The Regional Committee for South-East Asia is WHO’s governing 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 progress in health development in the Region as well as to consider the regional implications of the World Health Assembly resolutions, among others.

This report summarizes the discussions of the Sixty-eighth Session of the Regional Committee held in Dili, Timor-Leste, from 7 to 11 September 2015. At this session, the Committee reviewed and discussed a number of public health issues important to the Region, such as emergencies and outbreaks, patient safety, cancer prevention and control, antimicrobial resistance, community-based health services and their contribution to sustainable universal health coverage, and tobacco control. The Committee adopted a number of resolutions on these issues.
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1 Introduction

1. The Sixty-eighth Session of the WHO Regional Committee for South-East Asia was held in Dili, Timor-Leste, from 7 to 11 September 2015. It was attended by representatives of all 11 Member States of the Region, United Nations and other agencies, nongovernmental organizations having official relations with WHO, and observers.

2. The inaugural session of the Sixty-eighth Session of the WHO Regional Committee for South-East Asia was held on 7 September 2015. The Honourable Prime Minister of Timor-Leste, His Excellency Dr Rui Maria de Araújo, delivered the inaugural address.

3. The Regional Committee elected Her Excellency Dr Maria Do Céu Sarmento Pina da Costa, Honourable Minister of Health of the Democratic Republic of Timor-Leste, as Chairperson and His Excellency Mr Khagaraj Adhikari, Honourable Minister of Health and Population of the Federal Democratic Republic of Nepal, as Vice-Chairperson of the Sixty-eighth Session.

4. The Committee reviewed the Report of the Regional Director covering the period 1 January–31 December 2014.

6. A drafting group on resolutions comprising a representative from each of the Member States was constituted, with Dr Viroj Tangcharoensathien, Thailand, as Rapporteur. During the Session, the Committee adopted eight resolutions on the following subjects: Programme Budget 2016–2017; Response to emergencies and outbreaks; Antimicrobial resistance; Patient safety contributing to sustainable universal health coverage; Cancer prevention and control—the way forward; Community-based health services and their contributions to universal health coverage; Dili Declaration on Tobacco Control; and Resolution of thanks.
2 Inaugural session

Welcome address by H.E. Dr Maria do Céu Sarmento Pina da Costa, Minister of Health, Democratic Republic of Timor-Leste

7. Her Excellency Dr Maria do Céu Sarmento Pina da Costa, Minister of Health, Democratic Republic of Timor-Leste, extended a warm welcome to the honourable health ministers and other distinguished representatives from the Member States of the South-East Asia Region to the Sixty-eighth Session.

8. H.E. Dr Maria do Céu Sarmento conveyed deep gratitude to the Honourable Prime Minister of the Democratic Republic of Timor-Leste for lending wholehearted support and leadership in preparation for the Regional Committee being held in Dili – the capital city of Timor-Leste.
9. Her Excellency commended the leadership of Dr Poonam Khetrapal Singh, Regional Director, WHO South-East Asia Region, in highlighting the regional health agenda. Her Excellency said that it was a privilege to host this prestigious meeting for the first time in the country and to learn from the rich experiences of other Member States in the Region.

10. Though Timor-Leste was a young nation, its Constitution had included health and medical care as fundamental rights for all citizens; successive governments accorded high priority to health. Health being influenced by a number of social determinants, the country focused on delivering comprehensive primary healthcare services with community participation. Towards this end, attention was concentrated on development of basic infrastructure and human resources. Her Excellency looked forward to continued WHO support to achieve the specific health goals of her country.

(For full text of the address, please see Annex 1.)

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

11. Welcoming the representatives of the Member States of the South-East Asia Region, Dr Poonam Khetrapal Singh, Regional Director, WHO South-East Asia Region, congratulated the Prime Minister, His Excellency Dr Rui Maria de Araújo, who not only had a distinguished record as health minister, but was also an expert in health policy, management and finance, and wrote his Master’s thesis on the future health system of his country.

12. The Regional Director congratulated the National Malaria Control Programme of Timor-Leste for receiving the WHO Award for Excellence in Public Health for its remarkable success in achieving the Millennium Development Goal (MDG) for malaria and reducing the number of cases to less than one per 1000 population.

13. Dr Poonam Singh commended the leadership provided by the Prime Minister in fighting against tobacco use, which was pervasive among men and women. Enacting tobacco legislation and making public buildings and transport tobacco-free was a step in the right direction. She stressed that some serious public health challenges could be tackled by reforming governance mechanisms.
14. As the Region is disaster-prone, WHO had developed SEAR Benchmarks as the framework to strengthen the disaster preparedness and response capacities of Member States. In this context, establishment of the South-East Asia Regional Emergency Fund (SEARHEF), which had been functional for almost a decade, was a far-sighted move on the part of Member States. At the global level, an emergency fund was being established to tackle global health emergencies.

15. The Regional Director noted with satisfaction the number of countries committed to universal health coverage (UHC), which could bring diverse health communities together. Improving investment in health would not only have a significant impact on health delivery, but also bring about considerable economic returns. By showing that more people had access to the services they needed without suffering financial hardship, it would be possible to demonstrate progress towards achieving UHC.

(For full text of the address, please see Annex 2.)

Address of Director-General, Dr Margaret Chan, delivered by Dr Hans Troedsson, Assistant Director-General, World Health Organization

16. Dr Hans Troedsson, Assistant Director-General, General Management Cluster, WHO headquarters, conveyed the greetings of the Director-General, Dr Margaret Chan, and thanked the Government of Timor-Leste for hosting the Sixty-eighth Session of the Regional Committee for South-East Asia.

17. He stressed that the Regional Committee session had the opportunity to shape the future and could have a far-reaching impact at the national, regional and global levels. At the national level, the health agenda was being shaped and at the regional level, it provided an important forum for discussing regional health issues and finding solutions. The South-East Asia Region has one of the largest populations in the world and what was done here would have a global impact.

18. Referring to the United Nations General Assembly session in New York in the second half of September 2015, he said that adoption of the Sustainable Development Goals (SDGs) would be a milestone in the fight against poverty and disease, and towards development. He concluded by saying that what the Regional Committee discussed, decided and did would make the difference between life and death, diseases and health.
Inaugural address by H.E. Dr Rui Maria de Araújo, Honourable Prime Minister, Democratic Republic of Timor-Leste

19. The Honourable Prime Minister of the Democratic Republic of Timor-Leste, His Excellency Dr Rui Maria de Araújo, in his inaugural address, welcomed the participants and health ministers of the WHO South-East Asia Region to the Sixty-eighth Session of the Regional Committee.

20. Health has always been accorded high importance by the government and people of Timor-Leste, H.E. the Prime Minister said. Given the lack of access to primary health care for large sections of the hard-to-reach populations, the government had brought health services – including services for persons with disabilities – to the people themselves through its “Sauda Familia” (Healthy Families) programme, the Prime Minister said. “Healthy and strong people can build a healthy and strong nation.”

21. On the disaster-prone Region’s capacity to cope with natural and other emergencies, H.E. the Prime Minister announced the Cabinet’s decision to donate US$ 100 000 to the South-East Asia Regional Health Emergency Fund (SEARHEF), adding that it demonstrates the country’s commitment to the needs of the Region. “We can do better by working together,” he said.

22. Timor-Leste attaches great importance to the contribution of WHO to health in South-East Asia, the Prime Minister reiterated. On the health challenges facing Timor-Leste, he mentioned recurring cases of dengue and tuberculosis (TB) and rising prevalence of noncommunicable diseases (NCDs) such as cardiovascular diseases and chronic obstructive pulmonary disease.

23. Political will is key to eliminating challenges such as the tobacco menace, H.E. Dr Araújo said. The WHO Framework Convention on Tobacco Control (WHO FCTC) was ratified by the country in 2004. In a country where 70% of men aged 15 years or above use some form of tobacco, all government institutions banned smoking on their premises in June 2015.

24. H.E. the Prime Minister also outlined the steady progress in health that Timor-Leste has achieved over the last decade. Health facilities have been reconstructed, community-based health services expanded, and trained health professionals recruited in large numbers. Timor-Leste is set to meet the MDG targets on reducing infant and under-five mortality, which declined from 83 per 1000 live births during 1999–2003 to 64 per 1000 in 2009.

25. The government has prioritized nutrition and committed itself to end hunger and malnutrition in line with the 2010 Comoro Declaration. In 2014 Timor-Leste became the first Asia-Pacific country to launch a nationwide campaign under the United Nations Zero Hunger Challenge.
26. Large strides have also been made in malaria control, with a 75% decline in the incidence of malaria cases during 2000–2014. Riding on these successes, the Ministry of Health launched a comprehensive approach to strategic planning and policy-making for the development of health services. A National Health Sector Strategic Plan 2011–2030 provides the framework for health services delivery and outlines specific health goals for the next 20 years, including comprehensive and quality primary, secondary and hospital-care services accessible to all Timorese people.

27. His Excellency also acknowledged the importance of the Regional Committee as a platform that provides direction to the work of WHO at the regional level and an opportunity for bilateral discussions between Member States. He concluded with a call to all 11 Member States to collectively strive to improve health conditions in the Region.

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

Vote of thanks by H.E. Dr Ana Isabel Soares, Vice-Minister of Health, Democratic Republic of Timor-Leste

28. Her Excellency Dr Ana Isabel Soares, Vice-Minister of Health, Government of the Democratic Republic of Timor-Leste, extended a warm welcome to the Prime Minister of Timor-Leste, H.E. Dr Rui Maria de Araújo; the honourable health ministers of the Member States of the South-East Asia Region; the WHO Regional Director for South-East Asia, Dr Poonam Khetrapal Singh; Assistant Director-General Dr Hans Troedsson; the honourable ministers of Timor-Leste, and all other distinguished delegates from the Member States.

29. Her Excellency the Vice-Minister of Health said it was “a great honour and pleasure” for Timor-Leste to host the Regional Committee session for the first time in the country. She also particularly thanked the Minister of Health of the Democratic Republic of Timor-Leste, Her Excellency Dr Maria do Céu Sarmento Pina da Costa, for her “tireless interest” in every detail related to the elaborate preparations for the meeting.

30. Her Excellency thanked the WHO South-East Asia Regional Office for extending all possible administrative and logistical support to Timor-Leste that enabled a meeting of this scale to be organized in the country. She thanked the WHO Director-General, Dr Margaret Chan, for designating a representative from WHO headquarters to attend the meeting on her behalf.

31. Her Excellency also lauded the untiring and diligent efforts of the team of “motivated and dedicated colleagues from the ministries” who were members of the Inter-ministerial Organizing Committee.

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

Key addresses and report on the Work of WHO (Agenda item 5)

Introduction to the Regional Director’s Annual Report on the Work of WHO in the South-East Asia Region covering the period 1 January–31 December 2014 (Agenda item 5.1: Document number SEA/RC68/2)

32. Introducing her annual report on the Work of WHO in the South-East Asia Region for the period 1 January 2014–31 December 2014, the Regional Director, Dr Poonam Khetrapal Singh, said that she was presenting a new-look report that put country challenges and achievements centre stage. The report had a section on each country individually, reflecting the diversity of the Region and illustrating the different ways in which WHO contributes to national health priorities.

33. The report also covered the seven flagship programmes, focusing particularly on how the Regional Office added value to what happened in countries. The flagships had been used as a way of driving a more integrated approach to work across the Regional Office and in the WHO country teams, the Regional Director added.
34. The Committee was informed that reports, by their very nature, spoke of the past, but one of the key roles of WHO was to look to the future and to bring issues of global and regional significance to the attention of Member States.

35. The Regional Director said that in two weeks, heads of state and government would meet at the United Nations General Assembly in New York to endorse the next generation of global development goals – the SDGs. Health was in a good place, the list of targets under Goal 3 – Ensure healthy lives and promote wellbeing at all ages – was long, but included much of what one wanted to see. Neglected tropical diseases (NTDs) and hepatitis, noncommunicable diseases and mental health, road traffic accidents, environmental hazards, tobacco and substance abuse, narcotics and alcohol, sexual and reproductive health, as well as UHC.

36. The Committee’s attention was drawn to the United Nations Conference on Climate Change in Paris in December 2015 at which Member States – for the first time in 20 years of negotiation – would seek to finalize a universal and binding agreement.

37. Referring to how these global agreements affected the Region, the Regional Director highlighted four key messages. The first was about making health a genuine national priority. She pointed out that all Member States had argued fiercely that health must have a prominent place in the SDGs. All made the case to governments that health would be a major beneficiary of good climate policy. There was solid evidence to prove that health contributed to economic growth and national development. It was a well-known fact that the Region accounted for a disproportionate share of the global burden of disease. However, in the Region as a whole, total health expenditure as a percentage of GDP was lower than in any
other WHO region, and over 5 percentage points below the global average. Yet the Region had achieved so much with remarkably little: a polio-free Region, leprosy eliminated, falling child and maternal deaths, lower rates of AIDS, TB and malaria and much, much more.

38. The second message was about governance for health. Some of the big health problems such as the challenge of NCDs, antimicrobial resistance (AMR), the impact of conflict on the spread of disease, and ensuring access to safe and affordable medicines were not amenable to technical solutions alone. They were essentially problems of governance. Success depended on solidarity and cooperation within and between countries, and across different arms of government, the Regional Director added.

39. As they stood, the new SDGs offered little guidance as to how to tackle many of the targets. Even AMR – one of the greatest threats to global health, and one that required significant cooperation within and between countries – was only included in the final draft of the text presented to the heads of state.

40. It was important in this context not to see the new development goals just as a new set of separate programmes, each to be addressed in its own silo. Rather, it was necessary to recognize that the SDG targets had much in common – not least the need for high-level political support to energize efforts across governments to tackle their underlying causes. In this regard, the Regional Director felt encouraged to see health leadership coming from the highest levels of government in the Region – in many countries, heads of state and government had spoken out on the need for action to tackle the major risk factors for NCDs.

41. The third message was about preparation and preparedness for disasters. Once again, this year, a major disaster occurred in the Region. That we had long known about the risks posed by earthquakes in Nepal made it no less tragic when disaster actually struck, as it did in April and May 2015.

42. In addition to the lives lost, the Regional Director drew attention to the longer-term risks that disasters brought in their wake – to the economy; to food security; to peoples’ long-term health, incomes and livelihoods; and to peace and security.

43. The 2004 tsunami was a turning point. All the countries affected had worked hard to protect themselves against future events. The Regional Director highlighted the comprehensive investments made by Indonesia on disaster risk reduction: decentralizing resources and responsibilities, while encouraging provinces to work together.
44. Referring to the Ebola outbreak, the Regional Director said it had shed a stark and unforgiving light on the world’s capacity to act quickly and effectively. Only two countries in the Region had in place the core capacities required by the International Health Regulations. This was a matter of grave concern. We need mechanisms that give countries a real incentive to invest in building the capacity they need to keep people safe, and to report suspected outbreaks rapidly.

45. The fourth message looked to the future: it was about health in ageing populations. Ageing was an issue that received little attention in the country briefs in the annual report. It was even more of a surprise that a search for the terms “ageing” or “ageing populations” in the zero draft SDG document showed zero results. Yet ageing constituted one of the most profound, and largely, predictable and quick changes that will happen to all countries of the Region. A longer life is a valuable resource, but the opportunities that arise from extra years of life are dependent on one key factor – health. There was a need to think in terms of integrated care centred on the needs of older people and age-friendly environments that supports independence and autonomy.

46. The Regional Director informed the Committee that her prime concern was to ensure that WHO served the needs of Member States as effectively as possible. In this context, four strategic directions had been outlined, which responded to priorities she had heard from countries and linked what was done in this Region with the leadership priorities in the Twelfth General Programme of Work.

47. These four themes provided the overarching vision for WHO’s work, but they were very broad. The Regional Director went a step further to define a number of more specific initiatives, or flagship programmes. The flagship programmes served as a means to give further focus to WHO’s work and provide a framework for accountability.

48. Some of the flagships, such as universal health coverage, NCDs and emergency risk management remained broad, but within each, specific areas of focus had been defined – human resources for health and access to medicines in the case of UHC and implementing “best buys” in the case of NCDs, the Regional Director added.

49. The flagship on antimicrobial resistance represented an area of global and regional significance that had been relatively neglected and that required urgent action across governments. She felt encouraged to see cross-sectoral bodies to address the threat of AMR feature in several country reports.
50. The flagships provided focus by adding specific targets in relation to selected neglected tropical diseases. The diseases selected – kala-azar, leprosy, lymphatic filariasis, schistosomiasis and yaws – were chosen in part because the targets could be achieved in the timeframe specified.

51. Similarly, measles and rubella were chosen to provide a clear demonstration that, given the right level of political and financial support, it was possible to eliminate major public health problems in the Region.

52. Lastly, the flagship for the MDGs underscored the work to be done in achieving goals that all countries had signed up to. Drawing attention to the issue of neonatal mortality, the Regional Director said that countries such as Bangladesh, Nepal, the Democratic People’s Republic of Korea and others had made impressive progress on reducing child mortality. However, further declines would depend on reducing the significant proportion of child deaths (60% in the case of Bangladesh) that occurred in the neonatal period. As seen in Myanmar, this would require more attention being paid to the quality of care provided at health facilities, and helping mothers in hard-to-reach areas cover the cost of reaching them.

53. The flagship programmes gave focus, but were not set in stone. While the current seven areas would remain relevant for the next biennium, other issues such as health and ageing might emerge and be added to the list, the Regional Director said.

54. WHO’s resources were tiny, compared with the Region’s needs. So clarity was needed not just about what the Organization did, but how it was done. Good planning was key. It was no longer possible to accept plans that were ambiguous or vague. It was also pointless to divide small financial allocations between an unrealistic number of objectives that had no hope of being achieved – just so every department got a share.

55. The Regional Director said that she wanted to see country plans and budgets that focused on agreed priorities; allowed space for addressing specific national needs; used WHO resources strategically and tactically; were transparent and easily understood; and defined results for which WHO can be held accountable.

56. The Regional Director reminded the Committee that better health was not a luxury – it was an investment. It was also a right to be made available to all, not a privilege to be granted to a few.

57. The Committee noted that the annual report showcased the achievements of WHO over the corresponding period with the right focus on deliverables.
58. The Committee commended the unprecedented speed and efficiency with which WHO launched the emergency response operations in the immediate aftermath of the Nepal earthquake. It was observed that the Regional Director was in contact with the Honourable Health Minister of Nepal within a few hours of the disaster.

59. The Committee also noted the Regional Office’s contribution during the humanitarian and medical emergency following the outbreak of the Ebola Virus Disease in West Africa in 2014, noting that the Regional Office deployed personnel on field missions to Ebola-affected areas.

60. The Committee acknowledged the success of the open-air public gymnasiums set up by the Government of Bhutan with support and expertise from WHO. These affordable gymnasiums helped promote physical activity among the Bhutanese people and proved to be a very popular, effective and yet low-cost investment in combating lifestyle-related diseases, it observed.

61. The Committee also noted the various efforts by WHO to increase efficiency at the country level through its collaborative programmes, to enhance preparedness in emergencies during the last year. The report appropriately underscored the importance of multisectoral preparedness in health.

62. The Committee commended the Regional Director’s new-look report on the Work of WHO in the South-East Asia Region for the period 1 January–31 December 2014. It appreciated the emphasis on country challenges and achievements and lauded the Regional Director’s initiatives to further strengthen and facilitate WHO’s collaborative efforts in Member States.

63. The Committee placed on record its appreciation of the Regional Director’s vision and the commendable leadership of WHO and its action- and results-oriented support to Member States.

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

Address by the Director-General (Agenda item 5.2)

64. Speaking on behalf of the Director-General of WHO, Dr Hans Troedsson, Assistant Director-General, outlined the different challenges facing WHO. Noting the changed health scenario where noncommunicable diseases had overtaken communicable diseases worldwide, he said that health systems, originally designed to handle infectious diseases, were struggling to cope with the epidemic of noncommunicable diseases. It was evident from mortality attributed to air pollution that climate change had also contributed to health consequences. A common factor
in the new challenges was the complexity and the fact that the root causes lay outside the domain of health. Controlling the globalized marketing of unhealthy substances such as tobacco, alcohol, sugary beverages and trans-fat loaded foods was a major challenge.

65. Dr Troedsson said that some of the interventions that could be taken up to prevent emergence of AMR were: changing prescribing patterns, enacting legislation for using medicines on ‘prescription only’ basis, and reducing the massive use of antibiotics in food-producing animals.

66. The rise of emerging and re-emerging diseases such as dengue was a major cause for concern. There is a worldwide resurgence of dengue, which has seen an alarming thirtyfold increase. The human and economic cost of dengue was staggering, and explosive epidemics could drain national exchequers. The dengue virus was affected by heat, humidity and rainfall patterns and was likely to expand further with climate change.

67. The Ebola outbreak in West Africa was the largest, longest and deadliest event in 40 years of this disease. It was a tragic and dramatic demonstration of the consequences of not having a good primary health care system. A resilient health system was like a fireproof house, without which one had to undertake major firefighting exercises in the event of sudden fire incidents. Countries will need to develop well-functioning, resilient health systems that could withstand shocks of all kinds.

68. Dr Troedsson informed that the Director-General had accelerated reforms to help WHO discharge its mandate to control the global spread of disease. A review
committee had been set up to assess the implementation of IHR during the Ebola outbreak and its recommendations would be beneficial to everyone. Establishment of a global health emergency workforce would be an operational platform that could shift into high gear in no time.

69. He stressed that the main lesson learnt from the Ebola outbreak was that universal health coverage was the first line of defence for achieving health security in the Region. The Director-General was aware of the commitment of the South-East Asia Region to the primary health care approach for achievement of universal health coverage and was confident that countries were prepared to tackle any imminent threats to their health systems.

**Statements by representatives of the United Nations and Specialized Agencies**

70. Mr Knut Ostby, **UN Resident Coordinator, Dili**, referred to the Sustainable Development Goals (SDGs) in the context of global health and inequality, saying uneven access to health is one of the determinants of social and economic inequality. It directly affects the economy, productivity and well-being of individuals, families and communities. Improving health standards has a direct positive impact on poverty reduction and other development targets.

71. In a few weeks, the world will agree on the new global development framework of the SDGs with health as an important component. These goals emphasize equity issues and advocate for improving health systems to achieve universal health coverage. While rapid economic growth is a positive indicator of development, it can lead to widening inequalities if not addressed properly. High levels of inequality may eventually hurt economic growth and slow down the pace of development. He also reiterated that a strong spirit of cooperation – both within governments and with partners as well as between countries – can help achieve the sustainable health targets. Health hazards know no borders and only coordinated action will ensure the prevention and elimination of health threats such as infectious diseases.

72. Ms Desiree M. Jongsma, **UNICEF Representative, Timor-Leste**, drew attention to the high burden of disease and undernutrition in South-East Asia, home to one in four people in the world. Lauding Member States for collectively meeting more than 80% of the MDG targets, she drew attention to a particular area of concern: the slow reduction – and in some countries stagnation – in the reduction of newborn mortality. Another area of concern, she added, is the slow progress in reduction of undernutrition and micronutrient deficiencies among women and children. If
unaddressed, this will continue to affect progress in maternal and child mortality reduction, and add to the double burden of diseases which countries in the Region are targeting to address.

73. Ms Jongsma urged Member States to hasten the pace of implementation and scaling-up of evidence-based interventions, with regional and national commitments in place. Multisectoral partnerships investing in the early life of children are critical for a better future for every child, family and society at large.

74. Mr John M. Pile, United Nations Population Fund, urged Member States to set up an appropriate post-2015 United Nations development framework to continue the momentum towards eliminating preventable maternal deaths and morbidities even after the MDGs deadline expires. This framework must address globally the unequal access to health care that contributes to shortcomings in the health of women of all ages. Universal health coverage (UHC) is one of the most effective approaches that reduces inequitable access and addresses the full range of women’s health issues, he added. With 150 million people suffering financial catastrophe and another 100 million falling under the poverty line as a result of exorbitant out-of-pocket health spending, UHC makes it easier for families that otherwise could not afford to get essential primary care.

75. Services provided in the context of UHC become more user-friendly as they are integrated. Although maternal mortality rates have declined over the past two decades, the overwhelming need to create a framework that reduces persistent inequalities and improves life expectancy remains. UHC is the approach that addresses all the health needs of women and girls, ranging from sexual and reproductive health to infectious diseases, such as HIV, and chronic diseases, such as cervical cancer, he added.

76. Mr Stephen Kearney, World Food Programme (WFP), highlighted their efforts towards achieving a world with zero hunger and providing food assistance to the poorest and most vulnerable women and men around the world. In the past year WFP has provided food assistance to over 3.5 million people affected by the Ebola outbreak in West Africa. The organization noted with appreciation its partnership with WHO during the Ebola outbreak which was critical for support to reach the people affected.

77. WFP’s partnership with the Ministry of Health of Timor-Leste is focused on the prevention of malnutrition while seeking to support those currently affected. WFP gives particular importance to the behavioural changes that lie at the root of
malnutrition, such as hygiene, safe food, clean water and better education. Direct interventions to people suffering from moderate acute malnutrition are targeted at health centres. WFP and the Ministry of Health are also working with a local commercial producer to prepare fortified foods. A longer-term project is to advocate for the fortification of basic foods, such as salt and flour, to become the norm in markets, and to mitigate against malnutrition.

**Ministerial Round Table (Agenda item 14)**

**Accelerating implementation of the WHO FCTC in the South-East Asia Region (Agenda item 14.3)**

78. The Ministerial Round Table on Accelerating implementation of the WHO Framework Convention on Tobacco Control (FCTC) in the South-East Asia Region was moderated by His Excellency Lyonpo Tandin Wangchuk, Minister of Health, Bhutan. The ministers of health of Timor-Leste, Nepal, Myanmar and Sri Lanka participated in the panel discussion, which covered various issues including adoption process of tobacco legislation, graphic health warnings, smokeless tobacco and illicit tobacco products. Interventions were also made by other Member States.

79. The Committee was informed that, as part of WHO reform, separate meetings of ministers of health, scientific advisers and technical groups were now to be merged into one meeting, at which ministers of health, as the highest decision-makers within health systems, would discuss issues of importance to the Region. The topic of the round table had been suggested by the host Government, Timor-Leste, as tobacco was a key risk factor for noncommunicable diseases (NCDs), the greatest health threat in the Region.
80. The WHO FCTC, which came into force in 2005, was the first global public health treaty. Four aspects of tobacco control that require reinforcement were: raising taxes on tobacco products; prohibiting the marketing, sales, advertisement and sponsorship of tobacco; enforcing smoke-free policies; and warning people about dangers of tobacco use through printing graphic health warnings on tobacco product packaging.

81. The Committee noted with concern the high prevalence of tobacco use in the Region and the wide variety of tobacco products used. With over one fourth of all tobacco smokers and more than 90% of all smokeless tobacco users in the world, the Region was facing a large public health crisis. The rising prevalence of tobacco use among young people and emerging use of electronic nicotine delivery systems was also of concern.

82. The Committee acknowledged that all Member States are taking important steps for tobacco control, some with leadership at the highest level. Several countries have raised taxes on cigarettes to above 70%; similar increases are required in taxes on other tobacco products, such as bidis and smokeless tobacco. Many countries in the Region have achieved high coverage of graphic health warnings on tobacco packages reaching up to 90%. All countries in the Region have introduced policies to ban smoking in public places. Mass media and innovative social channels have been used to warn people about the harm of tobacco use. Regulations on tobacco advertising have been adopted in most countries, and cessation programmes were available in many, including community-based activities. The Committee noted that surveys to monitor tobacco use by young people and adults had been conducted in most countries.

83. It recognized that Member States face numerous challenges in implementing tobacco control measures, including tobacco industry interference, illicit trade, cross-border marketing, lack of enforcement of laws and limited resources for tobacco control. Social and cultural acceptability and the wide availability and affordability of tobacco are other important challenges.

84. Member States recognized that sharing of knowledge and best practices and cross-border collaboration are important for fighting the menace of tobacco. The need for capacity-building in surveillance, monitoring and research was highlighted. Tobacco legislation should be strengthened and made more comprehensive. In addition to demand reduction, supply measures could be taken by promoting alternative livelihoods for farmers and tobacco workers. The Committee suggested speeding up ratification of the protocol on illicit trade, and development of a regional strategy for tobacco control.
85. Tobacco control requires the highest level of political commitment. Calling for accelerated, united action to fight the tobacco menace, the Committee unanimously endorsed the Dili Declaration on tobacco control.

86. The committee adopted resolution SEA/RC68/R7 “Dili Declaration on Tobacco Control”.

**Programme Budget Matters (Agenda item 6)**

**Programme Budget 2014–2015 – Implementation and mid-term review**  
(*Agenda item 6.1: Document number SEA/RC68/3*)

87. The Committee was informed that the technical and financial implementation of the Programme Budget (PB) 2014–2015 is being continuously monitored. A mid-term review monitoring exercise was also carried out for the Programme Budget 2014–2015. The Committee was also informed of the status of financial implementation of the Programme Budget 2014–2015, and the recommendations for actions made by the Subcommittee on Policy and Programme Development and Management (SPPDM) at its Eighth session in the Regional Office on 3 July 2015.

88. The approved budget for the WHO South-East Asia Region for 2014–2015 was US$ 340 million, and the revised budget was US$ 378.6. The operational budget as per approved workplans was US$ 362.3 million. The total distributed resources were US$ 354.3 million and implementation levels as on 31 August 2015 stood at
US$ 229.4 million, which is equivalent to 61% of the allocated budget and 65% of distributed resources.

89. The Committee noted that an internal review in December 2014 revealed that most Member States had all programmes on track. There are also additional financial support mechanisms in place for key programmes. At the same time, the Committee cautioned against complacency. The uneven distribution of funds across Categories was noted as a cause for concern. Member States also differed in the degree of utilization of funds, with Bangladesh and Maldives having utilized 100% of their budgeted resources while some Member States had utilized much less.

90. Since donors were interested in specific areas and specific projects in countries, the importance of moving funds across areas appropriately and as per needs was mentioned. The Committee also recalled the SPPDM’s reiteration of the need to strengthen coordination between country offices and ministries of health to maximize quality implementation. Member States broadly supported having access to WHO’s dashboard data to monitor collaborative programmes.

91. The Committee observed that while some Member States faced with a number of challenges had performed well during the current biennium, others registered low levels of implementation. It was proposed that horizontal collaboration may be considered between countries that have no funds but projects to implement and those that can spare funds for projects of common health concern. This is particularly significant since status of implementation, past performance and capacity to implement financial allocations are key criteria for allocating core voluntary contributions. The Committee emphasized that coordination mechanisms between the ministries of health and WHO country offices, through the aegis of WHO representatives, be strengthened.

92. The Committee observed that the Global Financing Dialogue of November 2015 will help mobilize additional resources to fully fund the approved Programme Budget. This will also help reduce the uneven distribution of allocations in certain programme areas and bridge the funding gaps. In a new measure, workplans will be finalized earlier than before and funds released well before the start of the new biennium.

93. The Committee reiterated its commitment to make concerted efforts to bolster resource mobilization, allocation and monitoring to fully use the available resources and clear all encumbrances by the end of the biennium.
Programme Budget 2016–2017
(Agenda item 6.2, Document number SEA/RC68/4 and Inf. Docs.1, 2 and 3)

94. The Committee acknowledged the increased Programme Budget of WHO for 2016–2017, and stressed the need to allocate adequate budget and resources for priority country and regional needs.

95. The Committee appreciated the intensive collaboration of WHO and ministries of health at the country level, which resulted in a bottom-up planning process for 2016–2017, reflecting identification of country priorities and their alignment with regional priorities. While commending the bottom-up planning process for the 2016–2017 biennium, which had been more transparent in nature, they assured their commitment to further strengthen the collaboration during 2016–2017 and beyond. The Committee also appreciated the focus on results orientation and the emphasis on measuring not just inputs and activities but deliverables and outputs.

96. Some Member States expressed concern about the programme area and category-wise budget allocations for their respective WHO country offices and requested the Regional Office to be flexible in allocating the budget.

97. It was clarified that budget allocation had been based on country priorities as identified by WHO country offices, in consultation with respective ministries of health, at the beginning of the bottom-up planning process for 2016–2017. The need to be as precise as possible in future was stressed.

98. The Committee was further informed that budget distribution to the Region by WHO headquarters had been in line with budget requests calculated by the Regional Office based on Category-wise budget submissions of WHO country offices which could be adjusted based on country needs. Addressing the requests of some Member States to have more budget allocation in selected priority areas, the Secretariat assured them that requests could be addressed during the course of implementation of Programme Budget 2016–2017 if warranted.

99. The Committee was reassured that with the pro-rata-based distribution of the increased “base budget”, 50% of US$ 8.9 million – which was to be allocated to
country offices – no country would receive a reduced allocation when compared to the 2014–2015 biennium; the base budget (strategic core budget) would be used to fund the country’s core priorities. The rest of the increase of the “base budget” would be held in country reserves.

100. The Committee was informed that funds in the country reserves could be distributed to countries as and when needed. Such incremental distribution will be informed by implementation progress and improved performance. Once the planned outputs are achieved and implementation has progressed, budget and funds would be made available to WHO country offices to achieve further outputs.

101. The seven regional “flagship areas” were described in detail. These flagship areas were based on country priority needs, leadership priorities of WHO’s Twelfth General Programme of Work, and on a thorough analysis of previous global and regional resolutions.

102. Some Member States sought more information on the difference between “Base budget” and “Emergency budget” allocations, including distribution of the polio budget for 2016–2017. The Committee was informed that the “Base budget” of WHO is meant for WHO core activities while the “Emergency budget” comprises polio and outbreak and crisis response (OCR) segments of the Programme Budget. The Committee was informed that the nature of polio, which is unpredictable, is being addressed by a partnership, independent of WHO’s base budget. Outbreak and crisis response (OCR) segment is also flexible and somewhat unpredictable. The budget space allocated as emergency budget was based on past requirements simply to keep the budget line open; the actual budget and funding needs would be met according to the needs. The Committee was further informed that the budget allocation for polio, which is normally allocated to the Regional Office, has been shifted to WHO country offices to maintain the same budget level as that of the 2014–2015 biennium.

103. The committee adopted resolution SEA/RC68/R1 “Programme Budget 2016–2017”.

**Strategic budget space allocation**  
*(Agenda item 6.3, Document number SEA/RC68/5)*

104. The Committee recalled that at the Sixty-sixth World Health Assembly in May 2013, the Director-General, Dr Margaret Chan, was requested to propose, in consultation with Member States, a new strategic budget space allocation (SBSA) methodology for WHO. This methodology was placed before the Sixty-seventh World
Health Assembly in 2014, to be operative from the development of the Proposed Programme Budget 2016–2017.

105. The Committee further recalled that a Working Group (called Working Group on Strategic Budget Space Allocation) was established at the 134th Session of the WHO Executive Board in January 2014 for consultations on the SBSA, and to provide guidance to the Secretariat in further developing the proposal for a new SBSA methodology. Maldives represented the WHO South-East Asia Region in this Working Group.

106. The Committee recognized that the development of a new budget space allocation methodology is interdependent with many other initiatives that are part of the ongoing WHO Reform, such as bottom-up planning, identification and costing of outputs and deliverables, roles and functions of the three levels of the Organization, and review of the financing of administrative and management costs, and as such was a complex task. The Working Group over several meetings agreed on the scope, guiding principles and a set of criteria for the SBSA as well as four expenditure segments as the basis of the SBSA.

107. The Committee complimented the Working Group for introducing a new set of indicators for the methodology. Under the proposed formula that was ratified by the 137th Session of the WHO Executive Board, the allocation for SEARO was calculated to be at 14.1% for future bienniums, a decrease from 15.7%. However since WHO was receiving an 8% budget space increase, the total allocation to SEARO for PB 2016–2017 showed an increase of US$ 25.1 million (or US$ 17.7
million in the base budget). Moreover, the decrease would be effected over three bienniums, so as to minimize any negative impact.

108. The Committee observed that allocation of budget space is aligned with the priorities of Member States and development partners, and requested that WHO country budgets be used to fund and sustain WHO country programmes effectively. In the same vein, the Committee observed that the Region may need more allocation due to the triple burden of diseases.

109. The Committee was informed about the criteria used to enable an increase in allocation for the Region. This was based on improvements to the earlier model that included DALYs (disability-adjusted life-years) and other factors such as density of population. The new model included better indicators such as poverty, headcount indices, gross national income, social indicators, etc. What emerged was a more robust model and a formula based on ALPS\_min (Adjusted Logarithm Population Square Root) that helped secure an adequate working budget for both the South-East Asia and Western Pacific Regions.

110. The Committee complimented India, Maldives and Thailand for their diligent efforts in conveying the concerns and priorities of the Region to the Working Group.

WHO reform (Agenda item 7)

Programmatic reform – focus on results
(Agenda item 7.1: Document number SEA/RC68/6)

111. The Committee acknowledged that programmatic reform to improve people’s health is one of the three broad areas of WHO Reform, and involves explicit priority setting and a strengthened delivery model. Aligning technical and financial resources concurrently is essential for the effective and efficient delivery of these priorities, as well as to avoid an overcommitted and overstretched Organization.

112. The Committee also agreed that programmatic reforms along with financing reforms would continue to strengthen the Organization’s planning, budgeting and financing cycles towards more effective and efficient delivery of needs-based outputs agreed upon by Member States while contributing to improved health outcomes for individuals.

113. The Committee observed that programmatic reform ensures linkages of WHO work plans to country and regional priority areas and helps produce concrete results in a timely manner. To this end, greater collaboration among Member States is
essential. The Committee urged WHO to hold more regular consultations with the ministries of health in Member States through the WHO representatives to ascertain country priorities.

114. The Committee also observed that explicit priority setting, aligning technical and financial resources, and timely delivery would make outputs and deliverables more efficient. An accurate identification of priorities in consultation with WHO offices in Member States will ensure more meaningful cooperation between WHO and country offices.

115. The Committee also appreciated the emphasis on results-orientation and the measurement of deliverables and outputs and not just on inputs and activities. Planned allocation of resources can increase predictability of funding. The Committee urged that the lessons learnt from the Ebola Virus Disease outbreak in 2014–2015 be applied and local capacity-building and health systems strengthening be prioritized.

116. The Committee drew attention to emerging priorities in some countries in line with the post-2015 development agenda, which include antimicrobial resistance, ageing and mental health. While global priorities must continue to be reflected, equal or more weightage should be given to country and regional priorities. It was reiterated that programmatic reform stresses on measurable deliverables in all seven regional flagship areas, and hence delivery mechanisms in countries must be strengthened over a cross-section of areas.

117. The Committee also acknowledged that programmatic reform involves a robust reporting process on which country offices have to report on their outputs
in detail. A new approach on reporting of deliverables as part of both financial and programmatic reform is being prepared ahead of the Sixty-ninth World Health Assembly in 2016.

**Management reform – internal control framework**  
(*Agenda item 7.2: Document number SEA/RC68/7*)

118. Internal control framework is a part of WHO reform designed to provide reasonable assurance to WHO management regarding the achievement of objectives relating to operations, reporting and compliance. The key components and principles of the framework are: (i) internal environment; (ii) risk management; (iii) control activities; (iv) information and communication; and (v) monitoring.

119. The Committee noted that Member States appreciated the initiation of the reform process in the Regional Office with the key objective of building an Organization that was more effective, efficient, equitable, transparent and accountable, and enhance its credibility. Management reform was a continuous process subject to further refinement and improvement.

120. The Committee agreed that it was an evolving process and there were programmatic, governance and management reforms; however, specific activities and implications at the country level needed to be spelt out appropriately.

121. The Committee was informed that the Director, Department of Compliance, Risk Management and Ethics at WHO headquarters met WHO representatives, administrative officers and department directors to brief them on the risk register,
managerial self-assessment and other operational components of the internal control framework (ICF).

122. The Committee appreciated the application of the GMG audit site, where both internal and external audit recommendations could be viewed and responses identified. A web portal on implementation and resource allocation information had also been launched.

123. The Committee was informed that WHO would ensure effective, systematic and coordinated implementation of ICF in the countries.

124. The Committee noted that the recommendations of the administrative review missions to Indonesia, Nepal and Myanmar were being implemented. The queries raised during these missions were used as learning opportunities for regional and country office staff to understand how some of the new governance systems worked.

125. The Committee was informed that the Department of Compliance, Risk Management and Ethics at WHO headquarters was preparing some basic courses for all WHO staff. At the regional level, hands-on courses on risk management and managerial self-assessment were being rolled out. Such training would be integrated into the administrative processes of the Organization.

126. The Committee appreciated that management dashboards had been developed to monitor implementation performance based on budget, planning and financing, and summarize data at the regional and Budget Centre for presentation in innovative and flexible ways. The Committee urged that the Global Management System be
strengthened to capture monitoring of programmatic results of WHO collaborative activities including those funded by voluntary contributions.

127. The Committee was apprised of the importance of ensuring good planning and implementation of funds that, coupled with streamlining of processes, would result in more efficient and transparent delivery in line with managerial reform. Staff development and learning funds at the Regional Office would be used to build capacity of staff to comply with the rules of the Organization and spend wisely.

128. The recommendations of HLP for actions by WHO and Member States were noted and approved.

**Governance reform (Agenda item 7.3: Document number SEA/RC68/8)**

129. Governance reform was one of the three pillars of WHO Reform. However, unlike programmatic and managerial reform areas, governance reform had seen slower progress towards implementation of its activities due to the more complex nature of stakeholder interests.

130. An open-ended working group on governance reform had been established at the global level with priority to establish and expedite governance reform throughout the Organization, especially in regard to the (i) working methods of the governing bodies and (ii) alignment of governance across the three levels of WHO. India and Thailand represented the South-East Asia Region in this working group. Member States were encouraged to share their perspectives with them so that these may be communicated to the larger working group.
131. The Committee noted the challenges to governance reform and suggested that the process needed to be accelerated. It commended the Regional Office for the work done at the regional level including revised protocol for election of the WHO Regional Director, harmonizing methods of working of governing bodies across the three levels of the Organization, framework of engagement with non-State actors, simplifying the process of verifying credentials, and implementation of paperless meetings. It stressed that putting robust mechanisms in place to focus on transparency and accountability would enhance the credibility of the Organization.

132. The Committee requested that more attention be paid to recruiting experienced and knowledgeable WHO staff in the countries who could transfer knowledge and help in capacity-building.

133. The recommendations of HLP for actions by WHO and Member States were noted and approved.

**Framework of engagement with non-State actors**  
*Agenda item 7.4: Document number SEA/RC68/9*

134. As part of WHO Reform, the governing bodies requested the Director-General to develop an overarching framework as well as separate policies on WHO’s engagement with different groups of non-State actors.

135. The Secretariat submitted a draft framework for engagement with non-State actors to the Sixty-seventh World Health Assembly, which decided that it be discussed by regional committees and the revised draft submitted to the Sixty-eighth World Health Assembly through the Executive Board.

136. As recommended by the High-level Preparatory Meeting for the Regional Committee, an intersessional meeting of all Member States was convened from 24 to 25 August in Colombo, Sri Lanka, to further discuss the draft framework of engagement with non-State actors with an objective of reaching a regional one-voice position on selected issues. The report of this meeting, together with the proposed regional position on the draft framework, was submitted to the Committee for its consideration.

137. The Committee emphasized the importance of the draft framework, as Member States wished to see WHO work in accordance with its mandate, without in any way compromising its intergovernmental nature, or its integrity and objectivity.
138. The Committee noted the progress made by Member States of the South-East Asia Region in negotiating a common position on issues likely to affect the integrity and objectivity of WHO, such as secondments from the non-State actors and more transparent process of due diligence, which included electronic access to a summary report on due diligence.

139. The Committee further noted that it was important to engage with non-State actors in order to mobilize resources for health development in the Region. It was therefore necessary to have one regional voice on the various issues raised in the draft framework.

140. The Committee observed that engagement with non-State actors must be demonstrated to be beneficial to health development in the Region and conform to the mandate of WHO. The fundamental terms of engagement are already set out in the WHO Constitution.

141. The Committee noted that the revised framework document would need further discussion among Member States on some controversial issues such as the principle of “arm’s length” that needed more clarity for its practical application in real-life situations. The applicability of the provisions of private sector policy to non-private sector entities and the pooling mechanism for contributions from multiple sources also required clarification.
142. While the Committee agreed that there should be no engagement in any manner with tobacco and arms industries and their affiliates, a mechanism for screening and identifying such affiliates was required.

143. The Committee noted with serious concern the contentious issues raised by some Member States including the proposed deletion of clauses on accreditation of NGOs and making immediately widely available the final product under product development agreements to low- and middle-income countries at a preferential price for clinical trials arranged by WHO.

144. The Committee noted that substantial progress was made on many contentious issues at the Sri Lanka meeting on 24–25 August 2015 and that an agreement was reached on almost all issues except a few. However, it was noted that it may be difficult to have a common regional position on all issues. There are many issues where it might be more appropriate for countries to make their point at the global meeting since it is a work in progress.

Ministerial Round Table (Agenda item 14)

Strengthening health workforce in South-East Asia in order to expand delivery of effective services (Agenda item 14.1: Document number SEA/RC68/26)

145. The Ministerial Round Table on “Strengthening the health workforce in South-East Asia in order to expand the delivery of effective services” was moderated by Her Excellency Iruthisham Adam, Minister of Health, the Maldives. Dr Poonam Khetrapal Singh, Regional Director, WHO South-East Asia Region began the session by noting that this topic is a concern of all Ministers in the Region, and the Decade of Strengthening Human Resources for Health (HRH) was launched in December 2014 to accelerate progress. The moderator noted that achieving universal health coverage means that all individuals receive the services they need without suffering financial hardship, and health services cannot be delivered without health workers. Health ministers then provided their perspectives on progress being made, on the major obstacles encountered and on opportunities for accelerating progress.
146. All speakers agreed that a strong health workforce is a crucial element in advancing health care in the Region. While country situations differ widely, and some still have major shortages of health workers, in all countries shifts in demography and the rise in noncommunicable diseases are providing new service delivery challenges to which HRH must be able to respond. It was also noted that there is an explicit target related to the health workforce in the Sustainable Development Goal related to health.

147. Several common themes emerged during the discussion. In countries with shortages, several examples were given of successful strategies to increase numbers of health workers. The need for “balanced growth” i.e. thinking beyond just doctors and nurses to other types of health workers was emphasized. The value of implementing the Global Code of Practice on International Recruitment was noted. A second theme was around health workforce education, with examples of approaches to transform basic training and encourage more systematic and continuous professional development. Examples were also given of team-based models for delivering more integrated primary care, which require health workers to develop new ways of working. Many strategies for addressing the long-standing issue of retaining health-care workers in rural and/or remote areas were presented. These reflected the need for an intersectoral approach and include housing, child education, compulsory placement, career and financial incentives, and in-service training – where ICT is providing new opportunities. The need to improve the quality of health worker performance was also stressed, with approaches including quality-
control programmes and in-service training. There was repeated mention of the need for better health workforce data, better evidence for policy, and more systematic exchange of experience among countries addressing health workforce challenges.

148. In conclusion, it was noted that there is progress but still much more to do: globally 400 million people still do not have access to one or more essential health services. Human resources for health are key to the achievement of universal health coverage and health development in general.

Policy and technical topics (Agenda item 8)

Response to emergencies and outbreaks
(Agenda item 8.1: Document number SEA/RC68/10)

149. The screening of a video opened the session, outlining the response of the Regional Office and partner organizations to the 2015 earthquake in Nepal. The Committee noted the range of activities undertaken by the Government of Nepal, which included coordinating the work of around 150 foreign medical teams and 47 national medical teams. The film also emphasized what needs to be done before, during and after a disaster, with Nepal’s experience as the case study. The Government of Nepal conveyed its thanks for the assistance received, especially from other SEAR Member States, during this disaster.

150. The Committee noted the vulnerabilities of Member States to a range of hazards, including emerging infectious diseases and natural events as well as unnatural and technological emergencies. It was noted that both natural and unnatural events present a serious threat to nations, with the countries of South-East Asia particularly prone to such events. Capacity development needs as set out in the 2005 International Health Regulations (IHR 2005) and in SEAR Benchmarks for Preparedness and Response highlighted the gaps that exist in different countries. Nevertheless, all Member States were committed to becoming compliant with IHR core capacity requirements by 2016 and had established national disaster management authorities in which ministries of health actively coordinate key health sector actors before, during and after emergencies. The Region also has a WHO Collaborating Centre for Disaster Risk Reduction Research and Training in Indonesia.

151. The Committee noted the increasing emergence of epidemic diseases in the Region. Despite ongoing capacity-building efforts and surveillance and response strengthening activities in countries, gaps remain in addressing communicable disease outbreaks. There was broad recognition of the need for sensitive surveillance and other detection systems that would allow for a rapid response to emerging disease threats.
152. The Committee expressed appreciation for the support provided by the Regional Office during all recent emergencies and disease outbreaks. Countries stood ready to share their experiences and provide support as required as part of moving towards more coordinated and effective preparedness and response capabilities at the regional level. As part of this, the provision of intercountry medical support would remain a key element in response activities. A number of Member States provided examples of the recent provision of support to other countries of the Region and set out the specific activities now under way at the national level to put in place the required capacities and expertise needed to achieve compliance with the requirements of IHR 2005. The improved documentation of experiences and the more systematic harnessing of the various capacities that currently exist in countries would allow for a more collective regional capacity for emergency risk management for health. The Committee supported the recommendations of the High-Level Preparatory meeting, which called for Member States to invest further in capacity development using both IHR and SEAR benchmarks, and for WHO-SEARO to scale up its support for such efforts, including through improved documentation of the important lessons learnt during recent response efforts. Reference was also made to the Sendai Framework for Disaster Risk Reduction (2015–2030), which has a public health focus recommending to Member States to set up resilient health systems to address events from all hazards. With the regional flagship programme in scaling up capacities in emergency risk management, countries in the South-East Asia Region are well positioned to improve further investments in prevention and preparedness for various emergencies by reducing risks, especially for health.

153. The Committee was provided with a presentation on the WHO emergency reform process and of the intended timeframe for key stages. Each of the following
six process components had been designed to improve the capacity of WHO to provide support to countries during emergencies: (i) a unified WHO Programme for outbreaks and emergencies; (ii) IHR 2005 core capacities to be developed as an integral part of resilient health systems; (iii) establishment of a global health emergency workforce; (iv) improved functioning of IHR 2005; (v) an accelerated programme of research and development in relation to epidemics and other emergencies; and (vi) establishment of a WHO Contingency Fund for Emergencies. This process will be informed through various global mechanisms and its delivery overseen by a WHO project management team at headquarters. Regular updates were being provided on the WHO website with a formal progress report to the Executive Board scheduled for January 2016.

154. Mr John M Pile, United Nations Population Fund, pointed out that 80% of world disasters occur in the Asia-Pacific region, with countries in the South-East Asia Region frequently and severely impacted by both natural and unnatural events. When disaster strikes, it is women and children who are most affected. In such situations, nothing is more important than ensuring access to basic health-care services, including those for maternal, newborn and child health, and for sexual and reproductive health. Reducing vulnerability and managing risks cannot be achieved without empowering women, girls and youth, and addressing their needs and vulnerabilities during emergencies. UNFPA is encouraged that the Sendai Global Framework for Disaster Risk Reduction puts health at the centre of disaster risk management, and affirms its commitment to support government efforts in the Region to integrate disaster risk reduction into the health sector.

155. The Regional Director thanked the Committee for its supportive comments during the discussion and said the high degree of integration of health aspects into the Sendai Global Framework for Disaster Risk Reduction was a welcome development, as was the significantly increased emergency response capacities put in place in countries following the 2004 tsunami. The Committee was also informed that since the inception in 2008 of SEAHREF, financial support had been provided to 25 disaster response efforts in the Region. WHO-SEARO will continue to ensure that countries in the Region are well placed to further strengthen both national and regional emergency prevention and preparedness capacities.

156. The Committee adopted resolution SEA/RC68/R2 “Response to Emergencies and Outbreaks”.

157. The Committee noted that, in accordance with World Health Assembly resolution WHA68.7, almost all countries in the Region had initiated formulation of the National Action Plan for antimicrobial resistance (AMR) and nominated a focal point for AMR. It was informed that the Regional Office was prepared to provide any technical support required including services of experts from its Roster.

158. The Committee noted that advocacy at the highest level was required to implement a national plan on AMR. The Regional Director had named AMR as one of the “flagship” programmes for the Regional Office, and spared no opportunity to raise the issue at national and international meetings. Furthermore, an “Antibiotic Awareness Week” during 16–22 November had been designated, and countries were urged to adapt and translate the WHO material for that week into local languages.

159. In response to reports from countries of insufficient laboratory capacity for detecting AMR, the Committee was informed that the Regional Office has been organizing training programmes in laboratory techniques on an annual basis and is striving to establish a regional laboratory network. The regional monitoring system on use of antibiotics needs to be set up, and WHO shall provide assistance in building national capacity.

160. The Committee noted that several platforms had been made available for sharing best practices, including a meeting in Jaipur in November 2014. Similar
meetings are planned in the future. The Committee was assured that AMR would be further discussed in subsequent meetings of the Regional Committee.

161. The Committee was informed that a tripartite agreement exists between WHO, the Food and Agriculture Organization of the United Nations (FAO) and the World Organisation for Animal Health (OIE) to apply the “one health” policy, which covered the use of antibiotics in both humans and animals and in agriculture.

162. Ms Alison Macintyre, WaterAid, noted that resolution WHA68.7 emphasized “prevention first”, highlighting the benefits of good sanitation, hygiene and infection prevention as cost-effective means to reduce AMR. She recalled that a recent WHO report on water, sanitation and hygiene (WASH) stated that almost one fourth of health-care facilities in six countries in the Region for which data were available did not have access to water. She urged Member States to ensure universal access to WASH in households, health care facilities and schools; to invest in better sanitation, including wastewater management systems; and to enforce WHO’s essential environmental health standards in health-care facilities.

163. The committee adopted resolution SEA/RC68/R3 “Antimicrobial Resistance”.

Selected neglected tropical diseases targeted for elimination: kala-azar, leprosy, yaws, filariasis and schistosomiasis (Agenda item 8.3: Document number SEA/RC68/12)

164. The Committee noted that the five diseases being targeted were associated with poverty; therefore, their elimination would also be associated with development. One of the reasons for targeting these diseases in a flagship programme was their circumscribed distribution and the feasibility of eliminating them.

165. Although all Member States of the Region had eliminated leprosy at the national level in 2010, new cases were occurring. Last year, 155 000 cases were reported from the Region with one country reporting more than 100 000 cases. Six Member States from the Region have reported more than 1000 cases in a year. The Committee was reminded that the global programme against leprosy was the only global programme that had been given to a regional office, because of the huge burden mainly carried by two countries in the Region.

166. The Committee recalled that the global target for elimination of lymphatic filariasis was 2020. The Region is on track to achieve this by maintaining the current tempo. Research should be conducted to determine the reason for resurgence in two areas in Sri Lanka, and surveillance should be strengthened.
167. With regard to kala-azar, the Committee was informed that elimination of kala-azar as a public health problem before 2017 was also on track. Once achieved, a joint assessment would be made to confirm elimination of this disease in the Region in 2017. The disease was endemic in only three countries, with sporadic cases in two others. A new, single-dose drug had been developed, which is being made available free of cost by WHO to all affected countries in the Region.

168. The Committee learnt that yaws was endemic in two countries but that elimination appeared to be feasible. Schistosomiasis had been found in only two small foci in one country and can be targeted for elimination.

169. The Committee referred to the problem of dengue, which was the fastest-spreading viral vector-borne disease in the world, due to environmental changes, including climate change. There was no vaccine against the disease and no drug for treating it; the only possible solution was to reduce the vectors through proper water management.

170. The Committee also raised the problem of snakebite and was informed that the Regional Office organized a rapid shipment of anti-venom serum following the earthquake in Nepal.

171. Ms Alison Macintyre, WaterAid, recalled that the WHO global action plan called on people involved in WASH and those working on neglected tropical diseases (NTDs) to cooperate to achieve NTD control and elimination targets. Adequate WASH
was not only essential in reducing transmission of these diseases but also facilitated appropriate disease management and the prevention of disability.

**Adapting and implementing the End TB Strategy in WHO South-East Asia Region (Agenda item 8.4: Document number SEA/RC68/13)**

172. The Committee agreed that TB would have to stay high on national agendas if the epidemic was to be stopped, especially of the drug-resistant forms (MDR- and XDR-TB). It was noted that standard diagnostic tests were time-consuming and that rapid diagnostic tests should be developed especially for use in remote areas.

173. Management of drug-resistant TB was both financially and administratively complex. Cases of coinfection of TB with HIV added to the complications. The Committee was informed that guidance on treatment of comorbidities in TB had been drafted by a WHO collaborating centre and would soon be available.

174. The Committee expressed concern at the lack of laboratory diagnostic facilities in some countries, which resulted in delays in treatment when samples had to be sent out of the country for examination. The Committee was informed that WHO could send an expert to assess the requirements of countries and advise on setting up a diagnostic facility.

175. The Committee was further informed that seven new diagnostic methods were in various stages of development and would be available soon; and two new drugs had been licensed. Although research was being conducted to find a vaccine, one would not be available for many years.
176. The Committee recognized the financial burden caused by TB. Most countries in the Region were experiencing an over 5% increase in gross domestic product; therefore, investment in TB control could be increased. The continuing high TB burden in the Region, in spite of economic prosperity and technological achievements, called for innovation and investment in new diagnostics, drug development and vaccine initiatives. An investment case should be prepared, as for other diseases. The technical expert working group on TB was being reconstituted to serve as an advisory group. Countries should work together to prepare an operational plan for TB control at the district and subdistrict levels, with electronic monitoring, ensuring quality in both the public and the private sector. High-level commitment was needed to create a sense of urgency for reaching the End TB milestones on time, reaching the people left behind and mobilizing domestic financial resources.

**Patient safety contributing to sustainable universal health coverage**
*(Agenda item 8.5: Document number SEA/RC68/14 and Rev.1)*

177. The Committee acknowledged that health services are not as safe as they could be. Patient safety has become a key concern of modern health care, because as interventions have become more complex, patients are at higher risk of medical errors. Global evidence suggests that one in ten hospital patients experiences an adverse event, and 20–40% of health spending is wasted due to poor quality care. There are compelling health and economic arguments for improving patient safety.

178. The Committee recognized that patient safety is one of the key entry points for health-care quality improvement to support universal health coverage (UHC). Moreover, patient safety has to be addressed systematically, if countries are to make sustained progress towards UHC. The Committee noted examples given by Member States of action such as accreditation; infection prevention and control; better waste management; quality initiatives; inclusion of patient safety in basic training curricula; and protocols and guidelines for people-centred care that are being taken to improve patient safety in both hospitals and ambulatory care. But the Committee also recognized that many barriers remain.

179. The Committee noted the recommendations of the HLP meeting outlining actions to improve patient safety to contribute to sustainable UHC in the South-East Asia Region. It reinforced the message that more action is required by a range of stakeholders including the patients themselves, to create a culture of patient safety. It endorsed new regional strategy for patient safety 2016–2025, and the need for structured self-assessments of patient safety systems, better data on patient safety and improved documentation and cross-country exchange of experience.
180. Ms Alison Macintyre of WaterAid informed the Committee that WaterAid welcomed the recently developed Regional Strategy for Patient Safety and fully supported the six strategic objectives outlined. She provided some additional suggestions to support improved water and sanitation in health facilities.

181. The Committee adopted resolution SEA/RC68/R4 “Patient Safety Contributing to Sustainable Universal Health Coverage”.

**Prevention and control of cancer – the way forward (Agenda item 8.6: Document number SEA/RC68/15)**

182. The Regional Committee noted that cancer was one of the four major NCDs and a cause of high morbidity and mortality in all Member States. Health care costs associated with cancer diagnosis and treatment consume huge proportions of national budgets. Cancer was not only a health issue but a social, economic and development issue. The Committee recognized that the global and regional voluntary target of a 25% relative reduction in premature mortality from NCDs by 2025 could not be achieved without a substantial reduction in cancer mortality.

183. Despite many challenges, Member States have taken important steps towards the prevention and control of cancer in their multisectoral plans for the prevention and control of NCDs. These include adopting policies to prevent risk factors for cancer such as tobacco use, physical inactivity, unhealthy diet and the harmful use of alcohol. Also hepatitis B vaccination is a part of the national immunization programme for infants in all countries and vaccination for human papilloma virus (HPV) has been introduced in some countries. Action has been taken to reduce
exposure to environmental and occupational carcinogens, particularly agrochemical insecticides and asbestos, among others.

184. HPV vaccination within a comprehensive cancer control programme is an evidence-based, recommended intervention for the prevention and control of cervical cancer, one the most common cancers in the Region. The high cost of the vaccine is, however, a major barrier. Strategies to introduce HPV vaccination should include an assessment of the programmatic and economic feasibility of such programmes on a pilot scale in the country context.

185. The Committee noted that up to 80% of cancers in the Region were detected at an advanced stage, increasing patient suffering and reducing their potential for survival. Common cancers, such as of the oral cavity, breast and cervix, could be detected early, with high cure rates. Member States reported that they had initiated screening for these common cancers at the primary care level. The provision of pain relief and palliative care was considered an urgent humanitarian need.

186. The Committee noted that Member States had limited technology and human resources for the diagnosis and treatment of cancer, and WHO support was requested to build the capacity of various cadres of health workers to deliver cancer prevention, diagnosis, treatment and palliative care services. Communities and civil society could be involved in a range of cancer prevention and control services.

187. Financial resources for cancer prevention and control remained limited. Innovative financing by taxation of tobacco and other unhealthy products could be used for cancer activities and at the same time reduce the consumption of those unhealthy products. Social insurance schemes were needed to overcome the catastrophic financial burden of cancer to individuals and families.
188. The Committee requested WHO to provide technical support for strengthening cancer registries and for training health workers in the prevention, early detection, treatment and palliative care for cancer. Regional and international cooperation was requested for advocacy to making cancer technologies, medicines and vaccines more affordable and accessible.

189. Strong political commitment and governance mechanisms were prerequisites for effective cancer prevention and control programmes. The Committee agreed that the way forward was to provide a continuum of services, from health promotion, prevention of risk factors, screening, early detection, advanced diagnosis and treatment and palliative care, at various levels of the health-care system.


Progress reports on selected Regional Committee resolutions (Agenda item 9: SEA/RC68/16 and Add.1)

191. The attention of the Committee was drawn to the six progress reports on Regional Committee resolutions that were reviewed by the HLP meeting held in the Regional Office, New Delhi, India, during 29 June–2 July 2015. The recommendations made by the HLP on each of the above-mentioned progress reports as contained in document SEA/RC68/16 Add.1 were considered by the Regional Committee.

Measles elimination and rubella/CRS control in SEAR by 2020 (SEA/RC66/R5): (Agenda item 9.1)

192. The Committee was informed that measles elimination and rubella/CRS control by 2020 was a flagship priority area for the Regional Office.
193. The Committee agreed that in order to eliminate measles and successfully control rubella, efforts need to be made to achieve and maintain at least 95% population immunity with two doses against measles and rubella. This could be achieved through routine and supplementary immunization using a combination measles and rubella vaccine, and by developing and sustaining a sensitive and timely and integrated measles and rubella case-based laboratory-supported surveillance system, and surveillance for CRS.

194. The Committee noted that Member States were making good progress towards achieving the goal of measles elimination and rubella/CRS control by 2020 by making the best use of their health infrastructure and human resources with the support of UNICEF and WHO. Some of the critical factors for success included strong country ownership, high political commitment and creation of people’s demand.

195. The Committee observed that cross-border transmission of measles and rubella must be prevented by maintaining high immunization coverage and enhanced surveillance in border districts of Member States.

196. The Committee urged WHO to coordinate technical assistance including training, assessment and guidance, as well as capacity-building in Member States.

**Challenges in polio eradication (SEA/RC60/R8) (Agenda item 9.2)**

197. Noting with appreciation the high political commitment in Member States for polio eradication, the Committee cautioned against complacency and stressed the need to be vigilant.
198. The Committee noted that high-quality and sensitive AFP surveillance was being maintained to prevent any importation and spread of wild poliovirus. It noted with satisfaction that some countries also had emergency preparedness plans including screening of travellers to and from polio-endemic countries and areas with active polio transmission. The Committee noted that polio supplemental immunization activities were planned in some countries.

199. The Committee was informed that all Member States were on track to introduce IPV and that the Working Group of the Strategic Advisory Group of Experts on Immunization (SAGE) had recommended for decision by the SAGE at its meeting in October 2015, the switch from trivalent to bivalent oral polio vaccine in all countries in April 2016.

200. The Committee acknowledged the important role of WHO in providing technical support to vaccine manufacturers of developing countries and assistance to national regulatory authorities to monitor production licensing of relevant polio vaccines. It urged WHO to continue to provide support to Member States to ensure that appropriate vaccines for the switch are available in all countries.

Health intervention and technology assessment in support of universal health coverage (SEA/RC66/R4) (Agenda item 9.3)

201. The Committee recognized the critical role that health intervention and technology assessment (HITA) can play in providing evidence to inform policy and resource allocation decisions for Universal Health Coverage.

202. Several Member States provided the Committee with updates on national initiatives in this area. Although Member States were at different stages in the implementation of the approach, a number of studies had been undertaken; national programmes and committees had been established; workshops convened; and in some cases technical guidance developed.

203. Key issues that were raised included the need to build capacity for health technology assessments; improve health information systems; the role that health technology assessments can play in priority-setting; and their potential application in reducing prices and increasing quality in medicines procurement.

204. The Committee was informed of an upcoming meeting in Thailand and all Member States were invited to attend. The Prince Mahidol Award Conference will be held on 26–31 January 2016 on the theme of priority-setting for universal health coverage and health technology assessment.
205. WHO SEARO will continue to support countries in their efforts to make progress in this area.

South-East Asia Regional Health Emergency Fund (SEARHEF) (SEA/RC60/R7)
(Agenda item 9.4)

206. The Committee was informed that Indonesia is one of the countries most prone to natural disasters as it is located on four moving tectonic plates. In 2004, it experienced the huge tsunami caused by an earthquake measuring 8.9 on the Richter scale. The international cluster mechanism, which includes the health cluster, was activated by WHO after the earthquakes in Yogyakarta (2006) and West Sumatra (2009). WHO also mobilized resources from the Central Emergency Response Fund and SEARHEF to respond to the Yogyakarta earthquake and to the eruption of Mount Merapi in Yogyakarta (2010) and Mount Sinabung in North Sumatra (2014).

207. The Committee acknowledged that SEARHEF has been helpful for strengthening health service performance during emergencies, although the support should be extended until the early recovery phase. WHO funding should thus be adjusted to the country’s standards and reporting. Furthermore, the WHO internal emergency response framework should be implemented more effectively. In 2012, the Centre for Health Crisis of the Ministry of Health of Indonesia was designated the WHO Collaborating Centre for Training and Research on Disaster Risk Reduction, and various national and international activities were organized, with the support of the country office. The International Training Consortium for Disaster Risk Reduction will be held in October 2015.
The Committee noted that Bangladesh had benefited from SEARHEF after the devastating fire in Dhaka in 2010 that killed more than 100 people and injured many more. SEARHEF funds were used to procure blood products and emergency medicines to treat severe burns and to strengthen the Burns and Plastic Surgery unit of Dhaka Medical College Hospital. The country is ranked as the worst victim of climate change, with increasingly severe cyclones, floods and fires. Many districts are currently experiencing floods, and Bangladesh looked forward to support from the Regional Office should the need arise. Similarly, Myanmar also benefited from SEARHEF during cyclone Nargis and the recent floods.

**Effective management of medicines (SEA/RC66/R7) (Agenda item 9.5)**

209. The Committee welcomed the progress report on effective management of medicines. Examples were provided of actions being taken to improve medicines management, and ensure their safety, quality, efficacy and rational use through a range of measures including: medicines policy; related regulations; regular updates of the Essential Medicines list; creation of a specific unit to promote rational use of medicines; streamlined procurement; use of health technology assessment to support evidence-based procurement and price negotiation; introduction of an electronic logistic system; and enhanced monitoring and evaluation. The useful role of the medicines situation analysis was recognized, with joint advance preparation needed to ensure that it reflects local geographical characteristics. Multi-country pooled procurement was mentioned as one possible way to negotiate lower prices on medicines.

**Regional strategy on health information systems (SEA/RC63/R7) (Agenda item 9.6)**

210. The Committee recognized the many efforts in the Region to strengthen health information systems (HIS) in line with the Regional Strategy, and noted that strong HIS are needed for evidence-based policy; planning programmes; and better patient care. Specific examples were provided of progress by Member States in strengthening routine health information systems, including hospital information systems, civil registration and vital statistics; and the increasing use of modern information and communication technologies (ICT) from the local to the national levels.

211. The need for an integrated HIS approach was emphasized, creating HIS that can link data from different sources and serve national, regional and global reporting and monitoring requirements. The Committee was provided with examples of ways to overcome persistent challenges to building integrated HIS, including new rules and regulations; of making HIS part of the national data coordinated by one ministry;
developing strategic plans that can be supported by multiple partners; and with strong political commitment.

212. The Committee requested WHO to continue to provide technical support to Member States in HIS, including the simplified version of ICD-10 (International Classification of Diseases), CRVS (civil registration and vital statistics systems) and eHealth strengthening. The value of support from regional networks on health information systems, such as the Asia eHealth Information Network (AeHIN) of which some Member States were a part, was emphasized. Such networks play an important role in sharing knowledge for strengthening information technologies and collaborating to build technical capacity, it was observed.

**Ministerial Round Table (Agenda item 14)**

**Health in the post-2015 development agenda (Agenda item 14.2)**

213. The Ministerial Round Table was moderated by His Excellency Dr Rajitha Senaratne, Minister of Health, Nutrition and Indigenous Medicine, Sri Lanka. Dr Marie-Paul Kieny, Assistant Director-General, Health Systems and Innovation, presented an update on the development of the Sustainable Development Goals (SDGs). She highlighted that this has been a Member State-led process; that the 17 SDGs are relevant to all countries; are more ambitious than the Millennium Development Goals, and that health is well placed. The Declaration on the SDGs has been pre-endorsed by Member States and will be adopted at a United Nations Summit in New York in two weeks’ time.
214. The single health goal is broad (to “ensure healthy lives and promote well-being for all at all ages”). It covers (i) the unfinished MDG agenda; (ii) health systems and universal health coverage (UHC); (iii) noncommunicable disease and injuries; and (iv) social determinants of health including pollution. The synergies between these categories and with the Regional Director’s seven flagships were noted as was the fact that health is also part of the SDGs. On financing, the main message was that the debate has shifted from development assistance alone to financing for sustainable development from both domestic and external resources. The SDG monitoring framework is to be finalized in March 2016, and indicators for the health SDG are more advanced than for many other goals.

215. The Committee then provided its perspectives. Member States reflected on past progress on the MDGs, and agreed that the health SDG and its 13 targets reflect well the current and future critical health challenges in South-East Asia. Several commented that the SDGs will both foster and require a more integrated approach to health development, which is challenging but necessary. Progress on UHC will be central to achieving the health SDG. Strong political will, improved governance and accountability, and greater collaboration within and between SEA Region countries will be needed to reach the new SDG health targets. Several indicated that SDG health targets are already being incorporated into new national health plans. On financing, big ambitions will require big investment in health systems and sound financing frameworks. There were many comments on the proposed SDG monitoring framework – on the need for indicators to be valid; for the reporting process not to be too burdensome; on indicators that have been excluded; and on the need for comprehensive national information systems. There were several calls for WHO support, especially on strengthening national health information systems.

216. The Committee concluded that the SDGs will be with us for 15 years. Good governance and strong political will are paramount for making progress on them. Greater investment in health and cross-sectoral collaboration will be essential. WHO is ready to support all aspects of implementation, especially information system strengthening.

Technical Discussions
(Agenda item 10: Document number SEA/RC68/8)

Consideration of the recommendations on strengthening community-based health-care services (Agenda item 10.1: Document number SEA/RC68/17 and Inf. Doc. 1)

217. The Committee was presented with the report from the Technical Discussions held in June 2015, and the main messages and recommendations were outlined.
218. The Committee welcomed the report and supported its recommendations. It noted the crucial importance of community-based health-care services in achieving universal health coverage in the context of evolving health care challenges in the Region, such as the rise in noncommunicable diseases (NCDs) and ageing populations, and also their role in disasters.

219. Member States reiterated the key roles played by community-based health-care services in their countries and outlined a range of different service delivery approaches. The opportunities now offered by new communication technologies were noted, as were the varied types of health workers involved in delivering community-based services, from voluntary health workers to salaried professionals. In several countries, voluntary health workers still play a vital role, especially in rural and remote areas, and the Committee noted that hard-to-reach populations also exist in urban areas. Examples were given of changes in the range of services being offered in the community in response to changing health needs – services such as the prevention and management of NCDs, palliative care and rehabilitation. There is a need to develop the competencies of community-based health workers in intersectoral action and coordination as these are needed to address major health transitions such as ageing populations.

220. The Committee called upon WHO to continue to support countries in these efforts. This included the development of guidance on the range of services that can be provided in the community and on the resources and skills needed to deliver them. There was a request for holistic assessment of existing services to help develop recommendations on how they need to be adapted to respond to changing needs.
221. The Committee noted the need for more systematic sharing of national experience, and research into the role, models and costs of community-based health care within the health system. The Committee therefore fully supported the recommendations from the technical consultation of June 2015 as well as the additional comments from the High-Level Preparatory Meeting.

222. The Regional Director thanked all Member States for their positive comments and for sharing the rich experiences of implementing community-based health-care services. She reiterated that community-based services are the way forward for addressing NCDs and emphasized the need for looking at community-based services as a whole. She highlighted a number of successful approaches already under way in the Region. The Regional Director also stressed the importance of remaining mindful of the burdens placed upon community health care workers, particularly as countries look to expand their role and range of responsibilities in order to increase health service access. In addition to reaching remote populations, the health needs of migrant and other communities also need to be considered. She emphasized that in determining national approaches to make community-based services “fit for purpose”, there was a need to consider how to use existing data better, and that more sharing of information and tapping into the wealth of experience across countries in the Region was needed.

223. The Committee adopted resolution SEA/RC68/R6 “Community-Based Health Services and their Contributions to Universal Health Coverage”.

Selection of a subject for the Technical Discussions to be held prior to the Sixty-ninth Session of the Regional Committee
(Agenda item 10.2: Document number SEA/RC68/18)

224. The Committee was briefed about the discussions of the High-Level Preparatory Meeting held in the Regional Office, New Delhi, on 29 June–2 July 2015 to identify a topic for the Technical Discussions to be held prior to the Sixty-ninth Session of the Regional Committee in 2016.

225. The Committee reached consensus that the Technical Discussions should be discontinued and that the topics would instead be discussed at the Ministerial Round Tables during the Regional Committee sessions. It was proposed that the Round Tables be made more interactive, with exchange of views and experience, rather than the delivery of prepared statements. For that purpose, it was agreed that each round table should have an experienced moderator, who was well versed in the topic and familiar with WHO practice. The round tables should be conducted in closed sessions so that ministers would feel free to express themselves.
226. The Committee agreed that there should be two round tables at each session of the Regional Committee, held on consecutive days.

227. The topic of one of the round tables should be proposed by the country hosting the session, as had been done at the present session, for which Timor-Leste had proposed “Accelerating implementation of the WHO FCTC in SEAR”. The topic of the other round table would be decided by the Regional Director after meetings with health ministers at various venues, including the World Health Assembly. The topics would have to be chosen in time to invite a moderator with expert knowledge in the field. The topics proposed by the Committee were “Ending preventable maternal, newborn and child mortality” and “Air pollution”.

228. The Committee proposed that the two resolutions on Technical Discussions (SEA/RC5/R3 and SEA/RC7/R11) be “sunsetted”.

**Governing body matters (Agenda item 11)**

**Key issues arising out of the Sixty-eighth World Health Assembly and the 136th and 137th Sessions of the WHO Executive Board (Agenda item 11.1: Document number SEA/RC68/19 and Add.1)**

229. The Committee noted the significant and relevant resolutions from the perspective of the South-East Asia Region adopted by the Sixty-eighth World Health Assembly and the 136th and 137th 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.

230. The Regional Committee considered the addendum to the main working paper (SEA/RC68/19) containing the concise write-up on all resolutions on technical matters of the Sixty-eighth World Health Assembly and noted it.

231. The Committee noted that there were extensive discussions during the Sixty-seventh and Sixty-eighth World Health Assemblies on infant and child nutrition. The Rome Declaration on Nutrition and Framework for Action adopted at the Second International Conference on Nutrition recommended a series of policies and programmes across the health, food and agriculture sectors to address malnutrition, as well as a set of indicators to measure nutrition among mothers, babies and young children.
232. The Committee was informed that there was a need to develop a regional nutrition strategy 2016–2030 with facilitation from WHO, so that this issue could be discussed at the Sixty-ninth Session of the Regional Committee.

Review of the Draft Provisional Agenda of the 138th Session of the WHO Executive Board (Agenda item 11.2: Document number SEA/RC68/20)

233. The Committee was informed that the 138th Session of the WHO Executive Board will be held at WHO headquarters in Geneva on 25–30 January 2016. Any proposal from a Member State or Associate Member to include an item on the Agenda should reach the Director-General no 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. Any proposal should, therefore, reach the Director-General by 10 September 2015.

234. Following its noting by the High-Level Preparatory Meeting, the Draft Provisional Agenda of the 138th Session of the WHO Executive Board was placed before the Committee for its review, comment and noting as appropriate.

235. A proposal made by India to include “Follow-up of Consultative Expert Working Group” as an agenda item for the 138th Session of the WHO Executive Board was endorsed by the Regional Committee. India requested that the WHO Secretariat communicate this proposal to the Director-General on behalf of the Committee. This was done, and a receipt of the message was confirmed by the Director-General’s Office.

Review of Regional Committee resolutions (Agenda item 11.3: Document number SEA/RC68/21)

236. The Regional Committee was informed that the High-Level Preparatory Meeting reviewed working paper SEA/RC68/21 to explore ways to phase out some of the resolutions adopted by it for the last 10 years, which would result in efficiently utilizing the time of the Regional Committee in future sessions.

237. The Committee noted that an informal working group consisting of Bangladesh, India and Thailand would study actions taken by the Eastern Mediterranean and European Regions in this regard.

238. The Committee was informed that a technical consultation would be organized before the next HLP meeting with the participation of all Member States to decide on a set of criteria and timeframe for phasing out resolutions that have outlived their relevance. The recommendations of this consultation would be submitted to the Sixty-ninth Session of the Regional Committee for its consideration.
Elective posts for governing body meetings (WHA, EB and PBAC)
(*Agenda item 11.4: Document number SEA/RC68/22*)

239. The Committee noted the elective posts in the WHO governing bodies – World Health Assembly, Executive Board and the Programme Budget and Administrative Committee – that are due to be filled by Member States of the South-East Asia Region. For the Sixty-ninth World Health Assembly, the posts of Vice-President, Chairman of Committee B, Rapporteur of Committee A and Member of the Committee on Credentials are available to be filled on rotational basis.

240. The Committee proposed Timor-Leste for the post of Vice-President; Thailand for the post of Chairman of Committee B; Maldives for Rapporteur of Committee A; and India for Member, Committee on Credentials.

241. The proposal was unanimously accepted.

242. The Committee also observed that for the 139th Executive Board, the posts of Member and Vice-Chair were vacant for Member States of the SEA Region. It was proposed that Bhutan be nominated as Executive Board member in place of Democratic People’s Republic of Korea whose term ends in May 2016, and Nepal be nominated as Vice-Chair of the 139th Executive Board in May 2016.

243. The proposals were unanimously accepted by the Committee.

244. Two Member States, Nepal and Thailand, are current members of the Programme Budget and Administrative Committee (PBAC), with their terms of membership due to expire in May 2016 and May 2017 respectively. The Committee nominated Bhutan as member of the PBAC for a term of two years in place of Nepal whose term expires in May 2016.

Management and governance matters (*Agenda item 12*)

Status of SEA Regional Office building
(*Agenda item 12.1: Document number SEA/RC67/23*)

245. The Committee was informed that the buildings housing the WHO Regional Office for South-East Asia in New Delhi, India, are now more than 50 years old necessitating greater investments to maintain the property fit for the purpose.

246. The results of two seismic vulnerability studies of the campus buildings in 2001 and 2010 independently agreed that in their current condition, the buildings present certain concerns in the event of seismic activity – particularly during the monsoon season when the ground water table is high. The situation is exacerbated by the ground conditions of the site and the seismic vulnerability of the Delhi area in general.
247. The Committee was also informed that the cost of reinforcing or retrofitting the annexe buildings is not economically viable. The long, thin footprint of these buildings, combined with an unorthodox foundation and structural design, puts in question the ultimate success of any reinforcement programme.

248. The Committee was informed that in collaboration with the Ministry of Health and Family Welfare of the Government of India, the Secretariat has invited the Central Public Works Department (CPWD) to perform a comprehensive study of the buildings and ground conditions. With this information, a better informed decision may be taken as to whether it is appropriate and more financially viable to also demolish the main block and rebuild. The new report on the condition of the campus will be presented to Member States incorporating the findings of the CPWD assessment in due course.

249. The Committee took note of the report.

**Special Programmes (Agenda item 13)**


250. The Committee noted that the Joint Coordinating Board (JCB) of the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR) acts as the governing body of the Special Programme and is responsible for its overall policy and strategy.

251. Currently, two Member States from the South-East Asia Region (India and Thailand) are members of the JCB under paragraph 2.2.1 for the term ending 31 December 2017. There is no representation from the South-East Asia Region for JCB membership under paragraph 2.2.3.

252. The Committee noted the report on the attendance of JCB members at the Thirty-eighth session of the Joint Coordinating Board, Geneva, Switzerland, 23–24 June 2015.


253. The Policy and Coordination Committee (PCC) acts as the governing body of the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research,

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

255. The Committee nominated Myanmar in place of Maldives, whose term expires on 31 December 2015, as a member of PCC for a three-year term starting 1 January 2016, and requested the Regional Director to inform WHO headquarters accordingly.

**Time and place of future sessions of the Regional Committee**
*(Agenda item 15: Document number SEA/RC68/29)*

256. The Regional Committee was informed of the invitation made in June 2015 by His Excellency NHRH Senaratne, the Minister of Health, Nutrition and Indigenous Medicine, on behalf of the Government of the Democratic Socialist Republic of Sri Lanka, to host its Sixty-ninth Session in September 2016 in Sri Lanka.


258. The Committee was also informed of the invitation by Her Excellency, Ms Iruthisham Adam, Minister of Health, Republic of Maldives, to host the Seventieth Session in September 2017 in Maldives.

259. The Committee decided to hold its Seventieth Session in Maldives in September 2017.
Closure of the session (Agenda item 18)

260. Representatives of Member States congratulated the Chairperson and the Vice-Chairperson for the smooth and successful conduct of the session. They conveyed their sincere thanks to the Government of Timor-Leste and the Ministry of Health for their warm hospitality and for the excellent arrangements made for the session.

261. The representatives expressed their gratitude to His Excellency Dr Rui Maria de Araújo, the Prime Minister of Timor-Leste, for his inspiring inaugural address. They also conveyed their appreciation to Dr Margaret Chan, Director-General of WHO, and Dr Poonam Khetrapal Singh, Regional Director, WHO South-East Asia Region, for their leadership. They thanked the WHO Secretariat for preparing the working documents and for their readiness to provide answers and clarifications. They were confident that efficient implementation of the resolutions adopted by the Committee would go a long way in improving the health of people in the Region.

262. The Regional Director also thanked His Excellency Dr Rui Maria de Araújo, the Prime Minister of Timor-Leste, for his gracious presence and address at the inaugural session and the ministries of health and of foreign affairs for their efficient cooperation. She also gratefully acknowledged Timor-Leste’s generous contribution of US$ 100 000 to SEARHEF. She was gratified that so many ministers of health from Member States had participated actively in the session and thanked them for their insights and comments, made in a spirit of collegiality. That spirit had reigned not only in the round tables and in the technical discussions but also in informal exchanges outside the meeting venue. WHO relied on guidance from its Member States, which was given on the basis of mutual trust and a shared vision of better health for all.

263. The Regional Director said it was an honour to have many ministers attending the entire session. She also thanked the many development partners who had been represented at the session, the staff from WHO headquarters who had provided relevant inputs on global issues, the Regional Office staff and the staff of the WHO Country Office. She looked forward to the next session of the Regional Committee, to be held in Sri Lanka, and to the session in 2017, to be held in the Maldives, where the Committee would “take the spirit of hard work to paradise”.

264. The Chairperson thanked representatives from Member States, nongovernmental organizations and development partners for their active participation and support. She expressed her deep appreciation to the Regional Director for her guidance on health priorities and for being an anchor for the meeting. She then declared the session closed.
Resolutions

**SEA/RC68/R1 Programme Budget 2016–2017**

The Regional Committee,

Acknowledging that the Sixty-eighth World Health Assembly in May 2015 approved the WHO Programme Budget 2016–2017 as the primary instrument to express the planned scope of technical work of the Organization, along with planned budgetary allocation,

Noting that the approved WHO Programme Budget 2016–2017 in its integrated form is based on the needs-based, bottom-up process involving Member States, in response to their requests to identify priorities for technical cooperation at the country level and aligning these with the regional and global commitments,

Reaffirming that the South-East Asia Region has received Programme Budget increase of US$ 17.7 million in the Base Budget,
of which US$ 8.9 million is for country component and US$ 8.8 million for the Regional Office, and an overall increase of US$ 25.1 million for the 2016–2017 biennium compared with the 2014–2015 biennium,

Recognizing that the budgets for polio-related activities and outbreak, crisis and response are considered as flexible budgets and can be reviewed and increased based on the requirements of Member States of the Region, at any time,

Endorsing the report and the recommendations of the Eighth Meeting of the Subcommittee on Policy and Programme Development and Management,

1. **URGES Member States:**
   
   (a) to further collaborate on technical work of national and regional importance, seeking improved management and optimum utilization of available Programme Budget resources;
   
   (b) to strengthen collaborative programme management capacities with the objective of improving the efficiency and effectiveness of WHO’s programme implementation; and

2. **REQUESTS the Regional Director:**

   (a) to allocate to WHO country offices 50% of US$ 8.9 million of the “country component” on a pro rata basis, based on their approved base budget allocations of 2014–2015, and the remaining 50% being kept as reserves to be distributed during the biennium based on needs and implementation status of WHO country offices;

   (b) to ensure efficient management of the Budget of the Region, through appropriate consultations with Member States, in the light of the Budget allocation, in a manner that aligns the Budget with priority programme areas as reflected by Member States in the Region;

   (c) to support mobilization of voluntary contributions, especially to countries and programmes that have been unable to achieve full funding of their workplans; and

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

The Regional Committee,

Recalling the adoption of United Nations General Assembly Resolution A/RES/69/283 on the Sendai Framework for Disaster Risk Reduction (2015–2030), Sendai Declaration (2015) and calls for action among stakeholders,

Recognizing that the Sendai Framework aims to achieve by 2030 substantial reduction of disaster risks and losses in lives, livelihoods and health and in the economic, physical, social, cultural and environmental assets of persons, businesses, communities and countries, with public health focus on enhancing the resilience of national health systems for all hazards,

Noting that six targets of the Sustainable Development Goals call for strengthening resilient systems against disaster which require multisectoral actions in a comprehensive manner,

Recalling World Health Assembly resolutions 54.14, 58.1, 59.22, 64.10, 65.20, 65.23, 68.5 and RC resolutions SEA/RC57/R3, SEA/RC60/R7 that call for improved capacities in Member States and WHO in preventing, preparing, responding to and recovering from emergencies from various hazards,

Recognizing the increasing trends and devastating impact of disasters, emerging infectious diseases and epidemics, and that the South-East Asia Region has prepared for, responded to and recovered from and continues to apply lessons for effective management on major disasters and emergencies,

Reaffirming that effective responses require disaster risk reduction policies, effective implementation through shared responsibilities by all levels of governments, stakeholders, with all-of-society engagement and partnership,

Recognizing the progress on the national commitment with regard to the achievement of core capacities as required by the International Health Regulations (IHR) (2005), and the South-East Asia Region benchmarks on emergency preparedness and response,

Appreciating the ongoing work of the WHO programme for outbreaks and emergencies, the revision of the Emergency Responses framework, the global health emergency workforce, the emergency contingency fund, the contributions of South-East Asia Regional Health Emergency Fund for immediate responses to emergencies
requiring health sector actions in the Region, the flagship on strengthening country capacities in emergency risk management,

1. **URGES Member States:**
   
   (a) to mobilize support for effective implementation of the health goals and targets of the Sendai Framework for Disaster Risk Reduction (2015–2030) and IHR (2005), through multisectoral, multi-stakeholders and all-of-society engagement and partnership;

   (b) to continue to strengthen and sustain the core capacities as required by the IHR (2005), and capacities on emergency preparedness and responses using the South-East Asia Region benchmarks;

   (c) to strengthen health systems to be resilient to events caused by all hazards; and

2. **REQUESTS the Regional Director:**

   (a) to provide support to scale up capacity for implementation of IHR and the health goals and targets of the Sendai Framework, through the flagship programme;

   (b) to monitor and continue support to strengthen the core capacities of IHR (2005) within the proposed timeline;

   (c) to continue the leadership role in coordinating and mobilizing technical and financial support from development partners, other stakeholders and technical support from WHO Collaborating Centres for prompt, appropriate and effective assistance to Member States across all phases of disasters and emergencies; and

   (d) to facilitate learning from the management of each emergency and sharing them with Member States to respond more effectively in future events in a systematic manner.

**SEA/RC68/R3 Antimicrobial resistance**

The Regional Committee,

Having considered World Health Assembly resolution WHA68.7 on antimicrobial resistance and having reviewed the Global Action Plan on Antimicrobial Resistance adopted by the Sixty-eighth World Health Assembly,
Recalling World Health Assembly resolutions WHA51.17 on emerging and other communicable diseases: antimicrobial resistance, WHA54.14 on global health security: epidemic alert and response, WHA58.27 on improving the containment of antimicrobial resistance, WHA67.25 on antimicrobial resistance, and the Regional Committee resolution SEA/RC63/R4 on prevention and containment of antimicrobial resistance,

Aware that the health and economic consequences of antimicrobial resistance shall be immense for the Member States of the WHO South-East Asia Region,

Recognizing that combating antimicrobial resistance shall require political commitments, multisectoral coordination, sustained investment and technical assistance,

Underlining the pressing need for availability of new affordable antimicrobial medicines, vaccines and diagnostics, and monitoring the potency of available antibiotics,

Underscoring the need for strengthened cooperation among health professionals in antibiotic stewardship including infection prevention and control, appropriate use of antimicrobials and regular monitoring of the magnitude and profile of antimicrobial resistance; as well as engagement by the communities in responsible use of antibiotics through effective public communication programmes, education and training in the human health, veterinary and agricultural sectors,

Appreciating the political commitment at the national and regional levels via the ministerial Jaipur Declaration of 2011 and subsequent inclusion of antimicrobial resistance in the Regional Director’s flagship priorities in 2014,

1. URGES Member States:
   (a) to include antimicrobial resistance as one of the top priorities on their national health agendas;
   (b) to develop and implement a multisectoral national action plan on antimicrobial resistance in alignment with the Global Action Plan on Antimicrobial Resistance in the country context; and

2. REQUESTS the Regional Director:
   (a) to provide technical support to Member States in the development and implementation of national action plans in line with the Global Action Plan on Antimicrobial Resistance;
(b) to assist Member States in mobilizing resources for sustainable implementation of national action plans on antimicrobial resistance;

(c) to support the establishment of a regional surveillance network and provide technical support for the development and strengthening of national reference laboratories in human and animal sectors that contributes to the magnitude and profile of antimicrobial resistance in both sectors at the country and regional levels;

(d) to build or strengthen capacity of Member States on the monitoring systems on the use of antimicrobials in human and animal sectors that contribute to national profiles and develop regional profiles;

(e) to strengthen regional tripartite collaboration among WHO, FAO and OIE to support national collaboration to combat antimicrobial resistance; and

(f) to submit to the WHO Regional Committee for South-East Asia reports on progress achieved in implementing this resolution in 2017 and in 2019; and conduct an assessment of regional achievements and challenges and present to the Seventy-fourth session of the Regional Committee in 2021.

**SEA/RC68/R4 Patient safety contributing to sustainable universal health coverage**

The Regional Committee,

Recalling Resolution RC59/R3 on promoting patient safety in health care,

Acknowledging that health services are still not as safe as they should be; that up to one in ten patients experience adverse events in health facilities, safety among health personnel is still a major concern, and that there are compelling health and economic arguments for improving patient safety,

Realizing that improved patient safety and quality of care are essential in gaining trust by the population, and an integral element in progressing towards universal health coverage, and further recognizing that improved quality and safety requires the engagement of stakeholders in particular patients and health professionals, and beyond health sector,

Recognizing barriers for improving patient safety, including reporting errors and adverse events, safety culture, effective communication and coordinated care among health professionals, and the need for a whole systems solution,
1. ENDORSES the Regional Strategy on Patient Safety (2016–2025);  

2. URGES Member States:  
   (a) to translate the six strategic objectives of the Regional Strategy for Patient Safety in the WHO South-East Asia Region into actions, implementation, monitoring and evaluations in line with country context;  
   (b) to engage all relevant stakeholders in building safer health-care facilities, creating and sustaining a culture of safety at all levels of health care;  
   (c) to create awareness and engage patients and communities in the process of improved patient safety, in strengthening health systems and supporting UHC;  
   (d) to consider allocating adequate resources to implement the country action plan; and  

3. REQUESTS the Regional Director:  
   (a) to provide technical support to Member States in implementing the Regional Strategy and country action plans;  
   (b) to facilitate collaboration and the exchange of information and best practices between Member States, regional and global networks; and  
   (c) to report progress, achievements and challenges in implementing this Resolution to the Regional Committee in 2017, 2019, and facilitate assessment of the patient safety in Member States in the Region, upon request, and report to the Regional Committee in 2021.  

**SEA/RC68/R5 Cancer prevention and control—the way forward**

The Regional Committee,

Recalling the Political Declaration of the High-level Meeting of the United Nations General Assembly on Non-communicable Diseases (NCDs) in 2011, World Health Assembly resolutions WHA58.22 on cancer control strategy and WHA65.10 on prevention and control of NCDs, and WHO South-East Asia Regional Committee Resolutions SEA/RC/65/R5, SEA/RC66/R6 and SEA/RC67/ R4 related to NCDs,

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1 Regional strategy for patient safety in the WHO South-East Asia Region, SEA-HSD-378 http://apps.searo.who.int/PDS_DOCS/BS187.pdf?ua=1
Concerned at the high and increased disease burden of cancer in SEAR Member States and its negative health and socioeconomic impacts,

Aware that tobacco use is the single greatest avoidable risk factor for cancer mortality worldwide, causing an estimated 22% of cancer deaths per year; physical inactivity, dietary factors, obesity and overweight are risk factors for certain cancers, excess consumption of red and preserved meat is associated with increased risk of colorectal cancer, and alcohol use is a risk factor for certain cancers; infectious agents are responsible for 22% of cancer mortality in the developing countries and 6% in developed countries; and air pollution and exposure to occupational carcinogens contribute to certain cancers,

Noting that many cancers are preventable, can be detected early and treated, which improves survival and quality of life; and concerned that late stage cancers result in catastrophic health expenditures and impoverishing households, and noting the inequities within and across countries on cancer prevention and control,

Recognizing the need for comprehensive cancer services including promotion, prevention of modifiable risk factors, early detection and treatment, and the availability of affordable diagnostics, medical products and palliative care,

1. URGES Member States:

(a) to develop/strengthen a comprehensive national cancer prevention and control programme, integrated within a broader multisectoral NCD action plan, with time-bound benchmarks and targets, effective governance and accountability, adequate and sustainable financing for programme implementation, monitoring and evaluation;

(b) to prioritize cancer prevention and implement multisectoral actions for primary prevention of cancer risk factors, in particular tobacco, alcohol, unhealthy diet and diet-related, physical inactivity, infections causing cancers, behavioural risk factors, exposure to environmental risk factors and occupational carcinogens; create public awareness to reduce modifiable risk factors and strengthen community-based interventions;

(c) to consider introducing or strengthening the innovative financing such as tobacco and alcohol taxes to support primary preventions of cancer, and in the context of comprehensive NCD preventions and control;

(d) to strengthen national Hepatitis B immunization programme for births and infants, strengthen cervical cancer screening; consider introduction of
affordable vaccination programmes, as appropriate in line with national policy and priorities;

(e) to strengthen all levels of the health delivery system to provide prevention, early detection and screening, diagnostic and the ranges of cancer treatment, effective pain management and palliative care including opioid as appropriate, while ensuring the availability of affordable essential medicines, technologies and vaccines;

(f) to establish or strengthen population-based cancer registries for effective programme monitoring and evaluation, as well as epidemiological, applied and operational research to generate local evidence for effective policy formulations; and

2. REQUESTS the Regional Director:

(a) to support Member States in developing and implementing comprehensive cancer prevention and control programme and establishment of population-based cancer registries;

(b) to establish, strengthen and expand partnership with multisectoral stakeholders to continue advocacy for cancer prevention and control; and

(c) to promote epidemiological, applied and operational research and training on cancer through close collaboration with national research agencies and International Agency for Research in Cancer including to identify effective and affordable cancer-related medical products.

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**SEA/RC68/R6  Community-based health services and their contributions to universal health coverage**

The Regional Committee,

Recalling its resolutions SEA/RC61/R3 on Revitalizing Primary Health Care and SEA/RC63/R5 on Regional Strategy on Universal Health Coverage,

Acknowledging the rapid demographic and epidemiologic transition with ageing and increased demand for health service, increased prevalence of non-communicable diseases (NCDs), requiring long-term effective management at the community level,

Recognizing that inequities in access to essential health services persist, especially among the rural and urban poor, and certain hard-to-reach areas and population groups,
Noting that the targets for health-related sustainable development goals (SDGs), to be adopted by United Nations General Assembly, include universal health coverage (UHC), to which Member States of the South-East Asia Region are committed; UHC provides equitable access to care and protects patients from being impoverished from using health services,

Recalling that World Health Report 2008 promotes the role of close-to-client community-based health services as people centred which supports equitable access, and that World Health Report 2010 reiterates the importance of effective primary health care as a critical platform in achieving UHC,

Noting that community-based services at primary health care level offer a range of integrated services, organized as outreach, team-based or facility-based services, by a range of health workers from volunteers to multi-disciplinary salaried professionals and that it is the strategic hub contributing to pro-poor utilization and improved health of the population, especially among people in rural and hard-to-reach areas and population groups,

Acknowledging that evidence shows a diverse picture of community health workers (CHWs) such as duration of training and level of supervision, CHWs link communities with the health services system, empower community to address social determinants of health, and are recognized by communities\(^1\); it improves outcomes for underserved populations for some health conditions\(^2\), achieve large gains in child survival in sub-Saharan Africa if implemented at scale\(^3\),

Emphasizing the CHWs’ need for continued training, support and supervision and ensuring strong links between community-based services, wider health system and collaboration with other sectors beyond health,

Having considered the report and recommendations of the technical discussions on “Strengthening Community-Based Health Services” (SEA/RC68/17 and Inf.Doc.1),

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1. ENDORSES the recommendations contained in the report;

2. URGES Member States:
   (a) to consider adequately reflecting comprehensive community-based health services in the national and sub-national health strategies, plans and budgets;
   (b) to strengthen the health workers’ capacities through continued training, adequate supervision and support and retention in places they are most needed, diversify their capacities in responses to changing health needs of the communities, addressing social determinants of health, in particular awareness and detection of NCD, care for elderly and persons with disability in the communities, rehabilitation and palliative care, disease surveillance and capacities to respond to emergencies and disasters;
   (c) to assess, strengthen the contributions of community-based health services and upscale as appropriate; support referral to and from higher level of health service, and ensure effective coverage of essential interventions; and

3. REQUESTS the Regional Director:
   (a) to support Member States to strengthen the community-based health services which contribute to progressive realization of UHC; and
   (b) to synthesize evidence from Member States on best practices, effective models of community-based health service, their experiences and contributions to improved and equitable access.

**SEA/RC68/R7 Dili Declaration on Tobacco Control**

The Regional Committee,

Having considered the Dili Declaration on Tobacco Control;

ENDORSES the Dili Declaration on Tobacco Control annexed to this resolution.
Dili Declaration on Tobacco Control

We, the Health Ministers of Member States of the WHO South-East Asia Region participating in the Sixty-eighth Session of the Regional Committee in Dili, Timor-Leste,

Note with deep concern that tobacco use, in all its forms, is most harmful to public health, being the major risk factor for many noncommunicable diseases (NCDs) and preventable and premature deaths; and that the prevalence of tobacco use in the Region is still unacceptably high and accounts for nearly half of global tobacco users; and that smokeless tobacco use, in particular, is highest in this Region as well as increasing alarmingly in many of the countries;

Further note that harmful effects of tobacco use are not confined to the users themselves or to merely health outcomes; and that family members and people around users, who face the effects of secondhand and thirdhand smoking, as well as society as a whole are also vulnerable to tobacco-related diseases, along with losses in productivity, impact on quality of life, and economic cost to society due to increased morbidity, mortality and health-care expenditure and damage to property;

Concerned with the prominence of tobacco use among the most socioeconomically vulnerable population groups, and the close association between tobacco use and poverty and social inequity at the individual and aggregated scales;

Aware that the Region has become an emerging market for the tobacco industry, which aggressively applies their marketing techniques – including introduction of new tobacco products tailored to each customer segment and conduct marketing beyond country borders in order to recruit and maintain their customers for long-term profit – as well as expand interference to limit tobacco control efforts and the effectiveness of the measures by governments and civil society, including through illicit tobacco trade within and across countries;

Recognizing that most tobacco-related health and socioeconomic impacts are preventable through implementation of appropriate cost-effective and robust interventions – particularly best-buy interventions, including tobacco tax and price measures, and comprehensive marketing regulations – to protect people, and through promoting tobacco-free workplaces and public spaces, and by issuing warnings about the threat from tobacco;
Concerned with the increasing use of electronic nicotine delivery systems (ENDS), including electronic cigarettes, and the emerging evidence of their adverse health impacts;

Acknowledging that the WHO Framework Convention on Tobacco Control (WHO FCTC), together with the WHO MPOWER measures, are guidelines for Member States in the South-East Asia Region in their efforts to develop, strengthen, implement and manage tobacco control, and to effectively address industry interference;

Mindful of the United Nations High-Level Political Declaration on the Prevention and Control of NCDs adopted by the United Nations General Assembly in 2011, and that tobacco control is a crucial element of NCD prevention and control, and further that Member States in the Region have committed during the Sixty-sixth session of the WHO Regional Committee for South-East Asia to achieve 30% reduction in tobacco use by 2025 as part of the regional voluntary targets on NCD prevention and control and through stricter implementation of supply-and-demand provisions of the WHO FCTC;

Noting that all Member States have programmes to prevent and control the tobacco menace, contributing to progress in tobacco control in the Region, and in particular by implementing the WHO FCTC;

Concerned with major challenges to the implementation of the WHO FCTC and to advance tobacco control in the Region, including challenges to strengthen regulatory systems and infrastructure, difficulties in implementing national tobacco control legislations, and the slow progress in policy strengthening, achieving tobacco-related social norms such as for smokeless tobacco, and the shortage of competent human resources, in particular to provide tobacco cessation services;

We, the Health Ministers of Member States of the WHO South-East Asia Region, commit ourselves to:

1. Further strengthening the coherent, comprehensive and integrated approach in tobacco control, including achievement of regional voluntary targets on NCD prevention and control;

2. Advocating for and facilitating a multisectoral and multidisciplinary approach on tobacco control, including implementation of the WHO FCTC and the WHO MPOWER measures at the highest levels;
3. Building and enhancing national capacity and mobilizing financial, technical and human resources – as well as facilitating the proactive coordinated engagement of stakeholders including ministries other than health and communities – for effective tobacco control and prevention at all levels;

4. Developing, strengthening and/or implementing, as appropriate, legal frameworks, regulatory mechanisms and policies – including the regulation of importation, manufacture, storage, distribution, marketing and sale of all tobacco products – and public campaigns, and the promotion of health literacy on the harms of tobacco use;

5. Strengthening health systems to address tobacco control and prevention, including provision of tobacco cessation services at all health-care levels; user-friendly helplines; screening for tobacco-related cancers and other NCDs amenable to early detection; the training and retraining of health professionals; and strengthening laboratories and health information systems;

6. Promoting evidence-based national tobacco control and the implementation of the WHO FCTC through the strengthening of surveillance and database systems on tobacco use, including smokeless tobacco, and the health and social consequences of tobacco use, good practice in tobacco control, and progress in the implementation of the WHO FCTC, as well as basic and operational research;

7. Developing and reinforcing national, regional and intercountry collaborating mechanisms for regular sharing of data and best practices on tobacco control, in facing the challenges from the industry, and supporting cross-border control of tobacco-related trade and marketing;

8. Considering measures, as appropriate, even beyond WHO FCTC guidelines in the interest of protecting public health from the harms of tobacco use;

9. Developing smokeless tobacco control strategies specific to the Region and to Member States in the Region, including improved surveillance of smokeless tobacco products and related indicators as part of regular health surveys; and
10. Developing and adopting policies and new regulations on electronic nicotine delivery systems (ENDS), including, as appropriate, the banning or restricting of sales, promotion, advertising and sponsorship of ENDS.

We, the Health Ministers of Member States of the WHO South-East Asia Region, urge all Member States as well as the WHO Director-General and the Regional Director for South-East Asia to continue to provide leadership and technical support in building partnerships between governments, United Nations agencies, relevant global health initiatives, bilateral and multilateral agencies, and with academia, professional bodies, civil society organizations, related sectors and the media, to jointly advocate, provide technical and financial support and effectively follow up on all aspects of this Dili Declaration on Tobacco Control.

Dili, Timor-Leste, 7 September 2015

SEA/RC68/R8 Resolution of thanks

The Regional Committee,

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

(a) THANKS His Excellency Dr Rui Maria de Araújo, Prime Minister of the Democratic Republic of Timor-Leste, for inaugurating the Session and for his inspiring address;

(b) THANKS Dr Hans Troedsson, WHO Assistant Director-General, for delivering the thought-provoking address of the Director-General, Dr Margaret Chan;

(c) CONVEYS its appreciation to Her Excellency Dr Maria do Céu Sarmento Pina da Costa, Minister of Health of the Government of the Democratic Republic of Timor-Leste, to the officers and staff of the Ministry of Health, other ministries and national officials for facilitating the successful organization of the Session; and

(d) CONGRATULATES the Regional Director and her staff for their dedicated efforts towards the smooth and efficient conduct of the Session.
Decisions

**SEA/RC68(1) Discontinuation of Technical Discussions prior to the Regional Committee Session**

The Committee reached consensus that the Technical Discussions should be discontinued and that the topics would instead be discussed at the Ministerial Round Tables during the Regional Committee Session. The Committee agreed that there should be two round tables at each session of the Regional Committee, held on consecutive days.

**SEA/RC68(2) Sunsetting of Resolutions**

The Committee proposed that the two resolutions on Technical Discussions (SEA/RC5/R3 and SEA/RC7/R11) be “sunsetted”.

**SEA/RC68(3) Review of the Draft Provisional Agenda of the 138th Session of the WHO Executive Board**

A proposal made by India to include “Follow-up of Consultative Expert Working Group” as an agenda item for the 138th Session of the WHO Executive Board was endorsed by the Regional Committee. India requested that the WHO Secretariat communicate this proposal to the Director-General on behalf of the Committee. This was done and a receipt of the message was confirmed by the Director-General’s Office.

**SEA/RC68(4) Elective posts for governing body meetings (WHA, EB and PBAC)**

For 69th World Health Assembly:

The Committee proposed Timor-Leste for the post of Vice-President; Thailand for the post of Chairman of Committee B; Maldives for Rapporteur of Committee A, and India for Member, Committee on Credentials.
For 139th Executive Board:

The Committee also proposed that Bhutan be nominated as Executive Board member in place of Democratic People’s Republic of Korea whose term ends in May 2016, and Nepal as Vice-Chair of the 139th Executive Board in May 2016.

Regarding the Programme, Budget and Administration Committee (PBAC):

Bhutan was proposed to be nominated for a term of two years in place of Nepal whose term expires in May 2016.

SEA/RC68(5) Nomination of a Member State to the Policy and Coordination Committee (PCC) of the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP).

The Committee nominated Myanmar in place of Maldives, whose term expires on 31 December 2015, as a member of PCC for a three-year term starting 1 January 2016, and requested the Regional Director to inform WHO headquarters accordingly.

SEA/RC68(6) Time and place of future sessions of the Regional Committee

Annex 1

Text of welcome address by the Minister of Health, Democratic Republic of Timor-Leste

At the outset, please allow me to express my deepest gratitude to H.E. Dr Rui Maria de Araújo, Prime Minister of the Democratic Republic of Timor-Leste for his acceptance to grace this meeting and for the support of the whole of government under his guidance and leadership during the preparation stage of this meeting. I would also like to express my appreciation to my fellow ministers and their respective ministries for the support extended to me and my ministry during preparation as well as their clear commitments to support all of us during the course of the meeting this week.

On behalf of the Ministry of Health, Democratic Republic of Timor-Leste, it is my privilege to extend a warm welcome to Excellencies, the Health Ministers and distinguished representatives from WHO South-East Asia Region to the Sixty-eighth Meeting of the WHO Regional Committee for South-East Asia being held here in Dili – the capital city of Timor-Leste.

Our warmest greetings and welcome to Dr Hans Troedsson, Assistant Director-General of the World Health Organization.

A very warm and cordial welcome to Dr Poonam Khetrapal Singh, Regional Director for WHO South-East Asia Region. Dr Singh’s leadership in pushing forward regional health agenda is very well recognized and truly deserves our high appreciation.

We are really honoured to have the privilege of hosting this prestigious meeting in Dili and we look forward to learning from the rich experience of other Member States in WHO South-East Asia Region.

As you all know it is just about a little more than a decade that we started our journey as a sovereign nation. The Constitution of the Democratic Republic of Timor-Leste declares health and medical care as fundamental rights for all citizens. In fact health is referred to as a commodity and all citizens – as the consumers – are
entitled to health through good quality protective health care. Accordingly, Health has been a priority with successive constitutional governments.

Health cannot be dealt with in isolation as it is influenced by a variety of determinants, like, education, income, housing, food, water and sanitation. With this background, our vision is – “Healthy East Timorese People in a Healthy Timor-Leste”. And our specific health goals include: comprehensive primary health-care services, adequate support system to health-care services delivery and promoting higher community and partnership participation in the continuous efforts to strengthen the national health system.

In order to achieve specific health goals outlined above, we have identified some major thrust areas, like, development of basic infrastructure required for access to quality health services and development of appropriate human resource therefore.

We are working on promotion of family health and digitization of family records is the first step in this direction. In other words, we will be working on making optimum use of information technology for pursuing the goals of this sector.

We are also working on strengthening institutional set up for healthcare with proper accountability. Since the first contact point for medical care is primary health-care centre, our endeavor is improve its quality over time. We supported the introduction of emergency essential surgical care at PHC level and this item was discussed in the Regional Committee agenda for the year 2014 and in the WHA thereafter.

Maternal health, child health, nutrition and control of communicable diseases have been identified as national priority health programmes and there have been visible improvements. Strategic Development Plan for 2011–2030 envisages establishment of health clinic in each of the country’s 442 sucos on priority basis. Presently there are 272 health clinics manned by qualified health professionals with proper equipment and technology.

Development of emergency health-care services and pediatrics department at National Hospital Guido Valadares is also a priority with us. The endeavor is to obviate the necessity of medical evacuations in the near future.

We appreciate WHO’s support in displaying medical camp kit as part of the exhibition at the venue of the meeting. This is very impressive arrangement and I personally request all Honourable Ministers, delegates and special invitees that they
must visit this emergency set-up. It is quite reassuring to see the level of preparedness for meeting any emergency situation.

WHO has been one of our major partners in developing health-care services and we look forward to its continued assistance in the achievement of stated objectives.

I would like to take this opportunity, on behalf of all of us, to express our deepest appreciation to WHO/SEARO Disaster Management Team for their superb handling of emergency assistance in Nepal during recent series of earthquakes. Also, our appreciation goes to the highest solidarity expressed by Member States in the Region to support each other whenever needed the most including in Nepal Earthquake.

As part of the agenda for the Regional Committee meeting we have prepared ‘Dili Declaration on Accelerating Implementation of WHO Framework Convention on Tobacco Control’ which will be presented for adoption during ministerial round-table to reflect a strong political commitment on the part of the governments of the Region for bringing down the use of tobacco and tobacco products. Our government is seriously concerned with the increasing use of tobacco in younger generation and we are happy to inform that Timor-Leste would soon be bringing a legislation in this regard and have already imposed a ban on smoking in government offices and public transport.

As decided in the last meeting held in Dhaka, we are going to follow a revised format for this meeting of the Regional Committee for South-East Asia in the sense that there are no separate meetings of the senior advisers to the ministers or the ministers of health. I am sure Dr Singh will elaborate a little more on this revised format when we all reassemble for the opening session of the Regional Committee in the Conference Hall at Ministry of Foreign Affairs and Cooperation.

I, once again, welcome you all to Timor-Leste. We are very pleased that you could take time off your busy schedule to be with us. Ministry of Health team will be around throughout the duration of your stay to make your visit to Dili a pleasant and memorable one. Am sure you all will ignore our shortcomings, if any, but appreciate the spirit behind organizing this activity in our capital.
Annex 2

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

It is a pleasure to add my warm welcome to the Regional Committee for the WHO South-East Asia Region and to thank our hosts, the Government of Timor-Leste, for their generous hospitality.

Mr Prime Minister, we are particularly honoured by your presence here.

Someone once said that all ministers should be health ministers. So Timor-Leste is fortunate to have a Prime Minister who not only has a distinguished record as Health Minister, but who is also an expert in health policy, management and finance, and who wrote his Master’s thesis on the future health system of his country.

Last year the National Malaria Control Programme of Timor-Leste was honoured with the Award for Excellence in Public Health for its remarkable success in achieving the MDG goal for malaria and reducing the number of cases to less than one per 1000 population.

This year I want to draw the attention of this audience to the leadership you are showing in the fight against tobacco.

There is no doubt that this country has a serious problem - one-third of adult men and 50% of male teenagers smoke. The number of teenage girls smoking is on the increase. Cigarettes are cheap. And advertising is pervasive.

As I have said many times, the big public health challenges we face – and the rising tide of NCDs is one of the biggest – are not amenable to technical solutions alone. They are problems of governance, and require a response across several sectors. To make this happen requires real leadership. It is not easy.

Your Excellency, I have heard, on YouTube, your powerful personal statement made on World No Tobacco Day.

In it, you challenged all your Ministers to be health ministers and declare their public buildings tobacco free. The same goes for schools, universities and public
transport. I understand that you plan to bring legislation before parliament that would ban advertising and restrict the age that young people can buy cigarettes.

I warmly applaud these actions. Through your continuing commitment to the health of the people of Timor-Leste, you are showing us all the real meaning of governance for health.

In the South-East Asia Region, in 2012 it is estimated that about 62% of deaths were attributable to noncommunicable diseases; of these, 48% occur in those aged below 70 years. Thus, premature deaths are not only a loss to the families, but also have a huge economic impact on the country.

We know that tobacco use is the leading cause of preventable deaths. Worldwide, tobacco use kills nearly six million people annually with over 600 000 deaths due to exposure to second-hand smoke.

In the WHO South-East Asia Region, the toll of death is estimated to be over 1.3 million. Our Region has about 250 million smokers and nearly the same number of smokeless tobacco users.

The Region is one of the largest producers and users of tobacco products in the world. Many types of smoking and smokeless tobacco products are used in the Region, which poses difficulties to harmonize taxation and regulations for controlling tobacco use.

I am encouraged by the fact that Member States in the Region have intensified their tobacco control activities. Several countries have adopted “comprehensive” national tobacco control “legislations”. Many countries have established smoke-free public places and banned advertisement of tobacco products. In five Member States, “pictorial health warnings” are put on tobacco packages and other tobacco products; in fact, in terms of graphic health warnings, Nepal’s 90% and Thailand’s 85% are among the largest in the world, and close to the plain packaging adopted by Australia and Ireland. More countries are in the process of doing the same.

Other countries such as Bhutan are ramping up their advocacy on physical activity, diet and lifestyle changes. Expanding access to open gym has become a national priority for the government of Bhutan. Sri Lanka’s programme to deliver NCD services at the primary care level through 650 life style clinics is a model for screening for diseases such as hypertension and diabetes.
Our Region, as you are all well aware of, is a disaster-prone region; be it natural or man-made. And we have had our fair share this year too. The devastating earthquakes of 25 April and 12 May in Nepal have left more than 9000 dead and more than 23 000 injured with millions displaced. More recently floods in Myanmar ravaged 38 townships in seven provinces, leaving in its wake more than 106 dead and millions more displaced. Volcanic eruptions, forest fires and airline tragedy add to the list of disasters in Indonesia. And most recently, the cowardly attack in Bangkok that devastated a most revered shrine and took the lives of scores of devotees and innocent bystanders.

It is now ten years since the December 2004 tsunami. Learning from that terrible tragedy, WHO Regional Office has worked with all Member States to strengthen their disaster preparedness and response, using the SEAR Benchmarks as the framework.

More importantly, the ministers of our Region created the SEA Regional Health Emergency Fund, or SEARHEF. This was a farsighted move on the part of our Member States and the Regional Office as access to this fund has helped many countries to respond rapidly and effectively to disasters wherever they occur, the most recent being Nepal and Myanmar. SEARHEF has been functional for almost a decade. At the global level, an emergency fund to tackle global health emergencies is now taking shape.

We declared the SEA Region polio-free last year and we have continued to maintain that status. Bangladesh, Bhutan, Democratic People’s Republic of Korea, Maldives, Nepal, Sri Lanka and Thailand consistently achieve and maintain high routine immunization coverage. And Bhutan, Maldives and Sri Lanka may be close to eliminating measles.

Last year at the Dhaka RC, the ministers of five Member States, namely Bangladesh, Bhutan, India, Nepal and Thailand, signed an MoU for the elimination of kala-azar. Since then, these countries have redoubled their efforts and are making notable progress towards the elimination goal. India eliminated yaws in 2006, thus paving the way for the elimination of this disease from the Region. All countries of the SEA Region have achieved leprosy elimination target at the national level. However, the Region still bears the highest burden of leprosy, contributing the largest number of cases to the global pool.

As I travel in our Region, I am encouraged by the number of countries that are committed to making progress towards universal health coverage. Our report this year shows many positive examples.
But as I have said before, UHC must be more than a slogan or a mantra. It must deliver results.

In our meeting we will be discussing the new Sustainable Development Goals. Compared with the MDGs, the new goals reflect a much wider agenda – there is little that is not now included under Goal 3 – *Ensure healthy lives and promote well-being at all ages*. In many ways this is good. We have fought hard for a more comprehensive approach to health.

But we also need to ask ourselves how we should now assess progress.

Reading off a list of 13 targets and indicators is not going to be convincing. We need a way of telling our people and our parliaments whether health is getting better or not. Whether we are succeeding in reaching the goal, and not just the targets.

More years of healthy life is one way, but it is not that easy to measure. Demonstrating progress towards universal health coverage – by showing that more people have access to the services they need, without suffering financial hardship when they use them – tells a powerful story.

Universal health coverage can, therefore, not only act as a way of bringing the diverse health community together, it can also serve as a way of charting our course towards our overall goal. Thailand has already achieved the goal of Universal Health Coverage and Indonesia is making rapid and commendable progress towards it.

While we celebrate our achievements, we also need to be aware of the challenges we face.

Health workforce, both in terms of number and quality, continue to be a major challenge for almost all countries.

I must draw your attention to the low levels of health spending in this region. We need to get better at making the case for more investment in health. Not just because of its human impact, but also because investment in health has real economic returns.

The recent Lancet Commission shows that one dollar spent wisely on health can yield between 10–20 dollars in return. We are also beginning to understand the cost of inaction – trillions of dollars in the case of NCDs.
Out-of-pocket spending remains high and access to essential medicine limited in many of our Member States. We need to redouble our efforts towards the goal of Universal Health Coverage in all countries.

Only two of our Member States, Indonesia and Thailand, have achieved core capacities as required by the IHR 2005. In the context of emerging and re-emerging diseases such as Ebola and MERS-CoV, it is vital that all countries achieve all the core capacities of IHR 2005 so that we are truly prepared to deal with any threats from disease outbreaks.

With these few words, I once again welcome you all to Dili, and I thank His Excellency the Prime Minister for inaugurating our meeting.
Welcome to Timor-Leste!

I am very pleased to be here today to inaugurate the Sixty-eighth Session of the World Health Organization (WHO) Regional Committee for South-East Asia. This is the first time this prestigious committee is meeting in Timor-Leste since we became a member of the World Health Organization in 2002. I remember representing Timor-Leste when we became the 192nd Member State of WHO, and when we first voted for WHO’s regional directorship.

I am very proud that 13 years on, Timor-Leste is able to host this event in our country with eleven (11) health ministers of WHO’s South-East Asia Region present with their delegations to actively engage in talks and in productive discussions over the next five days.

You will set the health priorities as well as the health agenda for our Region; a tremendous task that will affect the lives of millions of people.

Good Health is paramount for the people of Timor-Leste and a priority for my government, and I am sure you wish the same to your people.

The strength of our peoples and of our nations depends on some of the decisions we will be making collectively here, because this regional meeting presents opportunities for the Member countries to contribute towards the direction of the WHO at the regional level.

We will also have ample opportunity for bilateral discussions between our countries on issues of shared interest in the health sector.

Since the restoration of our independence in 2002, one of the key priorities for Timor-Leste has been to build a health sector that can respond to our needs efficiently and adequately, in particular the needs of 70% of our population who live in the rural areas of the country.

We have achieved much in this regard over the past 16 years through assertive leadership, evidence-based policies such as emphasis on primary health care,
and sound partnerships, including with many of the UN agencies, international development agencies and NGOs present here today.

With adequate foresight we were able to train some 1000 medical doctors through a strategic partnership with Cuba, and because of this we have now been able to intensify the primary health care approach through comprehensive programs like the *Programa Nacional de Saúde na Família* (The National Programme of Health in the Family), which started to provide unprecedented health care assistance to our People. It is expected that by 28 November 2016, every family member in this country has had a first contact with a health care provider, with subsequent visits planned as needed. Within this approach families are categorized according to public health risks, individuals within the family will have their health status monitored on a regular basis, and interventions both at family and individual levels provided accordingly. Home visits for consultations, counselling and data gathering are the cornerstones of this health in the family approach.

This is very important, because rather than expecting patients to access basic health services often having to travel many hours, if not days, on foot, and crossing dangerous rivers during the rainy season, we are taking health services to the People, into the families instead.

This is one of the ways we are investing in our future in Timor-Leste.

With a strong and healthy people we will have a strong nation capable of expressing our full sovereignty, including reclaiming our yet to be resolved maritime sovereignty.

My government’s programme is guided by the vision and ambition of Timor-Leste’s Strategic Development Plan 2011–2030 and we are continuing the work already started by previous governments.

By 2030, we aim to have comprehensive high quality health services accessible to all Timorese people.

This is a bold ambition that we need to achieve because good health is essential for a good quality of life and all Timorese are entitled to it.

Our Ministry of Health has embarked on a comprehensive approach to strategic planning, policies, directions and has set out strategic goals and strategies that will guide the development and the growth of health services across the country.
We now have the National Health Sector Strategic Plan 2011–2030, which provides the framework for moving forward with a sense of direction.

It is a living document that will be revised periodically based upon national, regional and global health dynamic policies to be able to properly and timely deliver health services to our people and to appropriately contribute to global public health developments.

We welcome new initiatives in order to strengthen the quality of healthcare services to our people.

In the last decade, Timor-Leste has made steady progress in the health sector including the reconstruction of health facilities, expansion of community based health services like the integrated community health services, and a considerable number of national medical graduates have joined the health work force and are serving communities across our nation, in particular in the more rural and remote areas.

Nevertheless, there is a need for renewed focus on communicable diseases such as dengue and TBC that still pose public health challenges to the country. Focus is also required to address the rising level of noncommunicable diseases such as cardiovascular and chronic obstructive pulmonary diseases that are among the ten leading causes of death.

We also need to increase health services for persons with disabilities, in particular those with mental disabilities.

Timor-Leste attaches great importance to the contributions made by the international community to our health sector but also to our overall development journey towards future prosperity.

Timor-Leste ratified the WHO Framework Convention on Tobacco Control (FCTC) in 2004 and domestically we finally started to take concrete steps towards tobacco control and consumption in Timor-Leste.

We are actively engaged in an anti-tobacco national campaign that is starting to get the message across to our people. In May this year, for example, an executive order was issued to all line ministries banning smoking in public spaces, including public transportation, followed one month later, by a decision of the Chair of the Civil service Commission reinforcing the prohibition of smoking in all public administration working environment. We are now receiving encouraging messages from schools
in remote areas such as in Baguia, in the Eastern region of the country, saying that teachers are no longer smoking inside the classrooms.

In this regard, I also congratulate the UN Resident Coordinator, Mr. Knut Ostby and WHO’s Representative, Dr Rajesh Pandav for making the United Nations compound in Timor-Leste a tobacco free zone.

These are all positive steps we are taking in Timor-Leste, but the implementation of the WHO FCTC needs to be accelerated.

Timor-Leste has one of the highest tobacco consumption rates in the world with over 70% of Timorese men using tobacco. This is a tragic and unacceptable figure for the type of prosperous nation we strive to become. Tobacco is present on our streets, it is in our homes, it is advertised on our kiosks and it is present in our schools.

As a Party to the WHO’s Framework Convention for Tobacco Control, Timor-Leste must adopt comprehensive tobacco control laws including the prohibition of illicit trade in tobacco products.

I am happy to share with you that the decree law that will allow us to take concrete legal and policy measures to control tobacco consumption and sales in Timor-Leste is circulating within the Government for comments prior to being tabled at the Council of Ministers for approval. I will make sure this will happen shortly so that we can put a halt to Timor-Leste being exploited through weak legislation.

I understand that the FCTC is on the agenda of this Regional Committee and will be discussed.

We must achieve regional political will that will enable our region to bring down the rates of consumption of tobacco and tobacco products. I am sure we are all concerned with the rising trend of consumption of tobacco in our younger generations and how this will affect the future prosperity of our nations and of our region.

All of us, who are here representing our nations agreed also through the International Health Regulations (IHR) 2005, to build our capacity to detect, assess and report public health events, towards ensuring greater global health security.

None of us would like an event, similar to the unfortunate Ebola outbreak that has hit the African continent the hardest, or the earthquakes in Nepal and the
spread of MERS Coronavirus, to take place in any of our own countries or in our region. These types of events have devastating effects, which a nation like Timor-Leste would struggle to cope with. Nevertheless these events take place, and we must be ready.

In this regard, I am very happy to inform that just last week in our Council of Ministers meeting we decided to donate US$100,000 to WHO’s South-East Asia regional emergency fund. This is a modest contribution which can be taken as a signal of our commitment to the needs of the region.

In addition to emergency readiness, we need to take particular measures at our ports, airports and ground crossings to mitigate the spread of health risks into our nations and also to our neighbouring countries.

At this WHO Regional Committee meeting we will also be advocating for health in the post-2015 Global Sustainable Development Goals, and how we can domestically as well as nation-to-nation, be able to expand more effective health services with stronger health workforces.

For nations like Timor-Leste, this is very important. We cannot just wait for our own health sector to develop overnight. Even if it did we would lack the maturity most of you already have.

We will need to make better use of regional health services to ensure we keep our population healthy, whilst at the same time building our own health infrastructure and cadres, so that in the future, it is your people that come to Timor-Leste to access our future state of the art health care services.

We have to be able to aim for this kind of health services reciprocity in our Region.

When I took the helm of this Government and during my many interventions so far I often close with the motto ‘Um Por Todos e Todos Por Um’, meaning “one for all and all for one”.

It is my strong belief that “we can do better by working together” and I am encouraged to see so many of our regional health leaders in one room to discuss how we can keep our region prosperous and healthy.

I would like to once again thank the Honorable Ministers and distinguished delegates from Bangladesh, Bhutan, Democratic People’s Republic of Korea, India,
Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand for coming to Timor-Leste, and I look forward to positive and constructive deliberations that will benefit us all.

I wish you a memorable stay in Dili, and if you have time, please visit other parts of our amazing Timor-Leste.

I hereby declare the Sixty-eighth Session of the WHO Regional Committee for South-East Asia open.
Annex 4

Text of vote of thanks by the Vice-Minister of Health, Democratic Republic of Timor-Leste

It is my proud privilege to propose vote of thanks on this great occasion, that is, Timor-Leste hosting the Sixty-eighth Session of the WHO Regional Committee for South-East Asia – the first in this country.

First of all, I would like to place on record our thanks to Excellencies – Ministers of Health and distinguished Representatives from the countries of WHO South-East Asia Region for accepting our invitation for the Regional Committee in Dili.

Our deepest gratitude and appreciation go to His Excellency, Dr Rui Maria de Araújo, Prime Minister of the Democratic Republic of Timor-Leste, for his inspiring key-note address. Health has always been his first love. Distinguished guests, as you may know, His Excellency Prime Minister was Minister of Health before. Excellency, we look forward to your joining us in some selective business sessions also to let us have the benefit of your rich expertise in health sector.

I must express our deep sense of appreciation for His Excellency Mr Mohammed Nasim, Minister for Health and Family Welfare, Peoples’ Republic of Bangladesh, as the chairperson of the WHO Regional Committee, for sharing with us the milestones achieved during the last one year.

Our thanks to Excellency, Dr Maria do Ceu Sarmento Pina da Costa, Minister of Health, Democratic Republic of Timor-Leste, who has been the guiding force behind preparations for this meeting. She took personal interest in every minute detail and desired to be kept informed of the progress.

Thank you Dr Poonam Khetrapal Singh, Regional Director, WHO South-East Asia Region, for extending all possible administrative and logistics support and making the organization of a meeting of this magnitude in Timor-Leste a reality. Thank you also for providing us the organizational support by periodic visits of your senior officers who worked very closely with our organizing team for fine-tuning the arrangements.
Further, we are grateful to Dr Margaret Chan, Director-General, WHO, for according due importance to the hosting of Regional Committee by Timor-Leste and designating Dr Hans Troedsson, Assistant Director-General, WHO, to represent WHO headquarters.

An event of this magnitude cannot happen overnight. The wheels started rolling several months ago. It required comprehensive planning and a bird’s eye for details. We have been fortunate enough to be backed by a team of very motivated and dedicated colleagues – not only from the Ministry of Health, but also from other line ministries of the Democratic Republic of Timor-Leste, who all were members of the Inter-ministerial Organizing Committee, constituted with the blessings of the Hon Prime Minister.

We would like to take this opportunity to place on record our sincere thanks to all the members of the organizing team for the perfect logistic support, and for all the undying efforts they have put into making this programme a huge success.

We cannot thank everyone enough for their involvement and their willingness to take on the completion of tasks beyond their comfort zones.
Annex 5

Text of introductory remarks by the Regional Director on the Annual Report on the work of WHO in the South-East Asia Region

It is the tradition of our Regional Committee meetings that my address to you today is used to introduce our Annual Report. As I said last year, I wanted a new-look report that puts country challenges and achievements centre stage.

The report you have in front of you seeks to do just this. You will see that there is a section on each country individually, reflecting the diversity of our Region and illustrating the different ways in which WHO contributes to national health priorities.

I also report on our seven flagship priority areas, focusing particularly on how the Regional Office adds value to what happens in countries.

As many of you are aware, we have used the flagships as a way of driving a more integrated approach to work across the Regional Office and in our WHO country teams.

Please take a careful look at the report and give us your feedback so we can make it even better next year.

Reports, by their very nature, speak of the past but I believe that one of the key roles of WHO is to look to the future and to bring issues of global and regional significance to the attention of Member States.

This year – 2015 – is a busy year on the global stage. What happens at a series of key meetings will have implications for us all.

In July, countries met in Addis Ababa at the UN Conference on Financing for Development. The outcome document focuses on the role of domestic financing for development and the importance of private finance as an engine for growth. Aid is still there, but in a diminished role, with greater focus on the poorest countries.
I welcome this trend; national self-reliance must be our goal. But we need to think carefully about what it means for our work in middle-income countries, with large poor and under-served populations.

In two weeks’ time, heads of states and governments will meet at the UN General Assembly in New York to endorse the next generation of global development goals – the SDGs.

Health is in a good place, the list of targets under Goal 3 – Ensure healthy lives and promote wellbeing at all ages – is long, but includes much of what we wanted to see. Neglected tropical diseases and hepatitis. Noncommunicable diseases and mental health. Road traffic accidents. Environmental hazards. Tobacco is there, as is substance abuse, narcotics and alcohol. Sexual and reproductive health. And of course Universal Health Coverage.

In the coming months we need to think what the SDGs will mean for health. For example, moving, from seeing UHC as one target in a list of 13, to becoming the organizing principle for bringing the health community together – as it is in countries like Thailand. I look forward to discussing the implications of the SDGs in more detail at our Ministerial Round Table tomorrow.

There are many other global events that I could mention, including the recently concluded WTO Information Technology Agreement that affects over one trillion US dollars in world trade and holds the promises of reducing prices in vital medical equipment.

But the last major meeting of the year is the one I want to bring to your attention: the UN Conference on Climate Change (COP21) in Paris in December at which Member States – for the first time in 20 years of negotiation – will seek to finalize a universal and binding agreement. I would urge our ministries of health to actively participate in this meeting.

In this Region the government of the Maldives has been an outstanding global champion: making us realize that the impact of our changing climate is not something that may happen in the future; it affects people’s lives and health today.

How do these global agreements affect us in this Region? I would like to highlight four key messages.

**The first is about making health a genuine national priority.**
We have all argued fiercely that health must have a prominent place in the SDGs. We have all made the case that health will be a major beneficiary of good climate policy. We have solid evidence that says health is a contributor to economic growth and national development. We know that our Region accounts for a disproportionate share of the global burden of disease.

But when we look closely, what do we find?

We find that in the Region as a whole, total health expenditure as a percentage of GDP is lower than in any other WHO region, and over 5 percentage points below the global average.

Then, when we look at individual countries, we find several in which government spending on health as a proportion of GDP is close to the bottom of the global scale, and out-of-pocket expenditure is close to the top.

When we see these figures how can we say that health is a real priority? There is a gap between rhetoric and reality when positive statements of intent do not match real resources.

And yet...to be fair...we have achieved so much with remarkably little. A polio-free Region. Leprosy eliminated. Falling child and maternal deaths. Lower rates of AIDS, TB and malaria. And much, much more.

I know how hard our ministers of health fight their corner with ministries of finance. I know you have an uphill struggle!

But just think what we might achieve if our Region was to really make health the priority it deserves to be. Just one or two percentage points towards the global average of health spending against GDP could make such a difference.

**My second message is about governance for health.**

I have said many times that some of the big health problems we face – the challenge of NCDs, antimicrobial resistance, the impact of conflict on the spread of disease, ensuring access to safe and affordable medicines – are not amenable to technical solutions alone.

They are essentially problems of governance.

Success depends on solidarity and cooperation within and between countries, and across different arms of government.
As they stand, the new SDGs offer little guidance as to how to tackle many of the targets. Even anti-microbial resistance – one of the greatest threats to global health, and one that requires significant cooperation within and between countries – was only included in the very final draft of the text presented to the heads of states.

It is therefore important that we do not see the new development goals just as a new set of separate programmes, each to be addressed in its own silo.

Rather, we need to recognize that the SDG targets have much in common – not least the need for high-level political support to energize efforts across governments to tackle their underlying causes. And when it comes to NCDs – the causes of their causes!

In this regard, I feel encouraged that we now see health leadership coming from the highest levels of government in this Region – in many countries, heads of state and government have spoken out on the need for action to tackle the major risk factors for NCDs.

India has led the way by being the first country to set national targets in line with the global indicators for monitoring NCDs. Sri Lanka has pledged to increase health spending, and Thailand has its unique National Health Assembly.

I think of Bhutan’s leadership setting an example to encourage more active lifestyles. In many countries we now see an intense focus on reducing tobacco use. I have been impressed by what our hosts in Timor-Leste are doing, not just with tobacco, but by making links between health, nutrition, food security and climate change.

These are all examples of governance for health in action.

**The third message will be no surprise coming from me: it is about preparation and preparedness for disasters.**

Once again, this year, we have seen a major disaster in our Region.

That we have long known about the risks posed by earthquakes in Nepal makes it no less tragic when disaster actually strikes, as it did in April.

In addition to the lives lost, we see the longer-term risks that disasters bring in their wake – to the economy; to food security; to people’s long-term health, income and livelihoods; and to peace and security.
Every disaster, every outbreak, every incident of major flooding—as we have just seen in India, Bangladesh and Myanmar—act as a reminder of the need for better risk reduction and preparedness. As always WHO has promptly provided support.

The 2004 tsunami was a turning point. All the countries affected have worked hard to protect themselves against future events. I think particularly of the comprehensive investments made by Indonesia on disaster risk reduction: decentralizing resources and responsibilities, while encouraging provinces to work together.

You will see that we are today launching a new book—“10 years after the tsunami: impact, action, change, future”. Why now, you may ask?

The reason is that it is useful to consolidate the lessons learnt, and show that what has been done in this Region is consistent with the Sendai Global Framework for Disaster Risk Reduction and with the new SDG goal on “making cities and human settlements inclusive, safe, resilient and sustainable”. The book starts in 2004, but also fast-forwards to April 2015 and Nepal.

Preparedness in Nepal helped mitigate the scale of the disaster.

The six major hospitals in the Kathmandu Valley were all intact and functioning, and staff were ready to implement their contingency plans. Training in mass casualty management served the population well.

Within two hours of the disaster, the Emergency Operations Centre at the ministry of health was up and running, and within 24 hours the first funds from the South-East Asia Regional Health Emergency Fund had been released.

The process of rebuilding now begins in consultation with a recently formed Technical Advisory Group. The first priority must be to get services to those most in need. But as we plan reconstruction, there is also a need for reflection. Don’t just rebuild, rethink.

Before merely replacing what was lost, consider: are there better, more effective, ways of providing health care than what we had before?

We are all aware that the Ebola outbreak has shed a stark and unforgiving light on the world’s capacity to act quickly and effectively.

Only two countries in the Region have in place the core capacities required by the International Health Regulations. This is a matter of grave concern.
We need mechanisms that give countries a real incentive to invest in building the capacity they need to keep people safe, to report suspected outbreaks rapidly.

Independent assessment of country capacities can highlight challenges and gaps as the Democratic People’s Republic of Korea has shown with its recent expert review of influenza surveillance.

Ebola has reinforced the fact that a disease that affects several thousand people can have a devastating economic effect and impact the lives of millions around the world.

Countries face economic and political risks when they experience an outbreak, and like any risk they need ways of insuring against the negative consequences.

I should also add that Ebola has brought home to a much wider political audience something that those of us directly involved in public health have known for a long time. Health security will be fatally compromised in the absence of a functioning health system.

One cannot talk of a silver lining in the face of a tragedy of this magnitude. But if what has happened in West Africa results in greater investment worldwide in making health systems more effective, then we can count this as one positive outcome of the crisis.

**My fourth policy message looks to the future: it is about health in ageing populations.**

Ageing is an issue that receives little attention in the country briefs in the annual report.

Even more of a surprise: a search for the terms “ageing” or “ageing populations” in the zero draft SDG document showed zero results. Not a single mention.

And yet ageing constitutes one of the most profound, and largely predictable changes that will happen to all of our countries. And it will happen quickly.

In France, it took 150 years for the proportion of 65 year-olds to increase from 10–20% of the population. A forthcoming WHO global report on health and ageing will show that India and Thailand will have to adapt to the same changes in just over 20 years.

A longer life is a valuable resource. But the opportunities that arise from extra years of life are dependent on one key factor – health.
If people are experiencing additional years in good health, their ability to do the things that matter will be little different from that of a younger person. But if these added years are dominated by declines in physical and mental capacity, the implications for older people and for society are much more negative.

Sadly, the limited evidence we have suggests that older people today are not experiencing better health than was the case for their parents.

But this does not have to be the case. Most of the health problems of older age are linked to chronic diseases. Many of these can be prevented or delayed by healthy behaviours. Indeed, even in very advanced years, physical activity and good nutrition can have powerful benefits on health and wellbeing.

Even for people with declines in capacity, supportive environments can ensure they can live lives of dignity and continued personal growth.

In all our countries, health systems focus on treating acute problems. Success is seen in terms of curing single diseases, rather than helping individuals remain active in the face of multiple pathologies. In too many places it is unsafe and impractical for older persons to leave their homes.

We need to think in terms of integrated care that is centred on the needs of older people and age-friendly environments that support independence and autonomy.

The report will highlight several examples of good practice in our Region: the Resource Integration Centre enabling older people to claim their entitlements in Bangladesh, helping old people to feel more secure in Delhi’s informal settlements, connecting experienced retired people through “brain banks” in Thailand.

I look forward to working with you as we develop a comprehensive public health approach towards health and ageing in our Region.

As Regional Director, my prime concern is to ensure that WHO serves the needs of Member States as effectively as possible.

When I spoke to you this time last year, my prime concern was to ensure a clear focus for our work. I outlined four strategic directions that responded to priorities I had heard from countries and linked what we do in this Region with the leadership priorities in the Twelfth General Programme of Work.

These four themes provide the over-arching vision for our work, but they are very broad. I therefore went a step further to define a number of more specific initiatives, or flagship priority areas. The flagship priority areas serve as a means to give further focus to our work and to provide a framework for accountability.
Some of the flagship priority areas, such as universal health coverage, NCDs and emergency risk management remain broad, but within each we have defined specific areas of focus – human resources for health and access to medicines in the case of UHC and implementing ‘best buys’ in the case of NCDs.

As I mentioned earlier, the flagship priority areas on antimicrobial resistance represents an area of global and regional significance which has been relatively neglected and which requires urgent action across governments. I am encouraged to see that cross-sectoral bodies to address the threat of AMR feature in several country reports.

The flagship priority areas provide focus by adding specific targets in relation to selected neglected tropical diseases. The diseases selected – kala-azar, leprosy, lymphatic filariasis, schistosomiasis and yaws – are chosen in part because the targets can be achieved in the timeframe specified.

Similarly, measles and rubella are chosen to build on the expertise and the infrastructure created for polio eradication. It is also a clear demonstration that, given the right level of political and financial support, we can eliminate major public health problems in our Region.

If we succeed, this kind of achievement gives governments confidence that an investment in health pays real dividends. Confidence gained through short-term results provides a persuasive platform for longer-term investment.

Lastly, the flagship priority areas on the MDGs reminds us that we still have work to do in achieving goals that all countries have signed up to. However, I want to draw your attention to the issue of neonatal mortality.

Countries like Bangladesh, Democratic People’s Republic of Korea, Nepal and others have made impressive progress on reducing child mortality. However, further declines will depend on reducing the significant proportion of child deaths that occur during the neonatal period.

This will require more attention being paid to the quality of care provided at health facilities, and helping mothers in hard-to-reach areas, cover the cost of reaching them.

The flagship priority areas give us focus, but they are not set in stone. While the current seven areas will remain relevant for the next biennium, other issues – such as health and ageing – may emerge and be added to the list.
WHO’s resources are tiny in comparison to the Region’s needs. So we need to be clear not just about what we do, but how we do it. WHO is not a donor, so we must use the funds we have strategically – to stimulate action on the part of others and to leverage resources from our partners.

At the same time, we have to make sure we use the resources available to us. We are striving hard to do better and better. But as I said at the Regional Committee last year, it is not just a question of spending fast; we must also spend wisely.

Good planning is the key. Over the last few months we have been planning for the new biennium – focusing on outcomes and deliverables.

We can no longer accept plans that are ambiguous or vague. It is also pointless to divide small financial allocations between an unrealistic number of objectives that have no hope of being achieved – just so every department gets a share.

I want to see country plans and budgets that focus on agreed priorities; that allow space for addressing specific national needs; that use WHO resources strategically and tactically; that are transparent and easily understood; and that define results for which WHO can be held accountable.

I have also insisted that plans for work at the regional office, set out how each department, will add value to what is happening in countries. In this context I have advised regional and country staff to ensure that monitoring be made a priority. What is not measured and monitored is not done.

We must remain responsive to Member States as we plan for the future. Priorities and focus are important, but this cannot preclude the need to address the specific needs of individual countries. Given the diversity of our Region – not everything that is important to Bhutan will be relevant to the Maldives – one size cannot ever fit all.

As we continue our discussions at this Regional Committee, let us remember: Better health is not a luxury, it is an investment. It is also a right to be made available to all, not a privilege to be granted to a few.

We are living in a fast changing world. We must expect the unexpected and be ready to face the challenges that the world will continue to throw our way.

WHO is here to support you. To offer advice based on the best evidence, to facilitate, to convene and to link each country to a growing network of global and regional resources.
### Agenda

1. Opening of the Session
2. Credentials of Representatives
3. Election of office-bearers
4. Adoption of the Agenda
5. Key addresses and report on the Work of WHO
   5.1 Introduction to the Regional Director’s Annual Report on the Work of WHO in the South-East Asia Region covering the period 1 January–31 December 2014
   5.2 Address by the Director-General
6. Programme Budget Matters:
   6.1 Programme Budget 2014–2015 – Implementation and mid-term review
   6.2 Programme Budget 2016–2017
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7. WHO reform
   7.1 Programmatic reform – focus on results
   7.2 Management reform – internal control framework
   7.3 Governance reform
   7.4 Framework of engagement with non-State actors
8. Policy and technical topics
   8.1 Response to emergencies and outbreaks
   8.2 Antimicrobial resistance
   8.3 Selected neglected tropical diseases targeted for elimination: kala-azar, leprosy, yaws, filariasis and schistosomiasis
   8.4 Adapting and implementing the End TB Strategy in WHO South-East Asia Region
8.5 Patient safety contributing to sustainable universal health coverage  
     SEA/RC68/14 and Rev.1
8.6 Prevention and control of cancer – the way forward  
     SEA/RC68/15
9. Progress reports on selected Regional Committee resolutions:  
     SEA/RC68/16 and Add.1
9.1 Measles elimination and rubella/CRS control in SEAR by 2020  
     SEA/RC66/R5
9.2 Challenges in polio eradication  
     SEA/RC60/R8
9.3 Health intervention and technology assessment in support of universal health coverage  
     SEA/RC66/R4
9.4 South-East Asia Regional Health Emergency Fund (SEARHEF)  
     SEA/RC60/R7
9.5 Effective management of medicines  
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9.6 Regional strategy on health information systems  
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10. Technical Discussions  
     SEA/RC68/17 and Inf. Doc.1
10.1 Consideration of the recommendations on strengthening community-based health-care services  
8. Technical Discussions to be held prior to the Sixty-ninth Session of the Regional Committee
10.2 Selection of a subject for the Technical Discussions  
     SEA/RC68/18
11. Governing body matters  
     SEA/RC68/19 and Add.1
11.1 Key issues arising out of the Sixty-eighth World Health Assembly and the 136th and 137th Sessions of the WHO Executive Board  
8. Governing body matters
11.2 Review of the Draft Provisional Agenda of the 138th Session of the WHO Executive Board  
     SEA/RC68/20
11.3 Review of Regional Committee resolutions  
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11.4 Elective posts for governing body meetings (WHA, EB and PBAC)  
     SEA/RC68/22
12. Management and governance matters  
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12.1 Status of SEA Regional Office building  
13. Special Programmes  
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14. Ministerial Round Table
   14.1 Strengthening health workforce in South-East Asia in order to expand delivery of effective services
   14.2 Health in the post-2015 development agenda
   14.3 Accelerating implementation of WHO FCTC in S.E.A.

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

16. Adoption of resolutions

17. Adoption of the report of the Sixty-eighth session of the Regional Committee

18. Closing of the session
Annex 7
List of participants

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SHARE  
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Chief of Party, USAID Health Project  
John Snow, Inc.  
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Water Aid  
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WaterAid  
Dili, Timor-Leste
Mr Justino Da Silva  
Head of Policy and Campaigns  
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6. Ambassadors/High Commissioners

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Ambassador  
Embassy of Malaysia  
Dili, Timor-Leste

*Embassy of the Republic of Indonesia*  
H. E. Mr Primanto Hendrasmoro  
Ambassador  
Embassy of the Republic of Indonesia to Timor-Leste  
Dili, Timor-Leste

Mrs Novita Supit  
Second Secretary  
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Dili, Timor-Leste
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The Regional Committee for South-East Asia is WHO’s governing 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 progress in health development in the Region as well as to consider the regional implications of the World Health Assembly resolutions, among others.

This report summarizes the discussions of the Sixty-eighth Session of the Regional Committee held in Dili, Timor-Leste, from 7 to 11 September 2015. At this session, the Committee reviewed and discussed a number of public health issues important to the Region, such as emergencies and outbreaks, patient safety, cancer prevention and control, antimicrobial resistance, community-based health services and their contribution to sustainable universal health coverage, and tobacco control. The Committee adopted a number of resolutions on these issues.