among the general population – particularly among adolescents, youth and also women in some Member States – and quite a high prevalence of heavy episodic drinking or binge drinking and unrecorded alcohol consumption in the Region,

Deeply concerned that the South-East Asia Region is an emerging market for the alcohol industry which is progressively investing and marketing in the Region, and that there is a shift in consumption of beverage types from indigenous/traditional to modern beverages such as wines and beers, as well as from ritual use to lifestyle-related drinking,

Recognizing the consequences of trade agreements that facilitate the free flow of and investment in alcohol, which may increase the consumption and negative impact of alcohol in the Region, and may limit the ability of Member States to prevent and control alcohol-related harms,

Concerned that consumption of illicit or informally produced alcohol has additional negative consequences, partly due to a higher ethanol content and potential contamination with toxic substances, such as methanol,

Noting that alcohol consumption leads to many health problems including NCDs such as cardiovascular diseases and cancers, which contribute to a great proportion of the global and regional burden of disease,
Mindful of the concern that alcohol consumption also has a negative impact on people other than those who drink, and also social and economic consequences on the population, in particular the poor,

Reiterating that the basis for prevention of alcohol-related harm in the context of the South-East Asia Region may also include negative social and economic consequences related to productivity loss, poverty, social safety and quality of life, and also take into account social structure and sociocultural norms,

Further noting the progress of work of the WHO Global Network of National Counterparts to implement the Global Strategy, formed in 2011, and their task forces and working groups, as well as the establishment of the South-East Asia Region Network of National Counterparts and other regional initiatives,

Recognizing the commitment to address the harmful use of alcohol as a risk factor for NCDs, in particular the outcomes of the 2012 Bi-Regional Workshop in Bangkok on building capacity for reducing the harmful use of alcohol at the country level in coordination with NCD prevention and control programmes of the South-East Asia and Western Pacific regions,

Acknowledging the need for further strengthening of national and regional capacities, including institutional capacity, and further accelerating the implementation of the Global strategy to reduce harmful use of alcohol at the national level, and

Noting the draft regional action plan that was developed through consultations among SEA Network of National Counterparts on Implementing the Global Strategy to Reduce Harmful Use of Alcohol,

1. ENDORSES the Regional Action Plan to Implement the Global Strategy to Reduce Harmful Use of Alcohol for the South-East Asia Region (2014–2025);

2. URGES Member States:

   (a) to consider setting targets, as appropriate, on the reduction of the harmful use of alcohol;

   (b) to develop and/or strengthen, as appropriate, a comprehensive alcohol policy framework to reduce the harmful use of alcohol, taking into consideration the Regional Action Plan to Implement the Global strategy to reduce harmful use of alcohol for the South-East Asia Region (2014–2025);
(c) to develop and/or strengthen, as appropriate, systems and mechanisms to facilitate the implementation of the WHO Global strategy to reduce harmful use of alcohol, which may include responsible institutional, human and financial resources, multisectoral collaborating mechanisms, and technical knowledge and information systems;

(d) to promote the linkages between the implementation of the Global strategy to reduce the harmful use of alcohol and efforts on NCD prevention and control;

(e) to strengthen surveillance for alcohol consumption and related harm including integrated surveillance for NCDs, and

(f) to consider observing a regional/national non-alcohol day and advocate for global non-alcohol day,

3. REQUESTS the Regional Director:

(a) to provide technical support and build capacity of Member States to advance the implementation of the Regional action plan for reducing the harmful use of alcohol, in accordance with the implementation of the Regional action plan and targets for prevention and control of NCDs;

(b) to support capacity strengthening and international collaboration mechanisms, including setting up the Regional Technical Advisory Group on Alcohol and Health, to support the WHO Global and Regional Networks of National Counterparts for Implementation of the global strategy to reduce harmful use of alcohol and their subsidiary groups, and to continue the biennial regional forum of key partners from Member States and international partners; and

(c) to report progress on this resolution to the Seventieth, Seventy-third, Seventy-sixth and Seventy-ninth sessions of the Regional Committee for South-East Asia in 2017, 2020, 2023 and 2026.

SEA/RC67/R5 Viral Hepatitis

The Regional Committee,

Recalling that, approximately 1.4 million deaths are caused by hepatitis viruses every year globally, with an estimated 800 000 due to hepatitis B and 500 000 as a result of hepatitis C infection, and that around 500 000 of these estimated deaths
occurs in the WHO South-East Asia Region alone, with deaths associated with viral hepatitis exceeding the mortality estimates for malaria, dengue and HIV/AIDS combined,

Mindful of the fact that an estimated 100 million people infected with hepatitis B virus and 30 million infected with hepatitis C reside in the South-East Asia Region, and that the prevalence of hepatitis B and hepatitis C co-infection is up to 60% among persons living with HIV infection,

Concerned about the limited and fragmentary nature of the available data from the Region on the rates of infection with hepatitis viruses, clinical disease caused by these viruses, and the associated morbidity and mortality, and further, that no data are available on the societal and economic impact (in terms of years of life lost, disability, loss of productivity, expenditure on medical care, etc.) of these infections in the Region,

Taking note that in 2010, the Sixty-third World Health Assembly adopted its first resolution on viral hepatitis and called for a comprehensive approach to its prevention and control, and that in June 2013, WHO launched the Global Hepatitis Network, one of its aims being to support Member States with planning and implementation of viral hepatitis plans and programmes,

Further recalling World Health Assembly resolution WHA67.6 that called upon all Member States to launch nationally coordinated programmes to combat viral hepatitis,

Noting that WHO launched the guidance for the screening, care and treatment of persons with hepatitis C infection in April 2014, updated its prequalified list of hepatitis B and C serological tests and prepared treatment guidelines for hepatitis B and C that will be issued later in 2014,

Affirming that the WHO Regional strategy on prevention and control of viral hepatitis (SEA-CD-282) is aligned with the WHO Global action plan, and that the Strategy defines actions that need to be undertaken by Member States with support from WHO,

Realizing the inadequate awareness among health administrators and policymakers, medical professionals and the general population about hepatitis viruses, including their routes of transmission, risk factors and impact on human health,
Recognizing that various health systems challenges need to be addressed to prevent and control viral hepatitis, in particular, inadequate disease surveillance systems; low rates of infant hepatitis B vaccine coverage, especially for the dose at birth; lack of access to clean water and sanitation; limited knowledge, availability of, access to and use of preventive services for viral hepatitis, including screening of transfused blood and blood products; and inadequate allocation of financial and manpower resources,

Concerned about the high cost of and inadequate and inequitable access to affordable treatment for viral hepatitis, and its long-term complications (cirrhosis and liver cancer), and cost of liver transplantation in patients with end-stage disease, and

Keenly aware of the importance and need for timely prevention and control of viral hepatitis,

1. URGES Member States:

   (a) to designate a focal point and/or establish a unit/programme, as appropriate, responsible for the prevention and control of viral hepatitis;

   (b) to establish/strengthen national viral hepatitis surveillance systems;

   (c) to develop/update and implement national plan(s) for the prevention and control of viral hepatitis including management of individuals living with hepatitis;

   (d) to promote rational use of medicines for the management of viral hepatitis;

   (e) to advocate for political commitment and mobilize adequate resources for the prevention and control of viral hepatitis; and

   (f) to promote research in order to strengthen prevention and control of viral hepatitis, including research and development of medical products.

2. REQUESTS the Regional Director to accord priority and organizational capacity in order to provide technical support to Member States in implementation of national viral hepatitis prevention and control efforts based on the WHO Regional strategy on prevention and control of viral hepatitis.
The Regional Committee,

Recognizing the importance of the health workforce and its essential contribution to health systems functioning, which further contributes to the health of the population,

Noting with concern that the critical shortage of health workforce remains a problem in the South-East Asia Region and has not improved significantly, while inequitable distribution further exacerbates the problems of access to the health workforce in rural and remote areas,

Reaffirming the 2006 Dhaka Declaration on Strengthening the Health Workforce in Countries of the South-East Asia Region,

Recalling Regional Committee resolution SEA/RC59/R6 on Strengthening the Health Workforce in the South-East Asia Region and the Regional Strategic Plan for Health Workforce Development adopted in 2007,

Acknowledging that some progress has been achieved with several Member States developing their national strategies and/or country human resources for health (HRH) profiles, though these plans need adequate funding for effective implementation and monitoring outcomes,

Further noting the 16 recommendations in the WHO publication entitled “Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations” and the 11 recommendations in the WHO publication entitled “Transforming and scaling up health professionals’ education and training: WHO education guidelines 2013”,

Noting that some Member States in the Region have limited health workforce production capacity which hampers self-sufficiency and will require effective collaboration across Member States,

Also recalling Regional Committee resolution SEA/RC65/R7 based on which Member States had conducted a comprehensive assessment of the current situation of health workforce education and training, and noting that these assessments serve as a foundation for evidence-based policy formulation and implementation for strengthening health workforce education systems, and
Having considered the Regional strategy on strengthening health workforce education and training in the South-East Asia Region,

1. **ENDORSES** the Regional strategy on strengthening health workforce education and training in the South-East Asia Region (2014–2019); and

2. **URGES** Member States:

   (a) to take steps, in the context of their existing national strategies on health workforce, to integrate and implement the Regional strategy on strengthening health workforce education and training in the South-East Asia Region, and in particular to:

   (i) increase capacity of quality training for an adequate number of relevant health workforce through institutional and instructional reforms;

   (ii) ensure educational and other strategies that will enable the health workforce to serve and sustain their contributions in rural communities or places where they are most needed;

   (iii) strengthen the synergies between health workforce education systems and health-care systems;

   (b) to strengthen the implementation of the 16 WHO global policy recommendations on increasing access to health workers in remote and rural areas through improved retention;

   (c) to establish/strengthen health workforce information systems for monitoring progress, supporting management and appropriate policy actions;

   (d) to consider reviewing periodically, preferably every three years, achievements and challenges of the implementation of health workforce strengthening;

3. **REQUESTS** the Regional Director:

   (a) to support Member States in their implementation of the Regional strategy on strengthening health workforce education and training in the South-East Asia Region (2014–2019); and

   (b) to report progress on the implementation of health workforce development to the Regional Committee for South-East Asia every two years starting 2016 for the next decade.
SEA/RC67/R7  Resolution of Thanks

The Regional Committee,

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

(a) THANKS Her Excellency Sheikh Hasina, Prime Minister of the People’s Republic of Bangladesh, for inaugurating the Session and for her thought-provoking statement;

(b) THANKS the Director-General, Dr Margaret Chan, for her inspiring address and participation;

(c) CONVEYS its gratitude to His Excellency Mr Mohammed Nasim, Minister of Health and Family Welfare, Government of the People’s Republic of Bangladesh, the officers and staff of the Ministry of Health and Family Welfare, and other national authorities for facilitating the inauguration of the Session; and

(d) CONGRATULATES the Regional Director and her staff on their dedicated efforts towards the successful and smooth conduct of the session.

Decisions

SEA/RC67(1)  Strategic Budget Space Allocation

The Committee requested the Regional Director to submit to the Director-General its recommendations as well as those of the Inter-sessional Meeting held in the Regional Office for South-East Asia on 25–27 August 2014, particularly on inclusion of criteria of burden of disease, unit cost of care, geographical situation and terrain, need for emergency and disaster preparedness to “Segment 1” of the proposed methodology, for consideration of the Working Group of WHO Executive Board when developing the methodology on strategic budget space allocation.

SEA/RC67(2)  Framework of engagement with non-State actors

The Committee requested the Regional Director to submit to the Director-General its recommendations as well as those of the Inter-sessional Meeting held in the
Regional Office for South-East Asia on 25–27 August 2014 to be considered when preparing discussion papers for the 136th Session of WHO Executive Board to be held in January 2015 and for further discussion at the Sixty-eighth World Health Assembly in May 2015.

SEA/RC67(3) Nomination of a Member State to the Policy and Coordination Committee (PCC) of the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction

The Committee nominated Indonesia as member of the PCC for a three-year term starting 1 January 2015, and requested the Regional Director to inform WHO headquarters accordingly.

SEA/RC67(4) Nomination of a Member State to the UNICEF/UNDP/World Bank/WHO Special Programme of Research and Training in Tropical Diseases: Joint Coordinating Board (JCB)

The Committee nominated Maldives as member of the JCB for 2015–2018 in place of Nepal, whose term expires in December 2014, and requested the Regional Director to inform WHO headquarters accordingly.

SEA/RC67(5) Time and place of future sessions of the Regional Committee

The Committee decided to hold its Sixty-eighth Session in 2015 in Dili, Timor-Leste.
Respected Chairperson, Mr Mohammed Nasim, MP, Honourable Minister for Health and Family Welfare of Bangladesh, Honourable Chief Guest, Sheikh Hasina, the Honourable Prime Minister of the People’s Republic of Bangladesh, Special Guest, Her Excellency Dr Margaret Chan, Director-General, World Health Organization, Special Guest Mr Zahid Maleque MP, Honourable State Minister for Health and Family Welfare of Bangladesh and Special Guest, Her Excellency Dr Poonam Khetrapal Singh, Regional Director, WHO South-East Asia, Excellencies, Ministers, heads and members of delegations, members of the diplomatic missions, WHO technical staff, officers and staff of the Ministry of Health and Family Welfare, Bangladesh, and its agencies and institutions, dignitaries, invited speakers, experts, distinguished guests, representatives from the print and electronic media, ladies and gentlemen,

With great pleasure, I welcome you, on behalf of the Ministry of Health and Family Welfare of the Government of the People’s Republic of Bangladesh, to this Joint inaugural ceremony of the Thirty-second Meeting of the Ministers of Health and the Sixty-seventh Session of the Regional Committee of WHO South-East Asia being held in Dhaka.

For the last several months, we, under the leadership of our Honourable Minister and State Minister for Health and Family Welfare, have worked closely with the WHO Regional Office for South-East Asia under the leadership of the Regional Director and the WHO Country Office, Bangladesh under the leadership of the WHO Representative to Bangladesh, to make these two great WHO regional events successful. Our great leader, Honourable Prime Minister Sheikh Hasina has the holy and committed blood of our late Father of the Nation, Bangabandhu Sheikh Mujibur Rahman, flowing in her veins. Her Excellency kept a constant watch on our preparation and progress. We are specially delighted that she, despite her very busy schedule, has kindly graced this Joint Inauguration and has given her warm consent to stay with us longer to express her full solidarity with WHO’s efforts to change the health of our peoples. Our whole nation is overwhelmed to greet you
in this sweet land of Golden Bangla. We will really feel fulfilled if you kindly find our heartiest efforts acceptable.

The Government of Bangladesh values WHO and its contribution over the past seven decades since its birth in 1948 in shaping the global good health through developing new knowledge, best practices and appropriate tools. We salute WHO for its remarkable achievement in the eradication of smallpox, in attaining the last mile of global polio eradication, in ending all vaccine-preventable diseases, in promulgating International Health Regulations 2005, in controlling NCDs and in establishing intervening measures regarding autism and mental health.

WHO’s magnificent leadership in the formulation and attainment of health-related MDGs, and towards adoption of the Post-2015 Development Goals are unique examples that WHO is always alert, and is present everywhere, in every moment, when the issue involved is health.

The WHO Regional Office for South-East Asia undeniably shares all credit in translating and transferring the roles and successes of WHO across its Member States in the Region. This joy is also shared fully by all of our 11 regional Member States, as we actively participate, as State Parties, in all the major WHO policy decisions and their implementation.

The meetings of the health ministers are instrumental in expressing readiness of national governments to align their respective country positions to WHO’s leadership and goodwill with a view to addressing regional health issues.

These meetings also act as an inspiration for the Regional Committee sessions towards taking bold and positive decisions for good health of our regional citizens, who comprise one quarter of the global population.

Given the importance of health ministers’ meetings and the Regional Committee sessions, our Ministry of Health and Family Welfare is very happy to get the opportunity to host the Thirty-second Health Ministers’ Meeting and the Sixty-seventh Session of the Regional Committee in Dhaka.

I warmly welcome Excellencies Health Ministers, WHO Director-General Her Excellency Dr Margaret Chan and the WHO Regional Director for South-East Asia, Dr Poonam Khetrapal Singh, senior officials and delegates from the health ministries of Member States of our Region, as well as from WHO headquarters, and from the WHO Regional Office and its country office to Bangladesh. We promise to do our best in extending our warm hospitality.
There will be several side-events during the two meetings, one of which will be on autism. Our Honourable Prime Minister has kindly consented to grace the autism side-event as the Chief Guest. I invite all Excellencies to kindly join our Honourable Prime Minister in this special and very important side-event.

In the end, I sincerely acknowledge the generous support received by us from the Government of Bangladesh, WHO, and from all other partners, both at home and abroad, in organizing this very important event.

I wish that you feel at home during your stay here. Please inform us without any hesitation if you feel any inconvenience or have any requirement. We will do our best to make your stay smooth and enjoyable. I hope that you will like our traditional Bangladeshi hospitality and will be generous to pardon our unintended mistakes.

Thank you very much.
Annex 2

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

Your Excellency, Honourable Prime Minister of the People’s Republic of Bangladesh Madam Sheikh Hasina, Mr Mohammed Nasim, Minister for Health and Family Welfare, People’s Republic of Bangladesh, Dr Harsh Vardhan, Minister for Health and Family Welfare, Government of India, Dr Margaret Chan, Director-General, WHO, Honourable Ministers of Health of Member States of WHO South-East Asia Region, distinguished delegates, partners, friends from the media, ladies and gentlemen,

It is a privilege to welcome you all to the Thirty-second Meeting of the Health Ministers and the Sixty-seventh Session of the WHO Regional Committee for South-East Asia.

We are deeply honoured by your presence Madam Prime Minister. Under your leadership the health advances of Bangladesh have truly been remarkable. Despite many challenges, we have seen steep and sustained reductions in birth rates and mortality. Indeed, Bangladesh offers an object lesson in how gender equity can improve health outcomes, how innovations by government and NGOs can go to scale, and how direct health interventions can offset socioeconomic constraints. Madam Prime Minister, your presence at this occasion is an inspiration for us all.

Excellences, distinguished delegates,

We have health achievements in this Region of which we can be very proud. Certification that the Region is now polio-free was a defining moment. It is a cause for celebration, and I congratulate you for your collective political commitment and the untiring efforts of the thousands of frontline workers that could make this happen. Success on one front should make us pause for thought. The Region and, indeed the world is changing fast. We must be ahead of the curve if we are to confront the many issues that we face.

Let us think for a moment about the challenges. NCDs approach like a juggernaut, threatening communities, health systems and economies if we do not act now.
Antibiotic resistance if not checked and soon, can return us to an era where we will be stripped of tools that today we take for granted.

Expectations for better health are rising. Health has to be seen as a right for all, not a privilege for a few. Health equity must be a cornerstone of our policies: not tomorrow, but today.

Disasters, man-made and natural, something to which the Region is so prone, can destroy what we have worked so hard to build. We must not just expect the unexpected, we must have what it takes to do something about it, and fast.

At this point, I must mention about our colleagues in the national governments and the international community who are fighting to overcome the unprecedented outbreak of Ebola fever in west Africa, which has claimed nearly 2000 lives so far. We salute the efforts of the brave health workers and others battling this outbreak.

Excellencies,

Health in the 21st century requires a 21st century approach.

The challenges I outline are not amenable to technical solutions alone. What we have learned in the fight against tobacco stands us in good stead. We cannot hope to outrun NCDs without action in the many sectors that impact health: finance, trade, agriculture and education among others. Partnership across all sectors of society is not an add-on in this fight. It is an absolute necessity. Ensuring access to medicines requires that we interact with legislators and trade negotiators. To fight antimicrobial resistance means working at the interface between health and agriculture. We must embrace new technologies. We will see some exciting examples of how this is being done during our meeting. We have to look beyond the health sector regarding the impact of the environment. Universal health coverage (UHC) promotes equity and is a key weapon in the fight against poverty. Support for universal health coverage is growing. This is good news. UHC can be a game changer, but it must become more than just a mantra. UHC must deliver results.

We need UHC to breathe life into the way we work by putting people at the centre of a joined-up approach that bridges the divides that have long bedevilled the health sector.

Excellencies, ladies and gentlemen,

Together we can be champions for health in our Region. When we met in May, I outlined the strategic directions that will guide our work. These are aligned to
WHO’s 12th General Programme of Work, but also reflect your priorities. I spoke then of four directions: addressing the persisting and emerging epidemiological and demographic challenges; advancing universal health coverage and robust health systems; strengthening emergency risk management for sustainable development; and articulating a strong regional voice in the global health agenda.

These directions define what we will do. Let me conclude with a few words about what this means for how we work together.

Global health is an increasingly crowded place. A bit of healthy competition is not a bad thing, of course. It keeps us all on our toes. But fragmentation and duplication is wasteful and costs lives. All of us in organizations that support health must focus on what we do best and where we add real value.

One of our core functions in the Region is to act as a convener, but I am convinced WHO can do more to drive policy agendas in the interest of better health. We must bring better analysis, better evidence and up-to-date science to the table.

Lastly, when resources are scarce, value for money has to be uppermost in our minds. I see this as a strategic function: It should not be just spending, but spending wisely — the right people, the right level of resources, deployed in the right places, to do the right things. Bringing staff and resources closer to countries is part of this picture.

Excellencies,

Better health is not a luxury; it is an investment. I salute you for the rise in levels of government spending in several of our Member States. I am determined that the WHO Regional Office and the country offices will provide the support you need as governments invest more in the health of the people.

With these words, I once again welcome you all and thank Madam Prime Minister for hosting and inaugurating these meetings.

Thank you.
Honourable Prime Minister of Bangladesh Her Excellency Sheikh Hasina, Honourable Minister of Health of Bangladesh, His Excellency Mohammad Nasim, Honourable Colleague Health Ministers from WHO South-East Asia Region, Madam Director-General, WHO, Dr Margaret Chan, WHO Regional Director for South-East Asia, Dr Poonam Khetrapal Singh, distinguished ambassadors, representatives from WHO and other UN agencies, donor partners, distinguished delegates from Member States of the WHO South-East Asia Region, representatives of nongovernmental organizations, the media, friends, ladies and gentlemen,

On behalf of the Ministry of Health and Family Welfare, Government of India, I am honoured to address this august gathering and bring greetings to you from more than 1.2 billion people of India.

At the outset, I would like to thank the Honourable Prime Minister of Bangladesh for hosting the meetings in Bangladesh and also for sparing her valuable time to be with us today to grace this joint inaugural session. Madam Prime Minister, we are truly honoured by your presence. We share an emotional chord with Bangladesh and especially with the memories of your father Bangabandhu Sheikh Mujibur Rehman, who was the liberator of Bangladesh and a great friend of India.

Excellencies, ladies and gentlemen,

I have recently taken over as the Union Health Minister of India. In this new role, I seek your valuable support in traversing a path where we can attain the highest standards of health not only for our countries but for the entire Region and for the entire league of nations. The Indian philosophy teaches us that the whole world is our family. I can assure you that we would strive to stay close to this philosophy in all our actions and deeds at regional and global levels.

Excellencies, ladies and gentlemen,

I have a strong faith in the power of belief. In the mid-1990s, as the Health Minister of the state of Delhi in India, I had the privilege to be one of the architects
...and initiator of the polio eradication campaign in India. At that time, no one really believed that it was possible to make India polio-free. From day one, when we came to know that poliomyelitis could be eradicated through the scientific pulse polio technique, we started working on it in spite of heavy odds and strong apprehension about its successful implementation. The certification of India being polio-free today signifies the “power of belief”. It has also given us new hope, new energy, new enthusiasm and a new vision to take on even greater health challenges.

We know that noncommunicable diseases (NCDs) are the major killers of people in this Region in their most productive years. We need to tackle the threat of NCDs through preventive, evidence-based interventions and by promoting “health-in-all policies”. I am happy to inform you that we have taken strong measures to intensify implementation of the WHO Framework Convention for Tobacco Control (FCTC) and to strengthen primary health care systems for delivery of NCD services to affected people.

We have recently taken up a comprehensive review of our tobacco control laws and regulations. We have also taken strong steps in prohibiting certain most prevalent forms of smokeless tobacco through our food safety law and regulations. India is a pioneer in the regulation of scenes depicting tobacco use in films and TV programmes to protect youth and children from the negative influence of tobacco use. We want to make our public places not only smokefree but tobacco free.

The South-East Asia Region is home to many vector-borne diseases. Malaria continues to be a threat. The Region has become hyperendemic with regular reporting of dengue cases since 2000. Almost 67% people globally at risk of lymphatic filariasis reside in the Region. About 147 million people in three countries – Bangladesh, India and Nepal – are at the risk of kala-azar.

In this background, we fully endorse the Draft Dhaka Declaration on Vector-borne Diseases.

Today is the time to launch and celebrate the power of partnership, since five countries of this Region are going to sign an agreement for the prevention and control of kala-azar. Let us pledge to work together, with active support from WHO, to tackle this malady.

Excellencies, ladies and gentlemen,

My mantra for success is simple. We need to invest more resources into our health system and get more value for our money. We need to improve access to
essential and critical medicines. We must use the power of evidence, technology and effective communication. We must provide health assurance to our people through an assured package of preventive and positive health services, diagnostics and medicines. We need to promote traditional medicines and the ancient healing systems such as yoga.

India has a very rich ancient system of medicine called Ayurveda, based on scientific principles. It regards and considers both the body and the soul while treating patients. Ayurveda was the first to conceptualize spiritual health, which even modern medicine now views as being important.

Ayurveda for the first time exhibited an understanding of environmental health describing the body as being composed of five elements: earth; space; fire; water, and wind. So if these get polluted the body gets polluted. This fact the modern science learned only in the twentieth century. In no other traditional system medical ethics is given as much importance as in Ayurveda. The distinguished physicians of that era laid stress on ethical practices and observed that “medicine should be practised for healing and not for any financial gain or fulfilment of desires”.

We are aware that Ayurveda today needs more research, and drugs need better manufacturing practices and to some extent toxicological evaluation by conducting clinical trials to test their potency, efficacy, and safety. However, we would like this ancient system to be used for effective healing of the mind and the body and to be restored to its old glory by making it a holistic part of health care.

I am very happy to note that “traditional medicines” are an important agenda item for consideration of the Regional Committee this year. We are also delighted that we are going to sign an agreement today with Bangladesh on cooperation in traditional medicines.

Excellencies, ladies and gentlemen,

My mantra for success is to find a way to convert health issues into a social and community movement. In my personal experience I have found tremendous value in involving adolescents and the youth to communicate and disseminate messages of positive health. It is the power of community participation and partnership that can empower us to achieve what we seek to achieve. It can bring an end to preventable deaths, including child and maternal deaths. It can strengthen and sustain high-quality universal immunization services. In India, we are trying to strengthen community participation by involving medical professionals in the process of planning for important health-care issues.
Excellencies, ladies and gentlemen,

I would like to take this opportunity to congratulate Dr Margaret Chan, Director-General, WHO, for her inspirational leadership. I have had the pleasure of listening to her inspiring address at the Singapore International Tobacco Conference. Her handling of the Ebola virus outbreak has also been very impressive.

Before I conclude, I would like to again express my gratitude to the Honourable Prime Minister of Bangladesh for her gracious and inspiring presence. I shall also like to congratulate and wish success to my colleague, the Health Minister of Bangladesh, for taking over as the Chair of the Health Ministers’ Forum. I am sure that the Region would progress well under his motivational leadership.

Thank you for giving me this opportunity to share my thoughts and for your patient hearing. Let us all pledge to create a better and a healthy world for all of us and for all our children to live in. I believe that together we can and we will make a difference.

Thank you for your attention.
Annex 4

Text of address by the Director-General, World Health Organization

Mr Chairman, Excellencies, honourable ministers, distinguished delegates, Dr Singh, colleagues in the UN family, ladies and gentlemen,

I thank the government of the People’s Republic of Bangladesh for hosting this Regional Committee. I thank this country’s friendly people for making us feel so welcome and at home.

Bangladesh has championed the importance of better health as a nation-building strategy. It has done so with the most appropriate emphasis — that is, on reaching the community at the grassroots level through its widespread network of community health workers.

This is a solid foundation for universal health coverage. It is one of the best ways to ensure that a country has the resilience to withstand shocks, whether from climate change, with its promise of more frequent and severe extreme weather events, or from a virus.

Like other parts of the world, countries in this Region are on high alert for any possible importation of the Ebola virus in an air traveller. Hardly a day goes by without rumours of an imported case at an airport or in an emergency room somewhere in the world. This is understandable. The virus is deadly. The disease is dreadful. People are afraid. This is the largest, most severe, and most complex Ebola outbreak ever seen in the nearly four-decade history of this disease. This is a fast-moving outbreak, with a number of unprecedented features, that is delivering one surprise after another. As we look at what this virus has done to affected parts of west Africa, every country in the world wants to keep the Ebola virus out of its borders. What we see is this: decimated families and communities, abandoned villages, food and fuel shortages, uncollected bodies, 2000 fresh and recent graves, a rising number of orphans, and hospitals overflowing or shut down entirely. As the economists tell us: revenues are down. Foreign exchange levels are down. Markets are not functioning. Airlines and ships are not coming in. Development projects are being cancelled. And business people have pulled out. In some areas, no health services whatsoever are functioning. Not for malaria, or tuberculosis, or
WHO REGIONAL COMMITTEE FOR SOUTH-EAST ASIA

AIDS. Not for childhood diarrhoeal disease and pneumonia, or even safe childbirth. Not for anything.

Honourable ministers, imagine, just imagine something like that happening to your country, to your people.

Ladies and gentlemen,

The whole world is watching this disease, and how WHO performs as we try to bring it under control. What does this outbreak, that has been making headlines for months, tell us about the state of the world at large? What does it tell world leaders, and the citizens who elect them, about the state and status of public health?

I see six things.

First, the outbreak spotlights the dangers of the world’s growing social and economic inequalities. The rich get the best care. The poor are left to die.

Second, rumours and panic are spreading even faster than the virus. Ebola sparks nearly universal fear. Fear vastly amplifies social disruption and economic losses well beyond the outbreak zones.

The World Bank estimates that the vast majority of economic losses during any outbreak arise from the uncoordinated and irrational efforts of the public to avoid infection.

Third, when a deadly and dreaded virus hits the destitute and spirals out of control, the whole world is put at risk.

Our 21st century societies are interconnected, interdependent, and electronically wired together as never before. We see this now with a very dangerous outbreak in Nigeria’s oil and natural gas hub. Nigeria is the world’s fourth largest oil producer and second largest supplier of natural gas. The outbreak in the country’s energy hub can potentially dampen economic outlooks worldwide.

Fourth, decades of neglect of fundamental health systems and services mean that a shock, like climate change or a disease run wild, can bring a country to its knees. You cannot build these systems up during a crisis. Instead, they collapse. A dysfunctional health system means zero population resilience.

Fifth (and I feel very strongly about this): Ebola emerged nearly 40 years ago. Why are clinicians still empty-handed, with no vaccine or cure? Because Ebola has
been, historically, geographically confined to poor African nations. The research and development incentive is virtually nonexistent. A profit-driven industry does not invest in products for markets that cannot pay. We have been trying to make this issue visible for ages. Now people see it clearly and dramatically, in the daily headlines and TV news.

Finally, the world is ill-prepared to respond to any severe, sustained and threatening public health emergency. This was the conclusion reached by a panel of experts commissioned to review events during the 2009 influenza pandemic and distil lessons for the future.

With Ebola, that prediction has come true.

I also see two specific lessons for WHO.

One: We must continue to push for the inclusion of health, and health systems, on the post-2015 development agenda. We now have some much more compelling evidence for doing so, and a much more responsive audience. People are now willing to hear arguments that have fallen on deaf ears for years.

Two: The pressures of this outbreak are revealing some cracks and weaknesses at WHO, some dysfunctional elements that must be corrected urgently as part of the Organizational reform at all three levels.

Ladies and gentlemen,

Let us get down to business. You have a packed and important agenda. Accountability means counting. You must improve your systems for civil registration and vital statistics. You need more, and better educated, health-care staff. Find them. Train them. Encourage them. Give them the right incentives. Traditional medicine is important for this Region. Improve it. Continue to work on the various prongs of your strategy for preventing noncommunicable diseases, also by reducing the harmful use of alcohol. WHO has given countries a menu of proven alcohol policy options. They work. Use them. Viral hepatitis has finally emerged from obscurity to receive the attention it deserves. Make that attention even sharper.

I thank you for your attention and wish you a most productive session.
Annex 5

Text of address by
the Minister of Health and Family Welfare,
Government of Bangladesh

Bismillahir-Rahmanir-Raheem.

Honourable Chief Guest, Sheikh Hasina, Honourable Prime Minister of the Government of the People’s Republic of Bangladesh, Special Guest, Her Excellency Dr Margaret Chan, Director-General of WHO, Dr Poonam Khetrapal Singh, Regional Director, WHO South-East Asia, Excellencies, Ministers of Health, Honourable Cabinet Ministers, Honourable State Ministers, Honourable Parliamentarians of Bangladesh, Special Guest Mr Zahid Maleque MP, my colleague and State Minister for Health and Family Welfare, heads and members of delegations, diplomats, senior officials from WHO headquarters, Geneva, officers and staff of WHO Regional Office for South-East Asia, WHO Bangladesh Country Office and our ministries, invited speakers, experts, dignitaries from the civil society and NGOs, distinguished guests, representatives from the print and electronic media, ladies and gentlemen,

Assalamu alaikum and a very good morning to you all.

As the Minister of Health and Family Welfare of the Government of the People’s Republic of Bangladesh, I am privileged to warmly welcome you to Dhaka on the occasion of these two highly prestigious regional meetings of WHO.

We were waiting eagerly for the past one year since the last meeting of health ministers and the Regional Committee session to greet you here in Dhaka. Now you have given us the opportunity to host these important meetings to render our warm hospitality to you. We are grateful to you and we hope you will enjoy your short stay in Dhaka. I also request you to please express your desire and needs to us as and when required during your stay here. We are all here to make your stay as comfortable and enjoyable as possible.

At the beginning of this Joint Inaugural Session, you heard Dr Margaret Chan. In her wonderful speech that was full of information, she offered guidelines to achieve the targeted goals of health. She also made observations regarding the
global health situation and challenges, highlighting the directions we should take to overcome those challenges. Dr Poonam Khetrapal Singh Regional Director, WHO South-East Asia, also highlighted the regional health situation and challenges.

My secretary, Mr M.M. Neazuddin briefly pointed out some of the key areas of Bangladesh’s health situation, successes and challenges.

I want to express my utmost thanks and gratitude to the Honourable Prime Minister, the Chief Guest of this occasion to kindly offer us important suggestions and guidance to make these events successful. We also feel proud of her as she is the illustrious daughter of Bangabandhu Sheikh Mujibur Rahman, the eternal source of our national aspirations and inspirations to excel as a Bangladeshi nation.

I am personally amazed to note that our Honourable Prime Minister is well conversant with every aspect of all the sectors of the government. Virtually all the sectors of the country are developing fast under her able leadership and visionary statesmanship. I am personally grateful to her for taking time out of her busy schedule to attend today’s function. She has also kindly consented to attend the side-event on autism and neurodevelopmental disorders on 11 September 2014. These gestures are highly evident of her wholehearted support and patronization to take Bangladesh forward on the way to continuous improvement.

Distinguished ladies and gentlemen,

I look forward to receive your feedback and contribution from your active participation at the proposed meetings of today and for the days ahead. I believe your thoughtful ideas and recommendations will help eradicate many of the health challenges facing us in the Region.

With these few words, Excellencies, distinguished ladies and gentlemen, I once again welcome you to Bangladesh and wish you a memorable stay here.

Khoda Hafez!

Joi Bangla! Joi Bangabandhu! May Bangladesh live for ever!
Annex 6

Text of inaugural speech by the Prime Minister of Bangladesh

Mr Chairperson, Madam Director-General, WHO, Dr Margaret Chan, Excellencies Health Ministers of Member States of the WHO South-East Asia Region, distinguished participants, ladies and gentlemen,

Assalamu alaikum and good morning, everyone.

I welcome all of you to the inaugural session of the Thirty-second Meeting of the Ministers of Health of Countries of the WHO South-East Asia Region and the Sixty-seventh Session of the WHO Regional Committee for South-East Asia.

I thank you for taking part in the important discussions about WHO issues and particularly for improving the health of one quarter of the global population that lives in the South-East Asia Region.

It is a great pleasure for me to be here today to share some of our success stories in the health sector.

Distinguished guests,

Health is wealth. In recognition of this, the greatest Bangalee of all times, the Father of the Nation, Bangabandhu Sheikh Mujibur Rahman, accorded the highest priority to medical care of people and incorporated it in the Constitution of Bangladesh in 1972 as one of the five fundamental rights of the people that the State should provide.

The Father of the Nation in addition to rebuilding the war-ravaged Bangladesh established a 10-bed thana health complex in each thana to make the healthcare facilities available to rural people. He upgraded the status of doctors in the government service. He also ensured provision of incentives to create specialized doctors.

Bangladesh experienced a dark period after 1975 during the socioeconomic development of the country. The health sector followed suit.
During our government’s tenure from 1996–2001, we improved the overall facilities of medical care, including provision of 7000 more beds in hospitals and recruitment of more than 2000 doctors. We waived duties on the import of medical equipment to facilitate the private sector in providing medical care.

We also took initiatives to build 18,000 community clinics based on the principle of one centre for every 6000 rural people. Under this programme, we built more than 4000 community clinics by 2001. Unfortunately, the subsequent regime stopped the implementation of the programme.

Since 2009, our governments have been giving emphasis on the improvement of the health sector and on the overall improvement of medical care to people. We have formulated a pragmatic health policy. Some 13,000 community clinics have been made operational and trained health personnel have been employed there. They have been provided with laptops with internet connections. Rural people are getting medical services including medicines fully free of cost from these centres. We have introduced e-health and telemedicine services too.

Through these, we have established one of the world’s most extensive and equitably distributed health-care networks across the country having domiciliary care, primary daycare clinic, and primary, secondary, tertiary and specialized hospitals to work as upward and downward referral linkages.

In recognition of this achievement, Bangladesh received the South-South Award in 2011.

We have increased the number of beds and equipment at all levels of hospitals. The number of general hospitals and specialized hospitals has also been increased. The government has set up new medical colleges, dental colleges, health technology institutes, nursing colleges, and nursing training institutes. The overall manpower in all areas of the health sector including doctors and nurses has been increased substantially.

Ladies and gentlemen,

Health is one of the most important determinants of people’s overall well-being. In this process, we have paid special attention to women’s and children’s health through introducing woman- and child-friendly direct, indirect and innovative services and benefit packages. We believe that a healthy woman can only bear and raise healthy children, and thereby, can contribute to making a healthy nation.
In order to build a healthy nation, our policies have put emphasis on the holistic dimensions of social, economic and environmental determinants of health including poverty reduction, education, gender equality, women’s empowerment and family planning.

Food safety has become a great concern for public health. In this regard, we have taken proactive steps to stop the mixing of chemicals, organic pollutants, enzymes and hormones, etc.

We have accorded priority to providing primary health care and to achieving the MDGs. We have ensured food and nutrition security to people with low incomes. As a result, the rate of poverty has been reduced to 25% from 40% in 2005.

We have introduced midwifery training course using globally competitive curriculum and standards. We have created 3000 posts of midwives; persons from the first batch completing the midwifery course will soon be given appointment.

We achieved the MDG-4 three years ahead of the 2015 dateline. We are on the right track to attain the MDG-5 by 2015.

For materializing the United Nations Global Strategy for Women’s and Children’s Health, we have introduced nationwide pregnancy and child-tracking system using 11 indicators known as the COIA indicators, and are ensuring follow-up services for them. The electronic registration system is being monitored regularly.

Ladies and gentlemen,

We eradicated polio and eliminated leprosy. We are keeping tuberculosis, avian influenza, anthrax, Nipah, SARS, dengue and malaria under control through effective nationwide public health measures.

We have mainstreamed nutrition, noncommunicable disease control, autism and mental health programmes into primary health care. We have also engaged the community clinics in screening, identification and follow-up activities.

We have launched effective health and social response programmes for climate change and climate vulnerability.

Our vibrant pharmaceutical sector meets 97% of domestic needs. We have established the WHO-certified National Drug Testing Laboratory. We export medicines to about 87 countries, including the United States of America and the United Kingdom.
Excellencies, ladies and gentlemen,

These successes are the results of our commitment to our people and of our adherence to global knowledge and best practices, shared with us by WHO, development partners and by nations friendly to us. Your collaboration has always been instrumental.

However, Bangladesh as well as the world face a challenge to sustain the achievements and to counter new health challenges. The Ebola epidemic has exposed a gaping hole in the ability of the world to tackle outbreaks in an increasingly interconnected world. It is also taking a heavy toll on the global economy. We should expedite medical research across the world to face such health challenges.

Dear delegates,

The Member States of the WHO South-East Asia Region largely share similar economies and similar socioeconomic and health situations and challenges. Our Region bears the major proportion of the global burden of diseases and deaths, and thus also harbours hope of enjoying a larger share of global health, if we can solve the health problems of this Region.

The health ministers of our Region are aware of these challenges. I firmly believe that in these two important meetings, with effective technical guidance provided by WHO, you will be able to find the best solution to these challenges.

I am very happy to learn that a wide range of issues critical to global, regional and national health will be discussed in the two meetings. I am truly looking forward to the success of these discussions. On behalf of the Government of Bangladesh, I assure you that we shall provide our full support to your work and recommendations.

I am delighted to learn that during the four-day meetings, there will also be side-events including one on autism on 11 September 2014.

It is imperative that individuals with autism and other developmental disabilities must find easy access to improved diagnosis and services.

My daughter Saima Wazed Hossain, who is a child psychologist by profession, is taking the utmost interest in mobilizing global support to the cause of autism. Saima will present the keynote address at the autism side-event.

I invite Dr Margaret Chan, Dr Poonam Singh, Excellencies Ministers, and the heads of delegations to make time to join the side-event.
Ladies and gentlemen,

Bangladesh has been an active participant in all discussions of WHO and will continue to do so. I hope that WHO emerges as a stronger organization through implementing the reform agenda. It will help WHO to provide more technical support to Member States.

Let us renew our commitment to universal health coverage as an essential precondition to transforming people as human assets and ensuring sustainable growth. Our collective spirit can make us do wonders.

I hereby declare the Thirty-second Meeting of Ministers of Health of Countries of the WHO South-East Asia Region and the Sixty-seventh Session of the WHO Regional Committee for South-East Asia open.

I thank you all.

*Joi Bangla, Joi Bangabandhu*

May Bangladesh live for ever
Annex 7

Agenda

1. Opening of the Session

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

3. Election of office-bearers

4. Adoption of the Agenda SEA/RC67/1Rev.4

5. Key addresses and report on the Work of WHO
   5.1 Introduction to the Regional Director’s Biennial Report on the Work of WHO in the South-East Asia Region covering the period 1 January 2012–31 December 2013 SEA/RC67/2
   5.2 Address by the Director-General

6. WHO reform:
   6.1 Framework of engagement with non-State actors SEA/RC67/3, Add.1 and Inf. Doc.1
   6.2 Follow-up of the Financing Dialogue SEA/RC67/4
   6.3 Strategic Resource Allocation SEA/RC67/5, Add.1, Inf. Doc.1 and Inf. Doc.2

7. Programme Budget matters:
   7.2 Implementation of Programme Budget 2014–2015 SEA/RC67/7 Rev.1
   7.3 Proposed Programme Budget 2016–2017 SEA/RC67/8, Add.1 and Inf. Doc.1
8. Technical matters:

8.1 Consideration of the recommendations arising out of the Technical Discussions on “Covering every birth and death: improving civil registration and vital statistics” SEA/RC67/9 and Inf. Doc.1

8.2 Selection of a subject for the Technical Discussions to be held prior to the Sixty-eighth session of the Regional Committee SEA/RC67/10

8.3 Traditional medicine: Delhi Declaration SEA/RC67/11

8.4 Strengthening the implementation of the WHO Global Strategy to reduce the harmful use of alcohol to support the achievement of the regional targets on prevention and control of noncommunicable diseases SEA/RC67/12

8.5 Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage SEA/RC67/13

8.6 Viral hepatitis SEA/RC67/29

8.7 Regional strategy on strengthening health workforce education and training SEA/RC67/21 Rev.1

9. Progress reports on selected Regional Committee resolutions:

9.1 Nutrition and food safety in the South-East Asia Region (SEA/RC60/R3) SEA/RC67/14 Rev.1

9.2 South-East Asia Regional Health Emergency Fund (SEA/RC60/R7) SEA/RC67/15

9.3 Challenges in polio eradication (SEA/RC60/R8) SEA/RC67/16

9.4 Injury prevention and safety promotion (SEA/RC63/R2) SEA/RC67/17

9.5 2012: Year of intensification of routine immunization in the South-East Asia Region: Framework for increasing and sustaining coverage (SEA/RC64/R3) SEA/RC67/18

9.6 Regional Health Sector Strategy on HIV 2011–2015 (SEA/RC64/R6) SEA/RC67/19
9.7 Consultative Expert Working Group on Research and Development: Financing and Coordination (SEA/RC65/R3) SEA/RC67/20

9.8 Comprehensive and coordinated efforts for the management of autism spectrum disorders (ASDs) and developmental disabilities (SEA/RC65/R8) SEA/RC67/22


10. Governing body matters

10.1 Key issues arising out of the Sixty-seventh World Health Assembly and the 134th and 135th sessions of the WHO Executive Board SEA/RC67/24

10.2 Review of the Draft Provisional Agenda of the 136th session of the WHO Executive Board SEA/RC67/25 Rev.1

11. Special Programmes:


12. Time and place of future sessions of the Regional Committee SEA/RC67/28

13. Adoption of resolutions

14. Adoption of the report of the Sixty-seventh Session of the Regional Committee

15. Closing
Annex 8

List of participants

1. Representatives, alternates and advisers

**Bangladesh**

*Representative*  
H.E. Mr Mohammed Nasim  
Minister of Health and Family Welfare  
Ministry of Health and Family Welfare  
Dhaka

*Alternate*  
H.E. Mr Zahid Maleque  
State Minister of Health and Family Welfare  
Ministry of Health and Family Welfare  
Dhaka

*Alternate & Adviser*  
Mr M M Neazuddin  
Secretary  
Ministry of Health and Family Welfare  
Dhaka

*Advisers*  
Mr A M Badrudduja  
Additional Secretary  
Ministry of Health and Family Welfare  
Dhaka

Ms Roxana Quader  
Additional Secretary (PH and WHO)  
Ministry of Health and Family Welfare  
Dhaka

Dr Deen Mohd Noorul Huq  
Director-General, DGHS  
Dhaka

Professor Shah Monir Hossain  
Former Director-General, DGHS  
Dhaka

Professor Abul Kalam Azad  
Additional Director General  
DGHS  
Ministry of Health and Family Welfare  
Dhaka

Dr Syed Abu Zafar Md. Musa  
Director  
PHC and Line Director  
MNC&AAH, DGHS  
Ministry of Health and Family Welfare  
Dhaka
Mr Md. Azam-E-Sadat  
Deputy Secretary (WHO)  
Ministry of Health and Family Welfare  
Dhaka

Professor Baizid Khoorshid Riaz  
Head, Public Health and Hospital Administration  
National Institute of Preventive and Social Medicine (NIP-SOM)  
Dhaka

**Bhutan**

*Representative*  
H.E. Lyonpo Tandin Wangchuk  
Minister  
Ministry of Health  
Thimphu

*Alternate*  
Dr Ugen Dophu  
Director-General  
Department of Medical Services  
Ministry of Health  
Thimphu

*Adviser*  
Mr Kado Zangpo  
Deputy Chief Planning Officer  
Planning and Policy Division  
Ministry of Health  
Thimphu

**Democratic People’s Republic of Korea**

*Representative*  
H.E. Professor Dr Kang Ha Guk  
Minister of Public Health  
Ministry of Public Health

*Alternates*  
Dr Pak Jong Min  
Director, Department of External Affairs  
Ministry of Public Health  
Pyongyang

Mr Ri Jang Gon  
Senior Official  
Department of International Organizations  
Ministry of Foreign Affairs  
Pyongyang

*Adviser*  
Mr Choi Yong Su  
Officer  
Ministry of Public Health  
Pyongyang
## India

**Representative**
- H.E. Dr Harsh Vardhan  
  Minister of Health and Family Welfare  
  New Delhi

**Alternates**
- Mr Lov Verma  
  Secretary  
  Department of Health and Family Welfare  
  Ministry of Health and Family Welfare  
  New Delhi
- Mr Nilanjan Sanyal  
  Secretary  
  Department of AYUSH  
  Ministry of Health and Family Welfare  
  New Delhi
- Professor Dr Jagdish Prasad  
  Director General of Health Services  
  Ministry of Health and Family Welfare  
  New Delhi
- H.E. Mr Pankaj Saran  
  High Commissioner of India  
  Dhaka
- Mr Sandeep Chakravorty  
  Deputy High Commissioner  
  High Commission of India  
  Dhaka
- Professor Dr Smitha N. Deshpande  
  Head of Department, Psychiatry  
  Dr RML Hospital  
  Ministry of Health and Family Welfare  
  New Delhi
- Professor Dr Sheffali Gulati  
  Chief of Child Neurology Division  
  All India Institute of Medical Sciences  
  Ministry of Health and Family Welfare  
  New Delhi
- Mr Sujit Ghosh  
  Counsellor  
  High Commission of India  
  Dhaka
- Mr R. Masakaui  
  Counsellor  
  High Commission of India  
  Dhaka
Mr Amal Pusp  
Director  
Ministry of Health & Family Welfare  
New Delhi

Dr Abhimanyu Kumar  
Director  
All India Institute of Ayurveda  
Ministry of Health & Family Welfare  
New Delhi

Ms Ermelinda Dias  
Prasar Bharti Correspondent  
High Commission of India  
Dhaka

Adviser  
Mr D N Singh  
Private Secretary to Minister of Health and Family Welfare  
New Delhi

Indonesia

Representative  
H.E. Professor Dr Ali Ghufron Mukti  
Vice-Minister of Health  
Jakarta

Alternate  
Mr Bambang Guritno  
Special Adviser to the Minister of Health  
for International Cooperation and Institution  
Ministry of Health  
Jakarta

Advisers  
Mr Mohammad Subuh(*)  
Secretary of Directorate General of Diseases  
Control and Environmental Health  
Ministry of Health  
Jakarta

Ms Tini Suryanti Suhandi(*)  
Head of Bureau of Planning and Budgeting  
Ministry of Health  
Jakarta

Dr Ekowati Rahajeng  
Director of Noncommunicable Diseases Control  
Ministry of Health  
Jakarta

Ms Budi Dhewajani(*)  
Head of Centre for International Cooperation  
Ministry of Health  
Jakarta
Mr Andi Saguni  
Head of Budget Revenues and State Expenditures  
Bureau of Budget and Planning  
Ministry of Health  
Jakarta

Ms Ratna Budi Hapsari  
Head of Surveillance and Outbreak Response Sub-Directorate  
Directorate of Surveillance, Immunization, Quarantine and Matra Health  
Jakarta

Ms Naning Nugrahini  
Head of Diarrhoea and Digestive Infection Sub-Directorate  
Directorate of Communicable Diseases Control  
Ministry of Health  
Jakarta

Ms Yuniati Situmorang  
Head of Alternative and Complementary Health Services Sub-Directorate  
Directorate of Traditional, Alternative and Complementary Health Services Management  
Ministry of Health  
Jakarta

Dr Yuslely Usman  
Researcher at Centre for Humanities, Policies and Community Empowerment  
Ministry of Health  
Jakarta

Ms Hikmandari  
Head of Bilateral and Multilateral Health Cooperation Division  
Centre for International Cooperation  
Ministry of Health  
Jakarta

Mr Ferdinan Samson Tarigan  
Head of Multilateral Health Cooperation Sub-Division  
Centre for International Cooperation  
Ministry of Health  
Jakarta

Mr Roy Himawan  
Head of Evaluation and Report Sub-division  
Secretariat of Directorate-General of Pharmaceutical and Medical Devices Management  
Ministry of Health  
Jakarta
Maldives

Representative  
H.E. Mr Hussain Rasheed  
Minister of State for Health  
Ministry of Health  
Malé

Alternate  
Ms Geela Ali  
Permanent Secretary  
Ministry of Health  
Malé

Adviser  
Ms Aishath Sarniya  
Deputy Director-General  
Ministry of Health  
Malé

Adviser  
Ms Shareefa Adam Manik  
Director-General  
Ministry of Health  
Malé

Myanmar

Representative  
H.E. Dr Thein Thein Htay  
Deputy Minister  
Ministry of Health  
Naypitaw

Alternate  
Prof Myint Han  
Director-General  
Department of Food and Drug Administration  
Ministry of Health  
Naypitaw

Adviser  
Dr Maung Maung Than Htike  
Deputy Director  
International Health Division  
Ministry of Health  
Naypitaw

Nepal

Representative  
H.E. Mr Khaga Raj Adhikari  
Minister of Health and Population  
Kathmandu

Alternates  
Dr Bimal Prasad Dhakal  
Chief Specialist  
Ministry of Health and Population  
Kathmandu
Dr Padam Bahadur Chand  
Chief Public Health Administrator  
Policy, Planning and International Cooperation Division  
Ministry of Health and Population  
Kathmandu

Dr Sushil Chandra Baral  
Executive Director  
Health Research and Social Development Forum (HERD)  
Kathmandu

**Sri Lanka**

*Representative*  
H.E. Lalith Dissanayake  
Deputy Minister of Health  
Ministry of Health  
Colombo

*Alternates*  
Mr A.G. Abeysekara  
Acting High Commissioner  
High Commission of Sri Lanka  
Dhaka

Dr H. Suhashini R. Perera De Silva  
Director – Organization Development  
Ministry of Health  
Colombo

Mrs T.A.S.S.S. Thanbugala  
First Secretary  
High Commission of Sri Lanka  
Dhaka

Dr A.J.A. Lakkumar Fernando  
Paediatrician  
District General Hospital  
Negombo

Dr H.R.U. Indrasiri  
Adviser to the Hon. Minister  
Ministry of Health  
Colombo

**Thailand**

*Representative*  
Dr Suriya Wongkongkathep  
Inspector-General (Region 5)  
Office of the Inspector-General  
Ministry of Public Health  
Nonthaburi
Alternate

Dr Viroj Tangcharoensathien
Public Health Technical Officer, Advisory Level
International Health Policy Programme
Office of the Permanent Secretary
Ministry of Public Health
Nonthaburi

Dr Pasakorn Akarasewi
Medical officer, Advisory Level
Department of Disease Control
Ministry of Public Health
Nonthaburi

Dr Sopida Chavanichkul(*)
Director, Bureau of International Health
Office of the Permanent Secretary
Ministry of Public Health
Nonthaburi

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

Assist. Professor Dr Weerasak Putthasri
Deputy Director
International Health Policy Programme
Office of the Permanent Secretary
Ministry of Public Health
Nonthaburi

Dr Thaksaphon Thamarangsi
Medical Officer, Professional Level
Bureau of Epidemiology
Department of Disease Control
Ministry of Public Health
Nonthaburi

Mrs Sirinand Tiantong
Foreign Relations Officer
Senior Professional Level
Bureau of International Health
Office of the Permanent Secretary
Ministry of Public Health
Nonthaburi

Pol. Maj. Suriwan Thaiprayoon(*)
Policy and Plan Analyst, Professional Level
Bureau of International Health
Office of the Permanent Secretary
Ministry of Public Health
Nonthaburi
Timor-Leste

Representative
H.E. Dr Sergio G.C. Lobo
Minister of Health
Dili

Alternate
Mr Ivo Ireniu Da Conceicao Freitas
National Director
Planning, Policy and Cooperation
Ministry of Health
Dili

Advisers
Dr (Ms) Ines Teodora da Silva Almeida
Services Director, Disease Control
Ministry of Health
Dili

Mr Francisco Gama Da Costa Lobo
Personal Assistant to Minister of Health
Dili

2. Representatives of the United Nations and specialized agencies

Food and Agriculture Organization (FAO)
Mr Sridhar Dharmapuri
Food Safety Officer
Mohakali
Dhaka
Bangladesh

International Labour Organization (ILO)
Mr Srinivas B. Reddy
Country Director
ILO Country Office
Dhaka
Bangladesh

Office for the Coordination of Humanitarian Affairs (OCHA)
Mr Gerson Brandao Azevedo
Regional Office for Asia and the Pacific
Humanitarian Affairs Adviser
Dhaka
Bangladesh

UNAIDS
Mr Martin Leo Kenny
Country Director
UNAIDS Bangladesh
Dhaka, Bangladesh

United Nations Population Fund (UNFPA)
Ms Argentina Matavel
UNFPA Representative
Dhaka
Bangladesh
3. Intergovernmental organizations

United Nations Children’s Fund (UNICEF) ROSA

Dr Douglas Noble
Regional Health Adviser
UNICEF ROSA
Kathmandu
Nepal

Mr Pascal Villeneuve(*)
UNICEF Representative
Dhaka
Bangladesh

United Nations Industrial Development Organization (UNIDO)

Dr Zaki Uz Zaman(*)
Head of UNIDO Operations in Bangladesh
Dhaka
Bangladesh

United Nations Office on Drugs and Crime (UNODC)

Mr A.B.M. Kamrul Ahsam
Programme Coordinator
Dhaka

United Nations Women (UN Women)

Ms Christine Hunter
Country Representative
UN Women
Dhaka
Bangladesh

World Bank

Ms Burshra Binte Alam
Senior Health Specialist
Dhaka
Bangladesh

World Meteorological Organization

Ms Mahnaz Khan
Deputy Director
Agro-Meteorological Division
Bangladesh Meteorological Department
Bangladesh

Ms Mossammat Ayesha Khatun
Deputy Director
Meteorological Training Institute
Bangladesh Meteorological Department
Bangladesh

International Organization for Migration (IOM)

Dr Kaoru Takahashi
Chief Migration Health Officer
Dhaka
Bangladesh
4. Representatives from nongovernmental organizations in official relations with WHO

<table>
<thead>
<tr>
<th>Organization</th>
<th>Name</th>
<th>Title/Position</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBM International Office</td>
<td>Mr Mohammed Shahnawaz Qureshi</td>
<td>Country Coordinator</td>
<td>Dhaka, Bangladesh</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Country Coordination Office</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dhaka Coordination Office</td>
<td></td>
</tr>
<tr>
<td>Consumers International</td>
<td>Mr Ghulam Rahman</td>
<td>Consumers Association of Bangladesh</td>
<td>Dhaka</td>
</tr>
<tr>
<td>International Association for Hospice and Palliative Care Inc</td>
<td>Dr Rumana Dowla</td>
<td>ICCIDD National Coordinator for India</td>
<td>Dhaka, Bangladesh</td>
</tr>
<tr>
<td>International Council for Control of Iodine Deficiency Disorders (ICCIDD)</td>
<td>Dr Kapil Yadav</td>
<td>All India Institute of Medical Sciences</td>
<td>New Delhi, India</td>
</tr>
<tr>
<td>International Diabetes Federation</td>
<td>Professor Azad Khan</td>
<td></td>
<td>Dhaka</td>
</tr>
<tr>
<td>International Federation of Gynaecology and Obstetrics (FIGO)</td>
<td>Professor Latifa Shamsuddin</td>
<td>President</td>
<td>Dhaka, Bangladesh</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Obstetrical and Gynaecological Society of Bangladesh</td>
<td></td>
</tr>
<tr>
<td>International Federation of Medical Students’ Association (IFMSA)</td>
<td>Ms Wonyun Lee</td>
<td>Regional Assistant of Public Health, Asia-Pacific</td>
<td>Dhaka, IFMSA, South Korea</td>
</tr>
<tr>
<td>International Paediatric Association</td>
<td>Professor Ruhul Amin</td>
<td>President</td>
<td>Dhaka, Bangladesh</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bangladesh Paediatric Association (BPA), Dhaka</td>
<td></td>
</tr>
<tr>
<td>International Pharmaceutical Federation</td>
<td>Mr Nasser Zahedee</td>
<td>President, Bangladesh Pharmaceutical Society</td>
<td>Dhaka, Bangladesh</td>
</tr>
</tbody>
</table>
International Spinal Cord Society  Dr Nazirah Hasnan
Associate Professor and Consultant Rehabilitation Physician
Department of Rehabilitation Medicine
University of Malaya Medical Centre
Kuala Lumpur
Malaysia

International Society of Physical and Rehabilitation Medicine (ISPRM)  Professor Dr M. Taslim Uddin
Department of Physical Medicine and Rehabilitation, Bangabandhu Sheikh Mujib Medical University (BSMMU),
Dhaka. Bangladesh

International Federation of Pharmaceutical Manufactures and Associations (IFPMA)  Ms Rumana Ahmed
Communications Manager
IFPMA
Geneva
Switzerland

Project ORBIS International, Inc (ORBIS)  Dr Mr Abu Raihan
Regional Programme Director, Asia
ORBIS
Dhaka
Bangladesh

Rotary International  Mr Salim Reza
Rotary’s National PolioPlus Committee Chair in Bangladesh
Dhaka
Bangladesh

The Royal Commonwealth Society for the Blind (Sightsavers)  Dr Mohammad Golam Kibria
Country Director
Sightsavers Bangladesh Office,
Dhaka
Bangladesh

Union for International Cancer Control (UICC)  Ms Ranjit Kaur Pritam Singh
Patient Advocate
Petaling Jaya
Malaysia

World Federation of Societies of Anaesthesiologists (WFSA)  Professor A. B. M. Muksudul Alam
President
Bangladesh Society of Anaesthesiologists
SAARC-AA Representative of WFSA Shaheed Suhrawardy Medical College
Dhaka
Bangladesh
**World Hepatitis Alliance**
Dr Charles Gore  
President  
London  
The United Kingdom

**World Organization of Family Doctors (WONCA)**
Professor Pratap Narayan Prasad  
President, South Asian Region, WONCA  
Head, Department of General Practice and Emergency Medicine  
Tribhuvan University Teaching Hospital (TUTH) Institute of Medicine  
Kathmandu  
Nepal

**World Vision International**
Mr Bijoy Chandra Sarker  
National Nutrition Specialist  
Dhaka  
Bangladesh

**5. Observers**

**Ministry of Health, Republic of Indonesia**
Ms Alifatul Hi’miyah  
Staff, Multilateral Health Cooperation Sub-Division  
Centre for International Cooperation  
Ministry of Health  
Jakarta

Mr Bahtiyar Efendi  
ADC  
Ministry of Health  
Jakarta

**Ministry of Foreign Affairs, Democratic Republic of Timor-Leste**
Mr Fulgencio Jose Helvidio Corbafo  
National Director for International Organization  
Ministry of Foreign Affairs and Cooperation of Timor-Leste Praia dos Coqueiros  
Dili

Mr Sergio dos Santos  
Protocol Officer  
Ministry of Foreign Affairs and Cooperation of Timor-Leste Praia dos Coqueiros  
Dili

**Ministry of Health, Democratic Republic of Timor-Leste**
Mr Jose Antonio Martins de Oliveira  
Cameraman  
Television Timor-Leste  
Dili

Mr Aderito do Rosario  
Vice-Director  
Tempo Semanal  
Dili
<table>
<thead>
<tr>
<th>Organization</th>
<th>Contact Person</th>
<th>Position/Role</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action-Aid</td>
<td>Ms Nishat Fahmi Hassan</td>
<td>Programme Officer - Gender Based Violence</td>
<td>Dhaka, Bangladesh</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Women Rights and Gender Equity Team,</td>
<td></td>
</tr>
<tr>
<td>CARE, Bangladesh</td>
<td>Dr Jahangir Hossain</td>
<td>Programme Director – Health</td>
<td>Dhaka, Bangladesh</td>
</tr>
<tr>
<td>Dhaka Ahsania Mission (DAM)</td>
<td>Mr Kazi Rafiquil Alam</td>
<td>President</td>
<td>Dhaka, Bangladesh</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dhaka Ahsania Mission</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bangladesh</td>
<td></td>
</tr>
<tr>
<td>Embassy of Bhutan</td>
<td>Mr Kinzang Dorji</td>
<td>Second Secretary</td>
<td>Dhaka, Bangladesh</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Royal Bhutan Embassy</td>
<td></td>
</tr>
<tr>
<td>Embassy of the Republic of Indonesia</td>
<td>Mr Didik J. Zulhadji</td>
<td>Second Secretary for Political Affairs</td>
<td>Dhaka, Bangladesh</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EngenderHealth</td>
<td>Dr Abu Jamil Faisel</td>
<td>Country Representative</td>
<td>Dhaka, Bangladesh</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GAVI Alliance</td>
<td>Mrs Hind Khatib Othman</td>
<td>Managing Director, Country Programmes</td>
<td>GAVI Switzerland</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr Ranjana Kumar</td>
<td>Geneva</td>
<td>Switzerland</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr Miriam Clados</td>
<td>Geneva</td>
<td>Switzerland</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Commission of Canada</td>
<td>Ms Meaghan Byers</td>
<td>Health Sector Lead</td>
<td>Dhaka, Bangladesh</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
International Council for Control of Iodine Deficiency Disorders (ICCIDD)  
Dr Rakesh Kumar  
ICCIDD  
Centre for Community Medicine  
All India Institute of Medical Sciences, New Delhi

International Federation of Gynaecology and Obstetrics (FIGO)  
Professor Parveen Fatima  
Secretary-General  
Obstetrical and Gynaecological Society of Bangladesh  
Dhaka  
Bangladesh

International Federation of Medical Students’ Association (IFMSA)  
Dr Bronwyn Jones  
c/o WMA B.P.  
Ferney-Voltaire  
CDEX-France  
Mr Hamid Yameen  
Regional Assistant of Medical Education, Asia & Pacific  
IFMSA  
Dhaka  
Bangladesh

International Pharmaceutical Federation  
Dr Md Selim Reza  
Professor and Chairman  
Department of Pharmacology  
Dhaka University

International Federation of Pharmaceutical Manufactures and Associations (IFPMA)  
Dr Mohammad Mahbubur Rahman  
Director, Clinical R&D and Medical Affairs  
IFPMA  
Dhaka, Bangladesh

Partners in Population and Development (PPD)  
Dr Joe Thomas  
Executive Director  
Dhaka  
Bangladesh

Plan International, Bangladesh  
Dr Ikhtiar Uddin Khandaker  
Health Adviser  
Dhaka  
Bangladesh

Research, Training and Management (RTM) International  
Dr Ahmed Al-Kabir  
President Research, Training and Management (RTM) International  
RTM Complex  
Dhaka  
Bangladesh
US Embassy
Dr Amy DuBois
Health Attache and Regional Representative for South-East Asia
U.S. Embassy
New Delhi- 110021

World Federation of Societies of Anaesthesiologists
Professor A.K. M. Akhtaruzzaman
Professor of Anaesthesiology
Department of Anaesthesiology
Bangabandhu Sheikh Mujib Medical University Shahbag
Dhaka
Bangladesh

Professor Debabrata Banik
Bangladesh Society of Anaesthesiologists
Bangabandhu Sheikh Mujib Medical University
Shahbagh
Dhaka

World Vision International
Ms Samia Ahmed
Deputy Director, External Engagement
Dhaka
Bangladesh

6. SEAR Ambassadors/ High Commissioners
Embassy of Bhutan
H.E. Ms Pema Choden
Ambassador
Embassy of Bhutan
Dhaka
Bangladesh

Embassy of Nepal
H.E. Mr Hari Kumar Shrestha
Ambassador
Embassy of Nepal
Dhaka
Bangladesh

(*) did not attend
## Annex 9

### List of official documents

<table>
<thead>
<tr>
<th>Document Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEA/RC67/1 Rev.3</td>
<td>Agenda</td>
</tr>
<tr>
<td>SEA/RC67/2</td>
<td>Introduction to the Regional Director’s Biennial Report on the Work of WHO in the South-East Asia Region covering the period 1 January 2012–31 December 2013</td>
</tr>
<tr>
<td>SEA/RC67/3, Add.1 and Inf. Doc.1</td>
<td>Framework of engagement with non-State actors</td>
</tr>
<tr>
<td>SEA/RC67/4</td>
<td>Follow-up of the Financing Dialogue</td>
</tr>
<tr>
<td>SEA/RC67/5, Add.1, Inf. Doc.1 and Inf. Doc.2</td>
<td>Strategic Resource Allocation</td>
</tr>
<tr>
<td>SEA/RC67/7</td>
<td>Implementation of Programme Budget 2014–2015</td>
</tr>
<tr>
<td>SEA/RC67/9 and Inf. Doc.1</td>
<td>Consideration of the recommendations arising out of the Technical Discussions on “Covering every birth and death: improving civil registration and vital statistics”</td>
</tr>
<tr>
<td>SEA/RC67/10</td>
<td>Selection of a subject for the Technical Discussions to be held prior to the Sixty-eighth session of the Regional Committee</td>
</tr>
<tr>
<td>SEA/RC67/11</td>
<td>Traditional medicine: Delhi Declaration</td>
</tr>
<tr>
<td>SEA/RC67/12</td>
<td>Strengthening the implementation of the WHO Global Strategy to reduce the harmful use of alcohol to support the achievement of the regional targets on prevention and control of noncommunicable diseases</td>
</tr>
<tr>
<td>Document Code</td>
<td>Title</td>
</tr>
<tr>
<td>---------------</td>
<td>-------</td>
</tr>
<tr>
<td>SEA/RC67/13</td>
<td>Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage</td>
</tr>
<tr>
<td>SEA/RC67/14 Rev.1</td>
<td>Nutrition and food safety in the South-East Asia Region (SEA/RC60/R3)</td>
</tr>
<tr>
<td>SEA/RC67/15</td>
<td>South-East Asia Regional Health Emergency Fund (SEA/RC60/R7)</td>
</tr>
<tr>
<td>SEA/RC67/16</td>
<td>Challenges in polio eradication (SEA/RC60/R8)</td>
</tr>
<tr>
<td>SEA/RC67/17</td>
<td>Injury prevention and safety promotion (SEA/RC63/R2)</td>
</tr>
<tr>
<td>SEA/RC67/18</td>
<td>2012: Year of intensification of routine immunization in the South-East Asia Region: Framework for increasing and sustaining coverage (SEA/RC64/R3)</td>
</tr>
<tr>
<td>SEA/RC67/19</td>
<td>Regional Health Sector Strategy on HIV 2011–2015 (SEA/RC64/R6)</td>
</tr>
<tr>
<td>SEA/RC67/20</td>
<td>Consultative Expert Working Group on Research and Development: Financing and Coordination (SEA/RC65/R3)</td>
</tr>
<tr>
<td>SEA/RC67/21 Rev.1</td>
<td>Regional strategy on strengthening health workforce education and training</td>
</tr>
<tr>
<td>SEA/RC67/22</td>
<td>Comprehensive and coordinated efforts for the management of autism spectrum disorders (ASDs) and developmental disabilities (SEA/RC65/R8)</td>
</tr>
<tr>
<td>SEA/RC67/24</td>
<td>Key issues arising out of the Sixty-seventh World Health Assembly and the 134th and 135th sessions of the WHO Executive Board</td>
</tr>
<tr>
<td>SEA/RC67/25 Rev.1</td>
<td>Review of the Draft Provisional Agenda of the 136th session of the WHO Executive Board</td>
</tr>
</tbody>
</table>


SEA/RC67/28 Time and place of future sessions of the Regional Committee

SEA/RC67/29 Viral hepatitis

SEA/RC67/30 List of participants

SEA/RC67/31 Draft Report of the Sixty-seventh Session of the WHO Regional Committee for South-East Asia

SEA/RC67/32 List of resolutions and decisions

SEA/RC67/33 List of official documents

SEA/RC67/34 Report of Subcommittee on Credentials

SEA/RC67/35 Report of the Sixty-seventh Session of the WHO Regional Committee for South-East Asia
Side events
at the Sixty-seventh Session of
the WHO Regional Committee for South-East Asia
Signing of the MoU on Kala-azar

Visceral leishmaniasis or kala-azar is a vector-borne neglected tropical disease (NTD) transmitted by the bite of the sandfly, which breeds in forest areas, caves, or the burrows of small rodents. This is a deadly disease if left untreated, and can have a fatality rate as high as 100% within two years. Kala-azar is the second largest parasitic killer in the world, after malaria. An estimated 100,000 cases of kala-azar occur every year in the South-East Asia Region, while about 147 million people are at risk. About 400,000 disability-adjusted life years (DALYs) are lost in the Region due to this disease. The disease is endemic in Bangladesh, India and Nepal, with more than 50% of the cases occurring in areas that are close to the international borders. Recently, however, a small focus of kala-azar has been identified in Bhutan in the border districts, with sporadic cases reported from Thailand.

The Regional Director, WHO South-East Asia Region signed a Memorandum of Understanding (MoU) with the ministers of the five countries in the Region where kala-azar is reported, to make the South-East Asia free of kala-azar by strengthening intercountry collaboration with technical support from WHO at a side event held on 9 September 2014. The WHO Director-General and all the ministers of health/heads of delegation participating in the meetings of the health ministers and the Sixty-seventh Session of the Regional Committee attended it. This MoU is evidence of the strong political commitment and top priority given by endemic countries to eliminate this disease from the Region by 2017 or earlier.
The strategies to achieve the elimination target through this MoU include ensuring access to early diagnosis and treatment, particularly of the most vulnerable groups, strengthening disease and vector surveillance, integrated vector management with emphasis on improvement of environment, social mobilization, research and networking.

The signatories agreed to collaborate on several areas through mutually agreed mechanisms including mobilization of resources, exchange of information, strengthening of intersectoral collaboration, research, capacity-building and technical support.

The MoU will be in effect for five years from the date of signature and the progress in its implementation will be reviewed every two years following which recommendations for corrective measures will be made.
Ministerial Round Table on Traditional Medicine

A Ministerial Round Table of Traditional Medicine was held during the Thirty-second Meeting of Ministers of Health for countries of the South-East Asia Region on 9 September 2014 in Dhaka, Bangladesh. The round table was attended by the Ministers of Health and other delegates from all the Member States.

The Regional Director, Dr Poonam Khetrapal Singh welcomed the ministers of health and other participants and referred to the rich history of traditional medicine in the Region and to the Delhi Declaration on Traditional Medicine that was signed by all Member States of the Region in February 2013 and to the WHO Traditional Medicine Strategy 2014–2023 which was endorsed at the Sixty-seventh World Health Assembly in May 2014. She invited His Excellency, Dr Harsh Vardhan, Minister of Health and Family Welfare, Government of India, to moderate the session.

In his opening remarks, H.E. Dr Harsh Vardhan, highlighted the importance of traditional medicine and said that it was a good subject for major discussion in this forum.

The Director-General of WHO, Dr Margaret Chan, said that traditional medicine is the main source of health care in some countries, and that it is practised in all six WHO Regions, and that it is a part of the health care system in most countries of South-East Asia. It is important for governments to implement the WHO Traditional Medicine Strategy 2014–2023 and the World Health Assembly resolution WHA67.18 on traditional medicine adopted in May 2014, as appropriate. At the Sixty-seventh World Health Assembly, all Member States expressed the need to strengthen the evidence base of traditional medicine. Dr Chan said that all research must be done in a robust manner because governments are accountable for the safety, quality and efficacy of treatments recommended. How to ensure quality, efficacy and safety must also be addressed in all health policies. She added that this Region should work with other regions to move the traditional medicine agenda forward.

H.E. Dr Harsh Vardhan invited presentations from India, Bhutan, Myanmar, Nepal and Thailand.

India

H.E. Dr Harsh Vardhan mentioned that India has a pluralistic health-care delivery system. There is peaceful co-existence between allopathy and AYUSH – Ayurveda, yoga, unani, siddha and homeopathy – for which there is a separate department
within the Ministry of Health and Family Welfare. The AYUSH department is responsible for setting educational standards, quality assurance and standardization of drugs, improving the availability of medicinal plant materials, research and development, and mainstreaming AYUSH in health care. India is committed to implementing the Delhi Declaration on Traditional Medicine. Ayurveda is based on scientific principles and includes concepts of prevention of ill health, promotion of health, and treating patients in a holistic way, body and soul, which western science acknowledges is important. Ayurveda exhibits understanding of environmental health, describing the body as composed of the five elements of earth, space, fire, water, and wind – and if these get polluted so does the body. Ayurveda describes a patient’s *Pakriti* (implying his/her genetic constitution), *Pancha Karma* to detoxify the human body, surgical procedures (for cataracts, fractures, abdominal conditions, etc.) and ethical practices whereby medicine should be practised for healing and not financial gain. India is aware that more research and better manufacturing processes are needed and has designated three apex institutes on ayurveda (Jaipur), Unani (Bangalore) and homeopathy (Kolkata) for this purpose. Furthermore, India has earmarked 20 undergraduate seats (one seat each in ayurveda and homeopathy for each South-East Asian country) plus seven MD and two PhD seats for South-East Asian countries. These seats will include all student expenses. In addition, the Government of India will offer specific tailor-made courses under the WHO fellowship scheme.

**Bhutan**

H.E. Lyonpo Tandin Wangchuk, Minister of Health, Bhutan, mentioned that traditional medicine contributes to universal health coverage in Bhutan and that its development has been facilitated by the country’s rich flora. Bhutan’s traditional system of medicine, *Sowa-Rigpa*, was introduced in the eighth century by Guru Padmasambhava and was further consolidated by incorporation into the curriculum of the monastic system. In 1967, traditional medicine was formally established as an alternative to modern medicine. In 1970, a three-year diploma programme was launched and in 1978, a five-year degree programme. The Institute of Medical Sciences is also launching a two-year degree programme in traditional medicine therapy and pharmacy. Traditional medicine is available in 20 district hospitals and 30 primary care centres and the government’s goal is to expand this service to all health facilities. Bhutan has a traditional medicine manufacturing unit, which produces 10–12 tons of 94 different essential traditional medicines in seven different dosage forms, including powder, pills, capsules, tablets, syrups, ointment and oil. However, certain raw materials are only produced at very high altitude and there is
a problem of sustainability due to over-harvesting. There is an urgent need to carry out more research in this area.

**Myanmar**

H.E. Dr Thein Thein Htay, Deputy Health Minister, Myanmar, stated that many people in Myanmar rely on traditional medicine, particularly for mild and chronic conditions, so it should be integrated into the health-care system. While traditional medicine is an experience-based medicine (as opposed to western medicine) handed down from generation to generation, scientific research on medicinal plants is undertaken to support quality, efficacy and safety. Successful integration can be done by establishing laws and regulations. One of the objectives of the national health policy of Myanmar in 1993 was to reinforce the service and research activities of indigenous medicine to an international level and to involve traditional medicine in the community care activities. The Traditional Medicine Drug Law of 1996 requires that all traditional medicine drugs be registered and all traditional medicine manufacturers be licensed. So far, there are 12 712 traditional medicine products registered and 2578 manufacturers licensed. The Traditional Medicine Council, started in 2000, requires that all traditional medicine practitioners be registered and so far about 7000 practitioners have been registered. In view of the growing recognition of the positive contributions that traditional medicine can make towards universal health care, there is a need for further regional collaboration among Member States and all concerned agencies to make traditional medicine health care more scientific, effective and affordable.
Nepal

H.E. Mr Khaga Raj Adhikari, Minister of Health and Population, Nepal, stated that the Government of Nepal realizes that optimal use of traditional medicine – with regard to practices, practitioners and products - contributes to health and development of the country. Nepal is aiming for full integration of good quality services but needs to make further efforts. Ayurveda, yoga, naturopathy, unani, Tibetan medicine (Amchi), Chinese medicine and acupuncture, and homeopathy are all practised.

The Health Policy 2014 prioritizes research and development of ayurveda and the 2nd Long-Term Plan 1997–2017 proposes to include ayurveda in the district healthcare services. Since ayurveda is the most practiced traditional medicine system, the National Ayurveda Policy 1996 was adopted aiming to promote ayurveda health system throughout the nation. As of today, there is one 100-bedded central hospital, one 50-bedded regional hospital, 14 zonal hospitals and 61 district hospitals providing Ayurvedic services as well as 214 community ayurveda drug dispensaries. The Ayurveda Council certifies and registers qualified doctors and monitors the quality of education and Ayurveda medical products. About 2500 ayurveda practitioners and 500 other traditional medicine practitioners are registered. Three Ayurveda colleges are producing Bachelor-level doctors. In addition, the government runs one homeopathy, one unani hospital and some acupuncture units. In recent decades, there has been a significant increase in the use of traditional medicine and there is a need for mainstreaming traditional medicine with greater integration and institutionalization into the conventional health care system.

Thailand

Dr Suriya Wongkongkathep, Inspector-General (Regions), Office of the Inspector-General, Ministry of Health, stated that the main focus of the integration of Thai Traditional Medicine (TTM) in the health-care system is three-fold – to promote people’s self-reliance using TTM, to support medicinal plant growers and the production of TTM, and to revive and conserve TTM knowledge. TTM and acupuncture have been covered under the three health security systems since 2002 and services include: inclusion of 74 traditional and herbal medicines in the national list of essential medicines; Nuad Thai (traditional Thai massage); Luk Prakob (hot herbal compress); Herbal steam bath; and Hot salt pot compress for post-partum care. Currently there are more than 10 000 hospitals providing TTM and during 2013, 16% of outpatients received TTM. The government aims that 20% of outpatients should receive TTM. A key strategy is to integrate TTM into the health system under the national health security scheme (universal health care scheme) and to make it more visible as one of the health care packages for the population. In 2014, 400
million baht worth of TTM was reimbursed by the National Health Security Office. There are 26 certified universities offering four-year Bachelor degree courses on TTM. In order to strengthen the quality of practice and practitioners, certified training centres were established and doctors working in these centres must pass the training course to become qualified instructors. Thai traditional medicine products must be registered and manufacturers are now adjusting to new ASEAN rules on registration and GMP production standards. More clinical trials are needed on herbal medicines and procedure-based therapies and Thailand is now developing a 10-year research plan. In order to promote use of TTM, there are plans to give allopathic medical students some training in TTM and to develop a manual for allopathic doctors on the use of TTM. Thailand is ready to collaborate with WHO (SEARO and HQ) to provide technical support to implement the WHO global strategy.

H.E. Dr Harsh Vardhan then invited comments from other participants and also congratulated the Democratic People’s Republic of Korea on the production of their pamphlet on Koryo traditional medicine.

Bangladesh delegates stated that they had a long history of traditional medicine in urban and particularly in rural areas, where it is cheaper than allopathic medicine. Traditional medicine is often used by women and children. The government has a policy to promote traditional medicine. There is a post of a traditional medicine doctor in every district hospital. There are formal degrees in unani, ayurveda and homeopathy. Research and development facilities are needed because the efficacy and safety of some traditional medicines are unknown and Bangladesh hopes to get help from India, with whom the country has just signed a bilateral agreement.

Mr Choi Yong Su, Officer, Ministry of Public Health from the Democratic People’s Republic of Korea stated that Koryo traditional medicine has a history of over 5000 years. Some illnesses are very difficult to treat with allopathic medicine and Koryo can be of help. Koryo greatly contributes to health-care since about 50% of all patients in the country are treated with Koryo medicine. There is a six-year training programme for Koryo undergraduates and all undergraduates, whether allopathic or Koryo, get some training in both disciplines. Currently, priority is being given to train specialists in Koryo medicine. Thus, from the perspective of integration, Koryo doctors co-exist with allopathic ones in all health care facilities. There are regulatory systems for traditional medicine practitioners, practices and products at central and provincial levels to ensure the safety and quality of traditional medicine. Research by specialist institutes includes comparative studies between Koryo and modern medicines, identification of plants and active pharmaceutical ingredients in the plants, and standardization of formulations and doses. Research is also done on
the basic theory and principles of *Koryo* medicine on herbal and procedure-based therapies. The Democratic People’s Republic of Korea is happy to work with other countries to promote traditional medicine.

Delegates from Thailand mentioned that with increasing demand for herbal products, there is a need to pay more attention to quality, which may vary according to where and how plants are grown. Countries need to cooperate and share their own clinical experiences with regard to ensuring quality and safety.

Indonesian delegates stated that *Jamu* was the Indonesian traditional system and that 30% of the population used it. Massage is also used. There are 30,000 plant species of which 7,500 species are medicinal plants. Between 1,000 and 1,200 medicinal plants are used by the community and 300 plants are used as raw material for manufacturing traditional medicines. Indonesia supports the WHO global strategy and the three-pronged approach focusing on products, practices and practitioners. The MOH is working towards integration and enhancement of universal health coverage. So far, 72 doctors have been trained in acupuncture, 30 hospital doctors in herbal medicines, 849 health centre staff in acupressure and 475 staff in utilizing medicinal plants for family self-care. Currently, 80 hospitals and 840 health centres provide traditional medicine services. The new national insurance guidelines include acupuncture as an advanced referral service that is covered by the National Social Health Insurance Scheme. WHO’s assistance was requested to develop the knowledge base and perhaps a WHO Collaborating Centre could be established.
Dr Zhang Qi, Coordinator of Traditional Medicine in WHO/headquarters summed up the discussion. He stated that all the presentations, discussions and suggestions were in line with the WHO Strategy on Traditional Medicine. He felt that the round table discussions were very useful and would contribute to pushing the global agenda forward with regard to traditional medicine. He reiterated that joint efforts would be needed to cope with the challenges of appropriate integration of traditional medicine into national health-care systems and in ensuring the quality and safety of traditional medicine services.

In his concluding remarks, H.E. Dr Harsh Vardhan thanked all the participants for their active contribution to the discussion. He mentioned that India was developing a holistic system under the AYUSH umbrella and that though traditional medicine practitioners had not been properly recognized, they could alleviate the shortage of human resources for health.
Briefing on Ebola Virus Disease by WHO Director-General, Dr Margaret Chan

Epidemiology of Ebola virus disease
For the last few months, West Africa has been affected by an outbreak of Ebola virus disease (EVD). EVD is caused by Ebola virus that was discovered for the first time in 1976. Since then, it has caused 25 outbreaks in different parts of Africa. However, the current outbreak is the largest and the most complex of any Ebola outbreaks that have been seen in the past. This outbreak has already exceeded the number of cases and deaths than those in all previous outbreaks put together. This is deeply worrying.

The accumulated data till date (8 September 2014) exceeds 4290 cases and 2296 deaths, most of which have taken place in Guinea, Liberia and Sierra Leone. A few cases have been reported from Nigeria and Senegal and the origin of index cases in these two countries has been traced to three major affected nations.

The Democratic Republic of Congo (DRC) has been affected by an outbreak of EVD with 24 cases and 13 deaths. This outbreak has been shown to be independent of the major outbreak in West Africa on the basis of evidence generated by field epidemiology as well as molecular epidemiology that has conclusively shown that the two outbreaks are due to dissimilar viruses.

The number of cases has been increasing exponentially in Guinea, Liberia and Sierra Leone. Unless immediate steps are taken to curb the burgeoning epidemic, the number of cases and deaths are likely to increase manifold.

Factors that have fueled this outbreak
The unusual progress of the outbreak has been because of the inherent weaknesses of the local health system, especially trained human resources, inadequate infrastructure and scarce logistical support. The outbreak has also been influenced by social customs, mainly those related to burial practices. Rumours, misinformation and stigma are further fuelling resistance, evoking fear and preventing cooperation from the communities.
Impact of outbreak on Africa

The impact of this outbreak on Africa goes beyond human health. The epidemic has decimated numerous families. It has assumed serious dimensions – food and internal security, political, social and economic – not only for the highly-affected three countries, but for the entire African continent, and subsequently, the whole world.

Already a significant deflation of economy including substantial decrease in GDP has been estimated, which these developing countries can ill-afford. Many development projects have been stalled. If Africa is being increasingly isolated, it must be prevented in the context of global solidarity.

Pharmaceutical interventions (medicines and vaccines)

Unlike many other epidemic-prone diseases, there is no vaccine or specific medicine against Ebola virus. Several are being developed and WHO is mobilizing global expertise and resources to fast-track the availability of these products, and also a policy for their use in limited quantities, which may become available initially. Vaccine development is moving rapidly. Clinical trials have begun. If everything goes well, we may have a vaccine by end-2014 or beginning 2015.

Work is being done on convalescent serum, blood products and antivirals, including monoclonal antibody (zMAPP). However, to ensure the quality, efficacy and safety of these products, some regulatory processes need to be completed. Efforts are being made to bring these for use in the field at an early date, but it seems we may not have anything for the next 6–9 months.

Rigorous and appropriate infection control practices are at present the key to contain this outbreak. Proper use of personal protective equipment (PPE) and implementation of universal standard precautions can be life-saving and also cut down the transmission of infection.

What has WHO been doing?

WHO has been working closely with the national authorities in affected areas. On the recommendation of the Emergency Committee and under the provision of IHR (2005), WHO Director-General has declared this event as a Public Health Emergency of International Concern (PHEIC). However, as the outbreak is evolving, it is assuming greater dimensions than an emergency of public health importance.

WHO has also been continuously interacting with the national leadership, at the highest level in affected countries. WHO has deployed more than 400 experts,
including its own staff in the field, to support national efforts. Mobile laboratories have been provided, several guidelines quickly developed and disseminated.

WHO has developed a roadmap for Ebola control with an estimated budget of US$ 490 million (which may prove to be an underestimate of required resources if the outbreak continues to progress unabated).

The UN Secretary-General has ensured a whole-of-UN approach and established a coordinating hub in his office with Dr David Nabarro as the coordinator. WHO will take the lead in health-related issues, while for all other issues including food supply, logistics and infrastructure, other UN agencies will contribute.

The Presidents of Guinea, Liberia and Sierra Leone have requested the UN Secretary-General to discuss this issue in the United Nations General Assembly to mobilize global support.

WHO Director-General has met leaders in USA and her team is meeting with officials from the United Kingdom and France to obtain their support for the respective affected countries that were their colonies at some time in the past.

What should Member States do?

Member States should heighten alert and maintain vigil through an efficient surveillance system that can rapidly trace and monitor contacts of suspected cases, establish/designate health facilities for isolation of patients with exacting infection control practices, organize diagnostic services through WHO laboratory networks and educate communities to provide full cooperation in this endeavour.

What can Member States do for Africa?

Africa needs urgent assistance to fill financial (cash or kind) and human resource gaps. Specialists in epidemiology, clinical care, infection control, logistics and nursing care are urgently needed. It will be appreciated if support is provided with materials that are useful to the affected communities in handling the Ebola crisis.

This is the time to demonstrate global solidarity with the people of Africa who are undergoing a complex and unprecedented outbreak of Ebola.
Partnerships for innovation and affordable technology for public health

The side-event on “Partnerships for Innovation and Affordable Technology for Public Health” focused on innovation and certain technology interventions. This includes medical products\(^1\) that hold promise and have the potential to enhance quality and coverage of health services. The event was Chaired by H.E. Dr Sergio Lobo, Minister of Health, Timor-Leste. The Hon’ble Minister welcomed this initiative of the Regional Director and explained that discussion on Partnerships for Innovation and Affordable Technology for Public Health highlighted three very significant aspects influencing public health choices for policy-makers in our countries: 1. Innovation, 2. Affordable Technology, and 3. Partnership. While ministers of health promote innovations appropriate to the settings to achieve our public health goals, these are often not known beyond national boundaries. There are many high quality technologies that may benefit the people who may not be able to afford them.

Globally, the organization of research is changing driven by informatics and the relatively new notion that collaboration and sharing of knowledge is important. Of particular note are:

- convergence of technologies and other fields such as biology, engineering, IT, synthetic biology, nanotechnology including genomics, bio-based products (e.g. food and medical products). Biotechnology involves health

\(^1\) Medical products include medicines, vaccines, and diagnostics.
technologies and biomedical innovation (e.g. healthy ageing, neurosciences, biomedical products, translation of medical research) including biomarkers, bio-banking and genetic resources;

- digitization of biomedical and health data, information and knowledge and the increased importance of large databases for biomedical research and health decision-making;
- the need to access multiple sources of data and to make these interoperable;
- the shift towards knowledge-driven, evidence-based innovation in medicine and biology; and
- development of platform technologies/standards as globalization accelerates leading to ease of communication amongst a very broad scope of distributed, virtual and diverse knowledge resources. (Sophisticated use of information technologies enables users flexibly to interconnect these resources and to deliver research efficiencies.)

The side-event focused on interventions relevant to countries in the South-East Asia Region in two categories:

- product innovations—including drugs, devices, diagnostics; and
- health systems innovations, including innovations in health policy – new delivery strategies, mobile, e-health applications.

The foremost criteria for selection of innovations for health technologies is health technology assessment. Other criteria are that the innovation:

- addresses a prominent public health problem;
- represents different categories – drugs, diagnostics, vaccine, health systems;
- not yet fully known and exploited and has the ability to scale up- and is affordable; and
- in partnership with government.

On this basis, the side-event covered the following:

---

(1) **Drug innovation-demonstration project – The Visceral Leishmaniasis (VL) Global R&D & Access Initiative – Professor Dr Jagdish Prasad, Director-General of Health Services, Ministry of Health and Family Welfare, India.**

This is taken up as a demonstration project under resolution WHA66.22 to strengthen health R&D capacities and investments for diseases that disproportionately affect developing countries. Visceral leishmaniasis (VL) occurs on five continents with endemic transmission reported in 98 countries. VL is one of the most neglected tropical diseases despite the fact that it is the most deadly parasitic disease after malaria. VL is transmitted by bites of a sandfly and is endemic in the South-East Asia Region. The demonstration project calls for cross-regional collaboration of existing networks, open-innovation and knowledge sharing, equitable access to new products, as well as sustainable funding secured through existing and new funding mechanisms. The main objectives of the demonstration project by the Drugs for Neglected Diseases Initiative that were discussed are development of: new, safe and effective oral treatments as monotherapy; diagnostic technology (xenodiagnoses coupled with a quantitative PCR) in order to evaluate the role in transmission of asymptomatic cases and post kala-azar dermal leishmaniasis (PKDL) patients; a treatment for cutaneous leishmaniasis and post kala-azar dermal leishmaniasis (medical product); and a shared, open-access data base to identify determinants of treatment effectiveness.

(2) **Foundation for Innovative New Diagnostics (FIND) – Tuberculosis (TB) – Dr M Mostafa Kamal, Associate Professor & Head (in charge), Department Pathology & Microbiology, Coordinator of NTRL, NIDCH NTP, DGHS, MOH & FW, Bangladesh and Mikel Chakma, Consultant, FIND, EXPAND TB, Bangladesh**

TB is one of the greatest threats to health worldwide, with nearly nine million new cases annually. The most commonly used TB diagnostic is sputum smear microscopy, which was developed in the 1880s and has remained largely unchanged. It can only detect about half of patients tested and is particularly ineffective for diagnosis of TB in children and in patients co-infected with HIV. Although it is often described as a simple technology, microscopy requires a high level of training and diligence. Mounting drug resistance, including MDR-TB and extensively drug-resistant (XDR) TB, coupled with a growing number of people co-infected with TB and HIV, have highlighted the urgent need for more accurate and rapid diagnostic tests. The side-event discussed the work of the Foundation for Innovative New Diagnostics (FIND) in Bangladesh relating to:
a point-of-care test for use at the primary health-care level, where the majority of patients seek medical attention and where diagnosis is currently based on clinical symptoms only;

an alternative to microscopy for use at the peripheral laboratory level, health centre or district hospital, with a simpler technology that can detect both smear-positive and smear-negative tuberculosis.

(3) eHealth Directorate-General of Health Services, MOHFW, Government of the People’s Republic of Bangladesh – Dr Abul Kalam Azad, Additional Director General, Planning and Development and Line Director MIS and e-Health, Ministry of Health and Family Welfare, Bangladesh.

eHealth initiatives of the Government of Bangladesh which has achieved complete internet connectivity of the entire health sector that spans from rural community health workers, community clinics, and union, sub-district, district and divisional level health facilities, academic institutions and health administrative offices located in all subnational and national geographic boundaries were discussed. This eHealth infrastructure has started to establish itself as a powerful health transformation tool in terms of population – as well as facility-based data collection and analysis through routine health information system for correctly understanding, planning, intervening, and reviewing the actual health problems. Telemedicine service and other innovative ICT-based citizen-centric health services, such as pregnancy and child registration and follow-up, citizens’ grievance-
management, health awareness creation, etc. are being massively scaled up. The data will form the foundation of every citizen’s lifetime shared electronic health-record.

The Regional Director, Dr Poonam Khetrapal Singh in her closing remarks outlined that innovation is the new buzzword in every sector – governance, information and communication technology (ICT), energy as well as in health. She emphasized that innovation is essential to improve health through either improved technologies or new drugs and tools to treat diseases. She said that this side-event had generated a lot of interest in the Member States of the Region and the information shared would be most useful in taking forward some of the innovative projects in the respective countries.
Addressing autism through partnerships: A round-table discussion for the development of a multifaceted action plan

The side-event held on 11 September 2014 during the Sixty-seventh Session of the WHO Regional Committee for South-East Asia was a collaborative effort of the Ministry of Health, Government of Bangladesh and the WHO Regional Office for South-East Asia. The event was chaired by Ms Saima Hossain, Member, WHO Expert Advisory Panel on Mental Health and was moderated by Dr Poonam Khetrapal Singh, WHO Regional Director for South-East Asia. Her Excellency Sheikh Hasina, the Honourable Prime Minister of Bangladesh graced the occasion as the chief guest.

The objective of the side-event was to initiate a dialogue among stakeholders to develop partnerships for global action on autism. The discussion also aimed to build a momentum towards a Global Initiative for Autism through sharing of ideas for the development of a multifaceted action plan. The participants at the round-table discussion included ministers of health of WHO South-East Asia Region, heads of missions, ambassadors, representatives of World Bank, UNICEF and USAID.

In her opening remarks Ms Hossain highlighted the importance of convening the side-event and different aspects of autism, including its health, social and emotional implications and the need for a global initiative for concerted actions.
Dr Michael Klag, Dean, Bloomberg School of Public Health, Johns Hopkins University, USA, presented the public health perspective of autism. Dr Klag provided an insight to the probable causes of autism and its diagnosis and elaborated on the influence of environment on autism. He explained the different theories regarding the causes of autism and threw light on the importance of early diagnosis. Dr Klag also enumerated the common triad of symptoms seen in persons with autism and the spectrum of manifestations of the condition.

Dr Samira Al Saad, Founder and Director, Kuwait Centre for Autism and Vice President, World Autism Organization, made an eloquent presentation from the perspective of a parent. Ms Samira emphasized the need to understand autism and to provide support to persons with autism and their families. She mentioned that persons suffering from autism in many instances are gifted and have inner strengths that need to be recognized. Dr Samira reiterated that empathy and not sympathy is what persons with autism need.

Ms Saima Hossain presented the need for global action through collaborative partnerships. Ms Hossain touched on the prevalence of autism and its importance in appropriate policy formulation in the backdrop of a worldwide increase in prevalence of autism. She emphasized the importance of early diagnosis, management and rehabilitation and the need for autism to be considered a priority health condition. Ms Hossain also touched on real-life examples to show how with early diagnosis and management, persons with autism can lead a fulfilling and rewarding life.

The presentations were followed by brief remarks from the participants of the round-table.

The Honourable Health Minister of Bhutan, Mr Tandin Wangchuk, said that Her Majesty the Queen of Bhutan was a champion of autism and pledged Bhutan’s support for the cause of autism. Dr Harsh Vardhan, the Honourable Minister of Health, Ministry of Health and Family Welfare, Government of India, mentioned the declaration of South Asian Autism Network (SAAN) on autism and pledged India’s continued support on autism related issues.

The ambassadors of Japan, Turkey, Malaysia and the representative of the US Ambassador mentioned the importance of promoting awareness about autism, mental and neurological disorders including other disabilities, where they are providing support. They applauded the initiative of bringing autism to the forefront and identified areas which need focus, like social stigma, family reluctance to seek
support and treatment. The comprehensive approach taken by the Government of Bangladesh and the World Health Organization to address autism was appreciated.

The representative from USAID, KOICA talked about meaningful collaboration in the area of autism. The representative from China talked about autism being a global problem which required global cooperation and collaboration.

The Country Director, UNDP referred to the landmark strategy of the Economic and Social Commission of Asia-Pacific which has 27 targets and 62 indicators and are compiling disability data and will have autism on the agenda. The importance of ensuring employment, justice, accessible services and taking steps for non-discrimination was also mentioned. Human rights issues were also high on the agenda.

The Country Representative, UNICEF emphasized the importance of support, partnerships, generation of knowledge, and burden of disease, to evaluate what works for autism and what does not. The importance of evidence generation and using the partnership approach was also emphasized together with the need for multisectoral collaboration between stakeholders, service providers and parents to address the problem of autism. The need for information on global-level disability module, large household survey and partnerships with the social welfare sector was highlighted. Support provided to the Ministry of Social Welfare, Bangladesh for developing disability database and for providing support for strengthening knowledge on autism was mentioned. The importance of further exploring the existing instruments, primary education, monitoring and surveillance and partnerships was emphasized.

The Country Director, World Bank emphasized the importance of diagnosis and informed about the World Bank’s support to the Government of Bangladesh through partnerships with NCD-related activities and for the development of multifaceted action plans for health programmes. He praised the initiative taken by the Government of Bangladesh and the World Health Organization to mobilize action to facilitate global action on autism.

The Country Representative, UNFPA added a new perspective to the discussion by stating that nearly 50% of cancers were due to environmental hazards. He also talked about the ill-effects of pesticides, which were playing havoc with human health. The environment could have an influence on the increasing prevalence of autism and research needs to be promoted to address this issue.
The head of delegation of the International Committee of Red Cross (ICRC) mentioned that the agency worked very closely with the government, providing support in several areas pertaining to health.

There was general consensus on providing support to the noble endeavour for the development of a multi-faceted action plan and for a Global Initiative on Autism. The ministers of health and heads of missions attending the side-event pledged their commitment to concerted actions in advocating and supporting the cause of autism.

Dr Poonam Khetrapal Singh, Regional Director, WHO South-East Asia Region, in her concluding speech thanked all the presenters for their supportive statements. She particularly thanked the Honourable Prime Minister of Bangladesh for bringing autism in the forefront not only regionally but globally. The Regional Director acknowledged the commendable work by various organizations in the Region and appreciated the important issues raised during the event. Dr Singh reiterated the importance of research and requested Member States to support research and training activities pertaining to autism. She urged the ministers of health to take up autism as a priority health agenda and commit more funds in this area. She thanked the Honourable Prime Minister for her unwavering support to the cause of autism and other disabilities. The Regional Director congratulated Ms Saima Hossain for her tireless efforts to give autism the attention that it deserves, which in turn, had provided a platform to all mental and neurological disorders.
Her Excellency Sheikh Hasina, the Honourable Prime Minister of Bangladesh, in her closing remarks expressed her solidarity with the decisions of the round-table. The Honourable Prime Minister emphasized the importance of working together and on behalf of the Government of Bangladesh, expressed her support for autism. Her Excellency further assured that the Government of Bangladesh will continue to provide support to persons with autism and other disabilities. Her Excellency thanked the World Health Organization for prioritizing autism, which ensures that autism will get its due recognition and support.

Her Excellency Sheikh Hasina mentioned that persons with autism should not be considered a burden to the society; they should be nurtured, given proper education and raised to a level where the nation can be proud of them. Her Excellency talked about inclusive education and how Bangladesh stands firm on its commitment to ensuring that persons with disabilities are ushered into mainstream education. She mentioned about the work Bangladesh has undertaken to establish the rights of persons with disabilities. Her Excellency mentioned the honour that Ms Saima Hossain has brought to the country through her relentless work in the field of autism.

The session concluded with a vote of thanks by the Session Chair, Ms Saima Hossain. She thanked all for their presence, which reflected their commitment to the cause, and for the fruitful discussions. Ms Hossain concluded by saying this was the beginning of promising and effective partnerships for a Global Initiative on Autism.
The Regional Committee for South-East Asia is WHO’s decision-making body in the South-East Asia Region with representation from all 11 Member States of the Region. It meets in September every year to review the progress and regional implications of the World Health Assembly resolutions. This report summarizes the discussions of the Sixty-seventh Session of the Regional Committee held in Dhaka, Bangladesh from 10 to 12 September 2014. At this session, the Committee discussed a number of public health issues important to the Region, such as civil registration of vital statistics, reduction of harmful use of alcohol, autism, traditional medicine, viral hepatitis, strengthening health workforce education and training, International Health Regulations, and the WHO reform process. It adopted a number of resolutions on these issues.

WHO Regional Committee for South-East Asia

Report of the 67th session

Dhaka, Bangladesh, 9–12 September 2014