The Regional Committee for South-East Asia is the World Health Organization’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-ninth Session of the Regional Committee held in Colombo, Sri Lanka, on 5–9 September 2016. At this session, the Committee reviewed and discussed a number of public health issues important to the Region, such as the Sustainable Development Goals, addressing noncommunicable diseases at the primary health care level, neglected tropical diseases, migration and health, and International Health Regulations post-2016, among others. The Committee adopted a number of resolutions on selected issues.
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1. The Sixty-ninth Session of the WHO Regional Committee for South-East Asia was held in Colombo, Sri Lanka, from 5 to 9 September 2016. It was attended by representatives of all 11 Member States of the Region, United Nations and other agencies, and nongovernmental organizations (NGOs) having official relations with WHO, and observers.

2. The inaugural session of the Regional Committee was held on 5 September 2016. His Excellency, Mr Ranil Wickremesinghe, Prime Minister of the Democratic Socialist Republic of Sri Lanka, delivered the inaugural address.

3. The Regional Committee elected His Excellency Dr Rajitha Senaratne, Minister of Health, Nutrition and Indigenous Medicine, Democratic Socialist Republic of Sri Lanka, as Chairperson of the Sixty-ninth Session of the Regional Committee. His Excellency Mr Zahid Maleque, State Minister, People’s Republic of Bangladesh, was elected as Vice-Chairperson.

4. A drafting group on resolutions comprising a representative from each Member State was constituted
with Mr Amal Pusp, India, as Rapporteur. During the session, the Committee adopted eight resolutions on the following subjects: Colombo Declaration on Strengthening Health Systems to Accelerate Delivery of NCD Services at the Primary Health Care Level; Proposed Programme Budget 2018–2019; Ending Preventable Maternal, Newborn and Child Mortality in the South-East Asia Region in line with the Sustainable Development Goals (SDGs) and Global Strategy on Women’s, Children’s and Adolescents’ Health; Promoting Physical Activity in the South-East Asia Region; Strategic Action Plan to reduce the Double Burden of Malnutrition in the South-East Asia Region 2016–2025; Expanding the Scope of the South-East Asia Regional Health Emergency Fund (SEARHEF); Amendment to the Rules of Procedure of the WHO Regional Committee for South-East Asia; and a Resolution of Thanks.

5. The Committee reviewed the Report of the Regional Director on the Work of WHO in the South-East Asia Region covering the period 1 January–31 December 2015.
Welcome address by H.E. Dr Rajitha Senaratne, Minister of Health, Nutrition and Indigenous Medicine, Democratic Socialist Republic of Sri Lanka

6. Welcoming the distinguished delegates, H.E. Dr Rajitha Senaratne, Minister of Health, Nutrition and Indigenous Medicine, Democratic Socialist Republic of Sri Lanka, recalled that the Regional Committee was being held in Sri Lanka after 11 years since the Fifty-eighth session in Colombo in 2005.

7. The work of WHO and partners in the South-East Asia Region, home to a quarter of the world’s population, can definitely and tangibly influence health outcomes globally, he said. His Excellency expressed appreciation for the guidance of the World Health Assembly in shaping the global health agenda. He added that this Regional Committee Session will help in sharing experiences and knowledge that will impact on public health in the Region.
8. The Minister also highlighted public health successes in Sri Lanka, such as the availability of free health services for all. He thanked the distinguished delegates for attending the session, the importance of which was reflected by the fact that health ministers from Member States of the Region were present at the session.

9. He also thanked the Regional Director, Dr Poonam Khetrapal Singh, for her continued support and guidance for strengthening public health in the Region.

*(For full text of address please see Annex 1)*

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

10. Welcoming the representatives of Member States of the South-East Asia Region, the Regional Director, Dr Poonam Khetrapal Singh, thanked the Prime Minister, H.E. Mr Ranil Wickremesinghe, and the Government of the Democratic Socialist Republic of Sri Lanka for their warm hospitality.

11. Dr Singh lauded Sri Lanka for its “enviable and well-deserved reputation in the field of health for achieving good health outcomes at modest cost”. Stating that past investments in island-wide infrastructure guided by policies stressing primary health care have paid rich dividends, Dr Singh reiterated that there will not be a “global health textbook anywhere in the world that does not at some point cite the example of Sri Lanka”.

12. The Regional Director congratulated Sri Lanka for its many public health successes in the recent past: the World No-Tobacco Day Award in December 2015; certification of the country’s elimination of lymphatic filariasis and malaria; and unrelenting progress towards halting mother-to-child transmission of HIV infection.

13. The Regional Director also highlighted the challenges to health delivery that continue to affect the Region, including the “unacceptable gap” between the stated importance of health and the resources that governments actually commit to health. She urged the ministers to recognize that every dollar spent wisely on health can yield between US$ 10 and US$ 20 in return.

14. While with the right policies in place, there is no reason that countries in the Region should not aspire to having health systems on par with the best in the world, the road ahead is fraught with risks, Dr Singh said. Demographic
and epidemiological changes can pose a major threat to economies. The growing burden of noncommunicable diseases (NCDs), for example, including mental health, substance abuse and accidents, have the potential to bankrupt health systems and families. Outbreaks and epidemics have economic consequences, with diseases that affect thousands now resulting in the loss of billions of dollars worldwide.

15. People’s expectations are changing: they want the best from providers and are increasingly vocal if their demands are not met; but the resources are finite and have to be allocated equitably. This means setting priorities and the budgets that follow transparently. It also means a carefully negotiated relationship with the private sector to harness private assets for public good.

16. In conclusion, Dr Singh said the Regional Committee is an annual opportunity to reflect on the achievements and challenges to public health in the Region, and to be successful it must also be a forum where countries learn from each other and share experiences.

(For full text of address please see Annex 2)

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

17. Dr Margaret Chan, Director-General of the World Health Organization, observed that the South-East Asia Region brings together a diverse range of low- and middle-income countries that show wide variations in size, geography, culture and social and economic development, and are at different stages in the epidemiological and demographic transitions, but are nevertheless united by a firm commitment to the principles of primary health care.

18. Calling the health targets in the 2030 Agenda for Sustainable Development “supremely ambitious yet feasible”, Dr Chan said that these will build on the huge achievements for health made since the start of this century in this Region.

19. Calling Sri Lanka a model welfare state with its policy of universal free access to health care and education, Dr Chan said she looked forward to the discussions ranging around the “high ambitions for health” of the leaders of the Region and how to pursue them. In particular, she said, she was interested in the two Ministerial Roundtables on the rising challenge of noncommunicable diseases and the implications for health of the Sustainable Development Goals (SDGs) and their target for reaching universal health coverage (UHC).
20. Calling UHC the pillar of both sustainable development and global health security, the Director-General said countries of the Region can prove that any country at any level of development can achieve UHC since political commitment, and not national wealth, is the decisive factor.

21. Dr Chan also lauded Sri Lanka for the WHO certification of elimination of malaria, marking an end to the intensified campaign launched in 2008. In her opinion, the biggest overall determinant of these exceptional health outcomes is the high level of political commitment. This is reinforced by the enduring view of governments that a nation’s health is a nation’s wealth.

*(For full text of address please see Annex 3)*

**Inaugural address by H.E. Mr Ranil Wickremesinghe, Prime Minister, Democratic Socialist Republic of Sri Lanka**

22. In his inaugural address, H.E. Mr Ranil Wickremesinghe, Prime Minister of the Democratic Socialist Republic of Sri Lanka, highlighted the recent health successes and achievements in Sri Lanka that kept pace with public health successes in the rest of the Region. The people of Sri Lanka had access to both traditional and modern health systems for both prevention and cure. Although per capita GDP spending on health is relatively low and was expected to rise in the near future, the country had one of the highest life expectancies in the Region.

23. An extensive network of hospitals and health units extends from cities to the homes of the rural poor; a well-developed infrastructure provides safe drinking water and sanitation, again also in rural areas; and immunization coverage has been sustained at a high 99% in every district for several years.

24. While the government is committed to affordable health care and commensurate spending on research, finding resources to match the goals and targets remains a challenge. H.E. the Prime Minister said that the Regional Committee discussions may throw light on the interesting question of how to pool resources for common health research across the Region and also interlink health institutions across Member States to extend their reach.
Vote of thanks by H.E. Mr MCM Faizaal, Deputy Minister of Health, Nutrition and Indigenous Medicine, Democratic Socialist Republic of Sri Lanka

25. His Excellency Mr MCM Faizaal, Deputy Minister of Health, Nutrition and Indigenous Medicine, Democratic Socialist Republic of Sri Lanka, extended a warm welcome to the Prime Minister of Sri Lanka, H.E. Mr Ranil Wickremesinghe, the honourable health ministers of Member States of the South-East Asia Region, the WHO Director-General, Dr Margaret Chan, the WHO Deputy Director-General, Dr Anarfi Asamoa-Baah, the WHO Regional Director for South-East Asia, Dr Poonam Khetrapal Singh, delegates from the United Nations and its Specialized Agencies, and all other distinguished delegates to the Sixty-ninth Session of the WHO Regional Committee for South-East Asia. He also thanked his ministerial colleagues and Members of Parliament of Sri Lanka as well as provincial Governors and Chief Ministers for attending the meeting.

26. H.E. Mr MCM Faizaal said it was a great honour and pleasure for Sri Lanka to host the Sixty-ninth Session of the Regional Committee. He thanked the WHO Regional Office for South-East Asia for extending all possible administrative and logistical support to Sri Lanka that enabled a meeting of this scale to be organized. He also lauded the untiring and diligent efforts of the team of colleagues from the ministries of health and other ministries who were members of the National Organizing Committee and whose unflagging efforts and attention to every detail contributed greatly to the successful organization of the Regional Committee.

(For full text of address please see Annex 4)
Opening of the Session

27. In the absence of the Chairperson and Vice-chairperson of the Sixty-eighth Session of the Regional Committee, the Regional Director, Dr Poonam Khetrapal Singh, opened the meeting in accordance with Rule 12 of the Rules of Procedure of the WHO Regional Committee for South-East Asia. She extended a warm welcome to all representatives of Member States of the South-East Asia Region and other participants. She noted that despite steady progress, formidable health challenges remained to be addressed in the Region, and Regional Committee Sessions provided an important opportunity to discuss issues and to guide responses to such challenges. In this, WHO remained committed to providing support to all its Member States, she added.

Credentials of Representatives (Agenda item 2)

28. The Committee was informed that in line with Rules 3 and 3bis of the Rules of the Procedure of the Committee the validity of the credentials of representatives, including of all alternates and advisers from all Member States, had been examined and found to be in order.
Election of Officebearers (Agenda item 3)

29. The Regional Committee elected His Excellency Dr Rajitha Senaratne, Minister of Health, Nutrition and Indigenous Medicine, Government of the Democratic Socialist Republic of Sri Lanka, as Chairperson, and His Excellency Mr Zahid Maleque, State Minister of Health, Ministry of Health and Family Welfare, Government of the People’s Republic of Bangladesh, as Vice-Chairperson.

30. The Chairperson thanked the Committee for his election, which he deemed an honour and a privilege. He looked forward to the support and cooperation of the distinguished delegates in the conduct of the Regional Committee Session.

31. The Committee was informed that two of the candidates for the post of Director-General, elections to which are due during the World Health Assembly in May 2017, were present at the venue under the category of “Others in Attendance”. The two candidates are Dr Tedros Adharan Ghebreyesus from Ethiopia and Dr Sania Nishtar from Pakistan.

32. The Committee was also informed that the Code of Conduct for the Election of the Director-General of the World Health Organization encourages Member States and candidates to consider using as much as possible opportunities, such as Regional Committee sessions, for meetings and other promotional activities linked to their electoral campaigns. Accordingly, campaign events may be organized either by Member States or by prospective candidates in the margins of the Regional
Committee when the Committee is not in official session. A time and place has been set aside for such events. It was, however, clarified that campaigning will not take place as part of or interfere with the Regional Committee’s official programme and accordingly neither Member States nor prospective candidates will be given speaking time during the proceedings to promote their candidacy. The Committee was asked to respect this when making interventions on matters on the Agenda of the Regional Committee.

Adoption of the Agenda (Agenda item 4, SEA/RC69/1)

33. The Committee unanimously adopted the Agenda for its Sixty-ninth 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 2015 (Agenda item 5.1, SEA/RC69/2)

34. Introducing her annual report on the Work of WHO in the South-East Asia Region for the period 1 January–31 December 2015, the Regional Director, Dr Poonam Khetrapal Singh, expressed great pleasure to be able to speak to the distinguished delegates about the state of health of the people of the diverse Region. This report of WHO’s work, she said, is a record of the joint efforts of WHO and Member States that resulted in a series of health triumphs – and there are several that the Region can be very proud of – as well as ongoing challenges.

35. In this, her third address as Regional Director, Dr Singh said there is a sense of shared accomplishment about achievements in individual countries and the Region as a whole. To illustrate, she highlighted the example of governments such as that of Sri Lanka that have significantly increased health spending.

36. Dr Singh gave examples of significant public health achievements by Member States and highlighted major milestones achieved, key health challenges and how these are being addressed, and how, in each country, WHO’s work has made a difference.

37. Sri Lanka has established a new independent drug regulatory authority and is one of 12 pilot countries worldwide pioneering intensive efforts in the control of noncommunicable diseases (NCDs). Timor-Leste has embarked on an ambitious national programme to bring a comprehensive service package for primary health care (PHC) to all families, modelled on the Cuban primary health care system. Thailand has consolidated its leadership position in the global battle to end paediatric
AIDS and in enhancing health-care coverage. In June 2016, WHO declared Thailand the first country in Asia to eliminate mother-to-child transmission of HIV and syphilis.

38. Nepal received the GAVI Alliance Child Survival Award in 2015 and has committed in its Constitution to universal access to free health care. The new government in Myanmar has committed to significant increases in health spending. WHO recently confirmed that, following its success in eliminating malaria in 2015, Maldives has also eliminated lymphatic filariasis. In addition, it is on its way to eliminate measles and congenital rubella of which no cases have been reported since 2010.

39. In 2016, Indonesia is the chair of the Global Health Security Agenda Steering Group ensuring a powerful regional voice in a critical global agenda. India has committed to implementing an exemplary national action plan to combat antimicrobial resistance (AMR), and hosted an international conference on AMR earlier this year. The government also plans to leverage the polio legacy and the vast polio programme infrastructure to strengthen UHC.

40. The Democratic People’s Republic of Korea continues to play a steering role in traditional medicine, hosting a meeting that produced a Regional Action Plan in support of the new WHO Traditional Medicines Strategy. Bhutan pioneered new approaches to public sector accountability with annual performance agreements between the Prime Minister and ministers. Following the launch of the Global Finance Facility, Bangladesh became the first country in the Region to access these funds for maternal, child and adolescent health.
41. The Committee was also informed of an important regional milestone: the elimination of maternal and neonatal tetanus as a major public health problem. “It took longer than we expected, but it is a victory that we can celebrate,” she said.

42. On the subject of tobacco control, the Regional Director informed the Committee that in November 2016, India will host the Seventh Session of the Conference of Parties to the WHO Framework Convention on Tobacco Control (WHO FCTC), a conference that will enhance tobacco control measures, including plain packaging, across the Region.

43. The Committee’s attention was also drawn to the fact that different Member States of the Region are in a phase of transition, political, constitutional as well as economic. Sustained economic growth means that there will soon be only one low-income country in the Region as others transition to middle-income status. In the midst of this there is a disconnect between the priority that health gets in the rhetoric of speeches and the level of resources it receives in reality. Only three countries spend more than 10% of government budget on health (with the regional average being only 3.5% of GDP), with at least 60 million people being pushed into poverty each year as a result of out-of-pocket health-care costs.

44. The Committee was reminded of the increase in the role of the private sector as a financier and provider of health care, with the rider that, skillfully managed, resources of the private sector can be harnessed for the public good.

45. The Regional Director noted that the transition from the Millennium Development Goals (MDGs) to the Sustainable Development Goals (SDGs) is the biggest transition of all. The Committee was informed about the key themes that will guide health policy-making in the Region in the coming years: “Leaving no one behind”; and “an integrated and indivisible agenda”. “Leaving no one behind” requires that we go beyond overall achievements and focus on those who are excluded. We need to know who the people are and why they are being excluded, and what can be done to reach them more effectively. The Committee was informed that the Asia-Pacific Observatory on Health Systems and Policies, which can help answer these questions, is hosted by the Regional Office for South-East Asia with effect from August 2016. The “integrated and indivisible agenda” of the SDGs calls for health to be a cross-sectoral priority.

46. The launch of the SDGs has also put UHC at the centrestage, as UHC underpins all other health targets and helps make the health agenda cohesive and less like a list of separate programmatic silos. The key idea of UHC is that all people have access to the services they need, without facing financial hardship when they fall ill.
47. While progress has been positive, around 130 million people in this Region still lack access to one or more services, and at least 60 million are impoverished as a result of health-care costs. Sixty per cent of out-of-pocket spending is on medicines. Thus, reducing the cost of treatment becomes central to financial protection.

48. The Regional Director highlighted four key messages: first, priority-setting is central to UHC; second, we need to revisit our thinking on frontline services; third, financial protection is not just about insurance, other policies matter too; and fourth, the health SDGs require actions beyond the health sector.

49. Addressing NCDs, mental health and substance abuse – key problems in our Region – will place new demands on frontline health workers, outreach staff, referral systems, and on supply, logistics, education and information systems.

50. The Committee was informed about the progress made on the seven Flagship Priorities, which are the driving force behind new ways of working in the Regional Office. The Flagships have also been an important instrument for improving planning, enabling the Region not only to spend more wisely but also to spend well.

51. While the health SDGs require actions beyond the health sector, the Regional Director observed that many working for governments still underestimate the important role of other stakeholders in the health sector, and the potential for more productive partnerships with parliamentarians, the private sector, NGOs and civil society. The commitments made to universal health coverage mean that the challenge is no longer about what is to be achieved, but how to make progress, given the complexity of the challenges in the real world.

52. The Committee noted with appreciation the watershed public health milestones reached in South-East Asia in the recent past. The Region was certified as being polio-free in 2014 and the status has been maintained. Furthermore, the past two years have witnessed other outstanding public health successes. The Region as a whole achieved elimination of maternal and neonatal tetanus; India was declared yaws free; Maldives has eliminated malaria and also lymphatic filariasis; and Sri Lanka has done the same. Thailand became the first country in Asia and the second in the world to achieve elimination of mother-to-child transmission of HIV and syphilis.

53. The Regional Director said that her report had attempted to highlight the milestones and achievements of each country in the Region amidst the several health challenges being faced by the Member States. She thanked the ministers for their support to the Flagship Priorities, to which 75% of the regional budget had been devoted. The progress under each of the seven Flagship Priorities was being
separately shared with the Regional Committee. Flagships have helped in improving planning, increasing the focus of work, breaking silos, and have brought an emphasis on deliverables. The internal review mechanism had been strengthened in the Regional Office with the addition of a technical adviser and a WHO reforms adviser.

54. In conclusion, the Regional Director said that while there have been notable achievements in public health for this Region, new threats from outbreaks and emergencies continue to emerge, and “expecting the unexpected is the new normal in global health”. While the Region’s response to crisis will always be a yardstick by which it is judged, issues such as the long-standing problems of suffering and costs incurred by people from avoidable NCD risk factors, and of health systems that are under-resourced and exclude millions from receiving the care that they need, should not be overlooked. The Committee was assured of WHO’s continuing support by providing advice based on best evidence, and by facilitating, convening and linking each country to a growing network of regional and global resources, in the Region’s efforts to overcome the immense health challenges.

(For full text of Regional Director’s Address please see Annex 5)

Address by the Director-General (Agenda item 5.2)

55. Dr Margaret Chan, Director-General of WHO, congratulated Sri Lanka on having achieved UHC and many health outcomes comparable with those in richer countries. She said that the world was undergoing a profound transition, in which poverty persisted, especially in rural areas, while at the same time there was increasing prosperity accompanied by a rise in noncommunicable diseases. The SDGs were
based on the premise of intersectoral collaboration, as health was both the basis and the outcome of activities in other sectors. For example, malnutrition – both under- and overweight – could have severe wider consequences, as expressed by the Director of the African Development Bank: “Stunted children today, stunted economies tomorrow”. Furthermore, failures in other ministries, such as transport or public works, could affect the health sector by causing injuries or disease. Governments should have coherent policies.

56. Health thus represented the ultimate objective of many goals. As many health inputs and outputs could be measured reliably, the sector was transparent and reliable. UHC, with protection against financial risk, led to stable societies and less poverty; it was the ultimate expression of fairness and equity. She reminded the Committee that 75%–80% of health budgets were derived from domestic sources, and ministries should seek ways to maximize efficient use of domestic resources. She reiterated the five “Ps” that underpin the SDGs: people, planning, peace, prosperity and partnerships.

(For full text of Director-General’s Address please see Annex 6)

57. The Committee congratulated the Regional Director for her succinct and comprehensive report which highlighted the Region’s successes, experiences and good practices. It was recommended that areas in which more progress was needed be highlighted to guide country priorities and budgets. It was also recommended that the progress made with each of the seven Flagship targets, the results achieved by international nongovernmental organizations and the role of informal meetings
be further elaborated. The Committee also called for more allocations of WHO resources to countries to address their priorities; a strengthened process of internal review; more technical information from headquarters for use at the country level; and specific guidance on the implementation of resolutions.

58. The Committee recognized the important role of WHO country offices in identifying priorities for national health plans. The SDGs provided a framework for intersectoral partnerships to improve the lives of the increasingly ageing and urban population of a world in transition. The Regional Office was thanked for using the South-East Asia Regional Health Emergency Fund to support countries in responding to catastrophic natural disasters. Areas in which WHO support would continue to be required were identified as: information technology, health systems strengthening and health workforce training. The Region had tremendous opportunities for collaboration, which could result in huge health gains for one quarter of the world’s population.

59. The Committee thanked Dr Chan for her outstanding and strong leadership in global health and public health as Director-General. The world of public health will miss her strength and determination.

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

60. Dr Deepika Attygalle, Regional Coordinator, South-to-South Programme, speaking on behalf of Ms Jean Gough, Regional Director for South Asia, United Nations Children’s Fund (UNICEF), said that she supported the focus in the Regional Director’s report on universal health care. Countries should increase public-private financing and increase the percentage of their GDP for the health sector. Morbidity and mortality among mothers and children could be reduced by simple, inexpensive interventions to which they had ready access.

61. Ms Nelly Enwerem-Bromson, Director, Division Programme of Action for Cancer Therapy (PACT), Department of Technical Cooperation, International Atomic Energy Agency, reviewed the Agency’s Programme in cancer control, which included increasing national capacity for the prevention, diagnosis, treatment and palliation of cancer. With WHO and the International Agency for Research on Cancer, the Agency conducted national reviews on cancer control, providing data and indicating gaps and priorities. The Programme also included workshops in cancer registration to inform cancer control planning, palliative care, facilitated funding for equipment, and training of cancer control personnel.
62. Dr Sharika Lasanthi Peiris, Head of the International Organization for Migration (IOM), Sri Lanka Unit, expressed satisfaction with the inclusion of the issue of “Migration and health” as an Agenda item for the Regional Committee, calling it timely since we live in an era of unprecedented human mobility. While many South-East Asian countries are key source countries of migrant workers, there is a major mobility of migrant workers within the Region. For instance, Thailand hosts between 2.5 million and 3 million migrant workers, overwhelmingly from neighbouring Myanmar and Cambodia, and there are an estimated one million Indonesians in Malaysia and nearly 400 000 Malaysians in Singapore. In addition, South-East Asia is home to more than 500 000 refugees and asylum seekers.

63. The valuable contributions of migrants to the social and economic development of both their countries of origin and those of their destination within the SEA Region were highlighted, and it was stressed that this is only possible if migrants are physically and mentally healthy, regardless of their migration status. Many migrant groups that still lack access to affordable health services are exposed to occupational health hazards, and they are affected disproportionately by malaria, tuberculosis and HIV infection.

Ministerial Roundtable (Agenda item 6)

Strengthening health systems response to address noncommunicable diseases at the primary health care level (Agenda item 6.1, SEA/RC69/3 Rev. 1)

64. The Ministerial Roundtable on strengthening health systems to address noncommunicable diseases (NCDs) at the primary health care level was chaired by H.E. Dr Rajitha Senaratne, Minister of Health, Nutrition and Indigenous Medicine,
Democratic Socialist Republic of Sri Lanka, with Dr Palitha Abeykoon, Chairperson, National Authority on Tobacco and Alcohol, Sri Lanka, as Moderator, and Sir George Alleyne, health expert and Director Emeritus of the WHO Region of the Americas, as the invited global expert.

65. The session began with a video presentation on the significance of the primary health care (PHC) system for NCD management, followed by comments from Sir George Alleyne. Health ministers and chief delegates from Member States discussed country experiences, lessons learnt, and challenges to and solutions for strengthening NCD management at the PHC level in the Region.

66. Member States shared concerns about the impact of NCDs on health and society, including high and increasing health-care costs and the demands posed by major NCDs. Health ministers commented on the rapid changes in demographic profiles as well as the lifestyle of populations as determinants and correlates of the challenge of NCDs. The major gaps in the current health-care system were recognized, particularly with regard to PHC, including inadequate financial and competent human resources and lack of a robust health information system.

67. All Member States in the Region have demonstrated policy commitment in tackling NCDs, including setting national targets, multisectoral plans and strategies, increasing resource allocation to NCD programmes, and establishment of dedicated units responsible for NCD prevention and control. Further, countries in the Region had many good practices and experiences, as well as social assets, such as traditional medicine and health promotion activities, ready to be scaled up within and across countries.

68. Health ministers agreed on the significance of ownership and engagement of stakeholders beyond the health sector. NCD prevention and control required whole-of-society and whole-of-government approaches, with effective coordination and accountability mechanisms to promote collaboration across sectors, including the contribution of community and volunteers, and the education sector. Health ministers also acknowledged that NCD prevention and control needs proactive and innovative approaches, such as eHealth and information technology, working with mass media, and collective procurement of NCD medicines and technologies at the international level to address the high cost of treatment.

69. There is an urgent need to promote a comprehensive and integrated NCD management system, ranging from primary prevention to screening and palliative care in the community. NCD management at the PHC level should be well harmonized
with other components of NCD prevention and control systems, including risk reduction and primary prevention, school health programmes and health promotion. In particular, a robust health information system including surveillance and research, and a strong information-action linkage to monitor system performance, can be the backbone for an effective NCD prevention and control programme.

70. Health ministers appreciated WHO’s support for NCD prevention and control at the country level, and requested WHO to review existing plans and strategies in order to ensure alignment with the Colombo Declaration (see page 68), and identify room for improvement.

71. The Regional Director, Dr Poonam Khetrapal Singh, noted the progress made, initiatives taken as well as the lessons learnt on NCD prevention and control, which was a regional Flagship Priority. These included reorienting PHC centres into healthy lifestyle clinics in Sri Lanka and strengthening tobacco control in Timor-Leste. She reiterated WHO’s continued commitment to supporting Member States in the Region on NCD management, including visits by technical experts to countries upon request.

72. The Colombo Declaration on Strengthening Health Systems to Accelerate Delivery of NCD Services at the Primary Health Care Level was adopted by the ministers and endorsed by the Sixty-ninth Regional Committee through a resolution.

Sustainable Development Goals (SDGs) and universal health coverage (UHC) (Agenda item 6.2, SEA/RC69/4)

73. The Ministerial Roundtable was chaired by Her Excellency Professor Dr Nila Farid Moeloek, Minister of Health, Republic of Indonesia, and moderated by Dr Viroj
Tangcharoensathien, Adviser to the Office of the Permanent Secretary, Ministry of Public Health, Thailand. In her introduction, the Chairperson noted that the SDGs include “unfinished business” from the era of the MDGs and emphasized the need for stronger health systems, adding that countries in the Region should strengthen their collaboration to achieve the SDGs.

74. An update on global developments since the SDG Declaration was endorsed in 2015 was provided by Dr Nata Menabde, Executive Director, WHO Office at the United Nations. She noted that health is now almost always discussed as part of bigger multisectoral discussions, at which ministries of health are often not present. She emphasized that UHC is increasingly seen as central to achieving the health-related SDGs because of its focus on equity, and noted that UHC has been discussed in forums such as the recent G7 Summit in Japan and the World Economic Forum. Important gatherings related to the SDGs and UHC resulted in various reports from UN commissions on Economic Growth and the Health Workforce; and, on access to medicines, there are links with debates on AMR and migration. Overall, she observed, the success of the SDGs depends on country ownership and more integrated ways of working, which will affect everyone, such as engaging communities, working with the private sector, developing new forms of accountability, and also changing the ways UN agencies work together, which is already happening.

75. Ministers then discussed the lessons learnt from implementing the MDGs for addressing the SDGs. They reported that most of the MDGs had been achieved, and commented on the reasons for their success. They also highlighted some gaps and challenges: the MDGs addressed only part of a country’s health needs; there are critical health workforce gaps in many countries; out-of-pocket payments for health care are high in some countries and are difficult to reduce; and there are inequalities in service delivery. They noted the need for more intersectoral action and collaboration, for greater health literacy, for ways to work with the private sector and NGOs, and for stronger health monitoring systems and disaggregated data.

76. Looking forward, many ministers noted that although the SDGs are ambitious there are foundations to work on. Actions are already being taken. National SDG consultations are being held in many countries. A range of SDG coordination mechanisms are being introduced, from national health coordination focal points to the creation of task forces or ministries for sustainable development. In some, the SDGs are already being integrated into national health and development plans. Existing commitments to UHC are being extended, with some countries focusing on new service delivery models, some extending community-based services and others exploring how to involve the private sector or improve the quality of care. Examples
were given of extending access to free or lower-priced medicines. Interventions to reduce out-of-pocket payments are also being introduced, through increased government budget allocations for health and different forms of social health insurance. Some countries have begun to discuss how to monitor the SDGs in a more integrated way, to develop targets relevant to their own situations and to generate more disaggregated data.

77. Additional regional and global perspectives were provided by the Deputy Director-General of WHO, Dr Anarfi Asamoah-Baah. The need to disaggregate data to know who is being left behind was stressed by Sir George Alleyne, Director Emeritus of the WHO Region of the Americas. He also spoke of “the tyranny of national averages”, and the need for the health sector to speak the same language as other sectors if they are to work together.

78. The Regional Director, Dr Poonam Khetrapal Singh, noted how different the discussions are at the start of the SDGs compared with the beginning of the MDGs. She observed how most SDG discussions have UHC at their centre and address the steps being taken to promote intergovernmental collaboration, which is difficult but important.

79. Some misconceptions around the SDGs were highlighted by Dr Anarfi Asamoah-Baah. The first is that 2030 is far off, when in fact action is needed now; second, that the SDGs are too ambitious and costly, but in fact there are resources; and third, that the SDGs are “not for ministries of health” when in fact great advances in health – such as the WHO Framework Convention on Tobacco Control – have been made by health ministers working actively with other sectors.

80. In closing, the Chairperson reiterated the importance of prevention and health promotion, as well as PHC, in ensuring good health and well-being.

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

**Programme Budget 2016–2017: Implementation**  
(*Agenda item 7.1, SEA/RC69/5*)

81. The Committee noted that the Approved Budget for the WHO South-East Asia Region for 2016–2017 is US$ 365.1 million, and the Allocated Budget is US$ 367.3 million. The Operational Budget as per approved workplans is US$ 327.8 million. The total distributed resources as on 9 August 2016 were US$ 206.6 million. The implementation (expenditure) stands at US$ 88.9 million, which is 24%
of the Allocated Budget and 43% of the distributed resources. Funds utilization (encumbrances plus expenditure) stands at US$ 120.9 million, which is 33% of the Allocated Budget and 59% of the distributed resources.

82. The Committee was informed that in addition to the periodic mandatory reporting, which was previously done twice in the biennium – “end-of-first-year” and “end-of-biennium” – a six-monthly assessment has been agreed with budget centres. In line with this, the Committee noted with appreciation that the Region conducted an assessment of the Top Tasks, and 91.5% compliance had been reported as of 31 August 2016; to date, close to 99% compliance had been achieved.

83. The Committee was reminded that recommendations for action in the area of Budget implementation had been made by the Subcommittee on Policy and Programme Development and Management (SPPDM) at its Ninth Session held in the Regional Office on 15 July 2016. The Committee was then invited to provide its observations in relation to national and regional implementation activities.

84. Broad support was expressed by the Committee for the recommendations made by the SPPDM and appreciation expressed for the ongoing collaborative and support efforts made by WHO in this area. The Committee also suggested ways in which efforts could be further strengthened. It was noted, for example, that WHO is not the only agency with which countries collaborate in this respect, and a proposal was made to promote closer coordination between the range of major agencies active in countries, while also improving the standardization of reporting across countries.
85. The Committee was provided with updates on national initiatives and progress in Budget implementation, and expressed appreciation for the impetus which continued to be provided by the Regional Office and the Regional Director. It was noted that although the Region has performed relatively well in the global context, there was scope for further improvements and performance enhancements. The Committee noted with appreciation the regional achievements in terms of both technical and financial implementation and highlighted the need for continuous resource mobilization to ensure that funding gaps are filled.

86. The Committee expressed appreciation for the feedback and observations made. The Regional Director highlighted the crucial importance of improving both technical and financial implementation and of monitoring the progress made. Joint ministry of health-WHO coordination mechanisms needed to be further strengthened to accelerate implementation and address the funding gaps. Improved usage of key performance indicators will strengthen the above aspects.

87. The Committee was informed that various mechanisms had been strengthened to expedite high-quality implementation of programme management, including enhanced administrative and programme reviews of all country offices and joint collaboration monitoring mechanisms between ministries of health and WHO.

88. At the same time, the emphasis must be on ensuring the quality and efficiency of activities rather than simply achieving implementation targets. Member States were encouraged to focus on their priority needs in line with the “Flagship Programmes” through which WHO seeks to serve the needs of Member States in the Region as effectively as possible.
89. The issue of donor reporting was also raised in the context of a slowing of available funds from traditional donor sources in recent years. Donors view support as an investment and it is, therefore, crucial to link programmatic and financial implementation in order to demonstrate the achievements being made. The importance of ensuring the quality and timeliness of implementation and reporting was reiterated.

90. The Director-General, Dr Margaret Chan, reminded the Committee that programmatic reform to ensure the aligning of technical and financial resources is one of the three pillars of the current WHO Reform process. This process has been driven by Member States, and significant gains have been made. Within this process it is recognized that achieving results, rather than implementation in itself, is the key measure of success, and implementation is the joint responsibility of the Secretariat and Member States. Reiterating the comments of the Regional Director, she said that Member States are, therefore, encouraged to focus on a small number of key and meaningful activity areas.

91. The Director-General expressed appreciation for the recent efforts of Member States in this area, which had materially assisted WHO’s efforts to make the case for investment to donors. The timely reporting of activities remains a key requirement, and improvements in this respect are now needed. The Director-General assured Member States that she would address this issue as part of a broader approach to achieving results.

Programme Budget Performance Assessment 2014–2015 (Agenda item 7.2, SEA/RC69/6 Rev.1 and Inf. Doc. 1 and Inf. Doc. 2)

92. The Programme Budget Performance Assessment 2014–2015, a self-assessment exercise, is the first Organization-wide end-of-biennium review implemented within the Twelfth General Programme of Work (GPW) 2014–2019. The Committee was informed that the Organization-wide report on the 2014–2015 Programme Budget Performance Assessment was submitted to the Sixty-ninth World Health Assembly in May 2016, after it was initially reviewed at the Twenty-fourth Meeting of the Programme Budget and Administration Committee (PBAC) of the Executive Board in January 2016. The first part of the report provides the overview of the major health challenges that emerged during the biennium, including WHO’s response to them. The second part sets out the financial report for the biennium, including the audited financial statements for 2015.

93. The Committee noted with appreciation the new format of the joint report of the Programme Budget Performance Assessment, with information on technical as well as financial monitoring.
94. The Committee commended the recent joint collaboration agreement reached between the regional offices for South-East Asia and the Western Pacific with the Association of Southeast Asian Nations (for the period 2014–2017).

95. The Committee noted the achievements of the Organization, as well as the uncertainty of the long-term financing of WHO’s Budget, the financing of staffing for the Global Polio Eradication Initiative after 2019, the long-term liability for after-service health-care costs, and the long-term infrastructure needs; and encouraged Member States to engage positively in the discussion to increase Assessed Contributions.

96. The Committee was informed that the Twelfth GPW has 10 global impact targets to which WHO’s work contributes. Half of the 10 global targets were aligned with the 2015 targets set for the MDGs. Of these, the target of a 25% reduction in deaths from AIDS has been achieved, but the 50% and 75% reductions in deaths from tuberculosis and malaria, respectively, have not yet been met. Child mortality has decreased by 53% since the statistical baseline year of 1990 and maternal mortality by 44% over the same period. The impact targets will be updated so that they are aligned with the SDG targets when the monitoring framework is agreed upon.

97. The Committee endorsed the recommendations of the Ninth Meeting of the SPPDM for Member States to continue the discussions on and advocacy for increasing the Assessed and non-earmarked Voluntary Contributions, and for the Regional Director to continue to implement the Twelfth GPW and attempt to align the biennial indicators with the SDG targets; support Member States that are unable
to utilize resources and speed up utilization; and for technical meetings held in the Region to ensure inclusion of one session with potential donors on the topic under discussion to improve potential resource mobilization.

98. The Committee noted the implementation achieved by the South-East Asia Region in the 2014–2015 biennium and expressed the need to further enhance monitoring not only of quantitative but also qualitative aspects of implementation.

99. The Committee also noted the Programme Budget Performance Assessment exercise conducted in the WHO South-East Asia Region and requested an in-depth analysis of the lessons learnt, which could be applied to strengthen the efficiency of support, including preparation of timely and accurate financial and donor reports at the WHO country office level. This would help to increase the extent and quality of implementation for the current biennium. A suggestion to hold specific joint meetings with the ministries of health for lessons learnt was tabled.

100. The Committee was informed that to ensure full, high-quality implementation in the Region, the Regional Director has been working on linking the utilization of funds to the release of flexible funding for the current biennium.

101. The Secretariat requested active participation of Member States in the PBAC and informed the Committee that a communication had been sent to all Member States in July 2016 for an increased Assessed Contribution, and the discussions at the PBAC and the Executive Board in January 2017 will be crucial to this important Agenda item.

Proposed Programme Budget 2018–2019 (Agenda item 7.3, SEA/RC69/7 Rev. 3 and Inf. Doc. 1 Rev. 1)

102. The Committee reviewed and considered the Regional Committee version of the Draft Proposed Programme Budget 2018–2019. It noted that the Programme Budget for the 2018–2019 biennium is the third and last Programme Budget within the Twelfth General Programme of Work (GPW) and the outcome of the work on WHO Reform in response to emergencies, as well as in line with leadership priorities
and strategic directions indicated and programmatic structures set therein, especially taking into account that the global health roadmap now extends to 2030 with the SDGs in place.

103. The Committee noted that the SPPDM at its Ninth Meeting had discussed the development of the Programme Budget for 2018–2019. As the Regional Committee version of the Draft Proposed Programme Budget 2018–2019 was not available during the SPPDM Meeting, an Inter-sessional Meeting of Member States of the South-East Asia Region was held on 4 September 2016 to review the document. The Committee reviewed the Draft Proposed Programme Budget 2018–2019, which included the approach, proposed results chain, and shifts in emphases in the light of deliberations of the SPPDM and the Inter-sessional Meeting, and provided guidance for elaboration in the Executive Board version.

104. The Committee noted that the Programme Budget 2018–2019 has been developed through a robust process, starting with the identification of priorities from the country level, and aligned to regional and global commitments. The process also allowed iterative consultations on the implications of the 2030 Agenda for Sustainable Development for WHO’s work in the biennium 2018–2019 and the need for intensive collaboration within the Organization and with new partners and stakeholders. This Programme Budget makes programmatic adjustments with the SDG Agenda and also seeks to consolidate and institutionalize WHO Reform.

105. The Committee noted that the Regional Committee version of the Programme Budget 2018–2019 incorporates the new WHO Programme on Health Emergencies. A separate process was established to develop the results framework and budget for the new Health Emergencies Programme. The Draft Proposed Programme Budget 2018–2019 presents the new single programme, its programmatic structure, one budget and one set of performance metrics.

106. The Committee also noted that the Proposed Programme Budget amounts to US$ 4659.7 million of which US$ 3509 million is for the Base Programme. The Programme
Budget follows the structure of 2016–2017 with the new WHO Programme on Health Emergencies presented separately. Food safety and AMR are also presented separately at this stage. The allocations for the Programme Budget seek to emphasize WHO’s enduring role in global leadership in attaining UHC, worldwide action to control AMR, scaling up investments for NCDs and ending preventable maternal, newborn and child illnesses.

107. The Committee noted that the new Health Emergencies Programme saw an increase of US$ 160 million for the 2016–2017 biennium and a further increase is proposed for the biennium 2018–2019. The crucial task of countering AMR will be given greater emphasis with an increase in the budget of US$ 14 million.

108. The Committee also noted that for the biennium 2018–2019, the budget envelope to Major Offices was maintained at a similar level as in the 2016–2017 biennium, with adjustments due to implementation of the new Strategic Budget Space Allocation (SBSA) model and the increase of US$ 140.7 million proposed for the new Health Emergencies Programme and the increase of US$ 14 million proposed for work on AMR.

109. The Committee appreciated the fact that all country offices in the SEA Region have identified up to 10 priority areas and allocated 73%–88% of budgetary resources for them. In this connection, the Committee urged WHO to ensure that all deliverables were adequately and properly linked to ensure effective implementation. The Committee also sought clarity on proposals for allocations for deliverables country-wise and Category-wise for 2018–2019.
110. The Committee noted that the Proposed Programme Budget 2018–2019 for the SEA Region is US$ 349.6 million, of which US$ 249.1 million is for the Base Programmes. Budgetary increases for the Health Emergencies Programme and the programme on AMR have resulted in an overall Base Budget increase of US$ 7.3 million for the SEA Region. It also expressed appreciation to the Regional Director for focusing on implementation at the country level, and for the increase in the Country Office budget component of the Proposed Programme Budget 2018–2019 by US$ 9.1 million. This has resulted in a decrease by US$ 1.8 million in the Regional Office Budget for the Base Programmes.

111. The Committee appreciated the changes in emphasis that the Regional Director has initiated in the Programme Budget submission to focus on the regional Flagship Priority Areas and ensure transparency, accountability and risk management. In this context, the importance of dialogue and bottom-up planning as is envisaged currently is very important.

112. The Committee noted that as a result of the Region’s polio-free status, the budgetary need for the polio programme has decreased, and expressed concern that this significant decrease in the budget for polio could negatively impact the implementation of polio transition and end-game activities.

113. The Committee deliberated on the additional budgetary needs arising out of the shift of the Asia-Pacific Observatory on Health Systems and Policies (APO) to
the South-East Asia Region from the Western Pacific Region since August 2016. It was informed that the shift is mandated for five years.

114. The Committee also discussed the increased budgetary needs arising out of the proposed renovation and reconstruction of the Regional Office Building, including the costs of refurbishment, rentals and other expenses. It requested the Regional Director to negotiate and secure at the appropriate forums the additional budgetary requirements for these two needs.

115. The Committee provided its specific guidance to further inform the development of the Programme Budget for the 2018–2019 biennium, which will be presented for review by the Executive Board at its 140th Session in January 2017. In May 2017, the final draft of the Proposed Programme Budget 2018–2019 will be presented to the Seventieth World Health Assembly for approval.


**Overview of WHO Reform (Agenda item 8, SEA/RC69/8 Rev. 1)**

117. The Committee acknowledged the significant progress made by the Organization towards meeting the objectives and deliverables of WHO Reform, which consists of three components – programmatic, governance and managerial – and includes provision of effective policy and technical support to Member States; alignment of financing and staffing needs to match priorities and requirements; efficient mechanisms for compliance, accountability and risk management; and a culture of evaluation and strategic communication.

118. The Committee noted the progress made on adoption of the framework of engagement with non-State actors (FENSA) and looked forward to guidelines on implementation.

119. The Committee recognized the South-East Asia Region’s active
participation in the WHO Reform process and demonstrated measurable improvement in organizational performance.

120. The Committee noted the progress in programmatic reform with refined deliverables that include 10 priority areas to which 80% of resources are allocated, the Region’s focus on results with 75% of measurable Top Tasks, and the development of a regional evaluation framework, with two independent evaluations completed. A suggestion was made to look into means of reducing the burden of duplicate data reporting.

121. The Committee noted the regional contribution to governance reform that included a reduction in the number of Agenda items, pre-session documents and draft resolutions at Governing Body meetings, reduction of the use of paper during high-level meetings, and review and “sunsetting” of 32 past Regional Committee resolutions.

122. The Committee recognized the Region’s efforts and contributions towards managerial reform, including development and implementation of Management and Compliance Dashboards; conduct of administration and programme review missions in five country offices in the Region to identify best practices and areas for improvement in administration and programmatic management; and expansion of the Annual Representation letter. These would include WHO Representatives and department Directors to verify compliance and accuracy of financial records; development and implementation of electronic monthly Imprest returns;
establishment of the Regional Compliance Network with active participation and involvement of all country offices and departments at the Regional Office; and overall improvement in compliance, demonstrated by reduced number of outstanding audit recommendations and outstanding Direct Financial Cooperation (DFC) reports. Implementation of risk registers and Internal Control Framework checklists would also be covered.

123. In line with WHO Reform, the Committee recognized the work of the consultative meeting on the process for nomination of the Regional Director by the WHO Regional Committee for South-East Asia held in 2012. Subsequently, resolution SEA/RC65/R1 was adopted, and Rule 49 of the Rules of Procedure of the WHO Regional Committee for South-East Asia was revised. The Committee decided to set up an informal working group comprising some Member States of the Region to review the measures adopted by the other WHO regional offices in aligning the process for election of the Regional Director, and introducing a code of conduct and a standardized curriculum vitae.

**Policy and technical issues (Agenda item 9)**

**Antimicrobial resistance (Agenda item 9.1, SEA/RC69/9)**

124. The Committee noted that actions had been taken at the country level to counteract AMR. In adherence to the commitment made in World Health Assembly resolution WHA68.7 “Global Action Plan on Antimicrobial Resistance”, the development and/or alignment of national action plans (NAPs) to the Global Action Plan (GAP) has progressed well in all countries in the Region. The Committee emphasized the importance of intersectoral collaboration involving the human health, animal health and environmental sectors. Applying the “one-health approach” is key to preventing and combating AMR.

125. The Committee noted that the comprehensive approach of conducting situational analysis and planning, and of conducting activities across priority areas jointly with other sectors, would improve the response to AMR. Although the Regional Office had provided support for strengthening AMR surveillance and the capacity of laboratories, further support was required by some countries. Other important aspects were regulation of the sale of antibiotics in pharmacies, guidance on their prescription for medical practitioners, guidance on their use in the animal sector, and information, education and communication materials for the general public. The Committee noted the importance of innovative research and development of new antibiotics, based on strengthened public-private partnerships.
126. The Committee welcomed the high-level meeting on AMR to be held at the time of the United Nations General Assembly, on 21 September 2016.

127. The Regional Director, responding to comments, said that she was gratified that all Member States in the Region were taking action against AMR, following the ministerial Jaipur Declaration in 2011 and Regional Committee resolutions. She had included AMR among the seven Flagship Areas and noted progress in achieving key deliverables in countries. AMR is a global problem due to which the safety net generated by antimicrobials was shrinking. The health, agriculture, animal and environmental sectors needed to work together. She emphasized the coordinated approaches across sectors, especially through surveillance systems to prevent and combat AMR. Commendable actions, with growing momentum, were being taken by the Member States. Strong political leadership was needed, with enforcement mechanisms, to ensure good prescribing practices. She reiterated WHO’s commitment to support Member States in combating AMR through capacity-building and technical assistance.

128. Mr Satria Nur Syaban, **International Federation of Medical Students’ Associations**, said that the problem of AMR required a risk assessment approach and stronger regulatory mechanisms for the sale, prescription and use of antibiotics across sectors. He proposed that a forum be established in which Member States could share best practices in using the “one health” approach.

**International Health Regulations (IHR) post-2016 (Agenda item 9.2, SEA/RC69/10, SEA/RC69/10 Add.1)**

129. The Committee noted the progress made in Member States in achieving the “Core Capacities” defined by the International Health Regulations (IHR) 2005. Further, the Committee generally supported the recommendations on the draft Global Implementation Plan (GIP) of the International Health Regulations Review Committee. As some gaps in IHR Core Capacities had been mentioned by Member States, the Committee noted that the GIP can serve as a tool to scale up efforts in this area.

130. Clarifications were sought by the Committee from the Secretariat on the following: (i) classification of countries as per their vulnerability; (ii) the process for the Joint External Evaluation (JEE) as a component of the IHR Monitoring and Evaluation Framework; and (iii) alignment of self-assessments with JEEs. The Committee urged strengthening of certain areas of the GIP, specifically national IHR focal points; soliciting and sustaining high-level political support; working with other sectors; and facilitating capacity-building for the health workforce through regional networks.
The Committee also called for support for improving the following capacities: laboratories, addressing chemical and radionuclear events, and at points of entry.

131. The Secretariat provided clarification on the issues raised by the Committee with assurances of accepting their suggestions and addressing their concerns, while finalizing the draft global implementation plan in time for the 140th Session of the Executive Board.

132. The Committee was further informed that the Secretariat will continue to support the scaling up of Core Capacities in IHR in countries in the Region and in implementation of the GIP. The Regional Director also informed the Committee that, with the new WHO Health Emergencies Programme (WHE), the Secretariat will be further strengthened to provide adequate support to Member States.

**Ending preventable maternal and child mortality** *(Agenda item 9.3, SEA/RC69/11)*

133. The Committee noted the significant decline in child mortality in the South-East Asia Region over the past few years, from 118/1000 live births in 1990 to 43/1000 live births in 2015, or a decline of about 64%, while the regional maternal mortality ratio (MMR) declined from 525 to 164 per 100,000 live births, or a reduction of about 69%. Over the same period, neonatal mortality declined less rapidly: from 53/1000 live births to 24/1000 live births. These declines in mortality, however, narrowly missed the MDG targets of a 75% reduction in maternal mortality (MDG5) and a 67% reduction in child mortality (MDG4). In addition, there are significant disparities
among Member States in the achievements made in terms of social parameters such as poverty, education status and status of women. The main barriers to progress have been constraints related to health financing, health workforce (midwives and skilled birth attendants, in particular), and to essential supplies and equipment.

134. With the launch of the SDGs and the Global Strategy for Women’s, Children’s and Adolescents’ Health 2016–2030, new global targets have been set. This provides renewed impetus to the efforts to end preventable mortality among women, newborns and children through a broad-based multisectoral approach as well as to address areas such as adolescent health and early child development that received less attention during the MDG phase.

135. The Committee appreciated the leadership role of WHO in providing evidence-based guidelines and technical support to countries to continue to strengthen health systems and services to build on the achievements of the MDG era to make further gains on reducing maternal and child mortality from preventable causes. Member States appreciated that the Regional Director had made “Ending preventable maternal, newborn and child deaths with focus on neonatal deaths” as one of her Flagship Priorities.

136. The Committee was informed of the innovative strategies used by Member States to reach the unreached, so that “no one is left behind”. They also expressed their commitment to operationalize the Global Strategy for Women’s, Children’s and Adolescents’ Health, 2016–2030, and to expand infrastructure and the
health workforce to provide quality care to mothers and children. In doing so, Member States look upon WHO to provide technical assistance and, where feasible, even financial support to take this agenda forward. In addition to initiatives on maternal and child health, the well-being of adolescents was highlighted, with a special focus on prevention of adolescent pregnancy. Member States also emphasized the importance of strengthening the health management information system, including strong civil registration of vital statistics and surveillance of and response to maternal and perinatal death.

137. Dr Raman Krishna Kumar, World Heart Federation (WHF), welcomed the Committee’s report, and commended the significant progress achieved by Member States in the Region in reducing maternal and child mortality to date. WHF supports the recommendation for Member States to align national plans and targets with the recently agreed Global Strategy on Women’s, Children’s and Adolescents’ Health, and urges Member States to adapt and tailor this strategy to make it relevant and effective in their own settings. He highlighted five recommendations made by WHF and “RHD Action”, the global movement co-founded with WHF to combat rheumatic heart disease, and reaffirmed WHF support to Member States in the Region to help end premature maternal and child mortality.

138. The Committee adopted a resolution SEA/RC69/R3 on Ending Preventable Maternal, Newborn and Child Mortality in the South-East Asia Region in line with the Sustainable Development Goals (SDGs) and Global Strategy on Women’s, Children’s and Adolescents’ Health.

**Time-bound elimination of neglected tropical diseases (NTDs)**  
*(Agenda item 9.4, SEA/RC69/12)*

139. The Committee noted that more than a billion people across the world, mostly in the low- and lower-middle-income countries, are affected by neglected tropical diseases (NTDs). At least one NTD is endemic in each Member State in the Region, which bears the second highest burden of these debilitating infections globally. WHO’s NTD roadmap, endorsed by the World Health Assembly through resolution WHA66.12 entitled “Neglected tropical diseases”, identified specific NTDs with the aim to control, eliminate and, in a few cases, eradicate these diseases with specified time-bound targets. NTDs are also incorporated in the SDGs. Elimination of the targeted NTDs is a regional health priority and one of the Flagship Areas for the Region. The NTDs targeted for elimination in the Region are lymphatic filariasis (LF), visceral leishmaniasis (VL), leprosy and schistosomiasis, while yaws is targeted for eradication at the global level.
140. The Committee noted the commendable progress towards the WHO NTD roadmap targets. India has been formally recognized as being yaws-free, while elimination of LF as a public health problem has been verified in Maldives and Sri Lanka. However, new issues and challenges are emerging that need to be carefully addressed to keep the elimination process on track in order to achieve the 2020 elimination target.

141. The Committee appreciated inclusion of NTDs targeted for elimination in the regional Flagship Priorities, thanked WHO for the continued strong support to countries, expressed satisfaction for the background paper and fully supported the actions proposed.

142. The Committee further requested WHO support in strengthening cross-border collaboration, information-sharing between countries, strengthening vector control, and providing critical flexible funds to accelerate progress and address some of the last mile challenges.

143. The Committee also highlighted the possibility of re-emergence of some of the eliminated NTDs and underscored the need for continued vigilance and for a strong surveillance system. The importance of continued political commitment and resource allocation to sustain the gains and accelerate progress was emphasized. Stigma and legal issues related to leprosy were mentioned for further action.
The Decade for Health Workforce Strengthening in the SEA Region 2015–2024: First review of progress, challenges and opportunities (Agenda item 9.5, SEA/RC69/13)

144. Resolution SEA/RC67/R6 on “Strengthening Health Workforce Education and Training in the Region” requested the Regional Director to support Member States in implementation of the Regional Strategy on Health Workforce Education and Training in the SEA Region 2014–2019 and to report on progress to the Committee every two years, starting in 2016.

145. The Committee expressed its support for the decade-long commitment to strengthening the health workforce in the SEA Region and for this first progress report by the WHO Secretariat. Several countries emphasized the need to make the health workforce fit for purpose in the face of changing health service needs. The synergies between a strengthened health workforce, progress on UHC and advancing the health SDGs were noted. Persistent challenges were noted, which include low levels of health-care worker remuneration, high turnover, and delivering health care in rural and remote areas. Member States highlighted the wide range of actions being taken to make progress. There remains a clear emphasis on interventions to improve rural retention and transformative education. In addition, growing attention is being paid to health workforce governance and leadership, and to the need to improve health workforce data.

146. Countries are pursuing a mix of strategies to address rural retention, recognizing that there is no one magic bullet. Retention is linked to the larger issue of out-migration in some countries, for which the Global Code on International Recruitment of Health Personnel remains relevant and in need of further implementation. Countries also gave examples of actions to increase health worker numbers and to transform their professional education. Some are moving beyond a focus on changing the education of doctors and nurses to include allied health professionals who deliver most frontline health services.
147. Increasing attention is also being paid to human resources for health (HRH) leadership and governance, including the development of strategic HRH plans; the creation of HRH coordination committees and units; more attention to regulation and accreditation of training institutions; and recognition of the private sector’s significant role in health workforce production and employment in the Region. Lastly, there is an urgent need for better health workforce data, with some countries making progress on creating HRH registries. Member States noted that the new Global HRH Strategy reinforces the Decade for HRH Strengthening in the SEA Region.

148. The HLP recommendations were accepted, with the clarification that the Regional Office will work with Member States to develop indicators to track the progress and impact of HRH strengthening interventions. The Regional Office is also committed to continuing its support in the four areas outlined above and to facilitating the exchange of knowledge and experience between countries.

149. Professor Indika Karunathilake, spoke on behalf of the World Federation for Medical Education (WFME), a nongovernmental organization concerned with the quality of medical education worldwide. WFME has developed guidance on criteria to be considered when establishing a new medical school, which may be of use to countries in the Region. WFME is looking to share this guidance with the Regional Office and provide other assistance to improve the quality of medical education.
Emergency Reform (Agenda item 9.6, SEA/RC69/14)

150. The Committee took note of the various hazards and risks that Member States of the Region face, and recounted recent events such as the Nepal earthquake of 2015 and the monsoon floods in several countries. The Committee was provided with updates on the risk assessment-based preparedness that countries are currently doing for the Zika virus, which, together with its associated complications of microcephaly and neurologic symptoms and syndromes, has recently been declared a public health emergency of international concern (PHEIC).

151. The Committee noted the progress on the reform of WHO’s work in health emergency management. Committee members welcomed the adoption of an all-hazards approach to emergencies and a focus on preparedness of Member States.

152. The Committee raised the following points: (i) configuration of WHO country office emergency staffing; (ii) balancing resources for preparedness and response; (iii) regular information to Member States through a forum on the progress of Emergency Reform covering governance, coordination with other actors outside the health sector, and resource allocation for all hazards preparedness.

153. The Committee was assured that systems already in place, such as those for emergency funding, efforts for organizational readiness and the focus on country preparedness, will continue. It was observed that the Region has learnt its lessons from the 2004 tsunami and has built on these in the past years, citing the Regional Benchmarks for Emergency Preparedness and Response and the South-East Asia Regional Health Emergency Fund (SEARHEF). The Committee was also updated on the progress of Emergency Reform in the Region in the areas of programme development and planning, staffing in the Regional Office, readiness assessments and financing issues.

Promoting physical activity in the South-East Asia Region (Agenda item 9.7, SEA/RC69/15)

154. The Committee was addressed by two invited experts, Professor Fiona Bull, President of the International Society for Physical Activity and Health, and Dr Pandup Tshering, Director of Health Services, Ministry of Health, Royal Government of Bhutan. The two experts pointed out the impact of physical inactivity on the health of the people and the benefits accruing from policies that promote physical activity (PA). These policies should be comprehensive to address the social and economic determinants of behaviours and must be based on the local context, aiming to promote healthy norms in society. High-level and unrelenting political commitment, and the involvement and ownership of the local government and community are important to sustain PA programmes.
155. The Committee acknowledged that insufficient PA is the fourth leading health risk factor contributing to approximately 3.2 million lives and 69.3 million DALYs (disability-adjusted life years) lost each year globally. Inadequate PA leads to cardiovascular diseases, diabetes, obesity, colon cancer, high blood pressure, osteoporosis, lipid disorders, depression and anxiety. The prevalence of inadequate PA among adolescents aged 11–17 years has reached alarming levels globally, with 78% of adolescent boys and 84% of girls reporting insufficient PA. About 70% of boys and 80% of girls and nearly one third of all adults in the WHO South-East Asia Region report insufficient PA. Promoting physical activity is a cost-effective approach and has a long-term impact on healthy lifestyles for individuals, communities and entire populations when applied strategically and implemented effectively in all settings and across all walks of life.

156. The Committee reiterated its concern about the high degree of physical inactivity prevalent among large sections of the population in all countries in the Region, particularly among children and adolescents, along with an unrelenting increase in sedentary lifestyles aggravated by increasing incomes and the affordability and proliferation of motorized transport.

157. The Committee highlighted examples of policy commitment and shared experiences in promoting physical activity in Member States. Many Member States
have declared national targets, taking into account the global and regional voluntary targets on NCD prevention and control, which is a 10% reduction in the prevalence of physical inactivity by 2025.

158. The Committee also underscored the fact that promoting physical activity requires a multisectoral approach to operationalize policies, plans and strategies that are in place with appropriate measurable targets to reduce physical inactivity and sedentary lifestyles, and the engagement of stakeholders at all levels — including local government and the education sector as well as ministries of transport, youth affairs and others — in tandem with ministries of health. Strengthening the current agencies and structures and ensuring coordination across relevant agencies at all levels, rather than creating new isolated programmes, are crucial in this effort.

159. The Committee noted that effective interventions within and beyond the health sector focusing on policy, the environment, media, schools, workplaces, communities and cities can increase PA levels among populations. PA can also significantly contribute towards achieving many of the SDGs and is an important factor in ensuring sustainable and healthy lifestyles.

160. The Committee referred to the need to promote physical activity throughout the life-course in major social institutions, such as the family, schools, workplaces, villages, communities and cities, in order to “leave no one behind”. Promoting physical activity through school health programmes and healthy workplaces has shown its effectiveness. Countries in the Region have had experience in promoting
physical activity through traditional methods, including yoga, as well as through context-friendly approaches, it was observed. Social mobilization, including mass events, can promote healthy norms in society.

161. The Committee also enunciated the need to promote knowledge and experience-sharing within and across Member States. Monitoring and evaluation of the situation and the effectiveness of policy to promote physical activity are crucial challenges in the Region, and the Committee urged WHO to play a major role in supporting countries in this area, as well as to share good practices, such as yoga and other traditional approaches to physical activity.

162. Mr Bejon Misra, of the International Alliance of Patients’ Organizations (IAPO), congratulated Member States in the Region which supported and facilitated the attendance of disabled athletes to the 2016 Rio Paralympics and the Olympiad. The IAPO representative also stressed that traditional and rural sport initiatives must be integrated within rural community health workers’ programmes in the Region for greater reach. He mentioned that IAPO supported the findings that promoting physical activity is a cost-effective approach and has a long-term impact on healthy lifestyles for patients, communities and entire populations when applied strategically and implemented effectively in all settings and across all walks of life.

163. The Committee adopted a resolution SEA/RC69/R4 on Promoting Physical Activity in the South-East Asia Region.
164. The Committee took note of the fact that malnutrition in all its forms threatens human development. Both undernutrition and overweight and obesity throughout the life course are public health problems in the Region, affecting Member States to varying degrees. Undernutrition, including micronutrient deficiencies, contributes to about 45% of preventable deaths of children under five years of age annually, while overweight resulting from unhealthy diets and sedentary lifestyle underpins high rates of NCDs in Member States. Therefore, urgent attention is needed to reduce malnutrition. While the previous “Regional Nutrition Strategy: Addressing malnutrition and micronutrient deficiencies (2011–2015)” emphasized a multisectoral approach (SEA/RC64/R4), it cannot adequately address the current need in the Region to tackle both undernutrition and overweight and obesity.

165. Many global actions and policies have focused attention on the double burden of malnutrition, including the recent SDG agenda, which calls for an end to all forms of malnutrition. The Committee noted that this double burden of malnutrition, characterized by persistent undernutrition (stunting, wasting, micronutrient deficiencies) and coexisting overweight and obesity, affects most Member States in the Region. At the current rates of reduction, countries are unlikely to meet the Global Nutrition Targets nor the Sustainable Development Goal targets for nutrition.

166. The Committee was apprised of recent global policy platforms, such as the 2nd International Conference in Nutrition (ICN) and the Ending Childhood Obesity Consultation (ECHO) that have focused attention on the double burden of malnutrition and the availability of recent global guidance.

167. In response, the WHO Regional Office developed a Strategic Action Plan to Reduce the Double Burden of Malnutrition in the South-East Asia Region 2016–2025, through extensive consultation with Member States, technical experts and WHO country offices and headquarters. The plan focuses on creating an enabling environment that will facilitate the implementation of interventions focused towards both undernutrition and overweight and obesity.
The Committee noted the achievements made by Member States in reducing stunting and wasting, and the issues faced in attempting to reduce micronutrient deficiencies, which are persistent. The added burden of overweight and obesity that was occurring in varying degrees across Member States was considered to be a multidimensional challenge. The importance of addressing overweight and obesity without deprioritizing the undernutrition agenda was reiterated. Therefore, Member States appreciated the development of the Strategic Action Plan, which addresses undernutrition, micronutrient deficiencies, and overweight and obesity.

The Committee acknowledged that some Member States have already incorporated overweight and obesity strategies in their national policies. The Committee recognized the importance of strengthening the policy environment for successful implementation of interventions to improve food security and to reduce all forms of malnutrition. They agreed that enhanced political commitment, nutrition governance and multisectoral policy coherence, developing regulatory frameworks, relevant legislation and guidelines, and community empowerment are essential to this process.

The Committee also reiterated the issues that impede successful implementation of multisectoral processes and the need to learn from successful countries. The need for caution when dealing with the private industry was noted by the Committee, with an emphasis on the need for strong conflict-of-interest policies to safeguard policy-making and norms-setting processes.

The Committee agreed that this Strategic Action Plan will serve Member States as an advocacy and reference tool, to ensure that interventions covering the double burden of malnutrition are addressed comprehensively and simultaneously in Member State policies, strategies and actions, while taking into account individual country contexts.

A statement was made by Dr Chandrakant S. Pandav of the South Asia Iodine Global Network (IGN) (formerly International Council for Control of Iodine Deficiency Disorders or ICCIDD), who highlighted the consequences of severe
iodine deficiency, including irreversible brain damage in children. Further, iodine
deficiency during pregnancy and infancy leads to recurrent abortion, stillbirth, and
increased neonatal and infant mortality. Globally, 1.9 billion adults and 240 million
schoolchildren are at risk of iodine deficiency disorders (IDDs), and the corresponding
figures for the SEA Region are 541 million and 76 million respectively.

173. It was observed that iodized salt coverage in the Region has shown steady
progress over the last two decades, with three fourths of the population currently
consuming adequately iodized salt. Two countries (Bhutan and Maldives) in the
Region have achieved universal salt iodization, and 92% households in India have also
reached the mark. However, challenges remain, and there is a need to accelerate and
sustain progress towards universal salt iodization to cover the proverbial “last mile”.

174. The Committee adopted a resolution SEA/RC69/R5 on “Strategic Action Plan to
Reduce the Double Burden of Malnutrition in the South-East Asia Region 2016–2025”.

Migration and health (Agenda item 9.9, SEA/RC69/17)

175. One in every seven people living in the world today is either an international or
an internal migrant in times of war or peace. In the past few years, the Governing
Bodies of WHO and several global consultations have addressed the issues related
to migration and health in various forums. The recent unprecedented refugee crises
throughout the world have raised serious questions about the capacity of global
and national health frameworks to address the issue.
176. Globalization, climate change, global conflict, urbanization and economic necessity are factors driving the highest levels of migration ever recorded. There are approximately 244 million international migrants and 740 million internal migrants in the world today. More people have been forced to migrate in recent years than at any other time since the Second World War. Furthermore, 60 million people have been forcibly displaced, of whom 20 million are refugees and 40 million internally displaced.

177. The Sixty-ninth World Health Assembly deliberated on means to promote and protect the health of migrants. This Agenda item drew considerable attention and support from Member States and was unanimously acknowledged as an issue of global concern. The scope, types and socioeconomic dynamics of the health and well-being of migrants differ by country and region according to factors such as rural-urban residence and economic level.

178. The Committee was informed that a technical briefing on migration and health had been organized on the sidelines of the World Health Assembly, on 27 May 2016. It was attended by over 200 participants from Member States, UN specialized agencies, civil society, NGOs, partners and the media. Two Member States from the South-East Asia Region, Sri Lanka and Thailand, took part in the panel discussions, presenting their experience in multisectoral engagement in both national and international policy-making and describing key challenges in formulating policies on the health of migrants.

179. The Committee took note of the information that, subsequent to the First Global Consultation on Migration and Health held in Spain in 2010, the second consultation would be held in Sri Lanka in February 2017.
180. The Committee expressed its appreciation for the background paper and thanked the Regional Office for including the item on the Agenda of the Regional Committee Session. They fully supported the actions proposed in the paper but suggested that the title be changed to “Health of Migrants”, in line with the title and the discussion in the World Health Assembly.

181. The Committee proposed that rapid situational analyses be conducted in both individual countries and the Region on the health of migrants and that a report be made available before the second consultation to be held in Sri Lanka in February 2017.

182. The Committee noted the need for migrant-sensitive legislation, policies and health systems, emphasizing that the focus on migrant health in the health sector must be comprehensive, covering all public health functions and health system strengthening, with focused interventions and tailored services to address the special needs of different migrant groups.

183. The Committee requested work on an innovative regional funding mechanism to support the activities of Member States on the health of migrants.

184. The Committee noted that several countries in the Region are both recipients and areas of origin in terms of migration and expressed concern about the vulnerability and health issues of migrants in recipient countries. They highlighted the need for appropriate health screening, including pre-departure medical check-ups. The Committee emphasized that the focus should be not only on communicable diseases but also on other health conditions and services, such as accident and emergency services.

185. The Committee requested guidelines and global standards on the health of migrants to support Member States in their efforts to provide health services to migrants.

186. Mr Bejon Misra, International Alliance of Patients’ Organizations (IAPO), welcomed the Secretariat’s working paper on “Migration and health” and WHO-SEARO’s ongoing partnership with the International Organization for Migration and the UNHCR to address migrants’ health. He mentioned that IAPO, however, was concerned with the welfare and security of chronically-ill migrants, and displaced and refugee patients, especially child patients. It was noted that many such patients lacked access to health-care services and financial protection for health. IAPO urged Member States to develop and adopt coherent migrant-patient sensitive health policies that ensure equitable access to culturally and linguistically appropriate health-care services regardless of status and without discrimination or stigmatization,
and to develop a culturally competent health workforce able to address the needs of such patients.

**Progress reports on selected Regional Committee resolutions**
*(Agenda item 10) (SEA/RC69/18, SEA/RC69/18 Add.1, SEA/RC69/18 Add. 2, SEA/RC69/18 Add. 3)*

187. The attention of the Committee was drawn to the six progress reports on the Agenda: Consultative Expert Working Group on Research and Development: financing and coordination (SEA/R65/R3); Challenges in polio eradication (SEA/RC60/R8); South-East Asia Regional Health Emergency Fund (SEARHEF) (SEA/RC60/R7); Capacity-building of Member States in global health (SEA/RC63/R6); 2012: Year of intensification of routine immunization in the South-East Asia Region: Framework for increasing and sustaining coverage (SEA/RC64/R3); and Regional Action Plan and targets for Prevention and Control of Noncommunicable Diseases (2013–2020) (SEA/RC66/R6).

188. The recommendations of the High-Level Preparatory (HLP) Meeting held in New Delhi in July 2016 on each of the progress reports as contained in document numbers SEA/RC69/18, SEA/RC69/18 Add. 1, SEA/RC69/18 Add. 2, SEA/RC69/18 Add. 3 were considered by the Regional Committee.

**Consultative Expert Working Group on research and development (CEWG): financing and coordination** *(Agenda item 10.1, SEA/RC65/R3)*

189. Member States welcomed the progress made on the CEWG with the adoption of resolution WHA69.23. They expressed appreciation for the Regional Office’s support to date on the research and development agenda. Looking forward, several points were raised: the need to fully implement the CEWG strategic workplan; the need for more funds for research and development (R&D) and innovative R&D financing mechanisms; the links to and importance of the upcoming report of the High-Level Panel on Access to Medicines; the need for support to strengthen R&D capacity in smaller Member States; and more North-South collaboration on R&D.

190. SEARO was requested to work closely with WHO headquarters on implementation of resolution WHA69.23, including making the global
health R&D observatory operational; assisting Member States in creating national R&D observatories; continuing to strengthen research capacity in smaller Member States; closely following evaluation of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property; and working closely with headquarters on the financing meeting scheduled later this year.

191. The Regional Director said that she would convey to headquarters the request to convene another CEWG open-ended meeting at the Seventieth World Health Assembly. She emphasized that the Regional Office would give high priority to finding ways to fund research. She noted the increased momentum on the agenda with the WHO Expert Committee on Research and Development, and said that the suggestion for a regional coordinating mechanism for research development would be examined further, taking into account previous experience.

**Challenges in polio eradication** (*Agenda item 10.2, SEA/RC60/R8*)

192. The Committee noted the Secretariat’s progress report on the challenges in polio eradication. Member States are committed to ensure high population immunity to continue to maintain the polio-free status of the SEA Region. While all countries acknowledge the importance and value of high-quality surveillance for acute flaccid paralysis, some countries have challenges in ensuring a sensitive surveillance system. Member States are also aware of the shortage of inactivated poliovirus vaccine and requested WHO to do everything possible to ensure that there is no disruption of vaccination activities in countries, which would erode the credibility of immunization programmes.

**South-East Asia Regional Health Emergency Fund (SEARHEF)** (*Agenda item 10.3, SEA/RC60/R7*)

193. The Committee expressed its appreciation for the use of the South-East Asia Regional Health Emergency Fund (SEARHEF) in the past year for various emergencies in the Region. At the fifth working group meeting for the governance of the Fund, a set of policies and guidelines was prepared to explore a preparedness stream for the Fund (SEA/RC69/18 Add.3) as per the recommendation of the High-Level Preparatory Meeting. The Committee noted the document and expressed its support for the efforts to establish a preparedness stream for the SEARHEF.
194. The Committee adopted a resolution SEA/RC69/R6 on “Expanding the Scope of the South-East Asia Regional Health Emergency Fund”.

**Capacity-building of Member States in global health** *(Agenda item 10.4, SEA/RC63/R6)*

195. The Committee recalled the adoption of the resolutions A/RES/63/33 in November 2008 and A/RES/64/108 in February 2010 by the United Nations General Assembly in New York and the progress report submitted by the Director-General of WHO, in consultation with Member States, to the Sixty-fourth United Nations General Assembly in September 2009, entitled “Global health and foreign policy: Strategic opportunities and challenges”, that highlighted the need to increase the capacity and raise the levels of training of diplomats and health officials in global health diplomacy and to develop training standards and open-source information for education and training purposes.

196. The Committee was informed that capacity-building in Member States had helped to resolve global health issues and that global investment in human capital, in particular the young generation of public health leaders, is a long-lasting investment, with substantial payoffs and returns. The Committee noted the recommendation of the High-Level Preparatory Meeting that Member States effectively engage in capacity-building in global health and support for greater participation in Governing Body meetings.

197. The Regional Director was requested to conduct an assessment of five years of experience (2011–2015) in capacity-building in global health in the Region in response to resolution SEA/RC63/R6 and to report to the Seventieth Session of the Regional Committee in order to obtain a more systematic understanding of the strengths, weaknesses and impact of activities, and to provide recommendations on effective management of capacity-building on global health.

**2012: Year of intensification of routine immunization in the South-East Asia Region: Framework for increasing and sustaining coverage** *(Agenda item 10.5, SEA/RC65/R3)*

198. The Committee noted the Secretariat’s progress report on intensifying routine vaccination in the Region. Almost all countries are achieving high coverage, reaching
a regional average of 87% coverage with three doses of diphtheria, tetanus and pertussis vaccine in 2015. To strengthen the routine immunization programme further, Member States are looking carefully at local data to identify pockets of missed children and develop micro-plans to reach hard-to-reach areas.

199. All countries are committed not only to ensuring routine vaccination coverage but also to continuing to strive to add new antigens in their routine programmes, strengthening surveillance for measles and rubella and working towards local production capacity, for which WHO’s support has been sought to assist countries in relevant research and development of new vaccines and technologies in immunization.

Regional Action Plan and targets for Prevention and Control of Noncommunicable Diseases (2013–2020) (Agenda item 10.6, SEA/RC66/R6)

200. The Committee noted the progress made in implementation of the Regional Action Plan for the Prevention and Control of Noncommunicable Diseases, in particular in adapting and contextualizing the Regional Action Plan and regional voluntary targets into national multisectoral action plans and targets. Effective implementation of the national NCD multisectoral action plans remained a critical challenge, it was noted.

201. Mr Pubudu Sumanasekara, of the Framework Convention Alliance on Tobacco Control (FCA), which represents 500 organizations from over 100 countries working on tobacco control, through a written statement, called it encouraging to note that the Ministerial Roundtables equally focused on both the SDGs and NCDs, since diseases such as cancer, heart disease, diabetes and lung diseases threaten sustainable development. One of the key means of implementation of the targets under SDG 3, the goal on health, is to address NCDs. All delegates and particularly ministers of health were urged to attend the upcoming session of the WHO FCTC Conference of the Parties in New Delhi, on 7–12 November 2016, to identify and address obstacles to WHO FCTC implementation globally and in the Region.

202. Dr Raman Krishna Kumar gave a written statement for the World Heart Federation (WHF), commending the efforts made by Member States to develop and implement national multisectoral action plans to prevent and control NCDs, and welcomed the eight-point Declaration proposed during the Ministerial Roundtable to accelerate the delivery of NCD services within primary health care.
203. Dr Kumar praised the Region for recognizing the burden of NCDs for what it is: an epidemic that accounted for 8.5 million lives lost each year. Furthermore, cardiovascular diseases (CVDs) are killing people at a relatively younger age in this Region than other regions, with 27% of all CVD-related deaths in Member States occurring before the age of 60. Noting that the cost of action in tackling NCDs is outweighed by the cost of inaction, he said it is estimated that NCDs will cost more than US$ 30 trillion globally over the next 20 years. It is, therefore, imperative for Member States to fast-track national action on NCDs in order to close the implementation gap and achieve the targets in the Regional Action Plan.

204. Ms Radhika Shrivastav, of the NGO HRIDAY, a global civil society network of over 2000 organizations working on NCDs, speaking on behalf of Alzheimer’s Disease International and the NCD Alliance, observed that the WHO Global Action Plan 2013–2020 and the accompanying Global Monitoring Framework had been translated into a regional framework and 10 targets for the South-East Asia Region. Commending the Regional Office for the regional consultation on addressing NCDs at the primary health care level, she observed that the inclusion of NCDs under the health goal of the Agenda for Sustainable Development 2030 highlights at once the threat these pose to sustainable development and the opportunity to reverse this epidemic. Member States were urged to integrate NCD prevention and control into existing programmes and responses to other diseases, including HIV infection and tuberculosis.

205. Mr Satria Nur Syaban, of the International Federation of Medical Students’ Associations (IFMSA), highlighted the enduringly important issue of prevention
of NCDs and its risk factors. About 82% of premature deaths due to NCDs occur in the developing countries, many of which are a part of the South-East Asia Region, and the younger generation is getting affected on a very large scale. Socioeconomic and environmental factors have also greatly impacted working conditions which have invariably caused a midline shift in the level of physical activity of the common man. This calls for international cooperation of various sectors to address this issue. IFMSA also expressed support for the implementation of the South-East Asia Regional Action Plan for the Prevention and Control of Noncommunicable Diseases and related efforts.

**Governering Body matters (Agenda item 11)**

**Key issues arising out of the Sixty-ninth World Health Assembly and the 138th and 139th sessions of the WHO Executive Board (Agenda item 11.1, SEA/RC69/19)**

206. The Committee noted, from the perspective of the South-East Asia Region, the significant and relevant resolutions adopted, decisions endorsed and Agenda items discussed at the Sixty-ninth World Health Assembly and the 138th and 139th sessions of the WHO Executive Board. These resolutions, decisions and Agenda items relate to a range of health issues and to programme, budgetary and other financial matters deemed to have significant implications and which merited follow-up action by both Member States and WHO in the South-East Asia Region.

207. The Committee reviewed the working paper (SEA/RC69/19) and agreed with the proposed actions on these Agenda items both on the part of Member States as well as WHO at the regional and country level. It was pointed out that many landmark resolutions adopted by the World Health Assembly would require focused implementation. It also considered the recommendations made by the HLP Meeting and agreed that WHO could play the role of facilitator in taking forward many of the important Agenda items, while continuing to support Member States in the implementation of the resolutions and strategic plans of action.
Review of the Draft Provisional Agenda of the 140th Session of the WHO Executive Board (Agenda item 11.2, SEA/RC69/20)

208. The Committee was informed that the 140th Session of the WHO Executive Board will be held at WHO headquarters in Geneva from 23 January to 1 February 2017. Any proposal from a Member State or Associate Member of WHO to include an item on the Agenda should reach the Director-General of WHO not later than 12 weeks after the circulation of the Draft Provisional Agenda or 10 weeks before the commencement of the Session of the Executive Board, whichever is earlier. Proposals should, therefore, reach the Director-General by 12 September 2016.

209. Following its noting by the High-Level Preparatory Meeting, the Draft Provisional Agenda of the 140th Session of the WHO Executive Board was placed before the Committee for its review, comment and noting as appropriate.

210. The Committee noted the proposal made by India to separate a number of distinct sub-items currently grouped under Agenda item 8.4 and to take up each of these items individually for discussion rather than collectively for evaluation and review. The Committee also noted two further proposals made by India in relation to the addition of items to the current Draft Provisional Agenda. The first of these concerned the “m-Health” initiative, which had been proposed at the previous WHO Executive Board but did not appear on the current Agenda. The second proposal was to include an item to cover the United Nations Secretary-General’s High-level Panel on Access to Medicines. The Committee further noted the proposal made by Thailand to include “Promoting physical activity” as an Agenda item for the forthcoming Executive Board. Nepal recalled Regional Committee Agenda item number 12.1 and the decision of the Committee therein and requested that discussion on the SEA Regional Office Building be included in the Agenda of the 140th Session of the Executive Board.

211. Unanimous support was expressed by Member States for the proposals made, and the WHO Secretariat was requested to communicate these proposals to the Director-General on behalf of the Committee. Assurance was given to the Committee that WHO would facilitate transmission of the proposals made.

212. It was brought to the attention of Member States that as per the rules of the WHO Executive Board, the provisional agenda of each session shall be drawn up by the Director-General in consultation with the Officers of the Board on the basis of the Draft Provisional Agenda and any proposals received by 12 September 2016. Any proposal for inclusion of any item on the Agenda shall be accompanied by an explanatory memorandum.
Review of Regional Committee resolutions
(Agenda item 11.3, SEA/RC69/21)

213. The Committee noted the mandate given by the Sixty-eighth session of the Regional Committee to re-examine previous resolutions for their relevance and timeliness with a view to deciding upon a set of criteria and time frame for phasing out resolutions that have already been implemented and/or acted upon or have outlived their relevance. This will be important in streamlining WHO’s Governance functions to allow for a greater focus on global and regional priorities in the limited time available at the Governing Body meetings.

214. The Committee was informed that in pursuance of the mandate, an Informal Working Group on past Regional Committee resolutions met on 14–15 March 2016, followed by a Technical Consultation of Member States of the SEA Region at the Regional Office in New Delhi on 7–8 June 2016, to review Regional Committee resolutions adopted during the 15-year period 2000–2015.

215. The Committee was briefed on discussions of the above meetings and the recommendations of the technical consultation, including the department-wise categorization of 78 resolutions and the criteria proposed for such categorization of the resolutions, as reviewed and endorsed by the HLP Meeting.

216. The Committee appreciated the efforts made by Member States and the Secretariat in taking forward this important Agenda item in such a short time. It commended the commitment displayed by the members of the Informal Working Group and the technical consultation in thoroughly examining 78 resolutions and
expressed unanimous support for this reform, which would lead to better utilization of the time of the Governing Body.

217. The Committee endorsed the following recommendations of the HLP Meeting and decided to:

(a) adopt the categorization of past resolutions into “Sunset”, “Conditional sunset” and “Active” categories, and the criteria suggested for each such category by the Technical Consultation of Member States;
(b) categorize accordingly the 78 resolutions as 32 resolutions for “Complete sunset”, 16 resolutions for “Conditional sunset”, and retain 30 resolutions as “Active”;
(c) “Sunset” resolutions dating prior to the period of review undertaken through the Informal Working Group and Technical Consultation which are more than 15 years old, unless specific periodic reporting requirements are entailed and continue to remain therewith. In case any such resolution pertains to an issue of importance and/or continued relevance to the South-East Asia Region with an actionable agenda, the technical unit involved may propose a fresh resolution or decision to incorporate the latest technological/programmatic developments on the subject of the resolution;
(d) establish a mechanism to periodically review the existing “Conditional sunset” and “Active”, and the new resolutions at appropriate intervals and frequencies in a cost-effective manner, and place recommendations of the review for endorsement of the Regional Committee; and
(e) review all the proposed new resolutions and strategies to avoid overlapping and ensure streamlining of their contents.

Elective posts for Governing Body meetings (World Health Assembly, Executive Board, and the Programme Budget and Administrative Committee) (Agenda item 11.4)

218. The Committee noted that the elective posts are due to be filled by Member States of the South-East Asia Region.

219. For the Seventieth World Health Assembly, the posts of Vice-President, Vice Chairman of Committee B, Member of the Committee on Credentials and Member of the General Committee are available to be filled on a rotational basis. The Committee proposed the Democratic People’s Republic of Korea for the post of Vice-President, Indonesia for the post of Vice-Chairman of Committee B, Myanmar for
the Committee on Credentials, and Maldives as Member of the General Committee. These proposals were unanimously accepted.

220. The Committee also observed that for the 141st session of the WHO Executive Board in May 2017, the posts of Member and Vice-Chairperson were vacant for Member States of the SEA Region. It was proposed that Sri Lanka be nominated as Executive Board member in place of Nepal whose term ends in May 2017, and that Thailand be nominated as Vice-Chair. These proposals were unanimously accepted by the Committee.

221. Two Member States of the SEA Region – Bhutan and Thailand – are current members of the Programme Budget and Administrative Committee (PBAC), with their terms of membership due to expire in May 2018 and May 2017, respectively. The proposal to nominate Sri Lanka as a member of PBAC for a term of two years in place of Thailand, whose term expires in May 2017, was accepted by the Committee.

**Amendment to the Rules of Procedure of the WHO Regional Committee for South-East Asia** *(Agenda item 11.5, SEA/RC69/22)*

222. The Chairperson outlined the amendments proposed to the above rules (Rule 12). The Committee expressed support for the proposals made, and suggested a more comprehensive approach to the process of proposing and discussing future amendments of rules.

223. The Committee adopted a resolution SEA/RC69/R7 on “Amendment to the Rules of Procedure of the WHO Regional Committee for South-East Asia”.
Management and governance matters (Agenda item 12)

Status of the SEA Regional Office Building (Agenda item 12.1, SEA/RC69/23)

224. The Committee recalled that, during its Sixty-eighth session in Dili, Timor-Leste, in September 2015, the WHO Regional Committee for South-East Asia had reviewed the preliminary report on the status of the SEA Regional Office Building in New Delhi, India.

225. The Committee was informed that in response to concerns raised about the durability and usability of the buildings on the Regional Office campus — some of which, including the main building, are more than 55 years old — the Ministry of Health and Family Welfare of the Government of India had invited the Central Public Works Department of India to perform a comprehensive analysis of the facilities. The study confirmed that the Regional Office buildings are not seismically safe for use and, after exploration of all the options, recommended that the buildings on the campus be demolished and new premises be built to house the Regional Office.

226. The Committee also recalled that, following the findings of the study commissioned by the Government of India, the Secretariat consulted with the WHO Director-General and representatives of the Government of India and decided to move the Regional Office to alternative premises to ensure the safety of WHO staff at work while reviewing longer-term options for the current campus. To that end, the Regional Office management engaged the services of an international real estate consultant company to conduct a market search to identify suitable facilities in central New Delhi that could temporarily house the Regional Office for a tenure that would cover the duration of the work.

227. Following the deliberations at the High-Level Preparatory Meeting in July 2016 and to ensure due diligence, a further, more comprehensive study is underway on the options available for the Regional Office Building and to determine the accuracy of the cost estimates. Three options for the next 40-year period were considered:

- Option 1: Refurbishment of the existing main building
- Option 2: Redevelopment of the whole campus
- Option 3: Partial redevelopment and partial refurbishment

228. The Committee noted that the initial findings in the report reinforced the findings of previous studies that redevelopment of the whole campus is the most cost-effective solution to ensure safe, continued occupation by the Regional Office of the land provided by the Government of India.
229. The Committee was informed that the Ministry of Health and Family Welfare of the Government of India has been working closely with the Secretariat on this important issue, and that a joint standing committee was formed to provide strategic direction, coordination and facilitation of the relocation and reconstruction project.

230. Expressing concern over the safety of the current building, the Committee agreed that the condition of the Regional Office Building warranted an immediate decision on temporary relocation and construction of new premises, fully supporting the draft decision proposed.

231. The Committee also noted with satisfaction the updates reflected in the working paper on the status of the Regional Office Building and urged the Secretariat to provide regular updates on progress to Member States. The Committee noted that the building project should be managed in such a way that it is completed as early as possible.

232. The host Member State confirmed to the Committee that the current lease arrangements for the land on which the Regional Office Building is located will continue and pledged its support as well as a substantial contribution to the building and relocation project.

233. The Committee noted the constructive dialogue with the Government of India on their contribution to such a strategy and requested the Secretariat to proceed as soon as possible with relocation to temporary accommodation in New Delhi after duly considering the appropriateness of the premises in relation to the convening mandate of the Regional Office.

234. The Committee requested the Secretariat to finalize a sustainably funded reconstruction strategy for the Regional Office, considering all available funding mechanisms, including but not limited to real estate funds, other potential reserves and contributions from the host Member State to enable due consideration of the issue by the World Health Assembly in May 2017 with the minimum possible delay. In this regard, the Committee desired that negotiations also be held with WHO headquarters to secure additional budget space and budget for the proposed construction and related costs.

235. It was observed that all Member States have a stake in ensuring the proper and smooth transitional continuity of the Regional Office premises. The distinguished delegate from Sri Lanka also assured a contribution.
236. The Committee was informed that a full report, including a financing plan for the new building, would be submitted for the Executive Board’s consideration by the end of October in order for the matter to be addressed and considered at the Seventieth World Health Assembly. It was observed that time is of the essence in order not to escalate the costs towards rentals and other overheads.

**Special programmes (Agenda item 13)**


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

238. At present, Maldives represents the WHO South-East Asia Region under paragraph 2.2.2 of the memorandum of understanding until 31 December 2018, and there are two Member States from the Region (India and Thailand) who represent a joint constituency and are members of JCB under paragraph 2.2.1 until 31 December 2017. The Seventy-first session of the WHO Regional Committee for South-East Asia in 2018 will be required to take a decision on the regional membership for a four-year period from 2019 onwards to step in for Maldives. Currently, there is no representation from the SEA Region for JCB membership under paragraph 2.2.3.
239. The Thirty-ninth session of the Joint Coordinating Board for TDR (JCB TDR) was held at WHO headquarters in Geneva on 21–22 June 2016. The Committee took note of the report of the session of the Joint Coordinating Board for TDR.


240. The Committee noted that the Policy and Coordination Committee (PCC) acts as the governing body of the Special Programme of Research, Development and Research Training in Human Reproduction. The Committee also noted the report of the previous meeting of the PCC held in Geneva on 23–24 June 2016.

241. At present, there are three Member States from the WHO South-East Asia Region (Indonesia, Myanmar and Timor-Leste) that are Members of PCC in Category 2, while India continues to be a Member of PCC in Category 1. Since the term of office of Timor-Leste ends on 31 December 2016, representatives of the HLP Meeting were requested to propose one of the Member States in the SEA Region to serve on the PCC for a three-year term of office from 1 January 2017.

242. The Committee noted the recommendation of the HLP Meeting and decided to nominate Sri Lanka to serve on the PCC for a three-year term of office from 1 January 2017.

**Time and place of future sessions of the Regional Committee (Agenda item 14, SEA/RC69/26)**

243. The Committee thanked the Republic of Maldives for its earlier invitation to host the Seventieth session of the Regional Committee for WHO South-East Asia in September 2017 in Maldives, and decided to hold its Seventieth Session in Maldives in September 2017.

244. The Committee also noted that the Seventy-first Session of the Regional Committee will be held in the Regional Office in September 2018.

245. The Committee also took note of the invitation from the distinguished delegate of the Democratic People’s Republic of Korea to host the Seventy-second Session of the Regional Committee in September 2019 in Pyongyang, and decided to hold the Seventy-second Session in Pyongyang, Democratic People’s Republic of Korea.
Closing of the Session (Agenda item 17)

246. In their closing remarks, representatives of all Member States congratulated the Chairperson, H.E. Dr Rajitha Senaratne, Minister of Health, Nutrition and Indigenous Medicine, Democratic Socialist Republic of Sri Lanka, and the Vice-Chairperson Mr Zahid Maleque, State Minister, People’s Republic of Bangladesh, for the smooth and successful conduct of the Regional Committee session. They also conveyed their appreciation to H.E. Mr Ranil Wickremesinghe, Prime Minister of the Democratic Socialist Republic of Sri Lanka, for his inspiring inaugural address, and thanked Dr Margaret Chan for sharing her thoughts on important global and regional health issues.

247. The representatives commended the exemplary vision and leadership of the Regional Director, Dr Poonam Khetrapal Singh, and observed that the “Region is in safe hands”.

248. The representatives also appreciated the early morning sessions on physical activity and found the two Ministerial Roundtables most interesting and useful. The contributions of the WHO teams from headquarters, the Regional Office and the country office were greatly appreciated.

249. The Regional Director congratulated H.E. Dr Rajitha Senaratne, Minister of Health, Nutrition and Indigenous Medicine, Democratic Socialist Republic of Sri Lanka, for his role in bringing the Sixty-ninth Session of the Regional Committee to a successful completion. She also expressed her gratitude and appreciation to the Vice-Chairperson Mr Zahid Maleque, State Minister, People’s Republic of Bangladesh, for conducting the sessions in the absence of the Chairperson.

250. Dr Singh also expressed her deepest gratitude and appreciation to H.E. Mr Maithripala Sirisena, President of the Democratic Socialist Republic of Sri Lanka, for so graciously leading a physical activity session for participants and for hosting a dinner in their honour. She also thanked H.E. Mr Ranil Wickremesinghe, Prime Minister of the Democratic Socialist Republic of Sri Lanka, for his inspiring address at the inaugural session.

251. She recalled how over the past two years the SEA Region had sought to look for more efficient ways of conducting the Regional Committee sessions and in this context mentioned that the Ministerial Roundtables that are a part of the Regional Committee sought to benefit from the presence and experience of ministers. The Colombo Declaration on Strengthening Health Systems to Accelerate Delivery of
NCD Services at the Primary Health Care Level was the result of one such roundtable held at the current session.

252. The Regional Director said that WHO enjoys a close relationship with Member States like “one happy family”, and thanked delegates for sharing their vision to improve the health and well-being of the people.

253. Dr Singh said it was very satisfying that so many health ministers were present at the session which reflected the importance Member States attach to the work of and partnership with WHO. Dr Singh also thanked Dr Margaret Chan, WHO Director-General, Dr Anarfi Asamoa-Baah, WHO Deputy Director-General, and Dr Hans Troedsson, Assistant Director-General, General Management, for their participation, and Dr Jacob Kumaresan, WHO Representative to Sri Lanka, and his team for the conduct of the session. She also thanked the WHO Secretariat for their hard work and diligent preparations.

254. In his closing remarks, the Chairperson, Dr Rajitha Senaratne, Minister of Health, Nutrition and Indigenous Medicine, Democratic Socialist Republic of Sri Lanka thanked all the representatives for their active participation and useful interactions. He thanked the Regional Director for her leadership and guidance and praised her initiative in identifying the Flagship Priorities. He also thanked Dr Jacob Kumaresan, WHO Representative to Sri Lanka, and the Secretariat, without whose cooperation the meeting would not have been so successful. He expressed appreciation for the work of the Resolutions Drafting Group and thanked the WHO Director-General, Deputy Director-General and the headquarters team for their participation. The Chairperson then declared the Sixty-ninth Session of the WHO Regional Committee for South-East Asia closed.
Resolutions

SEA/RC69/R1 Colombo Declaration on Strengthening Health Systems to Accelerate Delivery of NCD Services at the Primary Health Care Level

The Regional Committee,

Having considered the Colombo Declaration on strengthening health systems to accelerate delivery of NCD services at the primary health care level,

(a) ENDORSES the Colombo Declaration on strengthening health systems to accelerate delivery of NCD services at the primary health care level (annexed to this resolution);

(b) REQUESTS the Regional Director to submit an interim report and a full report on progress achieved in implementing the Colombo Declaration in 2019 and 2021 respectively.
Colombo Declaration

Strengthening Health Systems to Accelerate Delivery of NCD Services at the Primary Health Care Level

We, the Health Ministers of Member States of the WHO South-East Asia Region participating in the Sixty-ninth Session of the WHO Regional Committee for South-East Asia in Colombo, Sri Lanka,

Concerned with the unacceptable and increasing trends of premature mortality, morbidity and disability caused by noncommunicable diseases (NCDs), primarily cardiovascular diseases, cancers, diabetes and chronic respiratory diseases in the South-East Asia Region;

Aware that cardiovascular disease, cancers, diabetes, chronic respiratory diseases and NCD risk factors all require a well-functioning health system and enabling environment to mount the appropriate common and disease-specific responses ranging from health promotion, prevention, early detection of risks and diseases to long-term care provision;

Cognizant of the fact that strengthening the delivery of integrated NCD management1 in primary health care is the best approach to achieve universal health coverage – beginning with those at highest risk and leaving no one behind; and that the health-care systems of Member States have the potential to be better organized to manage the demographic and epidemiological transition that underpins NCDs;

Realizing that integrated NCD management at the primary health care level would strengthen the frontline health services while reducing the fragmentation and duplication of the vertical health programmatic approach;

Acknowledging that effective NCD management at the primary health care level requires appropriate mobilization, allocation and management of resources to strengthen the building blocks of health systems, including finances, workforce, medicines and technologies, infrastructure and information systems;

Reaffirming the Global and Regional Voluntary Targets for NCD Prevention and Control, and the time-bound commitment to strengthen and reorient health systems to address NCDs through people-centred primary health care systems by 2016, which includes achieving the national and regional targets of 80% availability of essential

1 NCD management, hereby, refers to the process in dealing with all building blocks of the health system to provide comprehensive NCD service and care; ranging from prevention, promotion and rehabilitation as well as screening, early diagnosis and health education.
NCD medicines and technologies and 50% of high-risk populations receiving drug and counselling therapies by 2025.

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

1. Improve access to and quality of integrated NCD management at the primary health care level by:

   (a) Strengthening and upscaling key components of comprehensive NCD management at the primary health care level, including targeted screening for early diagnosis, health guidance and counselling to promote healthy choices and self-care, appropriate treatment, robust follow-up and management of referrals to secondary and tertiary levels of health care, and

   (b) Applying a risk-based approach, focusing on populations with high risks, and adapting the WHO PEN Interventions or other clinical protocols for screening, diagnosis and management of major NCDs (cardiovascular diseases, diabetes, cancers and chronic respiratory diseases) to accelerate the expansion of NCD services particularly to low-access population groups.

2. Ensure adequacy and efficiency of resource mobilization and allocation to NCD management at the national and subnational levels by:

   (a) Encouraging adequate budget allocation in the health sector for NCD management at primary health care services, and

   (b) Advocating for innovative and sustainable financing for NCD management, including dedicated taxation of health damaging commodities such as tobacco, alcohol and unhealthy foods and beverages, as an additional measure that can both reduce exposure to NCD risk factors as well as mobilize more resources for NCD prevention and control at the same time.

3. Address the availability and accessibility of competent health workforces to manage NCDs at primary health care level, by prioritizing:

   (a) The training and orientation of health workforce, based on defined NCD service delivery packages, especially frontline health workers and volunteers to provide a whole-of-family and life-course approach;

   (b) The promotion of participation of communities and local governments in comprehensive NCD management;

   (c) The inclusion of NCD as a training component of any competency-based curricula for all categories of primary health care workforce;
(d) The support of multidisciplinary teams in health facilities with clear terms of function;

(e) The investment in the production of the primary care health workforce that can effectively adopt multi-tasking to meet the human resource gaps;

(f) Support of the primary health care level health workforce to accommodate the increasing workload associated with management of NCDs;

(g) The assurance of high-level supervised care by increasing the consultant coverage for NCD care at the primary care health level.

4. Increase the availability of and access to essential medicines and basic technologies for NCD management at the primary health care level by:

(a) Establishing, reviewing and updating the Essential Medicines List (EML) and devices needed to screen, diagnose and treat key NCDs at different levels of health care in line with standard treatment guidelines for NCDs;

(b) Improving the affordability of essential medicines and basic technology for NCD management;

(c) Strengthen the drugs and supplies monitoring system up to the primary health care level;

(d) Reviewing and strengthening procurement policy and capacity, including guidelines, logistic information systems and monitoring mechanisms to ensure uninterrupted supply of essential medicines and diagnostic kits for NCDs.

5. Strengthen and integrate health information systems for NCD services at all levels by:

(a) Developing patient tracking systems, preferably IT-enabled, to facilitate clinicians and other health-care workers to provide patient-centred continuous quality care;

(b) Developing continuous patient record for NCD patients, and promoting use of quality of care indicators;

(c) Promoting research in need for NCD prevention and control, including implementation research;

(d) Instituting and strengthening surveillance of NCD risk factors and monitoring and evaluation mechanisms to regularly assess the progress.
6. Promote a multisectoral approach to address major social and environmental determinants of NCDs by:

(a) Strengthening advocacy, partnerships and leadership with government agencies and non-State actors to address the major risk factors leading to NCDs, from early years of life;

(b) Develop mechanisms for evolving and accelerating the implementation of risk-reduction strategies, healthy public policies and population-based interventions for tobacco, alcohol, high intake of saturated fats/trans fats, sugar and salt, and increasing intake of fruits and vegetables, promotion of physical activity and non-sedentary behaviour and promotion of healthy behaviours in the general population and in key settings at educational institutes, in particular through strengthening of school health programmes, as well as at workplaces and at community level;

(c) Enhancing the roles of community-based organizations and community leaders in addressing the social determinants of health, taking into account the socioeconomic and cultural context.

7. Support knowledge and experience-sharing mechanisms, including national and international learning processes.

8. Establish a high-level national multisectoral taskforce to monitor and ensure the implementation of this Ministerial Declaration and report back in a timely manner.

We, the Health Ministers of Member States of the WHO South-East Asia Region, request the WHO Director-General and the Regional Director for South-East Asia Region 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, nongovernment organizations, related sectors and the media, to jointly advocate, provide technical and financial support, and effectively follow up on all aspects of this Colombo Declaration.

Colombo, Sri Lanka, 9 September 2016
The Regional Committee,

Having considered the Proposed Programme Budget 2018–2019, which builds on the approved Programme Budget 2016–2017; and which is the last of the three Programme Budgets covered in the Twelfth General Programme of Work 2014–2019, providing the overall strategic direction and results chain for the Organization,

Noting that the development of Programme Budget 2018–2019 too has followed a needs-based, bottom-up prioritization process involving the Member States, in response to their requests to identify a focused number of priorities for technical cooperation and aligning these with the regional and global commitments,

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

Noting that the Strategic Budget Space Allocation (SBSA) formula applied resulted in a gradual decrease of allocation to the South-East Asia Region by 1% spread over four bienniums,

Noting further that the budget for the new Health Emergencies Programme is likely to see an increase as also Antimicrobial Resistance (AMR),

Noting the Proposed Programme Budget 2018–2019 for the South-East Asia Region is largely commensurate with the priorities and areas of concern for the Member States, and is also in line with the Regional Flagships Priority Areas which in effect were an iteration of country priorities,

Noting that the total allocation for the Region has increased by US$ 7.3 million but considering the observations and concerns related to health in South-East Asia, there is a perceived need for an increase in the allocation of the Budget for the Region,

Acknowledging that although the Region’s needs for greater allocation of resources for NCDs has been reflected in the parameters of the Proposed PB, given the double burden of disease in the South-East Asia Region, the allocation for communicable diseases needs to be maintained at a higher level,
Noting the significant decrease in the Budget for polio and acknowledging that the Region is conducting transitional planning to address this shift in needs which include human, financial and material resources,

Noting that the South-East Asia Region continues to maintain its polio-free status and that the Member States are moving to implement the Polio Endgame Strategy, the significant decrease in the budget for polio, is a cause for concern as this could negatively impact the implementation of polio transition and endgame activities,

Endorsing the recommendations of the Inter-sessional Meeting held on 4 September 2016 and the Ninth Meeting of the Sub-Committee on Policy and Programme Development and Management in July 2016 on the Draft Proposed Programme Budget 2018–2019,

1. **URGES Member States:**

   (a) to continue active participation in the Programme Budget-related discussions at the Regional and Global Governing Body meetings; and

2. **REQUESTS the Regional Director:**

   (a) to continue to implement the Twelfth General Programme of Work and attempt to align its biennial programme implementation and performance indicators with the SDG targets;

   (b) to convey the following views of the Regional Committee to the Director-General for her consideration while finalizing the Proposed Programme Budget 2018–2019:

   (i) the need for a Programme Budget increase for the South-East Asia Region for the biennium 2018–2019, to account for the high disease burden and large population of the Region;

   (ii) the concern about the decreased funding allocations for certain areas such as communicable diseases of which the Region continues to share a disproportionate burden, especially for diseases such as tuberculosis wherein six of the 25 high-burden countries are situated in the Region;

   (iii) the Region should get full funding against the Programme Budget;

   (iv) the Region should get an increase in Assessed Contributions and flexible non-earmarked Voluntary Contributions to provide for sufficient resources to address the priorities set by the World Health Assembly;
(c) to negotiate and secure at the appropriate forums additional budget space and budget for the APO and the proposed shift of the Regional Office building including recurrent rental cost and planned moves of some WHO Country Offices and their refurbishment and increased rental costs,

(d) to continue supporting the corporate resource mobilization efforts, particularly to attract flexible and un-earmarked funds and other Voluntary Contributions for underfunded categories, priority programme areas and Member States with limited fund mobilization capacity as well as ensure that the Region receives adequate/full funding for the approved Programme Budget 2018–2019, and

(e) to advocate to Member States of the Region to consider supporting an increase in the Assessed Contributions.

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SEA/RC69/R3 Ending Preventable Maternal, Newborn and Child Mortality in the South-East Asia Region in line with the Sustainable Development Goals (SDGs) and Global Strategy on Women’s, Children’s and Adolescents’ Health

The Regional Committee,

Recalling its resolutions SEA/RC53/R9 on Maternal mortality, SEA/RC56/R9 on Health of the newborn1 and SEA/RC58/R2 on Skilled care at every birth, as well as the recent World Health Assembly resolution WHA69.2 on Committing to implementation of the Global Strategy for Women’s, Children’s and Adolescents’ Health,

Recognizing the significant progress made towards achieving MDGs 4 and 5 in countries of the South-East Asia Region with a regional decline in child mortality rate of 64% and a decline of 69% in the maternal mortality ratio, between 1990 and 2015, and the need to further build upon these achievements,

Noting that these figures fall short of the MDG targets of a two thirds reduction in child mortality and a three fourths reduction in maternal mortality, and that neonatal mortality has declined less rapidly than child mortality, that there are significant disparities in achievements across and within countries, and that maternal, newborn and child mortality continue to remain high in some countries in the Region,

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1 Newborn period is first 28 days of life after birth
Acknowledging that the UN Secretary-General’s Global Strategy on Women’s, Children’s and Adolescents’ Health (2016-2030), and the Sustainable Development Goals provide new opportunities and have set new targets for countries on reducing maternal mortality and ending preventable, newborn and child deaths,

Further acknowledging that Universal Health Coverage is the overarching umbrella for taking forward the SDG Goal 3 on health, and that the SDGs provide an excellent framework to accelerate efforts to narrow equity gaps in accessing quality care, ensure adequate health financing and sufficient numbers and appropriate skill-mix and deployment of health workforce,

Appreciating the Regional Flagship Priority on ending preventable maternal, newborn and child mortality with a focus on newborn deaths, and the partnership commitment as exemplified by the joint statement by H6 agencies (WHO, UNICEF, UNFPA, UNAIDS, UN WOMEN and World Bank) on ending preventable maternal, newborn and child mortality,

Considering that this resolution supersedes the three previous resolutions on related subjects namely, SEA/RC53/R9, SEA/RC56/R9 and SEA/RC58/R2;

1. URGES Member States:

(a) To achieve universal access to and coverage of essential intervention packages for reproductive, maternal, newborn, child and adolescent health (RMNCAH) across the continuum of care, with focus on good quality care of mothers and newborns at the time of childbirth and, including mothers and newborns with risks and complications,

(b) To review and strengthen national health systems, as appropriate, to identify gaps and solutions in relation to the needs of RMNCAH, including by investing in midwifery skills and development of sustainable health financing mechanisms to reduce out-of-pocket expenses for safe child birth and care of mothers and newborns,

(c) To strengthen the quality and use of data for programme improvement in line with the indicators and disaggregation in the SDGs and Global Strategy including still births and cause of death related to maternal, neonatal, child and adolescent health, and

(d) To reinforce multisectoral and multi-stakeholder partnerships and commitments to address underlying social determinants of women’s,
children’s and adolescents’ health such as early marriage\(^2\), nutrition, education, poverty, water-sanitation, and to promote early childhood development,

2. REQUESTS the Regional Director:

(a) To intensify technical collaboration with, and support to, Member States to update their national RMNCAH strategies and plans to address the coverage gaps for essential interventions for RMNCAH, with specific guidance on organizing, planning and setting up quality services for child birth and newborn care,

(b) To support Member States to strengthen the quality and use of data for programme improvement in line with the indicators and disaggregation in the SDGs and Global Strategy including still births and cause of death related to maternal, neonatal, child and adolescent health,

(c) To support Member States, upon request, for developing national RMNCAH investment case\(^3\) and encourage adequate national and international investments for ending preventable maternal, newborn and child mortality and improving health and wellbeing of women, children and adolescents, and

(d) To report progress on implementation of this resolution to the Regional Committee in 2018, 2022, 2026 and 2030.

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2 Early marriage defined as formal marriages or customary and statutory unions recognized as marriage before the age of 18 (at 18 a girl is still considered a child under the Convention on the Rights of the Child, except in countries where the age of majority is lower).

Alarmed by the increasing trend of sedentary lifestyle and screen time in the population, particularly among children and adolescents,

Recalling World Health Assembly resolution WHA57.17 and its own resolution SEA/RC60/R4 and reaffirming the World Health Assembly resolution WHA66.10, and the global commitment on prevention and control of NCDs, in particular, to reduce by 10% the prevalence of insufficient physical activity by 2025,

Appreciating the efforts by the global community to drive the physical activity agenda, in particular at the side event at the Sixty-ninth World Health Assembly on “Towards achieving the physical activity target 2025 (10x25): are we walking the talk?”, where consensus was reached for a need to foster country actions and monitoring on physical activity,

Recognizing the positive impact of promotion of physical activity on health, the need for Member States to strengthen national action plans on physical activity and non-sedentary lifestyle to sustain the high level of physical activity and address sub-national or population groups with high prevalence of physical inactivity; while at the same time addressing factors contributing to sedentary lifestyle and promote active lifestyle as primary prevention of NCDs,

Further recognizing that physical and social environments are important to promote physical activity and non-sedentary lifestyle and the need for coordinated actions and engagement across all sectors, and

Noting the need to strengthen monitoring and evaluation of physical activity and non-sedentary lifestyle to track the progress in a comprehensive way, and the lack of a regional status report on the subject,

1. **URGES** Member States:

   (a) to establish and/or strengthen, and implement the national action plan on physical activity and non-sedentary lifestyle, by adopting the WHO guidelines\(^1\) in line with national context;

   (b) to encourage the development of leaders, champions and change agents country-wide, and support them to promote physical activities as role models;

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(c) to develop and/or strengthen environments which are conducive to physical activity and non-sedentary lifestyle, through multisectoral coordinated actions, and support widest implementation such as through networks of actors, including but not limited to, community groups, civil society organizations, educational institutions, workplaces in the private sector and government agencies, various ministries and local governments;

(d) to strengthen monitoring and evaluation of physical activity and non-sedentary lifestyle as part of the national monitoring mechanism in harmony with the regional and global monitoring framework;

(e) Promote physical activities already ongoing in many Member States and share the experiences gained from the practice of alternative and traditional methods, including yoga; and encourage and share among Member States other local practices.

2. REQUESTS the Regional Director:

(a) to continue promoting and monitoring physical activity among WHO staff and support them to become change agents, leaders and role models in physical activity within the Region;

(b) to support Member States in the development and/or strengthening, and implementation of their national action plans for promoting physical activity;

(c) to share regional and global good practices such as yoga and other traditional approaches for physical activity among Member States;

(d) to support the creation and promotion of regional and national networks on physical activity and non-sedentary lifestyle, to provide a platform for regular learning and sharing experiences and best practices among leaders and champions in all Member States for strengthening the implementation of the national action plans on physical activity;

(e) to support Member States in the development and/or strengthening of the monitoring and evaluation of physical activity and non-sedentary lifestyle;

(f) to develop a status report on physical activity and health in the South-East Asia Region and present to the Seventy-first Session of the Regional Committee, and

(g) to report progress on implementation of this resolution every two years to the Regional Committee until 2025.
SEA/RC69/R5 Strategic Action Plan to Reduce the Double Burden of Malnutrition in the South-East Asia Region 2016–2025

The Regional Committee,

Having considered the Strategic Action Plan to reduce the double burden of Malnutrition in the South-East Asia Region 2016–2025,

Recognizing the global commitment and the adoption of “Transforming our world: the 2030 Agenda for Sustainable Development” that aims to end poverty and hunger everywhere; to combat inequalities within and among countries; to build peaceful, just and inclusive societies; to protect human rights and promote gender equality and the empowerment of women and girls; and to ensure the lasting protection of the planet and its natural resources,

Recognizing that reducing the double burden of malnutrition contributes to the achievement of a number of global goals and targets including the 2030 Agenda for Sustainable Development, Global nutrition targets 2025, Global Action Plan for the Prevention and Control of NCDs 2013-2020 and the Global Strategy for Women’s, Children’s and Adolescents’ Health 2016-2030,

Alarmed at the ongoing nutrition transition in the South-East Asia Region which is characterized by persistent under-nutrition including micronutrient deficiencies, and the emergence of overweight and obesity, which increases the risk of noncommunicable diseases (NCDs),

Emphasizing the varying extent and nature of challenges of the double burden of malnutrition across Member States in the Region which require urgent and sustained efforts,

Noting with appreciation that the Strategic Action Plan was developed through an extensive consultative process with Member States and nutrition experts, bringing together guidance from global and regional policy platforms,

Acknowledging the importance of country commitment, leadership and actions, and the need for applying the Strategic Action Plan into national health/nutrition plans, as appropriate to country context,

Recognizing the need for a life-course approach, multi-stakeholder and multisectoral partnerships including the private sector and civil society for effective and concerted actions,
Emphasizing the crucial role of data and information systems at all levels,

1. **ENDORSES** the Strategic Action Plan to reduce the double burden of malnutrition in South-East Asia Region 2016–2025;

2. **URGES** Member States:
   
   (a) To consider adopting and implementing, in accordance with their national priorities and context, the strategic action plan including multisectoral actions, in order to reduce the double burden of malnutrition;
   
   (b) To strengthen policy and legislative frameworks for this purpose, as well as monitoring, evaluation, accountability, policy uses and follow-up at all levels, including through improving the quality of national health information systems, and

3. **REQUESTS** the Regional Director:
   
   (a) To provide adequate technical support to Member States in the implementation of the strategic action plan including for strengthening monitoring and evaluation systems;
   
   (b) To continue to collaborate with the United Nations agencies, funds and programmes and other relevant partners and stakeholders, to advocate and leverage assistance for aligned and effective implementation of the strategic action plan in Member States, and
   
   (c) To conduct mid-term (2021) and end-term (2025) assessments of the progress and achievements of the strategic action plan and report to the subsequent Regional Committee meetings.

**SEA/RC69/R6 Expanding the Scope of the South-East Asia Regional Health Emergency Fund (SEARHEF)**

The Regional Committee,

Recognizing the Sendai Framework for Disaster Risk Reduction and Sustainable Development Goals adopted by the UN General Assembly,

Recalling World Health Assembly resolutions WHA54.14, WHA58.1, WHA59.22, WHA64.10, WHA65.20, WHA68.5, Executive Board Special Session on Ebola EBS53.R1 and its own resolutions SEA/RC57/R3, SEA/RC60/R7, SEA/RC62/R5 and
SEA/RC68/R2 which call for strengthening the resilience of national health systems in response to all hazards that may lead to emergencies and for improved investments of resources, systems and expertise for emergency preparedness and response,

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

Acknowledging the establishment of the South-East Asia Regional Health Emergency Fund (SEARHEF) as established through Regional Committee resolution SEA/RC60/R7,

Reaffirming that emergencies remain a concern in the Region and recognizing SEARHEF as an important component for regional solidarity for support in times of acute emergencies and that Member States have commended the speed and flexibility provided by the funds,

Appreciating the contribution of Member States to continuously support SEARHEF with AC and VC funds,

Endorsing the report and the recommendations of the High-Level Preparatory Meeting of Member States in July 2016 to expand the scope of SEARHEF to include a preparedness stream that would strengthen key aspects such as disease surveillance, health emergency workforce and health emergency teams, IHR core capacities and SEARO Benchmarks for emergencies,

1. URGES Member States:

(a) to endorse the expansion of the mandate of SEARHEF to include an additional stream covering preparedness;

(b) to endorse the recommendations of and the proposed policy and guidelines for the preparedness stream of SEARHEF developed during the Fifth Meeting of the Working Group for Governance of SEARHEF (Annex1);

(c) to use the preparedness stream of SEARHEF to support critical capacities in preparedness that include but will not be limited to:

1 Background document: http://www.searo.who.int/mediacentre/events/governance/rc/69/sea-rc69-r6-annex.pdf?ua=1
(i) strengthening capacities defined by IHR and SEAR benchmarks in order to enable a full and effective response to emergencies with health consequences;

(ii) ensuring that preparedness and risk reduction efforts across all hazards contribute to resilient health systems;

(iii) strengthening disease surveillance capacity and data and information flows and sharing between local and national levels and with WHO at country, regional and global levels in order to ensure early reporting and detection;

(iv) continue supporting the regional and sub-regional collaboration among disease surveillance networks within and across WHO regions;

(v) building up local and national surge capacity by strengthening the health emergency workforce through establishment of systematic systems that include training, efficient recruitment and deployment;

(vi) establish or strengthen multidisciplinary health emergency teams that can be deployed in a timely manner;

(d) to discuss within the internal government processes so as to mobilize resources to fund the preparedness stream of SEARHEF, and

(e) to continuously participate in the management and utilization of SEARHEF through its Working Group, and

2. REQUESTS the Regional Director:

(a) to facilitate discussion among Member States to determine the feasible options to fund the preparedness stream of SEARHEF;

(b) to support the implementation of the policy, guidelines and procedures drafted by the Working Group for the governance of SEARHEF;

(c) to mobilize technical and operational assistance to the initiatives that the preparedness stream of SEARHEF will support;

(d) to support resource mobilization efforts as guided by Member States, and

(e) to report annually to the Regional Committee on the progress of the preparedness stream of SEARHEF in conjunction with reporting on the response stream of SEARHEF.
Amendment to the Rules of Procedure of the WHO Regional Committee for South-East Asia

The Regional Committee,

Having considered the World Health Assembly Decision WHA65(9), by which the Sixty-fifth World Health Assembly decided *inter alia* that the regional committees should harmonize their practices in relation to the nomination of Regional Directors, and the review of credentials and the participation of observers,

Noting the revision to Rule 3 pertaining to “Credentials” in the Sixty-sixth Session of the Regional Committee (SEA/RC66/R8), a further revision was procedurally warranted based on the fact that while the revised Rule 3 was amended and implemented, the reference to the Credentials Sub-Committee continued to appear in Rule 12 of the said Rules,

Having been considered by the High-Level Preparatory Meeting, which for this purpose is deemed to be equivalent to a Sub-Committee in accordance with Rule 51 of the Rules of Procedure of the WHO Regional Committee for South-East Asia,

And having further considered the report of the Secretariat,

1. DECIDES to amend Rule 12 of its Rules of Procedure concerning Officers of the Committee by deleting the phrase “which shall be the item immediately following the acceptance of the report of the Credentials Sub-committee”.

2. DECIDES that the foregoing amendment will be reflected in the Rules of Procedure from the Sixty-ninth session of the Regional Committee.

Resolution of Thanks

THE REGIONAL COMMITTEE, having brought its Sixty-ninth Session to a successful conclusion,

1. THANKS His Excellency the President of the Democratic Socialist Republic of Sri Lanka, Mr Maithripala Sirisena;

2. THANKS His Excellency the Prime Minister of the Democratic Socialist Republic of Sri Lanka, Mr Ranil Wickremesinghe, for inaugurating the Session and for his inspiring address;
3.  THANKS the WHO Director-General, Dr Margaret Chan, for her thought-provoking address and participation;

4.  CONVEYS its gratitude to the honourable Minister of Health, Nutrition and Indigenous Medicine, Dr Rajitha Senaratne, the honourable Deputy Minister of Health, Nutrition and Indigenous Medicine, Mr Faizal Cassim, members of the National Organizing Committee, the staff of the Ministry of Health, Nutrition and Indigenous Medicine, and other national authorities of Sri Lanka for their efforts in ensuring the success of the session, and

5.  CONGRATULATES the Regional Director and her staff on their efforts towards the successful and smooth conduct of the Sixty-ninth Session.
Decisions

**SEA/RC69(1) Overview of WHO Reform**

The Committee, in line with World Health Assembly Decision WHA69(8), decided to set up a Working Group comprising Member States of the South-East Asia Region to review the measures adopted by the other regional offices and regional committees of the World Health Organization in aligning the process of nomination of the Regional Director, such as introducing a code of conduct for the nomination of the Regional Director, a standardized curriculum vitae, and a candidates’ forum.

The findings of this Working Group will be presented to the Seventieth Session of the Regional Committee for its consideration.

**SEA/RC69(2) Review of Regional Committee resolutions**

The Committee considered the report of its Sixty-eighth session on the establishment of an Informal Working Group consisting of members from Bangladesh, India and Thailand to study actions taken by the Eastern Mediterranean and European regions of WHO on reviewing Regional Committee resolutions in those regions, and to organize a Technical Consultation with Member States before the next High-Level Preparatory Meeting to decide on a set of criteria and time frame for phasing out resolutions that have already been implemented/acted upon or have outlived their utility and relevance.

The Committee noted the recommendations of the Informal Working Group and the Technical Consultation of Member States of the SEA Region to review past Regional Committee resolutions that outline the criteria to categorize a resolution as “Active” or “Conditional sunset” or “Complete sunset” and, reviewing a total of 78 resolutions based on these criteria, the Committee underscored the suggestions made by the High-Level Preparatory Meeting on the conditions to be attendant on the individual categories and, having further considered the report of the Secretariat, decided to:

(a) adopt the categorization of past resolutions into “Sunset”, “Conditional sunset” and “Active” categories, and the criteria suggested for each such category by the Technical Consultation of Member States;
(b) categorize accordingly the 78 resolutions as 32 resolutions for “Complete sunset”, 16 resolutions for “Conditional sunset”, and retain as “Active” 30 resolutions;

(c) “Sunset” resolutions dating prior to the period of review undertaken through the Informal Working Group and Technical Consultation which are more than 15 years old, unless specific periodic reporting requirements are entailed and continue to remain therewith. In case any such resolution pertains to an issue of importance and/or continued relevance to the South-East Asia Region with an actionable agenda, the technical unit involved may propose a fresh resolution or decision to incorporate the latest technological/programmatic developments on the subject of the resolution;

(d) request the Regional Director to establish, in accordance with this Decision, a mechanism to periodically review the existing “Conditional sunset” and “Active”, and the new resolutions at appropriate intervals and frequencies in a cost-effective manner, and place recommendations of the review for endorsement of the Regional Committee, and also

(e) request the Regional Director to review all the proposed new resolutions and strategies to avoid overlapping and ensure streamlining of their contents.

**SEA/RC69(3) Status of the SEA Regional Office Building**

The Committee noted the report on the status of the SEA Regional Office Building and the urgent need for temporary premises pending the establishment and implementation of a sustainably funded reconstruction strategy.

The Committee noted the constructive dialogue with the Government of India on their contribution to such a strategy and requested the Secretariat to proceed as soon as possible with the relocation to temporary accommodation in New Delhi duly considering the appropriateness of the premises in relation to SEARO’s convening mandate.

The Committee also noted the assurance given by the Sri Lanka delegate. The Committee requested the Secretariat to finalize a sustainably funded reconstruction strategy for the Regional Office, considering all available funding mechanisms, including but not limited to: real estate funds, other potential reserves and contributions from the Host Member State to enable due consideration of the issue by the Executive Board with the minimum possible delay. In this regard, the
Committee desired that negotiations with WHO headquarters may also be held to secure additional budget space and budget for the proposed construction and related costs involved.


The Committee nominated Sri Lanka in place of Timor-Leste, whose term expires on 31 December 2016, as a member of PCC for a three-year term starting from 1 January 2017, and requested the Regional Director to inform WHO headquarters accordingly.

**SEA/RC69(5)** Time and place of future sessions of the Regional Committee

The Committee decided to hold its Seventieth Session in Maldives in September 2017. The Committee noted that the Seventy-first Session of the Regional Committee will be held in the Regional Office in New Delhi in September 2018. It also noted the invitation from the representative of the Democratic People’s Republic of Korea to hold the Seventy-second Session of the Regional Committee in September 2019 in Pyongyang.
Annex 1
Text of welcome address by the Honourable Minister of Health, Nutrition and Indigenous Medicine, Democratic Socialist Republic of Sri Lanka

It is with much pleasure I warmly welcome you all today to this important Sixty-ninth Session of the WHO Regional Committee for South-East Asia. It was 11 years ago that the Fifty-eighth session of the Regional Committee was last hosted by Sri Lanka in Kandy in September 2005.

The 11 Member States of the South-East Asia Region represent a quarter of the world’s population, and thus have much influence on the global health delivery process mooted by WHO. Thus this Regional Committee Session, the first to meet after the Sixty-ninth World Health Assembly held in Geneva in May, would undoubtedly help to guide other regions to move forward with resolutions adopted in Geneva, and shape the global health agenda of WHO.

Thus, we have an imperative task of reaching agreement on resolutions, and sharing our experiences and knowledge to improve the health status of our Region, collectively.

We have with us this morning our Prime Minister Honourable Mr Ranil Wickremasinghe, who graciously accepted my invitation to be the Chief Guest and to inaugurate the Sixty-ninth Session in spite of heavy official commitments. Thank you, Sir, for accepting my invitation and gracing this occasion.

WHO has actively supported our efforts in improving health-care delivery to our people. Over the last few decades, my country has made vast strides in improving the health of our citizens. Free health service we enjoy, and the continued guidance and technical support from WHO has contributed much to our success.

Now, I wish to extend a warm welcome to Dr Margaret Chan, Director-General of WHO, who I believe is undertaking her maiden visit to Sri Lanka, for all the support and guidance extended to our Region, and to my country in particular, and gracing this Regional Committee Session with her presence. I also wish to welcome
Dr Anarfi Asamoah Baah, Deputy Director-General of WHO, who is the supportive element behind the great leadership of WHO.

Dr Poonam Khetrapal Singh, Regional Director, is no newcomer to health outfits in the region, due to her continued support and guidance in strengthening the health scenario in the Region. Thank you, Dr Poonam, and a warm welcome to you.

The importance Member countries attach to this process is shown by the presence of health ministers from 10 Member countries with us today, some of whom I have met earlier. Excellencies, a warm welcome to Sri Lanka and hope you will have a pleasant stay in my country.

I am also happy to note the presence of a large number of my ministerial colleagues and members of Parliament, as well as provincial Governors and Chief Ministers with us this morning, and wish to thank them for their presence and to extend them a very warm welcome.

I believe we have over 200 delegates and official representatives from over 15 countries attending this Session, as well as a large number of resource persons, representatives from donor agencies and development partners; your presence is most welcome.

I hope we all will have fruitful discussions and you will also get the time to enjoy the culture and beauty of my country and the warmth and hospitality of its people.

I wish to conclude by expressing my best wishes for a most rewarding conference and await the conclusions and recommendations with much interest, since I am sure they will contribute greatly to further improve the health of the people in the South-East Asia Region and beyond.
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 Sri Lanka, for their warm hospitality.

Honourable Prime Minister, we are honoured by your presence here today.

Sri Lanka has an enviable and well-deserved reputation in the field of health for achieving good health outcomes at modest cost. Past investments in island-wide infrastructure, guided by policies that have consistently laid emphasis on primary health care, have paid rich dividends.

I do not think you will find a textbook on global health anywhere in the world that does not at some point cite the example of Sri Lanka.

Your success continues: in December last year, the World No Tobacco Day Award; certifying the elimination of lymphatic filariasis; progress towards mother-to-child transmission of HIV; and just last week the elimination of malaria. You deserve our warmest congratulations.

I will be saying much more about the unacceptable gap between what we say about the importance of health to our economies and the resources that governments actually commit to health. But here too Sri Lanka is ahead of the game. Since your government came to power health spending as a percentage of GDP has increased significantly. It is now 2%, with a plan to take it up to 3%.

You recognize that a dollar spent wisely on health can yield between 10 to 20 dollars in return. A message that I hope will be heard by the ministers of finance across the region.

The world is changing fast. With growing economies, there are opportunities for us to make rapid progress. With the right policies in place, there is no reason
why Sri Lanka along with several other countries in the Region should not aspire
to having health systems on par with the best in the world.

But there are also risks. A healthy population contributes to the rising wealth of
its nation. But demographic and epidemiological changes can pose a major threat
to our economies. NCDs – including mental health, substance abuse and accidents –
have the potential to bankrupt health systems and families.

Countries in this Region will see an increase from 10%–20% in the proportion
of the population over 60 years of age in less than 20 years. This change took over
150 years in Europe. Are we prepared and ready for this change?

We have seen the economic fallout from outbreaks and epidemics. Diseases
that affect thousands now result in losses of billions of dollars worldwide. Do we
have the systems and policies to ensure our health security?

New technology can increase efficiency and revolutionise the way we work. But
do we have mechanisms in place to ensure the objective and transparent assessment
of value for money?

The politics of health are equally challenging.

People’s expectations are changing: they want the best from providers and are
increasingly vocal if their demands are not met. But – when resources are finite –
we cannot just respond to the demands of the loudest and most influential voices.
If we do, we will make inequities worse.

This means setting priorities and the budgets that follow transparently – and
then sticking to them. It means a carefully negotiated relationship with the private
sector. One that seeks to harness private assets for the public good. Not one that
allows private health care to be seen merely as a private industry run for the personal
gain of its shareholders.

Several countries protect the poor by offering free services. But we all know
that free services are an illusion if out-of-pocket payments continue.

The concept of universal health coverage, to which Sri Lanka and other countries
in the Region are committed, is perfectly consistent with a wholly tax-funded health
system. But it does require that tax funding provide a level of protection that prevents
financial hardship when people fall ill.

In our region we are seeing exciting and creative responses to all of these
challenges. We have a lot to learn – from each other, and from the rest of the world.
Our Regional Committee is our opportunity every year to reflect on our achievements and our challenges. But to be successful it must also be a forum where we can learn from each other. Where we can discuss the issues that really matter. And where we take full advantage – in formal sessions and in less formal gatherings – of the precious but limited time that we have together.

With these few words, I once again welcome you all to Colombo and thank His Excellency the Prime Minister for inaugurating our meeting.
I am honoured to participate in this inauguration of the Sixty-ninth Session of the Regional Committee for South-East Asia.

This Region brings together a diverse range of low- and middle-income countries. They show wide variations in size, geography, culture, and social and economic development. They are at different stages in the epidemiological and demographic transitions. Yet all countries are united by a firm commitment to the principles and approaches of primary health care.

The Region as a whole takes direction from frequent consultations and summits where health ministers find common ground, experiences are shared, and collaborative initiatives are forged.

I look forward, in particular, to the Ministerial Roundtables, which will be discussing the rising challenge of noncommunicable diseases and the implications for health of the Sustainable Development Goals and their target for reaching universal health coverage.

The health targets in the 2030 Agenda for Sustainable Development are supremely ambitious, yet feasible, as they build on the huge achievements for health made since the start of this century, also in this Region.

The host country for this event is a most appropriate venue for discussions about high ambitions for health and how to pursue them. Sri Lanka, with its policy of universal free access to health care and education, is often described as a model welfare state.

Universal health coverage is the pillar of both sustainable development and global health security. Throughout most of the 20th century, UHC was limited to just a handful of high-income countries. Sri Lanka proves that any country, at any level of development, can achieve UHC. Political commitment, not wealth, is the decisive factor.
A dense network of hospitals and health units extends from the cities to the homes of the rural poor. A well-developed infrastructure provides safe drinking water and sanitation, again also in rural areas.

Immunization coverage has been sustained, in every district, at 99% for several years. School enrolment, of girls and boys, is nearly as high. Adult literacy is above 90%. Education has improved the status and political engagement of women and the health-seeking behaviour of mothers, who want the very best for their families.

The benefits for health and society are readily apparent. Life expectancy, at nearly 76 years, is exceptionally high for a developing country. Low rates of maternal and child mortality compare well with those achieved in much richer nations.

Experts seeking to explain the country’s low maternal mortality rate point to the advantages of pro-poor universal health coverage, but also to the professionalism of well-trained midwives, who deliver the vast majority of babies in Sri Lanka.

As another major achievement, WHO has just certified that Sri Lanka has eliminated malaria, marking an end to an intensified campaign launched in 2008.

In my view, the biggest overall determinant of these exceptional health outcomes is high-level political commitment. That is the view of recent governments that the nation’s health is the nation’s wealth. It is good to speak to you in a developing country that is nonetheless so wealthy.
Annex 4

Text of vote of thanks by the Honourable Deputy Minister of Health, Nutrition and Indigenous Medicine, Democratic Socialist Republic of Sri Lanka

It is indeed my honour and privilege to propose the vote of thanks on behalf of the Government of Sri Lanka on this historic occasion.

First of all let me express our deep appreciation to our Prime Minister for inaugurating today’s important ceremony which is a landmark in the health sector of our country. Sir, we always value your deep insights into issues related to health and development and your customary words of wisdom.

Our Minister of Health, Honourable Dr Rajitha Senaratne, who provided the leadership, guidance and the inspiration to organize the chain of events of this week and personally maintained a very close oversight on all the arrangements. Thank you very much, Sir.

We are thankful to the Director-General of WHO for visiting our country after a while, but we know that you have held Sri Lanka and our Region on your radar all the time and you have always responded very positively and instantly whenever we faced serious or urgent issues related to health. Very often we quote and draw ideas from your inspiring speeches during some of our policy deliberations. We are hopeful that you will be able to pay a longer visit to Sri Lanka before you complete your term.

We thank the Regional Director who is a sincere friend for supporting us in numerous ways at all times and for her illuminating remarks. I wish to express my appreciation for her able and energetic staff, both from the WHO Country Office as well as colleagues from the Regional Office in Delhi for sparing no effort to make sure that everything went well. Their professionalism is highly appreciated. I must make a special mention of Dr Jacob Kumaresan, WHO Country Representative, who very willingly gave his fullest cooperation in organizing this meeting.
Honourable ministers of health of the Region, we are extremely honoured to host you and thank you for your presence. We will no doubt learn from each other’s experiences and I am confident that you will gain some insights into our health system during our field visit to Kandy.

The organization of an event like this always requires the cooperation from so many sectors, institutions and individuals. At the risk of missing a few I must place on record the support that we received from all other ministries as well. A special word of thanks to our own staff from the Ministry of Health headed by our Secretary, Mr Anura Jayawicrama, and guided by the Director-General of Health, Dr Palitha Mahipala, and his team.

It’s a great team and we were very fortunate to have officials and support staff who undertook all the necessary arrangements as a matter of honour and pride and spared no pains in making it a great success.

Finally, on behalf of the Government of Sri Lanka, it is my pleasure to express our deep appreciation and gratitude to each and every one of you for gracing this morning’s inauguration. It has been our privilege to host all of you here on behalf of my ministry.

Let me wish the Regional Committee all success. Thank you very much and have a good day.
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 covering the period 1 January–31 December 2015

It is once again a great pleasure to speak to you about the health of the people in our diverse Region.

My report of WHO’s work – which you have before you – is a record of our joint efforts over the last year; the triumphs – and there are several of which we can be very proud of – as well as the ongoing challenges.

This is my third address to you as Regional Director and I am happy that we can begin to feel a sense of shared accomplishments about what we have achieved – in individual countries, in the Region as a whole, and indeed, at a global level.

Let me illustrate what I mean.

Here in Sri Lanka the government has set an example to many by significantly increasing health spending. Sri Lanka has established a new independent drug regulatory authority and is one of 12 pilot countries worldwide pioneering more intensive efforts in the control of NCDs.

Our hosts last year, Timor-Leste, have embarked on an ambitious national programme to bring a comprehensive service package for PHC to all families, modelled on the Cuban primary health care system.

Thailand has consolidated its leadership position in the global battle to end paediatric AIDS and in enhancing health-care coverage. In June, WHO declared Thailand as having eliminated new HIV infections among children, the first country in Asia to do so.

Nepal was rewarded in 2015 by the GAVI Alliance Child Survival Award. The government has now launched a new National Health Sector Strategy that builds on the new Constitution’s commitment to universal access to free health care.
The new government in Myanmar has committed to significant increases in health spending. In addition, by the quality and speed of response to last year’s cyclone and severe flooding, Myanmar has shown the value of rigorous preparedness and effective national coordination.

Following its success in eliminating malaria in 2015, WHO has recently confirmed that Maldives has also eliminated lymphatic filariasis. In addition, it is on its way to eliminate measles and congenital rubella since no cases have been reported since 2010.

This year, Indonesia along with Finland will co-chair the Global Health Security Steering Group, ensuring a powerful regional voice in a critical global agenda.

India has committed to implementing an exemplary national action plan to combat antimicrobial resistance and hosted an international conference on AMR earlier this year. The government also plans to leverage the polio legacy and the vast polio programme infrastructure to strengthen universal health coverage.

The Democratic People’s Republic of Korea continues its leadership role in the field of traditional medicine, hosting a meeting that produced a regional action plan in support of the new WHO Traditional Medicines Strategy.

Bhutan is pioneering new approaches to public sector accountability with annual performance agreements between the Prime Minister and each sector of government, including health.

And, following the launch of the Global Finance Facility, Bangladesh became the first country in the Region preparing to access these funds for maternal, child and adolescent health.

Following recent successes in India and Indonesia the WHO South-East Asia Region as a whole has now reached an important milestone: the elimination of maternal and neonatal tetanus as a major public health problem. It took longer than we expected, but it is a victory that we can celebrate.

In November this year India will host the Seventh Session of the Conference of Parties to the WHO Framework Convention on Tobacco Control. This conference and the preparatory meeting in Maldives later this month will provide an opportunity to enhance tobacco control measures, including plain packaging, across the Region.
In this year’s report you will see for each of our 11 countries an analysis of major milestones achieved; key health challenges being focused; how those challenges are being addressed; and how, in each country, WHO’s work has made a difference.

This new approach to reporting is important.

For countries it provides a record of what you Excellencies – with your many partners – have achieved. Similarly, it provides an objective analysis of major health challenges for which national authorities must continue to assume responsibility.

For WHO it also serves a critical role. It forces us to think more clearly. How do we – as a key health partner – add value to national efforts? Do we make a real difference? Are we using our human and financial resources in the best way possible in each country?

It is no secret that too many reports from international organizations go unread. They take time, resources and energy to produce, but this investment is totally wasted unless the report provokes debate and generates real interest. This is how reporting helps hold us more accountable. I am, therefore, keen that we continue to improve the quality of our reports and I look forward to your feedback.

But let me turn now to some of the broader lessons that emerge from our work together.

_We are living in a region in transition._

We have seen a major political transition in Myanmar and a new Constitution in Nepal.

We are seeing an economic transition. Sustained economic growth means there will soon be only one low-income country in the Region as others transition to middle-income status.

But, and many of you have heard me say this before, here is a disconnect between the priority that health gets in the rhetoric of speeches and the level of resources that it receives in reality.

Our analysis of health financing in the Region – which you will also find in the report – still paints a somewhat disappointing picture. We see:

- low levels of tax revenues as a proportion of GDP, less than half the level in most European and Central Asian countries;
only one country last year with more than 1% increase in total health expenditure;

only three countries that spend more than 10% of government budget on health; and

upwards of 60 million people pushed into poverty as a result of health-care costs.

In a region that prides itself on economic dynamism, health is just not getting a fair deal. How can we justify a regional average of 3.5% of GDP?

With the economic transition comes a change in eligibility for external resources. If the health budget has to cover the cost of life-saving drugs and vaccines previously subsidized by donors, what will happen to other programmes? Where will the inevitable cuts fall? We need to think ahead. And think strategically.

We are seeing an increase in the role of the private sector as a financier and provider of health care. Skilfully managed, we can harness the resources of the private sector for the public good. But we have also seen people’s anger if they see health care being run purely as a private industry for personal gain.

Good health is a right for all, not a privilege for the few.

Paris last December saw a landmark agreement on climate change, but we are already seeing the effects of a changing climate in countries like Maldives, Bhutan and Bangladesh. In a Region so prone to natural disasters we have learned the value of preparedness the hard way.

All these changes point to a clear conclusion: health requires skilful management. The job of the health minister was never easy. But, my sense is that it is getting even harder!

Which brings me to the biggest transition of all: the transition from the MDGs to the SDGs.

We will be discussing the implications of the SDGs during the Roundtable. We have also prepared the first ever South-East Asia regional briefing that includes a summary of SDG health indicators for each country.

But let me highlight some key themes that should guide our thinking in the coming years.
Two phrases are emerging as the world gets to grips with the SDGs: “leaving no one behind” and the SDGs as “an integrated and indivisible agenda”. Both are important for health.

**Leaving no one behind** requires that we go beyond overall achievements. The data tell us about the numbers of people who do not receive services. But they tell us little about who those people are, why they are excluded, and what can be done to reach them more effectively.

Answering these questions will become an important part of the agenda for the Asia-Pacific Observatory on Health Systems and Policies that, I am pleased to report, is now hosted in our Regional Office.

But there is much that we know already from practical experience. We know that those who are excluded are often those at the periphery. We know that those who are left behind are those that live on the margins of society, in cities sometimes more than in rural areas. If they miss out on health care, chances are they miss out on education and access to other services – reinforcing a deadly spiral of poverty.

Exclusion is a governance issue. Everyone must be counted. Reducing exclusion needs to be addressed in setting priorities, as it has been in Thailand where migrants are now receiving greater attention.

Financial incentives such as reimbursement of travel expenses to pregnant mothers in hard-to-reach townships can make a real difference as seen in several countries of our Region.

Monitoring health systems performance is not just about efficiency but also about measurable reductions in inequality.

The second phrase, **an integrated and indivisible agenda**, is equally important.

In too many countries health is not seen as a priority or taken into account in policy-making beyond the health sector. We know the reasons all too well. Limited accountability and transparency mean that there are few constraints on sectors that compete with or undermine health.

The problem is reflected not just in inadequate health funding, but through policies that override health concerns in the short-term interest of economic growth.

The SDGs are an open invitation to address this problem.
Indeed, we are simply not going to achieve SDGs health targets in relation to NCD risk factors, nutrition, access to medicines and health technologies, or road safety unless we really start thinking in terms of better governance for health.

We should not see the SDGs just as the MDGs-plus – business as usual with a longer list of targets. We cannot retreat into our health silo, our comfort zone.

Planning to achieve the SDGs is not a zero sum game. Countries in our region need to pursue industrial development, to increase the number of people with decent jobs, to address food security and meet huge infrastructure gaps that limit communication, sanitation and electrification.

Progress in all these areas has clear health benefits.

At the same time, better health increases agricultural and industrial productivity. It promotes social stability. It is a major source of secure employment. And it is key to reaping the demographic dividend from our youthful populations.

Several countries in the Region have assigned responsibility to national coordinating bodies, Niti Aayog in India and the Gross National Happiness Commission in Bhutan, among others.

So my message today is this: health ministers, their senior officials and their partners in the international community need to be active players in overall SDG coordination.

It is important to be well briefed with evidence to make the case for health. There is a need to make sure that you are equally well informed about the health implications – positive and negative – of policy in other sectors. We all need to know more about how these coordination mechanisms work in practice.

The demand for more effective policy coordination is not new. But the SDGs provide a new opportunity for all of us to make a difference - and put health in the place that it deserves.

Let me now turn to the health sector itself, specifically to universal health coverage. The launch of the SDGs has given UHC centrestage as UHC underpins all others and helps make the health agenda cohesive and less like a list of separate programmatic silos. The key idea of UHC is that all people have access to the services they need, without facing financial hardships when they fall ill.
Nearly every country report this year speaks about UHC. No country is starting from zero as each one seeks to increase peoples’ access to the services they need without financial hardship.

Many countries like Indonesia, which now has the world’s largest single payer health insurance programme – *Jaminan Kesehatan Nasional* – have made rapid progress.

Progress is positive, but we must not forget that despite what has been achieved around 130 million people in this Region still lack access to one or more services, and at least 60 million are impoverished as a result of health-care costs.

We still have much to do.

We are gaining valuable practical experience in how to move forward and I want to highlight four key messages.

The first is that *priority setting is central to UHC*. UHC is not about trying to do everything at once. Neither is priority setting just about cost-effectiveness. We need to think about rights, ethics, a sense of fairness, and “reaching the furthest behind first”.

Whatever method is used for setting spending priorities, it is essential that the process is systematic and transparent. Priorities must be reflected in the way resources are allocated. Too often we see that policies say one thing while actual expenditures tell a very different story.

Second, we need to *revisit our thinking on frontline services*. The MDGs have conditioned us to focus on a limited number of programmes. The SDGs widen the agenda.

Addressing NCDs, mental health and substance abuse – key problems in our region – will place new demands on frontline health workers, outreach staff, referral systems, and on supply, logistics, education and information systems.

As new services come on stream, many countries report that first-line services are underutilized, while referral facilities are overcrowded, with serious consequences for quality of care.

A gatekeeper function through general practitioners may be the answer in some circumstances but increasing the attractiveness, effectiveness and reputation of frontline services is relevant everywhere.
Thirdly, financial protection is not just about insurance. Other policies matter too.

Too many people in this region have to meet the costs of health care from their own pockets. In most parts of the world it is costly one-off catastrophic events – hospital admission after a heart attack or a major accident affecting a breadwinner – that result in poverty. In this Region the situation is a little different: relatively modest expenditures can push people over the brink. This is particularly true if someone has to pay regularly for medicines, which happens more and more for NCDs.

Sixty per cent of out-of-pocket spending goes on medicines. So reducing the cost of treatment becomes central to financial protection. We know too that where pharmacists are present in health facilities, prescribing costs fall. So human resource policies too can reduce financial hardship.

In many countries, financial protection means that the poor receive free health care. But we must not forget that there are millions, not counted as poor, but who live precariously just above the poverty line. The families of daily wage-earners are often among the most vulnerable when illness strikes.

The fourth point I would like to make is that the health SDGs require actions beyond the health sector.

UHC is a powerful unifying concept for our work in the health sector. The SDG agenda makes it clear that to make real inroads into the health of people we need to think beyond the health sector.

There is much that needs to be done across sectors to improve health: in the field of nutrition and diet; decreasing exposure to harmful and polluted environments; reducing the harmful effects of sedentary lifestyles through greater activity and exercise; and stopping tobacco use and reducing alcohol consumption. Beyond these direct areas of intervention, policies in many other sectors – such as agriculture, housing, employment, social security and pensions, finance and trade – have a significant impact on health and on providing effective and affordable health services. It goes without saying that this is a huge agenda.

The country reports point to several closely related lessons, which I would like to highlight.

The first is that effective intersectoral action requires political leadership from the highest levels of government, as is seen when the Prime Minister of India was instrumental in establishing the International Yoga Day. In Timor-Leste new anti-
tobacco legislation has been made possible not just through sustained advocacy by WHO but through the personal engagement of the Prime Minister. Thailand’s Health Minister has led by example: being a role model for health promotion and in maximizing use of the WHO budget by mobilizing bigger budgets and social and intellectual capital from local sources to move on priority areas. In the Democratic People’s Republic of Korea, a country where 44% of all adult males smoke, it has required high-level government support to ban smoking in all health facilities and places of learning; a first step in a country where the growing prevalence of NCDs makes further efforts increasingly urgent. In Bhutan, the country’s leadership has been pivotal in encouraging more active lifestyles.

Globally, the urgency to address the threat of antimicrobial resistance has benefited from the fact that heads of state and government have promoted the agenda.

Linked to the first lesson is the importance of national ownership. Again, looking at Timor-Leste, 90% of the funding for the National Survey for Noncommunicable Diseases using the WHO STEPS approach came from domestic resources. The issue of ownership also looms large as part of the Global Health Security Agenda. Progress in building the capacities specified in the International Health Regulations (2005) has been slow. Success requires the cooperation of several sectors. As health security climbs up the global health agenda, it will be critical that the desire to create global structures is matched with similar enthusiasm and resources for building national capacity.

The third lesson is the need for specificity when engaging political leadership. A growing body of experience shows that political leaders need to prioritize the different problems, their relative priority and the feasibility and cost of proposed solutions. Armed with this kind of information they can bring the right actors together and use their political skills to make things happen. To reduce dietary salt intake, for instance, needs one set of institutional actors, reducing import tariffs and wholesale mark-ups on essential drugs a different set, and banning tobacco advertising yet another.

We must continue to learn from our growing experience of UHC. There are important lessons to be learnt about how better information and monitoring can contribute to accountability.

Many of us working for governments still underestimate the important role of other stakeholders in the health sector, and the potential for more productive partnerships with parliamentarians, the private sector, NGOs and civil society.
The commitments that you have all made to universal health coverage mean that the challenge is no longer about what we are trying to achieve, but it is about how to make progress, given the complexity of the real world in which we live.

Building a solid core of evidence-based experience on UHC and facilitating dialogue between countries is, I believe, one of the most important ways in which the Regional Office of WHO adds value to work at the country level.

In a competitive world, international organizations have to continuously prove their worth. We have to deliver and be seen to deliver. This, as we have all realized, requires focus and measurement.

It is for this reason that I set out seven Flagship Priorities at the beginning of my term. I have touched on several of these in the course of my remarks today. The final part of the report provides you with a more detailed update on each. Progress on selected Flagship Priorities are also reflected in each country’s report.

The Flagships are the driving force behind new ways of working in the Regional Office. Ways of working that have already started to break down separate silos.

We see for example how groups working on essential medicines and NCDs have joined forces to document the availability of NCD medicines in the health facilities of countries. We see too, how mapping data across all departments is beginning to give us a much richer understanding of the numbers of people still excluded from essential services.

The Flagships have been an important instrument for improving planning – increasing the focus of our work and requiring more careful definition of deliverables. The result, I am happy to report, is that in the last biennium not only did we spend more wisely, we also spent well.

*We live in challenging times.*

There has never been a better time than now for public health in this Region. We eradicated polio from the Region in 2014 and we continue to maintain that status. The Region as a whole achieved elimination of maternal and neonatal tetanus. India was declared yaws-free; Maldives has eradicated malaria and has also eliminated lymphatic filariasis; Sri Lanka has also done the same. Thailand became the first country in Asia and the second in the world to achieve elimination of mother to child transmission of HIV and syphilis. All these are notable achievements. And we can be proud of what we have achieved. But we know only too well that every
day can bring new threats to our peoples’ health. Outbreaks, emergencies, political upheaval. Expecting the unexpected is, as they say, the new normal in global health.

But while we will always be judged on our response to crises, we have to remember that we will also be judged on how we respond to the more mundane. The long-standing problems: of the cost and suffering caused to people and economies by avoidable NCD risk factors; of health systems that are under-resourced and that exclude millions from receiving the care that they need.

The sprint and marathon. If we were athletes we would specialize in one or the other. But we do not have that luxury. We have to show ourselves to be skilled and proficient in both.

The challenge is immense but let me end by saying that WHO is here to support you. To offer advice based on best evidence. To facilitate, to convene and to link each country to a growing network of regional and global resources.
I thank the Government of Sri Lanka for hosting the Sixty-ninth Session of the Regional Committee for South-East Asia.

During this first session held under the 2030 Agenda for Sustainable Development, I am especially pleased to speak to you in a country that provides universal health coverage to its citizens, and has health outcomes comparable to those seen in countries with several times its wealth.

As your Regional Director has noted, the health situation in South-East Asia is undergoing a profound transition. Well-known drivers of ill health, including poverty and poor living conditions, persist, especially in the region’s predominantly rural populations.

At the same time, growing economic prosperity and the reach of global trends are introducing new threats, including noncommunicable diseases, which are equally important drivers of ill health, especially in cities. Economic benefits do not always offset detrimental effects on health.

The technical document that best expresses the extreme health challenges facing the Region is the one on the double burden of malnutrition. The Region’s nutrition landscape is characterized by persistent undernutrition existing side-by-side with growing rates of obesity and overweight. This landscape of extremes can be seen in individual countries, communities, and even families.

The consequences of malnutrition are severe. Undernutrition contributes to about 45% of preventable childhood deaths in South-East Asia, while overnutrition drives high rates of diet-related NCDs. Regionwide, more than one fifth of adults are now overweight.

Wasting, stunting and micronutrient deficiencies are long-standing problems. Most of your established nutrition strategies and interventions, such as highly successful salt iodization, are designed to address these older problems.
Undernutrition continues to be driven by predominant dietary patterns that are plant-based, often inadequate in energy, protein and micronutrients, and lacking in diversity. At the other extreme is the rise of obesogenic environments shaped by an international food system that relies on the industrialized production of meat, the appeal of cheap, convenient and tasty, highly processed foods, and the aggressive marketing of these products, especially to children.

These are energy-dense but nutrient-poor foods, which helps explain why micronutrient deficiencies are found in both undernourished and overnourished populations in this region.

As elsewhere in the world, health in South-East Asia is being shaped by the same powerful forces: demographic ageing, rapid unplanned urbanization, and the globalized marketing of unhealthy products. Under the pressure of these forces, NCDs have overtaken infectious diseases as the leading killers. These diseases now account for an estimated 8.5 million deaths in the Region each year.

In this case, economic growth and modernization – long associated with better health outcomes – are actually creating the conditions that allow heart disease, stroke, diabetes, tobacco-related cancers and diet-related cancers to flourish.

Addressing the rise of these complex and costly diseases requires a major shift in the mindset of public health. That is: a move from curative care to prevention, from a focus on individual diseases to comprehensive people-centred care, and from a strictly biomedical model of health to one that embraces the social and life sciences.

It also requires greater financing and appropriately trained staff to cope with the ever-increasing costs of providing care for people living longer, sicker lives. As the root causes of these diseases lie outside the health sector, it requires a broad multisectoral approach led and coordinated at the highest level of government.

Above all, as so clearly stated in the document for the ministerial roundtable on NCDs, addressing these diseases depends on resilient health systems, based on primary health care and aiming for universal coverage.

The 2030 Agenda for Sustainable Development provides the impetus, the platform, and the ethical imperative to pursue all these transformational changes. I am impressed to see how quickly this Region has adapted its strategies to embrace the new Agenda for Sustainable Development.
I sometimes see articles arguing that health has been short-changed in the SDG agenda, given less prominence than it deserves. After all, three of the eight Millennium Development Goals were directly focused on health and two others, on nutrition and water supply and sanitation, addressed major determinants of health.

In the new agenda, health is only one in a crowd of 17 goals. As some have argued, such small space undermines the significance of health as an issue that matters profoundly to every person on this planet.

I disagree. What the SDGs do especially well is to recognize that health challenges can no longer be addressed by the health sector acting alone. Reducing the rise of antimicrobial resistance requires policy support from agriculture. Abundant evidence shows that educated mothers have the healthiest families. Access to modern energy fuels economies, but it also reduces millions of deaths from chronic lung disease associated with indoor air pollution.

In my view, health occupies pride of place in the agenda for several reasons. First, health is an end-point that reflects the success of multiple other goals. Because the social, economic and environmental determinants of health are so broad, progress in improving health is a reliable indicator of progress in implementing the overall agenda.

In the final analysis, the ultimate objective of all development activities, whether aimed at improving food and water supplies or making cities safe, is to sustain human lives in good health.

Second, all health targets can be reliably measured using sophisticated scientific methods. Disease burdens and their causes can be measured, the impact of specific interventions can be assessed, and changes over time can be tracked. This precision contributes greatly to transparency and accountability.

Finally, the inclusion of a target for reaching universal health coverage, including financial risk protection, gives health the power to build fair, stable and cohesive societies while also furthering the overarching objective of poverty reduction.

The UHC target provides the platform for moving towards all other health targets through the delivery of integrated, people-centred services that span the life course, bring prevention to the fore, and protect against financial hardship.

UHC is the ultimate expression of fairness. It is one of the most powerful social equalizers among all policy options.
Nobel laureate Amartya Sen has described UHC as “an affordable dream”. I agree. UHC is affordable if properly managed. As a way of organizing health services, it promotes a comprehensive and coherent approach to health which moves away from a focus on individual diseases and all the fragmentation and duplication that it brings.

UHC opens numerous opportunities to reduce waste and inefficiency. For example, studies show considerable savings when supply chains established to deliver drugs for HIV are used to deliver multiple other medical products.

Earlier this year, WHO verified that Thailand has interrupted mother-to-child transmission of both HIV and syphilis. Central to this success story was the integration of maternal and child health services with services for sexual and reproductive health and HIV.

Efforts to reach the ambitious goal of ending tuberculosis in this Region will benefit from comprehensive services that address risk factors like diabetes, poor nutrition, silicosis, and tobacco and alcohol use. Moreover, reducing user fees encourages more people to seek care early, when the chances of cure are best and the costs are lowest.

UHC is a direction on the route to better health, not a destination. Any country, at any income level, that really wants to can move towards universal coverage. As your Regional Director notes in her annual report, no country is starting from zero, especially given the Region’s long commitment to the principles and approaches of primary health care.

As this is the last time I will address this Committee, I want to commend the region on its achievements, which I have watched with pride.

Progress in reducing child mortality and curbing the epidemics of HIV and TB has been remarkable. The last case of polio in India was in January 2011. The Region proudly maintains its polio-free status. This is an inspiration for the entire world. India has also eliminated yaws. The Region is steadily ridding itself of lymphatic filariasis and visceral leishmaniasis. In an amazing feat, the prevalence of schistosomiasis has been pushed down to just two small districts in Indonesia.

You have challenges, of course. The Region is disaster-prone, which amplifies the havoc wreaked by climate change. Government expenditures on health are too low, and the proportion of spending from out-of-pocket payments is too high.
Weaknesses in public health services send too many people to private clinics and hospitals, where neither quality nor prices are regulated and waiting times can be extremely long. The health workforce is concentrated in cities, leaving the region’s vast rural population with limited access to care. These problems must also be addressed.

But you are moving in the right direction and are well on your way. As stated in the Regional Director’s Annual Report, “the future is bright”.
Annex 7

Agenda

1. Opening of the Session

2. Credentials of Representatives

3. Election of Officebearers

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 2015—31 December 2015
   5.2 Address by the Director-General

6. Ministerial Roundtable
   6.1 Strengthening health systems response to address NCDs at the primary health care level
   6.2 Sustainable Development Goals (SDGs) and universal health coverage (UHC)

7. Programme Budget matters
   7.1 Programme Budget 2016–2017: Implementation
   7.3 Proposed Programme Budget 2018–2019

8. Overview of WHO Reform
9. Policy and technical issues

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10. Progress reports on selected Regional Committee resolutions

| 10.1 Consultative Expert Working Group on Research and Development: financing and coordination (SEA/R65/R3) | SEA/RC69/18 Add. 1, Add. 2 and Add. 3 |
| 10.2 Challenges in polio eradication (SEA/RC60/R8) | |
11. Governing Body matters

11.1 Key issues arising out of the Sixty-ninth World Health Assembly and the 138th and 139th sessions of the WHO Executive Board

11.2 Review of the Draft Provisional Agenda of the 140th Session of the WHO Executive Board

11.3 Review of Regional Committee resolutions

11.4 Elective posts for Governing Body meetings (World Health Assembly, Executive Board and Programme, Budget and Administration Committee)

11.5 Amendment to the Rules of Procedure of the WHO Regional Committee for South-East Asia

12. Management and governance matters

12.1 Status of the SEA Regional Office Building

13. Special Programmes


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

15. Adoption of resolutions

16. Adoption of the report of the Sixty-ninth Session of the Regional Committee for South-East Asia

17. Closing of the Session
Annex 8

List of participants

1. Representatives, Alternates and Advisers

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Ministry of Health and Family Welfare
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Dr Sura Wisedsak
Assistant to the Permanent Secretary
Ministry of Public Health
Bangkok

Dr Phusit Prakongsai
Director, Bureau of International Health
Office of the Permanent Secretary
Ministry of Public Health
Bangkok

Dr Attaya Limwattanayingyong
Medical Officer, Senior Professional Level
Bureau of International Health
Office of the Permanent Secretary
Ministry of Public Health
Bangkok

Dr Chutima Akaleephan
Pharmacist, Professional Level
International Health Policy Programme
Office of the Permanent Secretary
Ministry of Public Health
Bangkok

Dr Warisa Panichkriangkrai
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Miss Orana Chandrasiri
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Office of the Permanent Secretary
Ministry of Public Health
Bangkok
Dr Thitikorn Topothai  
Medical Officer, Professional Level  
Division of Physical Activity and Health  
Department of Health  
Ministry of Public Health  
Bangkok

Mr Banlu Supaaksorn  
Foreign Relations Officer, Practitioner Level  
Bureau of International Health  
Office of the Permanent Secretary  
Ministry of Public Health  
Bangkok

**Timor-Leste**

*Representative*  
H.E. Dr Ana Isabel de Fatima Sousa Soares  
Vice-Minister of Health  
Ministry of Health  
Dili

*Alternates*  
Mr Pedro Canisio da Costa Amaral  
National Director of Public Health  
Ministry of Health  
Dili

Dr Gabriela da Conceicao Magno Pereira  
Executive Director  
Maubisse Referral Hospital  
Dili

*Advisers*  
Ms Bela Alerta Soares Pereira  
Executive Secretary to Minister of Health  
Ministry of Health  
Dili

Dr Avelino Guterres Correia  
Health Advisor to Cabinet of Vice-Minister of Health  
Ministry of Health  
Dili

**2. Representatives of the United Nations and Specialized Agencies**

*United Nations Development Programme (UNDP)*

Mr Jorn Sorensen  
Country Director, UNDP  
Colombo, Sri Lanka

Mr Uji Kazuyuki  
Policy Specialist  
Bangkok, Thailand
<table>
<thead>
<tr>
<th>Organization</th>
<th>Name</th>
<th>Position/Title</th>
<th>Location</th>
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<tbody>
<tr>
<td><strong>World Food Programme (WFP)</strong></td>
<td>Mrs Susana Rico</td>
<td>Officer In-charge</td>
<td>Colombo, Sri Lanka</td>
</tr>
<tr>
<td></td>
<td>Mr Nguyen Duc Hoang</td>
<td>Deputy Country Director</td>
<td>Colombo, Sri Lanka</td>
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<tr>
<td></td>
<td>Ms Anusara Singhkumarwong</td>
<td>Nutrition Officer</td>
<td>Colombo, Sri Lanka</td>
</tr>
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<td></td>
<td>Ms Sashirika Jayasinghe</td>
<td>Programme Policy Officer</td>
<td>Colombo, Sri Lanka</td>
</tr>
<tr>
<td><strong>International Labour Organization (ILO)</strong></td>
<td>Mr Donglin Li</td>
<td>Country Director, ILO</td>
<td>Colombo, Sri Lanka</td>
</tr>
<tr>
<td><strong>UNHCR</strong></td>
<td>Dr Herve Isambert</td>
<td>Senior Regional Public Health Coordinator</td>
<td>Bangkok, Thailand</td>
</tr>
<tr>
<td><strong>International Atomic Energy Agency (IAEA)</strong></td>
<td>Ms Nelly Enwerem-Bromson</td>
<td>Director, Division Programme of Action for Cancer Therapy (PACT)</td>
<td>IAEA Vienna International Centre, Vienna, Austria</td>
</tr>
<tr>
<td><strong>UNICEF</strong></td>
<td>Dr Deepika Attygalle</td>
<td>Regional Coordinator South-South Programme</td>
<td>Colombo, Sri Lanka</td>
</tr>
<tr>
<td><strong>UNESCO</strong></td>
<td>Ms Himali Jinadasa</td>
<td>UNESCO Country Focal Point</td>
<td>Ministry of Industry and Commerce, Colombo, Sri Lanka</td>
</tr>
<tr>
<td><strong>Amrita Institute of Medical Sciences and Research Center</strong></td>
<td>Prof. Krishna Kumar</td>
<td>Head, Department of Pediatric Cardiology</td>
<td>Amrita Institute of Medical Sciences and Research Centre, Kochi, India</td>
</tr>
</tbody>
</table>
3. Intergovernmental Organizations

*International Organization for Migration (IOM)*
- Dr Davide Mosca
  Director, Migration Health
  Geneva, Switzerland

- Sharika Lasanthi Peiris
  Head of Migration Health Unit
  Colombo, Sri Lanka

*AMSA International*
- Mr Santosh Upadhyaya
  AMSA International
  Maharajgunj Medical Campus
  Kathmandu, Nepal

4. Representatives from Nongovernmental Organizations in Official Relations with WHO

*Stichting Health Action International*
- Mr Thirukumaran Balasubramaniam
  Geneva Representative
  Geneva, Switzerland

*International Alliance of Patients’ Organizations (IAPO)*
- Mrs Jolanta Bilinska
  IAPo
  London, United Kingdom

- Mr Bejon Kumar Misra
  Board Member, IAPO
  New Delhi, India

*World Heart Federation*
- Dr Raman Krishna Kumar
  Clinical Professor and Head, Paediatric Cardiology
  Amrita Institute of Medical Sciences and Research Centre,
  Kochi, India

*Sarvodaya Shramadana Movement*
- Dr Vinya Ariyaratne
  General Secretary
  Sarvodaya Headquarters
  Moratuwa, Sri Lanka

*International Society of Physical Activity and Health*
- Dr Fiona Clair Louise Bull
  President of International PA and Health Society
  University of Western Australia
  Perth, Australia

*HelpAge Sri Lanka*
- Ms Chaminda De Sila M.S.
  Programme Manager
  HelpAge
  Boralesgamuwa, Sri Lanka
<table>
<thead>
<tr>
<th>Organization</th>
<th>Representative</th>
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</thead>
<tbody>
<tr>
<td><strong>Iodine Global Network</strong></td>
<td>Dr Chandrakant S. Pandav&lt;br&gt;Professor and Head, Centre for Community Medicine&lt;br&gt;All India Institute of Medical Sciences&lt;br&gt;New Delhi, India</td>
</tr>
<tr>
<td><strong>Framework Convention Alliance (FCA)</strong></td>
<td>Mr Pubudu Sumanasekara&lt;br&gt;FCA Representative&lt;br&gt;Colombo, Sri Lanka</td>
</tr>
<tr>
<td><strong>International Planned Parenthood Federation</strong></td>
<td>Ms Anjali Sen&lt;br&gt;Regional Director&lt;br&gt;New Delhi, India</td>
</tr>
<tr>
<td><strong>International Federation of Medical Students’ Associations</strong></td>
<td>Mr Satria Nur Syaban&lt;br&gt;Head of IFMSA Delegation&lt;br&gt;Amsterdam, The Netherlands</td>
</tr>
<tr>
<td><strong>Alzheimer’s Disease International</strong></td>
<td>Ms Prachi Kathuria&lt;br&gt;Representative of HRIDAY&lt;br&gt;New Delhi, India</td>
</tr>
<tr>
<td><strong>Association of Nutritious Products for Mothers and Children Companies (APPNIA)</strong></td>
<td>Ms Sarah Angelique Mustika Sari&lt;br&gt;Jakarta, Indonesia</td>
</tr>
<tr>
<td><strong>World Federation of Medical Education (WFME)</strong></td>
<td>Prof. Indika Karunathilake&lt;br&gt;Professor, Medical Education, WFME&lt;br&gt;Department of Medical Education&lt;br&gt;Faculty of Medicine&lt;br&gt;Colombo, Sri Lanka</td>
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### 5. Observers

<table>
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<tr>
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<tbody>
<tr>
<td><strong>WHO Regional Office for the Americas (AMRO)</strong></td>
<td>Dr George Alleyne&lt;br&gt;Director Emeritus&lt;br&gt;WHO Regional Office for the Americas&lt;br&gt;Washington D.C., United States of America</td>
</tr>
<tr>
<td><strong>SUMITHRAYO</strong></td>
<td>Mr Arosha Rajapakse&lt;br&gt;Volunteer&lt;br&gt;Colombo, Sri Lanka</td>
</tr>
</tbody>
</table>
Asia Pacific Infant and Young Child Nutrition Association
Ms Ling Di Koh
Associate
Asia Pacific Infant and Young Child Nutrition Association
Singapore City, Singapore

International Special Dietary Food Industries
Ms Venetta Miranda
Vice-President
Asia Pacific Infant and Young Child Nutrition Association
Singapore City, Singapore

University of Peradeniya
Ms Chamila P.T. Liyanaarachchie
Lecturer, Department of Pharmacy
Faculty of Allied Health Sciences
University of Peradeniya, Sri Lanka

The Global Fund to Fight AIDS, Tuberculosis and Malaria
Dr Enkhjin Bavuu
Senior Fund Portfolio Manager
Chemin de Blandonnet 8
Geneva, Switzerland

Reimagine Global Health
Dr John Aaron Mednoza
Ateneo de Manila University
Manila, Philippines

6. Ambassadors/High Commissioners
Embassy of the Islamic Republic of Afghanistan
H.E. Mr Munir Ghiasy
Charge d’Affaires
Embassy of the Islamic Republic of Afghanistan
Colombo, Sri Lanka

Nigerian High Commission
H.E. Mr M. Effiom Bosco
Head of Chancery
Nigerian High Commission
Colombo, Sri Lanka

Embassy of Nepal
H.E. Ms Dhana Kumari Joshi
Charge d’Affaires
Embassy of Nepal
Colombo, Sri Lanka

Embassy of the State of Palestine
H.E. Mr Zuhar Dar Zaid
Ambassador of the State of Palestine
Colombo, Sri Lanka

7. Others in Attendance
Sri Lanka
Dr Nalinda Wellapulli
Ministry of Health, Nutrition and Indigenous Medicine
Democratic Socialist Republic of Sri Lanka
Dr Ashani Rathnakeerth  
Ministry of Health, Nutrition and Indigenous Medicine  
Democratic Socialist Republic of Sri Lanka  

Dr Manuja Perera  
Ministry of Health, Nutrition and Indigenous Medicine  
Democratic Socialist Republic of Sri Lanka  

Dr T.B. Wimalasena  
Ministry of Health, Nutrition and Indigenous Medicine  
Democratic Socialist Republic of Sri Lanka  

Dr Sumudu Kunaratne  
Ministry of Health, Nutrition and Indigenous Medicine  
Democratic Socialist Republic of Sri Lanka  

Dr Chamila Tilakaratna  
Ministry of Health, Nutrition and Indigenous Medicine  
Democratic Socialist Republic of Sri Lanka  

Dr Nadeeka Chandraratne  
Ministry of Health, Nutrition and Indigenous Medicine  
Democratic Socialist Republic of Sri Lanka  

Dr Dammika Jayalath  
Ministry of Health, Nutrition and Indigenous Medicine  
Democratic Socialist Republic of Sri Lanka  

Dr Inoka Suraweera  
Ministry of Health, Nutrition and Indigenous Medicine  
Democratic Socialist Republic of Sri Lanka  

Dr R.L. Fernando  
Ministry of Health, Nutrition and Indigenous Medicine  
Democratic Socialist Republic of Sri Lanka  

Dr M.S. Umashankar  
Ministry of Health, Nutrition and Indigenous Medicine  
Democratic Socialist Republic of Sri Lanka  

Dr S. Panduwawala  
Ministry of Health, Nutrition and Indigenous Medicine  
Democratic Socialist Republic of Sri Lanka  

Dr Poornima Wimalaratne  
Ministry of Health, Nutrition and Indigenous Medicine  
Democratic Socialist Republic of Sri Lanka  

Dr D. Saranasinghe  
Dr C. Weerabaddna  

Dr WFD Ananda
Pakistan

Dr Sania Nishtar
Public Health Expert

Mr Sarfaraz Sipra
Deputy High Commissioner
High Commission of Pakistan in Sri Lanka

Ethiopia

H.E. Dr Tedros Adhanom Ghebreyesus
Minister of Foreign Affairs
Federal Democratic Republic of Ethiopia

Dr Senait Fisseha
Federal Democratic Republic of Ethiopia

Mr Morris Reid
Federal Democratic Republic of Ethiopia

Mr Nathan Zewdu
Federal Democratic Republic of Ethiopia

Mr Samuel Alemayehu
Federal Democratic Republic of Ethiopia

Mr Kahsay Gebremeskel Gebremariam
Personal Assistant to Minister of Foreign Affairs

Asfaw Dingamo Kame
Ambassador of Federal Democratic Republic of Ethiopia to India

Mollalign Asfaw
Minister Counsellor
Federal Democratic Republic of Ethiopia
### Annex 9

**List of official documents**

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<td>Adoption of the Agenda</td>
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<td>SEA/RC69/2</td>
<td>Introduction to the Regional Director’s Annual Report on the Work of WHO in the South-East Asia Region covering the period 1 January 2015—31 December 2015</td>
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<tr>
<td>SEA/RC69/3 Rev.1</td>
<td>Strengthening health systems response to address NCDs at the primary health care level</td>
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<td>Sustainable Development Goals (SDGs) and universal health coverage (UHC)</td>
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<td>Programme Budget 2016–2017: Implementation</td>
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<td>SEA/RC69/7 Rev. 3, and Inf. Doc. 1 Rev. 1</td>
<td>Proposed Programme Budget 2018–2019</td>
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<td>SEA/RC69/11</td>
<td>Ending preventable maternal and child mortality</td>
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<td>SEA/RC69/12</td>
<td>Time-bound elimination of neglected tropical diseases (NTDs)</td>
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<td>SEA/RC69/13</td>
<td>The Decade for Health Workforce Strengthening in the SEA Region 2015–2024: First review of progress, challenges and opportunities</td>
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<td>SEA/RC69/14</td>
<td>Emergency Reform</td>
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<td>SEA/RC69/15</td>
<td>Promoting physical activity in the South–East Asia Region</td>
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<td>SEA/RC69/16 Rev.3</td>
<td>Strategic Action Plan to Reduce the Double Burden of Malnutrition in the South-East Asia Region 2016–2025</td>
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<td>Migration and health</td>
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<td>SEA/RC69/18</td>
<td>Progress reports on selected Regional Committee resolutions Add. 1, Add. 2 and Add. 3</td>
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<td>Key issues arising out of the Sixty-ninth World Health Assembly and the 138th and 139th sessions of the WHO Executive Board</td>
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<td>Review of the Draft Provisional Agenda of the 140th Session of the WHO Executive Board</td>
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<td>Review of Regional Committee resolutions</td>
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<td>SEA/RC69/22</td>
<td>Amendment to the Rules of Procedure of the WHO Regional Committee for South-East Asia</td>
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<td>SEA/RC69/31</td>
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<tr>
<td>SEA/RC69/32</td>
<td>Report of the Sixty-ninth Session of the WHO Regional Committee for South-East Asia</td>
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</table>
Vignettes
from the Sixty-ninth Regional Committee
The Regional Director, Dr Poonam Khetrapal Singh, presenting the World Health Organization South-East Asia Region’s Award for Excellence in Public Health to H.E. Mr Maithripala Sirisena, President of the Democratic Socialist Republic of Sri Lanka, in recognition of his contribution towards strengthening the health system in Sri Lanka.

The Regional Director, Dr Poonam Khetrapal Singh, presenting the World Health Organization South-East Asia Region’s Award for Excellence in Public Health to the Ministry of Public Health of the Democratic People’s Republic of Korea, in recognition of the country strengthening its traditional medicine system to provide quality health care to the people. The Award was received by H.E. Dr Jang Jun Sang, Vice-Minister of Public Health of the Democratic People’s Republic of Korea, on behalf of the ministry.
WHO REGIONAL COMMITTEE FOR SOUTH-EAST ASIA

The World Health Organization’s South-East Asia Region, during the Sixty-ninth Session of its Regional Committee in Colombo, Sri Lanka, acknowledged and felicitated all Member States from the Region for their significant achievements and milestones reached in the control and prevention of many diseases of public health importance in recent years. All 11 Member States were presented with citations acknowledging their contribution towards eliminating maternal and neonatal tetanus from the Region, which was certified in May 2016. The Director-General, Dr Margaret Chan, and the Regional Director, Dr Poonam Khetrapal Singh, presented the citations to the honourable ministers and distinguished representatives from (see pix) (1) Bangladesh, (2) Bhutan, (3) Democratic People’s Republic of Korea, (4) India, (5) Indonesia, (6) Maldives, (7) Myanmar, (8) Nepal, (9) Sri Lanka, (10) Thailand, and (11) Timor-Leste.

In addition, Member States were also felicitated for eliminating yaws (India); lymphatic filariasis (Maldives and Sri Lanka); malaria (Maldives and Sri Lanka); and mother-to-child transmission of HIV and syphilis (Thailand).
REPORT OF THE SIXTY-FOURTH SESSION

[Image of people in traditional attire clapping and smiling]
REPORT OF THE SIXTY-NINTH SESSION
Distinguished delegates, representatives from Member States, and members of the Secretariat along with others enthusiastically participated in the yoga and physical exercise activities organized during the mornings on the pristine seaface on the days of the Regional Committee Session.
The Regional Committee for South-East Asia is the World Health Organization’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-ninth Session of the Regional Committee held in Colombo, Sri Lanka, on 5–9 September 2016. At this session, the Committee reviewed and discussed a number of public health issues important to the Region, such as the Sustainable Development Goals, addressing noncommunicable diseases at the primary health care level, neglected tropical diseases, migration and health, and International Health Regulations post-2016, among others. The Committee adopted a number of resolutions on selected issues.