REPORT
OF THE SIXTY-SECOND SESSION
OF THE WHO REGIONAL COMMITTEE
FOR SOUTH-EAST ASIA
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Part I
Introduction

1. The Sixty-second Session of the WHO Regional Committee for South-East Asia was held in Kathmandu, Nepal from 7–10 September 2009. It was attended by representatives of all 11 Member States of the Region, United Nations and other agencies, as well as nongovernmental organizations having official relations with WHO.

2. A joint inauguration of the Sixty-second Session of the Regional Committee and the Twenty-seventh Meeting of Ministers of Health of the South-East Asia Region was held on 7 September 2009. The Right Honourable Mr Madhav Kumar Nepal, Prime Minister of the Government of the Federal Democratic Republic of Nepal, delivered the inaugural address.

3. The Committee elected H.E. Mr Umakant Chaudhary, Minister of Health and Population, Nepal as Chairman and H.E. Dr Aminath Jameel, Minister of Health and Family, Maldives, as Vice-Chairperson of the Session.

4. The Committee reviewed the report of the Regional Director on the work of WHO in the South-East Asia Region covering the period 1 July 2008 to 31 August 2009.

5. The Committee decided to hold its Sixty-third session in 2010 in Thailand.

6. A group for finalization of resolutions comprising a representative from each of the Member States was constituted with Maldives as Convener. During the session, the Committee adopted seven resolutions.
Part II
Inaugural session

7. A joint inauguration of the Twenty-seventh Meeting of Ministers of Health and the Sixty-second Session of the WHO Regional Committee for South-East Asia was held in Kathmandu, Nepal on 7 September 2009. At the inaugural session, the Chief Guest, the Right Honourable Mr Madhav Kumar Nepal, Prime Minister of the Government of the Federal Democratic Republic of Nepal, extended his best wishes for the success of the Health Ministers’ Meeting and the Regional Committee Session, saying it was a privilege for the Federal Democratic Republic of Nepal to host the meetings.

8. The Prime Minister reiterated that his government accorded the highest importance to the meeting. Along with maintaining good relations with all states, and neighbouring states in particular, the government considered multilateralism as the basic tenet of its foreign policy and accorded due importance to all events of global impact.

9. Commending the leadership of the World Health Organization in securing the health of the people of South-East Asia in collaboration with Member States, the Prime Minister said the Region faced a complex range of health challenges. The discussions at the Twenty-seventh Meeting of Ministers of Health and the Sixty-second Session of the WHO Regional Committee for South-East Asia would focus on such key issues as protecting human health from climate change, progress and challenges in the eradication of polio, strengthening the health workforce of the Region, combating counterfeit medical products, the impact of the global financial crisis and pandemic influenza preparedness.

10. H.E. Mr Umakant Chaudhary, Minister of Health and Population, Government of the Federal Democratic Republic of Nepal, extended a warm welcome and thanked the Chief Guest, the Right Honourable Mr Madhav Kumar Nepal, Prime Minister of Nepal, for gracing the joint inaugural session, which he said reaffirmed the commitment of his government to securing the health of the people of the country.

11. He also extended greetings to health ministers from Member States of the WHO South-East Asia Region; country delegates; Dr Margaret Chan, Director-General of the World Health Organization, appreciating her leadership in taking forward the health agenda; and Dr Samlee Plianbangchang, WHO Regional Director for South-East Asia, thanking him for his help and support in regional activities for health.

12. H.E. Mr Khadga Bahadur Basyal, Minister of State, Ministry of Health and Population, Government of the Federal Democratic Republic of Nepal, proposed the vote of thanks and placed on record, on behalf of the Ministry of Health and Population, his deep appreciation and gratitude to the Right Honourable Mr Madhav Kumar Nepal, the Prime Minister of Nepal, for
inaugurating the Twenty-seventh Health Ministers’ Meeting and the Sixty-second Session of the Regional Committee. He conveyed his appreciation to Dr Margaret Chan, Director-General, for sharing her wisdom and experience and thanked Dr Samlee Plianbangchang, Regional Director, for his leadership and continued support to Member States of the SEA Region.

13. The Regional Director welcomed the Ministers of Health and representatives of Member States. He thanked the Government of the Federal Democratic Republic of Nepal for hosting the two high-level meetings. He conveyed his sincere thanks to the Right Honourable Mr Madhav Kumar Nepal, Prime Minister of Nepal, for kindly consenting to inaugurate the two meetings. He commended Nepal for the remarkable progress made towards achieving national health goals. Immunization coverage in Nepal had increased from 75% in 2005 to 84% in 2008 and there was a substantial increase in the per capita calorie consumption, which was now above the regional average.

14. The Regional Director expressed deep concern at the challenge posed by the influenza pandemic that was sweeping across the world. The negative effects of the global economic downturn were also being experienced in the Region. He pointed out that strategic planning for efficient use of resources should be the key focus (For the full text of the address, see Annex--).

15. The Director-General of WHO, Dr Margaret Chan, conveyed her appreciation to the Ministers of Health of Member States of the Region and thanked the Government of Nepal for hosting the two important meetings.

16. She expressed concern that the world was experiencing the most severe economic downturn in three decades and was in the midst of the first influenza pandemic in four decades. The adverse effects of climate change were also being felt. However, she was glad to note that the world was also in the midst of the most ambitious drive in history to reduce poverty and bridge gaps in health outcomes through achieving the Millennium Development Goals.

17. Dr Chan stated that the health of women was one of her two priority areas. She commended Nepal for developing policies aimed at reducing maternal mortality in a systematic manner. She emphasized that the number of deaths during pregnancy and delivery will not go down until more women have skilled attendants at birth, and access to emergency obstetric care and cost-effective means of transport. She stressed that a renewed commitment to primary health care underpins efforts to improve the health of women, which is evident in a report on “Women and Health” that she had commissioned and which will be released in November 2009.

18. Expressing concern about the new H1N1 pandemic virus, which had established itself in about 190 countries, she mentioned that the capacity of health systems will determine the extent of the pandemic’s impact. In conclusion, the Director-General said that public health had a major role to play in the management of the influenza pandemic. She urged the health
ministers to get the message across to heads of states, heads of governments and ministers of finance, tourism and trade, regarding the need for far-reaching, often costly decisions in an atmosphere of scientific uncertainty in order to resolve this public health emergency. (For full text of the address, see Annex ____).
Part III
Business session

Opening of the session
19. The Sixty-second Session of the WHO Regional Committee for South-East Asia was opened by H.E. Mr Lyonpo Zangley Dukpa, Minister of Health, Royal Government of Bhutan.

Sub-committee on credentials (Agenda item 2)
20. A Sub-committee on Credentials comprising representatives from Bhutan, Maldives and Myanmar was appointed. The Sub-committee met under the chairmanship of the representative of Myanmar and examined the credentials submitted by Member States. The credentials submitted by all Member States were found to be in order, thus entitling the representatives to take part in the work of the Regional Committee.

Election of office-bearers (Agenda item 3)
21. H.E. Dr Umakant Chaudhary, Minister of Health and Population, Government of Nepal, was elected Chairman and H.E. Dr Aminath Jameel, Minister of Health and Family, Republic of Maldives, was elected Vice-Chairperson. Dr Chaudhary thanked the representatives for electing him Chairman, which he considered an honour for himself and his country. He expressed confidence that with the cooperation and support of all concerned, the Committee would successfully cover the agenda. He looked forward to the support of the WHO Regional Director, Dr Samlee Plianbangchang, and his team for the success of the meeting. He was confident that constructive and meaningful deliberations during the meeting would provide direction for health development in the Region.

Adoption of the Agenda (Agenda item 4, document SEA/RC62/1)
22. The Committee adopted the Agenda as contained in document SEA/RC62/1.

Statement by representatives of UN and Specialized Agencies
23. Ms Frances Turner, Deputy Regional Director, UNICEF Regional Office for South Asia, Kathmandu, highlighted the discouraging trends being witnessed in the areas of maternal and neonatal mortality, and undernutrition in South Asia. She informed that support was being provided to countries of the Region to implement their maternal and child health programmes towards achieving Millennium Development Goals 4 and 5. Undernutrition is an area of concern for the Region as more than half the world’s underweight children are found in South Asia. Both WHO and UNICEF were working together with governments in the Region to regularly distribute
vitamin A capsules, deworm children, fortify flour to reduce anaemia and ensure universal iodization of salt, and to prioritize infant and child-feeding practices. Dr Turner mentioned that routine immunization coverage was still below par in the Region. She further stated that WHO and UNICEF were continuing to collaborate closely on polio eradication. She thanked WHO for inviting UNICEF to participate in the Sixty-second Session of the Regional Committee, and looked forward to enhancing the productive relationship with WHO and its Member States in the South-East Asia Region.

Introduction to the Regional Director’s Annual Report on the Work of WHO in the South-East Asia Region covering the period 1 July 2008 – 31 August 2009 (Agenda item 5, documents SEA/RC62/2 and Inf. Doc.)

24. Introducing his report, Highlights of the Work of WHO in the South-East Asia Region for the period 1 July 2008 – 31 August 2009, the Regional Director, Dr Samlee Plianbangchang, stated that the report covered a 14-month period and that next year’s report would cover the work of WHO in the South-East Asia Region for the entire biennium 2008-2009.

25. The Regional Director said Member States of the Region had maintained consistent progress in health development during the period under review. However, while many of the prevailing health problems persisted, the Region also faced new and emerging challenges such as the global economic slowdown and the spread of Pandemic (H1N1) 2009.

26. In the South-East Asia Region, Thailand was the first country to report a confirmed case of pandemic influenza on 12 May 2009. The total number of confirmed cases in the Region had crossed the 20,000 mark, with more than 200 reported deaths during the period under review, most of them in India and Thailand. WHO had worked closely with Member States in surveillance and management of cases.

27. Substantial achievements had been made in the control of other communicable diseases that persisted in the Region. In the case of tuberculosis, nine Member States achieved the global targets of 70% case detection with 85% treatment success. TB prevalence had been reduced from 554 per 100,000 population in 1990 to 280 per 100,000 population in 2008. TB mortality also declined, from 53 per 100,000 population to 31 during the same period.

28. The endemicity of avian influenza had persisted in the Region, though the number of reported human cases declined significantly from 43 in 2007 to 25 in 2008.

29. With regard to leprosy, only two Member States were yet to achieve the global elimination target of a prevalence rate of less than 1 per 10,000 population. The incidence of kala-azar showed an appreciable decline, from 45,000 cases in 2007 to 31,000 in 2008; however, the case-fatality rate increased marginally, perhaps due to rising coinfection between kala-azar and HIV.
30. The Region continued to face the challenge of malaria control due to increasing drug-resistance and difficulty in containing newly emerged resistance. Deaths due to malaria had declined marginally.

31. Incidents of diarrhoea and cholera outbreaks were reported in Nepal. The diarrhoea outbreak in May 2009 affected 206 villages in 20 districts of Nepal, with nearly 60,000 cases and more than 300 reported deaths, highlighting the re-emergence of the disease as an important public health concern, particularly in countries where water supply and sanitation were not adequately improved.

32. With regard to noncommunicable diseases (NCDs), an estimated eight million deaths, or 54% of all deaths in the Region, in the past year were due to such diseases. NCD control efforts in the Region shifted focus to interventions at the primary health care level, with an emphasis on preventive measures. A WHO training package for NCD interventions through primary health care was pilot-tested in Bhutan and Sri Lanka.

33. In the area of health development, social determinants of health received increased attention. A regional meeting was held in February 2009 in Colombo to discuss the report of the WHO Commission on Social Determinants of Health. The “Colombo Call for Action” was adopted at the meeting and a technical unit established at the Regional Office.

34. Tobacco use remained a major concern, with an annual 1.2 million reported deaths due to tobacco use in the Region. The Sixty-first Session of the Regional Committee in 2008 urged Member States to accelerate scaling-up of their national tobacco control measures in line with the Framework Convention for Tobacco Control, and efforts were made during the year to strengthen surveillance mechanisms.

35. In the area of Family Health and Research, the major concern in the Region was the achievement of Millennium Development Goals (MDGs) 4 and 5. A high-level consultation on MDGs 4 and 5 was held in October 2008 in Ahmedabad, India, wherein the pressing need to scale up maternal and child health services through the primary health care approach was emphasized.

36. Neonatal mortality rates remained high, accounting for almost 70% of all infant mortality in the Region. The regional average routine immunization coverage remained low in 2008, reaffirming the urgent need to accelerate the level of coverage for the prevention of childhood diseases.

37. The Regional Director commended Bangladesh for eliminating maternal and neonatal tetanus (MNT) from the country in 2008. The achievement was all the more remarkable, given the fact that Bangladesh had one of the highest death rates from neonatal tetanus in the 1980s.
38. The Ninth Meeting of the Regional Nutrition Research-cum-Action Network that was held in Hyderabad, India, in September 2008 discussed the effect of rising global food prices on household food security.

39. In view of its impact on growth and development of children, iodine deficiency disorders (IDDs) continued to be a public health concern. Assessments of the national IDD control programmes were carried out in DPR Korea, Sri Lanka and Thailand. New training guidelines on salt iodization were developed in collaboration with the International Council for the Control of Iodine Deficiency Disorders (ICCIDD).

40. With regard to sustainable development and healthy environments, the “Healthy Settings Programme” in the Region stressed country capacity-building with a focus on water supply and sanitation. Support was provided for strengthening community-based occupational health services in Bangladesh, Bhutan and Sri Lanka.

41. Advocacy material on “protecting human health from climate change” was developed and widely disseminated in the Region in 2008. WHO continued to help strengthen the capacity of the health sector in building community resilience against adverse effects of climate change.

42. Indoor air pollution caused by smoke from cooking annually led to the death of nearly 300,000 children aged under five years in the South-East Asia Region. Some Member States had prepared an “action plan” to deal with this problem.

43. A Regional Conference on Revitalizing Primary Health Care was held in Jakarta, Indonesia, in August 2008. This was followed by regional meetings on self-care in the context of PHC and on the use of herbal medicines in primary health care.

44. In the area of research, the Thirty-first Session of the South-East Asia Regional Advisory Committee for Health Research (ACHR) was held in July 2009. The session focused on research in drugs and vaccines, health research management, research priorities in communicable and noncommunicable diseases, and a regional strategy on research for health. With regard to information management and dissemination, two new health libraries were established in Bhutan and Timor-Leste during the period.

45. In the area of medical services, a Regional Network of Medical Councils was established for intercountry cooperation to promote the quality of medical practice, improve medical education and also bolster the ethical code in medical practice. The Network met in 2008 to finalize the accreditation guidelines and a teaching module on medical ethics.

46. In the area of human resources for health, the Regional Strategy on Health Workforce was implemented with a focus on strengthening community-based health workers (CBHWs) and community health volunteers (CHVs). Regional guidelines for Health Workforce Strategic Plans were prepared for use by Member States. Member States also participated in the development of an “International Code of Practice for International Recruitment of Health Personnel”.
47. WHO’s regional budget for the current biennium was more than US$ 700 million, 81% of which was through Voluntary Contributions (VCs). These VC had a significant impact on the Region’s efforts towards controlling communicable diseases, particularly HIV/AIDS, TB, malaria, poliomyelitis, leprosy and other vaccine-preventable diseases.

48. The Regional Office for South-East Asia continued to collaborate with all partners within and outside the UN system and with governments and nongovernmental organizations. A regional coordination meeting between WHO, the United Nations Children’s Fund (UNICEF) and the United Nations Population Fund (UNFPA) was held in July 2008. The meeting focused on further strengthening collaboration, particularly in achieving health-related MDGs.

49. During the period under review, WHO continued to provide support to Member States through the “country focus” and “country-specific” approaches with the aim of strengthening country capacities for long-term sustainable health development. The resources and activities of WHO were further decentralized and more national staff were involved in implementing WHO programmes at both the country and regional levels (For full text of the Regional Director’s introductory remarks see Annex ----).

50. The Committee commended the leadership of the Regional Director in guiding Member States in their quest to improve the health of their people and for collaborating with governments in health development programmes. The Committee also urged WHO to provide technical and financial support to help Member States face and overcome the multitude of health challenges confronting the Region. The Committee reviewed the Report of the Regional Director in toto and made the following observations after comprehensive deliberations:

51. The Committee expressed its appreciation to the Regional Director for recognizing Bangladesh’s achievement in elimination of maternal and neonatal tetanus (MNT) in 2008. It also noted that under the aegis of the “Digital Health by 2021” programme, efforts are under way to establish a comprehensive information and communication technology (ICT) network across Bangladesh to cover all health facilities up to the subdistrict level.

52. The representative from Bangladesh also requested the Committee to support the country’s proposal to include a draft resolution on cholera prevention and control in the Agenda for the 126th session of the Executive Board. Bangladesh had earlier proposed the same for inclusion in the Agenda of the 125th session of the Executive Board. The Committee was subsequently informed that the draft resolution would be placed on the Agenda of the 127th session of the Executive Board.

53. The Committee conveyed its appreciation to the WHO Director-General for requesting Her Excellency Madam Sheikh Hasina, Prime Minister of Bangladesh, to address the World Health Assembly in 2011 as Invited Speaker.
54. It was observed that more efforts were needed to sustain the initiatives by Member States to improve the health of their populations, especially in the context of the quadruple challenges that confront them: the global economic downturn and consequent financial crisis; Pandemic (H1N1) 2009; the spate of natural disasters that have occurred in the Region at regular intervals; and the consequences of human-induced emergencies. The Committee was urged to increase budgets for country-specific health programmes for full utilization of Assessed Contributions (ACs) and Voluntary Contributions (VCs).

55. The Committee acknowledged the support of the World Health Organization in mitigating the effects of disasters in Member States, including assistance from the South-East Asia Regional Health Emergency Fund to displaced persons in Sri Lanka, to victims of the Kosi river floods in India and Nepal, and victims of Cyclone Nargis in Myanmar.

56. The Regional Director was commended by representatives of Member States for promoting the use of herbal medicines in primary health care, prevention and cure.

57. The Committee’s attention was drawn to the need to build entomological capacity in Member States to successfully combat communicable diseases and to the need to rehabilitate persons who had been cured of diseases such as leprosy but were left with persistent disabilities.

58. The Committee was informed that Member States had succeeded in mitigating the impact of Pandemic (H1N1) 2009 after the initial onslaught through aggressive strategies to reduce mortality; active pursuit of campaigns to promote hand-washing and the use of facial masks; and accelerating the early start of oseltamivir within 48 hours of illness. The Committee was also informed that pandemic flu vaccine would be available in most Member States by early 2010. There was need to consider whether the same strategy should be adopted for eliminating lymphatic filariasis having a different level of endemicty.

59. The Committee’s attention was drawn to the need for more support to Member States in health promotion, behavioural change and health education, and to the lack of adequate resources for revitalizing primary health care to the fullest extent. It was also pointed out that changing patterns of diseases and occurrence of vector-borne diseases in new areas due to climate change needed urgent attention.

60. The Committee urged WHO to provide technical support to strengthen research capacity in countries.

61. WHO accorded the highest priority to eradication of polio from the SEA Region as early as possible. It was observed that the last vestiges of polio had been curbed both spatially and clinically, and of the seven genetic families of the more virulent P1 virus that were circulating in the endemic states of India, only one was now circulating in the western part of the state of Uttar Pradesh and the Kosi river basin of Bihar. The support of WHO was sought in this “difficult last mile” on the long road to eradication of polio.
62. The Committee, after extensively deliberating on the report of the Regional Director, noted with satisfaction the progress made during the period under review on the collaborative programmes in the Region between the World Health Organization and Member States.

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

63. Dr Margaret Chan, Director-General of the World Health Organization, appreciated the determination demonstrated by Member States of the South-East Asia Region and the striking successes achieved with strategies to secure and promote the health of their people. She said that practical ways to bring health care into the private sector should be explored; governments need to be made more accountable; and a balanced distribution of motivated health workers achieved, with the ultimate goal of ensuring equitable health services.

64. She commended the Member States, saying that the Region now stood on the brink of success in the drive to eradicate polio, with only parts of two states in India remaining endemic. India’s steadfast political commitment to eradicate polio along with the allocation of extraordinary financial support by the Government of India played a vital role in this achievement.

65. Dr Chan noted that Member States had demonstrated a strong commitment to the renewal of primary health care through a set of social values and ethical commitment. However, a great deal of determination was needed to achieve this at a time of global recession and the unstoppable spread of Pandemic (H1N1) 2009.

66. She expressed concern at the fact that the influenza virus had rapidly established itself as the dominant influenza strain. Though the virus had reached the Region later than other regions, India, Indonesia and Thailand were feeling the brunt of the outbreak. Pandemic (H1N1) 2009 was not the same as seasonal influenza, and it will test the world in a manner that will tangibly and tragically reveal the consequences of decades of failure to invest adequately in health. In the case of the influenza pandemic, most of those who died were under the age of 50, and countries must be prepared for the inevitable burden on their health systems, she cautioned. Saving lives depended on highly specialized intensive care and specialized skills. Furthermore, pregnant women faced a higher risk from pandemic influenza in a Region where maternal mortality is already too high.

67. Expressing concern over the widespread inequity in access to health, the Director-General said the world had come to recognize that blind faith in market forces was misplaced. It had been expected that living conditions and the health status of the poor would improve as countries modernized and liberalized trade and commerce. This, however, had not happened. All over the world, and especially in the South-East Asia Region, there was an increasingly greater divide in the quality of care available, which in many cases only benefited the wealthy.
At the G20 Summit in London in April 2009 the world’s leaders called for a fundamental re-engineering of international systems, urging countries to be more responsive to the genuine concerns of society, such as community, equity and social justice.

68. Dr Chan underlined the importance of public health at a time of multiple crises. The failures in international systems occurred due to the inequitable distribution of benefits. In conclusion, the Director-General expressed her appreciation for the Region’s renewed commitment to public health through primary health care. The PHC approach was the most effective to promote fair and efficient health care and “build global resilience against the next global crisis that our imperfect world would certainly deliver”.

69. The Committee appreciated the Director-General’s vision to have encouraged the development of avian influenza preparedness plans. As a result of having these plans in place, countries were better prepared to manage the Pandemic (H1N1) 2009.

70. Member States had responded promptly in mitigating the effects of the H1N1 virus; efforts were under way to invest in research and development to produce the H1N1 vaccine indigenously, within countries. However, production and use of unlicensed vaccines to combat the disease should not be allowed.

71. Regarding the pandemic, the Committee was informed that screening was not totally effective since the vast majority of those affected are asymptomatic; quarantining should be done only after weighing its economic and social consequences. The Committee was assured that the H1N1 situation would be reviewed continuously and information updated regularly.

72. The Committee was also informed that intensive efforts were under way to produce between 2 and 4.5 billion doses of the vaccine in one year.

73. It was noted that WHO would accord due importance to the use of traditional/herbal medicines at the PHC level. Appreciation was also expressed for the commitment shown by Member States towards eradication of polio (For full text, see Annex ___).

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

74. Dr H.B. Tamitegama, Alzheimer’s Disease International (ADI), stated that Alzheimer’s disease and other dementias were emerging as a major health hazard of the twenty-first century. He appreciated that in response to the ADI’s request made last year, the subject of dementia had been accorded priority by WHO through its inclusion in the mental health GAP programme.

75. Dr Tamitegama said that ADI would launch the First World Alzheimer’s Report on 21 September 2009 to coincide with World Alzheimer’s Day. He cautioned that as the life expectancy of the world’s population continued to rise, the prevalence of dementia would increase proportionately.
76. In this context, it was important that the following steps were taken: awareness about the disease should be raised among the general public and amongst health professionals; health professionals should be trained on how to deal with dementia in their day-to-day practice; and family caregivers should be supported in their demanding role. These steps could help countries develop their respective national strategies for control of dementia.

77. Dr Vijay K. Edward, World Vision India, in his statement, underscored the need to make child malnutrition the centre-piece of health programming through renewed focus and targeted investment in primary health care at both family and community levels. This should be done by allocating adequate financial resources for achieving MDG 4, aimed at reducing child mortality. Furthermore, the need for multi-stakeholder involvement, supportive national governments and working in coalitions was stressed.

78. Prof. Rabiul Husain, Regional Chair, International Agency for the Prevention of Blindness (IAPB), said that IAPB (an umbrella organization of international nongovernmental development organizations, academia and the corporate sector), which was in official relations with WHO, had joined hands with WHO, over 10 years ago, to launch a collaborative Global Initiative for the Elimination of Avoidable Blindness under the caption VISION 2020: the Right to Sight.

79. Prof. Husain elaborated that visual impairment and blindness had far-reaching social, developmental, economic and quality-of-life implications for affected individuals, their families and communities as a whole. This was true across the individual’s whole life spectrum. Prevention of visual impairment was not only a health imperative, it was also a moral compulsion. It was a fundamental human right. This was the reason why VISION 2020 had been launched. He emphasized the need to accord eye health the priority it deserved.

80. Dr Prosanto Kumar Chowdhury, Thalassaemia International Federation (TIF), highlighted the role of TIF in promoting equal access to quality health care to patients with haemoglobinopathies, such as thalassaemia, across the world. Nearly 20% of TIF’s thalassaemia member associations were in countries of the Region. He requested the Committee to encourage national authorities to employ effective control strategies and support national efforts in promoting public awareness regarding the disease. He also requested support for twinning programmes between countries that had achieved measurable success in haemoglobinopathy control policies with countries that had achieved minimal or no progress. Dr Chowdhury expressed his deepest appreciation for the ongoing productive collaboration between TIF and WHO and reiterated TIF’s firm commitment and support in placing haemoglobinopathies on the national health agenda of countries of the Region.

81. Ms Andrea Reisinger, International Federation of Red Cross and Red Crescent Societies (IFRC), spoke about the new health challenges arising out of climate change, e.g. increased recurrence of natural disasters; changing patterns of infectious diseases due to droughts and
water crisis; food insecurity; malnutrition and vector-borne diseases including dengue, malaria and chikungunya. Warmer temperatures will not only increase air and water pollution but also harm human health through respiratory problems and a variety of food and water-borne diseases.

82. Ms Reisinger highlighted the role played by IFRC in promoting home gardening to improve the lives of thousands of people by helping them with additional nutritional intake and thus preparing them to face potential food crises. She also highlighted IFRC’s strong collaboration and cooperation with WHO, UNICEF and other health partners in addressing important health issues such as HIV, polio, tuberculosis, malaria, influenza, blood safety and measles. She emphasized the need to scale up countries’ capacity to: help communities to adapt to climate change; respond to changing patterns of infectious diseases; put early-warning information systems in place; build up essential stocks of emergency medicines and health kits; and establish closer collaboration with all health partners to strengthen preparedness and response measures for saving lives in emergencies.

83. Ms Sarala K.C., President, International Council of Nurses (ICN), informed the Committee that the mandate of the ICN was to improve the standards of nursing practice, education, management and research, and to strengthen the contribution of nurses to health systems at all levels. The ICN appreciated the attention being given to the code of practice for international recruitment of health personnel. Migration of nurses and other health workers had increased significantly in the past few decades. Although it supported fully the individual’s right to migrate, the ICN was deeply concerned that migration of health personnel was weakening the health systems in many countries. Indeed it was a matter of concern that the severe shortage of nurses and other health workers would undermine the achievement of MDGs and national health targets.

84. Ms Sarala stated that the ICN fully supported measures to formulate national and international policy instruments to reduce migration and believed the code of practice to be one such measure. The WHO code of practice aims to strengthen the capacity of governments to manage migration flows and international recruitment of health personnel.

85. Ms Pennapa Kaweewongprasert, International Federation of Medical Students’ Association (IFMSA), said that the IFMSA was continuing its mission to build skilled and sensitized physicians by supporting the exchange of best practices. The IFMSA felt that the voice of physicians to-be, medical students, as well as other groups of students in health-related professions was normally not heard at important forums.

86. Ms Pennapa expressed the hope that Member States would recognize the importance of ensuring high-quality education for medical and other students in health-related professions as a means to the best-quality health care and overall strengthening of health care systems. The IFMSA felt that providing primary health care or working in rural areas was not as attractive,
because of scarce professional opportunities, little possibilities of advancement, often unsafe working conditions and a symbolic, rather than a decent, pay. This was the reason behind IFMS' decision to adopt a Declaration on Migration of Health Care Professionals and a Declaration on the Health of Indigenous People at its Fifty-eighth IFMSA General Assembly that addressed the brain-drain effects and problems of underserved areas and populations. The IFMSA supports the finalization, signing and implementation of the code of practice.

87. Mr Kalyan Banerjee, Rotary International PolioPlus Committee, informed the Committee that the polio eradication programme was more geographically focused than ever before; however, some challenges remained. Apart from Rotary International, the other three partners spearheading the polio eradication initiative were WHO, UNICEF and the Centers for Disease Control (CDC), Atlanta, United States. Mr Banerjee said that while considerable progress had been achieved under the polio eradication programme – a reduction of 99% in the total number of cases since 1985 – now only four countries in the world remained polio-endemic and the circulation of the virus was also limited to specific geographic locations in each country.

88. Mr Banerjee briefed the Committee about the unprecedented support and political commitment for the Global Polio Eradication Initiative, such as commitments made by the Bill and Melinda Gates Foundation that provided US$ 255 million in January 2009. This was in addition to the Gates Foundation’s 2007 grant of US$ 100 million. He stated that during the last phase of the programme, concerted action was needed including all-out support by all stakeholders to end polio in the world.

89. Mr Mario Ottiglio, International Federation of Pharmaceutical Manufacturers and Associations (IFPMA), informed that IFPMA was the global non-profit nongovernmental organization representing research-based pharmaceutical, biotech and vaccine sectors and comprising 27 leading international companies and 52 national and regional industry associations from all the five continents. He briefed the Committee on the impact of counterfeit medical products on public health, on patient’s health and on patients’ confidence in health systems, including local regulators, pharmacists, doctors and legitimate manufacturers.

90. Mr Mario stressed that a coordinated and long-term international approach for combating counterfeiting was needed. The International Medical Products Anti-counterfeiting Task force (IMPACT) was using an approach that brought together representatives from the regulatory agencies, patients, health professionals, pharmaceutical distributors and wholesalers, relevant international organizations and pharmaceutical industries; the approach had the requisite potential to address the technical, regulatory and enforcement gaps that facilitated the prevalence of counterfeits.
Matters relating to Programme Development and Management

Programme Budget Performance Assessment: 2006–2007 (Agenda item 7.1)

91. The Committee was informed that the summary report on the Programme Budget 2006-2007: Performance Assessment (Document: A61/19) was reviewed by the Eighth Meeting of the Programme, Budget and Administration Committee (PBAC) of the Executive Board in Geneva, in May 2008. The summary report was also submitted to the Sixty-first World Health Assembly in 2008.

92. At the request of the PBAC that the full version of the report be discussed at the next session of the respective regional committees in 2008 and be considered by the Executive Board at its 124th session in January 2009, the summary report (A61/19) and the full version of the Programme Budget Performance Assessment report were submitted to the First Meeting of the Sub-committee on Policy and Programme Development and Management (SPPDM) and the Sixty-first Session of the Regional Committee in 2008 for their review and consideration.

93. The full report of Programme Budget Performance Assessment, along with the views of the regional committees, was submitted to the 124th session of the Executive Board and the Sixty-second World Health Assembly in 2009 for noting.

94. The Committee noted with appreciation that the Regional Office would be using the process of the global exercise on Programme Budget Performance Assessment as an opportunity to improve the quality of programme planning and implementation at regional and country levels, and that more frequent meetings of programme managers with WHO staff in planning and managing WHO collaborative programmes should be held.

95. The Committee suggested that WHO lend greater focus to the qualitative aspect of programme budget performance assessment. Furthermore, it was stressed that the end-of-biennium assessment reports should be shared with programme managers in WHO country offices and their respective counterparts in ministries of health of Member States.

96. The Committee endorsed the recommendations of the SPPDM meeting held on 2 July 2009 in the Regional Office, on this agenda item.

Review of the implementation of workplans for PB 2008–2009 (Agenda item 7.2)

97. The Committee noted that the effective working budget for Assessed Contribution (AC) for the Region for the 2008-2009 biennium stood at US$ 102 million, while the Voluntary Contribution (VC) budget was US$ 437 million, for a total regional budget of US$ 539 million. Voluntary Contributions were playing an increasingly significant role in financing the programme.
of work of the Region (81%). Over 95% of VC to the Region are specified and contribute to disparities in the distribution of resources between countries and across Strategic Objectives.

98. The Committee was informed of the challenges associated with the mobilization and implementation of voluntary contributions, especially with respect to the additional implementation capacities required, as well as the disparities in funding countries, specific technical programmes or staff. Typically, donors tend to make allocations based on their own agenda rather than that of WHO or Member States. The tendency of voluntary contributions to come through multiple sources contributed to a fragmented and inefficient approach to programming of health activities in Member States. Furthermore, flexible core VC (CVC) funding was not enough to fill programme and country funding gaps.

99. The Committee urged WHO not to set overambitious targets for voluntary contributions; to strive to increase unearmarked VC to counter the rising trend of specified VC; to ensure efficient implementation of the WHO collaborative programme and to increase the technical capacity of country office staff. It noted that greater emphasis should be accorded to developing relevant indicators to adequately measure WHO’s contribution to improve health in countries.

100. The Committee endorsed the recommendations of the SPPDM meeting on this agenda item and adopted resolution SEA/RC62/R1 on this agenda item.

Preparations for Programme Budget 2010–2011 including implementation of the Regional Committee resolution SEA/RC61/R2, and discussions on the impact of the global financial crisis (Agenda item 7.3)

A. Preparation of proposed PB 2010-2011

101. The Committee noted that the Programme Budget for 2010-2011 had been finalized over the last year, following up on the recommendations of the first SPPDM meeting and the Sixty-first Session of the Regional Committee. Because of the financial crisis and the recommendations of the 124th meeting of the Executive Board, the Director-General had decided on a reduction in the proposed budget. The Region’s budget was therefore reduced by US$ 60 million to US$ 544.5 million. Although this resulted in the smallest increase in the Region’s budget over the past decade, it still represented an 11% increase over the 2008-2009 budget. While Assessed Contributions (AC) decreased by 1.5%, the budget for Voluntary Contributions (VC) rose by 14%, thus increasing the proportion of VC funding to 81% of the total budget.

102. The Committee was also informed that the reductions in the proposed budget were not evenly distributed across the Strategic Objectives (SOs); the largest reductions were effected in the area of communicable diseases that still form 48% of the total budget of the Region. There is still a tendency for donors to favour support to communicable disease programmes, thereby
making it difficult for the Region to mobilize resources for other programme areas. Member States requested further support for Strategic Objectives related to the Millennium Development Goals, noncommunicable diseases and health systems including health information.

103. The Committee also noted that the country workplans for 2010-2011 were further refined through a peer review process in August 2009 with the involvement of government officials and WHO country office planning focal points and Regional Office staff to ensure the expected results and indicators are measurable, concrete and achievable, keeping in mind the individual country priorities.

104. The Committee noted that there is increased dependency on Voluntary Contributions usually for specific communicable diseases. This prevented flexibility to reallocate resources for other under-funded programme areas targeted to achieve the MDGs and reduce the increasing burden of noncommunicable diseases, and strengthening health systems.

105. The Committee was informed that although VC funding had increased severalfold over the past decade, the human resources in the Regional Office have not increased proportionately, which posed a challenge to implementation. Core WHO positions should be funded by AC since the uncertainty of VC funding makes it difficult to recruit staff, although VC funding can be used for short-term assignments.

106. The Committee supported WHO’s effort to improve efficiency, as well as the establishment of a Health Intelligence Unit to monitor the financial crisis and its health implications in Member States. The importance of sharing the outcome of the work performed by the Unit was emphasized.

107. The Committee observed that the reduction of 10% in the budget might be inadequate and that further reductions might be more realistic. Improved programme management and rational use of human resources were seen as key factors in achieving efficiencies. Also important was the support for resource mobilization efforts to equalize the imbalances between Strategic Objectives.

108. The Committee endorsed the recommendations of the SPPDM meeting on this agenda item.

B. Impact of the global financial crisis

109. The Committee noted that the global financial crisis was the most severe financial and economic downturn since the Great Depression. The crisis will affect all stakeholders—people, government, civil society, the private sector and development work of international agencies. WHO would be no exception and Voluntary Contributions could also be affected. The Committee was informed that actions that needed to be initiated could include continued monitoring of the impact of the crisis through active involvement of the Health Intelligence Units
set up in countries; working with development partners for sustained ODA for health; enhanced resource mobilization by WHO; more effective and efficient management of the programme budget; and supporting Member States through a flexible process of workplan implementation.

110. The Committee was informed that the Regional Office would give increased attention to efficiencies in view of the likely reduction in VC funds in the current global economic crisis. There would also be increased attention to expected results and simple and concrete indicators of achievement of these results.

111. The Committee endorsed the recommendations of the SPPDM on this agenda item.

**Technical Discussions: (Agenda item 8)**

**Consideration of the recommendations arising out of the Technical Discussions on “Protecting Human Health from Climate Change” (Agenda item 8.1, document SEA/RC62/6)**

112. The Committee’s attention was drawn to the decision of the Sixty-first Session of the Regional Committee in New Delhi, India, in September 2008 recommending the topic “Protecting Human Health from Climate Change” for the Technical Discussions to be held prior to the Sixty-second Session of the Regional Committee. Following the said decision, experts on the subject of “Protecting Human Health from Climate Change” deliberated on the issue and developed a position paper with technical inputs from WHO.

113. The Committee noted that Technical Discussions on “Protecting Human Health from Climate Change” were held by experts from Member States in New Delhi, India, from 18 to 21 August 2009. Representatives from all Member States of the Region were invited, representing ministries of health as well as ministries of environment, along with experts and representatives of centres of excellence from the Region and beyond.

114. Participants included 24 representatives from nine Member States of the WHO South-East Asia Region, five experts from centres of excellence in the Region, four international experts and 11 representatives from partner agencies. Participants from WHO headquarters, the Regional Office and other international experts also attended.

115. The Technical Discussions dealt with all the key issues related to the subject and came up with a number of recommendations for Member States and for WHO.

116. The Committee noted that climate change will affect, in profoundly adverse ways, some of the most fundamental pillars of health: food, water and air. The gradual and irreversible warming of the planet will trigger more frequent and extreme weather events such as intense storms, heat waves, droughts and floods. During the last 100 years human activity, particularly related to the burning of fossil fuels, has led to a 30% increase in carbon dioxide levels in the
atmosphere, causing the trapping of more heat. Consequently, 11 of the 12 years between 1995 and 2006 rank among the 12 warmest years in human history. Health impacts will be disproportionately greater in vulnerable populations; in the Region the people at greatest risk include the very young, the elderly and the medically frail.

117. The Committee was informed that more than 50 research projects on the health impact of climate change had been undertaken by institutions in the Region and that more than 35 research centres of excellence are currently conducting research.

118. The Committee discussed the background document on “Protecting Human Health from Climate Change”; its comprehensiveness was commended. The Committee’s attention was drawn to the fact that the impact of climate change on human health affects nutrition, food safety, disaster management, and the rise in vector-borne and waterborne diseases.

119. The vulnerability of certain populations in some Member States, such as those living in mountain areas, to vector-borne diseases, diarrhoea and cholera outbreaks, which had increased due to the rise in average temperatures due to climate change was noted. In the case of low-lying parts of the South-East Asia Region which were particularly vulnerable to rising sea levels on account of climate change, the Committee’s attention was drawn to the need for mitigation measures to improve health and bolstering research capacity with a focus on island states. Since climate change intensifies health problems, reducing greenhouse gas emissions using non-fuel based alternate energy and implementing carbon conservation measures should be encouraged through incentives to countries.

120. The Committee also urged WHO to facilitate the monitoring of the progress of implementation of the recommendations of the Technical Discussions on “Protecting Human Health from Climate Change” through a panel that could meet at intervals of two years.

121. The importance of training community health workers to better understand climate change, and to enhance the capacity of national meteorological panels in each Member State was also reiterated.

122. The Committee’s attention was also drawn to the fact that women were most at risk in the event of a disaster and/or adverse climatic situation, wherein they are often left to fend for themselves and their children in the initial stage after the men in the community have migrated.

123. The Committee endorsed the report and recommendations of the Technical Discussions as contained in document SEA/RC62/6 and adopted resolution SEA/RC62/R2 on this agenda item.
Selection of a subject for the Technical Discussions to be held prior to the Sixty-third Session of the Regional Committee ( Agenda item 8.2, document SEA/RC62/7)

124. The Committee noted that the High-Level Preparatory (HLP) Meeting had discussed this item as part of an in-depth and wide-ranging review of various issues relating to a subject of regional interest. The subjects that were considered by the HLP were:

(1) Injury prevention and safety promotion
(2) Tobacco control—Meeting the obligations of the Framework Convention on Tobacco Control (FCTC)
(3) Innovative approaches to child and adolescent health in the South-East Asia Region.

125. While recognizing the importance of the subjects under consideration, it was suggested that the impact of the global financial crisis and Pandemic (H1N1) 2009 also be considered as subjects for Technical Discussions prior to the Sixty-third Session of the Regional Committee. However, taking cognizance of the endorsements made by most Member States, the Committee recommended that these subjects be considered for inclusion in the Agenda for the Sixty-third Session of the Regional Committee.

126. Accordingly, considering its importance, the Committee endorsed the subject of “Injury Prevention and Safety Promotion” selected by the HLP, and decided to hold Technical Discussions on it prior to the Sixty-third Session of the Regional Committee in 2010.

Measles (Agenda item 9, document SEA/RC62/8)

127. The Committee was informed that the global goal for measles control is to reduce measles mortality by 90% by 2010 in comparison to the 2000 levels. Nevertheless, four WHO Regions have set a measles elimination goal. With the success achieved in the Americas, there is global interest in exploring the feasibility of setting a global measles elimination goal. In the South-East Asia Region, which has a measles mortality reduction goal, four Member States are implementing strategies for measles elimination and all Member States except India have achieved or exceeded the 90% mortality reduction target. More Member States are ready for the adoption of a measles elimination goal.

128. Routine immunization coverage for measles in the Region increased from 61% in 2000 to 73% in 2007. During this period, all Member States except India and Thailand, conducted measles catch-up campaigns and immunized 120 million people. As a result, between 2000 and 2007, the estimated number of annual measles deaths in the Region was reduced by 42%, from 235 000 to 136 000.
129. Key considerations for setting a measles elimination goal include reaching appropriate immunization targets (routine measles immunization coverage of more than 95% for two doses, initial catch-up campaign, and periodic follow-up campaigns as necessary); establishing sensitive surveillance systems; mobilizing adequate resources; ensuring vaccine supply of assured quality, and injection safety; and building political and societal commitment.


131. The Committee noted the progress in measles mortality reduction made in the Region and towards elimination in four Member States. It noted the requirements, and key challenges that must be overcome, to achieve an elimination goal. The strategies for measles elimination were the same as the strategies for measles mortality reduction, with the added requirement of achieving higher performance levels through intensification and acceleration. Strengthening health systems to achieve and sustain immunization coverage with two doses of measles vaccine would be critical. Case-based surveillance with strong laboratory support would be essential, as would supplementary immunization campaigns.

132. The resources required could be considerable and a high level of political commitment would also be required. Adequate supply of a safe and quality vaccine must be assured. Concerns regarding injection safety would need to be adequately addressed.

133. The Committee noted that 10 of the 11 Member States of the Region were ready to adopt a measles elimination goal by 2020. These Member States expressed the need for WHO technical support in the development of their national plan for measles elimination and mobilization of resources, and asked for a progress report at the Sixty-third Session of the Regional Committee in 2010, at which time the Committee would consider a regional elimination goal. In the remaining Member State, the implementation of the supplementary immunization campaign was delayed by certain adverse effects following immunization. After a thorough investigation, it was decided to conduct the supplementary immunization campaign in 2010.

134. The Committee adopted resolution SEA/RC62/R3 on this agenda item.

**Code of practice for the international recruitment of health personnel** *(Agenda item 10, document SEA/RC62/9)*

135. The Committee noted that the World Health Assembly resolution WHA57.19 had requested the WHO Director-General to develop a draft code of practice for international recruitment of health personnel. The WHO Secretariat, through a comprehensive programme and a stakeholder participatory process with web-based public hearing, prepared the draft code
in 2008 and presented it to the 124th session of the Executive Board in January 2009. The draft “Code of Practice” includes articles reflecting key areas and issues that may be considered. The 124th session of the Executive Board observed that Member States might need further consultation at both country and regional levels on the code of practice. The Director-General therefore requested all regional committees to include this item in their respective agendas.

136. Acknowledging the importance of formulating a comprehensive code of practice for international recruitment of health personnel, the Committee appreciated the continuing and concerted efforts being taken by WHO to address the phenomenon of “internal” and “international” migration of skilled health workforce. It was also important to critically review the code of practice in the context of the real intention or purpose behind the various objectives outlined in it. However, it urged WHO to provide relevant and adequate support to Member States to help them forge a regional consensus through national consultations and regional meetings on the draft code of practice in preparation for the 124th Session of the Executive Board to be held in January 2010.

137. The Committee felt that it was important to balance the positive and negative impacts of migration of the health workforce between both the “source” and “destination” countries. In this context, the manpower and transaction costs involved in international recruitment of health personnel needed to be carefully considered and dealt with appropriately. While it was true that migration of health workforce impacted some countries negatively, there were others, especially those less developed, that in fact gained/benefited from such migration through wage earning. Thus, it was essential that different objectives outlined in the draft code were properly balanced in terms of their benefit to all Member States.

Engagement with the private sector (Agenda item 11, document SEA/RC62/10)

138. The Committee was informed that the topic of engagement with the private sector was put forward for discussion by Thailand at the Sixty-first Session of the Regional Committee in 2008, to be developed as an agenda item for the 124th session of the Executive Board in January 2009. The Executive Board agreed that the topic be further deliberated upon at the Sixty-second World Health Assembly in 2009; however, further discussion was postponed until the Sixty-third World Health Assembly in 2010.

139. The subject was reviewed and deliberated upon in detail at the HLP meeting held in the Regional Office in 2009, which made the following specific recommendations.

- First, the key to effective engagement of the private sector is understanding the size and scope of its involvement in health, as well as its strengths and weaknesses in comparison to the public sector. Comprehensive profiling of the role of the private sector in health is a first step for countries considering public-private partnerships.
Second, after identifying a formal role for the private sector in the national health agenda, it is important to create an enabling environment for launching public-private partnerships. National forums for dialogue could be a useful platform to do this, especially to remove the mistrust between public and private actors. Further, health systems themselves need to be ready to engage the private sector. This will require action in several areas, such as strengthening regulatory capacity of government as well as consumer protection agencies to ensure effective and quality private care. Additionally, a review of human resources would be needed, as would an updating of health information systems to cover both the public and private health sector. Last, a restructuring of health financing to include private providers would be needed.

140. The Committee also noted that countries would need assistance and reinforcement from development partners for initiating and institutionalizing these actions.

141. The Committee acknowledged that the nongovernmental sector in the Region plays a large and significant role in the provision of essential and specialized care, and does have a potential to contribute effectively to the national health agenda.

142. Strategic engagement of the private sector to realize this potential requires an emphasis on the stewardship role of the government, specifically in the area of regulating the private sector, including monitoring private sector activity and ensuring accountability. It was noted that the other components of engagement with the private sector also critically depend on government capacity in this area.

143. The Committee emphasized that universal coverage must be at the heart of all public-private partnerships, to ensure that health systems overall make significant progress towards equity. It further underlined that public investment in health should continue to be a priority.

144. The Committee adopted resolution SEA/RC62/R4 on this agenda item.

Collaboration within the UN system and with other international agencies and partnerships (Agenda item 12, document SEA/RC62/11)

145. The Committee noted that the recognition of health as a key element for sustainable development and global security had resulted in a substantial increase in global resources for health in recent years; these stood at US$ 22 billion in 2007. At the same time, the diversity and number of health actors have also increased significantly. With this proliferation of actors in health, WHO—particularly at country level—must coordinate its work through effective partnerships not only with government authorities and other UN agencies, but also with donors, NGOs and the private sector, in order to ensure alignment of health strategies and goals and other development objectives.
146. The collaboration of WHO within the United Nations system and with other international agencies and partnerships is targeted to improve the effectiveness of the global health community in accelerating the achievement of internationally agreed development goals, with particular emphasis on those focusing on improving global health.

147. The Committee reiterated the importance of defining the roles and responsibilities of the international partners and UN agencies. It was important to avoid duplication of funds over the same programmes and to keep country priorities in mind. It commended the emergence of robust global partnership funds to support health efforts, and suggested ways of overcoming practices like inefficient aid, duplication, fragmentation, multiple reporting levels, high transaction costs and lengthy bureaucratic procedures. There is a need to look forward to international health partnerships and to make pooled funds more flexible in preference over bilateral partnerships with donors—since the latter did not always tend to take a holistic view. It also recognized the importance of effective partnerships with NGOs and the private sector. The Committee noted that national priorities and building capacity of Member States would be the key guiding factors for taking forward the Harmonization and Alignment Agenda at the country level.

148. The Committee endorsed the recommendations of the HLP meeting on this agenda item.

**Governing Bodies**

**Key issues and challenges arising out of the Sixty-second World Health Assembly and the 124th and 125th sessions of the WHO Executive Board (Agenda item 13.1, document SEA/RC62/12)**

149. The Committee noted that the HLP meeting was presented with a working paper highlighting the most significant and relevant decisions and resolutions emanating from the Sixty-second World Health Assembly.

150. Highlights from the operative paragraphs of selected decisions/resolutions, as well as the regional implications of each decision and/or resolution, as applicable, and actions proposed for Member States and WHO, were presented.

151. The Committee noted the recommendations on regional perspectives made by the HLP meeting in regard to the following selected World Health Assembly resolutions:

1. **Prevention of avoidable blindness and visual impairment (WHA62.1)**
2. **Primary health care, including health system strengthening (WHA62.12)**
3. **Traditional medicine (WHA62.13)**
(4) Reducing health inequities through action on social determinants of health (WHA62.14)

(5) Prevention and control of multidrug-resistant and extensively drug-resistant tuberculosis (WHA62.15)

152. The Committee also noted that these resolutions were particularly relevant to the South-East Asia Region and had obvious and immediate implications meriting follow-up actions.

Review of the draft provisional agenda of the 126th session of the WHO Executive Board (Agenda item 13.2, document SEA/RC62/13 and Inf. Doc.)

153. The Committee noted the Draft Provisional Agenda of the 126th session of the Executive Board. This was also presented at the HLP meeting in New Delhi in June 2009, and it was noted that any proposals from Member States or Associate Members to include an item on the Agenda should reach the Director-General by 14 August 2009.

154. The Committee noted that the Draft Provisional Agenda of the 126th Executive Board session had:

   (1) Eighteen sub-Agenda items under Technical and Health Matters;
   (2) One sub-Agenda item under Programme and Budget Matters;
   (3) Two sub-Agenda items under Financial Matters;
   (4) Five sub-Agenda items under Management Matters;
   (5) Seven sub-Agenda items under Staffing Matters;
   (6) One sub-Agenda item under Matters for Information; and
   (7) Ten sub-Agenda items under Progress Report.

Follow-up Action on Pending Issues and Selected Regional Committee Resolutions/Decisions For The Last Three Years

South-East Asia Regional Health Emergency Fund (Agenda item 14.1, document SEA/RC62/14)

155. The Committee noted that the South-East Asia Regional Health Emergency Fund (SEARHEF) was officially established by Regional Committee resolution SEA/RC60/R7, which was adopted by the Committee at its Sixtieth Session in Thimpu, Bhutan, in 2007. The fund became operational in January 2008. It has two parts: an assessed contribution (AC) consisting of US$ 1 million, and a voluntary contribution (VC) of US$ 100 000 from the Royal Thai Government.
156. The Committee was informed that SEARHEF had since supported health interventions in four emergencies in three Member States of the Region:

(1) A release of US$ 350,000 in May 2008 to Myanmar in the aftermath of Cyclone Nargis;
(2) A release of US$ 23,000 in June 2008 for those displaced by the flash floods in Sri Lanka;
(3) A release of US$ 325,000 for those affected in the flooding of the Kosi River plains in Nepal in September 2008;

157. The funds allocated for these emergencies were used to:

(1) Support initial and periodic assessments and coordination activities;
(2) Procure and distribute essential medicines and emergency relief supplies such as tents, bleaching powder and other essential items;
(3) Ensure the mobility of health staff in affected areas; and
(4) Support specific health interventions such as improved surveillance, water and sanitation, and psychosocial and mental health.

158. Pursuant to the above Regional Committee resolution and in conformity with the policies and guidelines of the fund, a working group—comprising representatives nominated by all 11 Member States of the Region—was established to oversee the management of the fund. The first meeting of the working group was held in July 2008, at which the following key points were discussed: (i) refinement of the policies, guidelines and procedures of the fund; (ii) monitoring and reporting methods; and, (iii) replenishment strategies.

159. The Committee was informed that in efforts to sustain the fund and improve mechanisms for replenishment of its resources, the Regional Committee—vide resolution SEA/RC61/R2—had last year requested the Regional Director to take steps to roll over assessed contributions of the fund. This was not possible, however, due to financial regulation constraints. The Committee agreed to alternative mechanisms and agreed to provide an allocation from assessed contributions (AC) for 2010-2011 of 1% of the budgets of Member States amounting to approximately US$ 1 million, as had been done for the 2008-2009 biennium.

160. The Committee appreciated the vision behind the fund, especially in the context of South-East Asia Region, which is particularly vulnerable to natural disasters and calamities such as cyclones, tornadoes, tsunamis, floods and earthquakes. It reiterated that the fund can be a
source of valuable and timely support to countries in emergencies. The Committee underscored the need to strengthen communications and advocacy to help further advance replenishment through donations.

161. The Committee expressed its gratitude to the Government of the Democratic Republic of Timor-Leste for pledging a contribution of US$ 10,000 to SEARHEF.

162. The Committee adopted resolution SEA/RC62/R5 on this agenda item.

**Update on the progress and challenges in polio eradication** *(Agenda item 14.2, document SEA/RC62/15)*

163. The Committee deliberated on the update provided by the Secretariat on the progress and challenges in polio eradication in the South-East Asia Region. The Committee was informed that polio eradication continued to be a high priority in the Region and 10 of the 11 Member States are polio-free.

164. In India, the Member State that is still polio-endemic, polio transmission is now restricted to a few districts in the western part of the state of Uttar Pradesh and in the Kosi River basin in northern Bihar. The Committee was informed that there is unprecedented political will to eradicate polio in the country; India’s polio eradication programme is the largest health programme in the country with a financial outlay of US$ 267 million for the current financial year (April 2009-March 2010). As many as 172 million children were covered in the nationwide immunization drive in January and February 2009. The programme is guided by the recommendations of the India Expert Advisory Group—the Government of India’s technical advisory body on polio—which meets twice a year. The Group last met on 24-25 June 2009 to review the status of polio eradication and to recommend adjustments to the immunization strategies.

165. A comprehensive programme of supplementary immunization campaigns, including national immunization days, has been planned for the year 2009-2010 for endemic areas with special strategies being implemented to track missed children—through community-based health workers (CBHW) and community health volunteers (CHV)—to cover all major transit sites and border points and to map and immunize migratory populations. The programme in India is supported by a highly sensitive surveillance system that utilizes 30,000 reporting sites.

166. In order to make more effective tools available to the programme, the national regulatory authority in India has ensured an increase in potency of the monovalent Type 1 oral polio vaccine and of the Type 1 component of the trivalent oral polio vaccine. A clinical trial of bivalent oral polio vaccine containing Types 1 and 3 will soon be undertaken in India to make this vaccine available for at least one supplementary immunization campaign in the high-risk areas of Uttar Pradesh and Bihar by the end of 2009. A high-titre monovalent Type 1 vaccine is
also available and in use. With the current unprecedented levels of government commitment and support, the availability of more effective tools, and the implementation of the strategies as recommended by the India Expert Advisory Group, India is on track to eradicate polio sooner than later, the Committee was informed.

167. The Committee was also informed that neighbouring countries continue to be at risk because of the shared open borders with India. Polio importation and re-infection of a country entails significant costs to that country. Member States who have been re-infected have effectively dealt with the crisis utilizing their own and external resources, as well as technical and other assistance from WHO. The risk of re-infection can be minimized by ensuring high and uniform routine immunization coverage, including synchronized immunization along border areas, and through highly sensitive surveillance, and by conducting supplementary immunization campaigns in high-risk areas or on a nationwide scale as determined by periodic risk assessments. Some Member States are scheduled to conduct national immunization days in the early half of 2010 with technical and logistical support from WHO in high-risk areas to catch all missed children.

168. The Committee was also assured of the continued support of WHO to Member States in the elimination of polio from the Region, strengthening of the Regional Polio Laboratory Network and the use of the new and highly efficacious vaccine in India, along with continued technical support for the national immunization days in Member States.

169. The Committee endorsed the recommendations of the HLP meeting on this agenda item.

**Strengthening the health workforce in South-East Asia** *(Agenda item14.3, document SEA/RC62/16)*

170. The Committee was informed that at the Twenty-fourth Meeting of Ministers of Health of the South-East Asia Region held in Dhaka, Bangladesh, in 2006, the Ministers of Member States had expressed concern over what they felt was an unacceptable shortage in the health workforce (HWF) in countries. The existing health workforce was also constrained by an unbalanced skill-mix, improper distribution and paucity of appropriate competency levels. The Ministers also recognized the significant lack of human resource (HR) management capacity in the Member States of the Region. Along with an acute shortage of trained health manpower there are also related issues of inadequate training and investment, poor planning, an unfavourable demand-supply ratio of trained workforce, and the effects of “brain drain”.

171. The Committee’s attention was drawn to the need to strengthen the HR planning and management capacity of Member States, while at the same time enhancing the training, education and research capacity, to revitalize the community-based health workforce.
172. The Committee also committed itself to further action on international migration of health personnel in line with the World Health Assembly resolution WHA57.19 (2004). The Committee noted that the Regional Office was working with all WHO country offices, as well as with Ministries of Health, to strengthen HWF in line with these commitments.

173. The Committee recommended that a multicountry comparative study on the best practices in the management of community-based health workers (CBHWs) be conducted, in order to motivate CBHWs. The Committee also reiterated its commitment to support the public health care delivery system.

174. The Committee stressed the importance of strengthening the health workforce through the PHC approach. The Committee emphasized the importance of revitalizing the training of community-based health workforce.

175. The Committee also noted the importance of standardizing the curriculum of health workers and the role of WHO in standardizing the Preventive and Social Medicine (PSM) curriculum in medical schools. The Committee was also reassured that special attention was continually being paid to human resource development.

176. The Committee endorsed the recommendations of the HLP meeting on this agenda item.

Public health, innovation and intellectual property (Agenda item 14.4, document SEA/RC62/17)

177. The Committee noted that after intensive negotiations over a two-year period, in which Member States of the Region actively participated, the World Health Assembly in May 2008 adopted resolution WHA61.21 on public health, innovation and intellectual property, together with a global strategy and plan of action (GSPOA). Several outstanding issues in the plan of action were finalized during the Sixty-second World Health Assembly in May 2009.

178. The GSPOA aims to promote new thinking on innovation and access to medicines, and to enhance needs-based research and development relevant to diseases that mainly affect developing countries. The scope of the GSPOA, however, is vast; thus, there may be a need for prioritization at national and regional levels.

179. The Committee noted with appreciation the spirit of compromise and accommodation displayed by all Member States throughout the long negotiation process, during which Member States of the South-East Asia Region spoke with a single voice.

180. It was noted that GSPOA gives an overall framework to guide Member States in developing a national approach to intellectual property and innovation. The main challenge now is to fine-tune and focus the proposed activities contained in the GSPOA, and to prioritize and implement those that are most relevant in the national and regional context. There may be a need to develop concrete milestones.
181. The Committee expressed the desire to further develop research in the area of traditional medicine. Referring to the exploitation of traditional medicines through new technologies such as biotechnology, the Committee underscored the need to protect intellectual property rights on traditional medicines, as well as to enhance capacity in the area of biotechnology.

182. The need for increased human resources for research and development, ongoing capacity-building, developing and implementing regulations for pharmaceutical products and establishing ethical review boards were cited.

183. The Committee was assured of WHO’s continued technical support to strengthen national capacity with regard to public health, innovation and intellectual property.

**Combating counterfeit medical products (Agenda item 14.5, document SEA/RC62/18)**

184. The Committee noted that WHO activities in combating counterfeit medical products began in 1985, but became a priority issue at the Sixty-first World Health Assembly in 2008. The topic was discussed at a meeting in the Regional Office in August 2008 and subsequently at the Sixty-first session of the Regional Committee in September 2008. The issue was further discussed at meetings in November 2008 and December 2008 of the International Medical Products Anti-Counterfeiting Taskforce (IMPACT). At the 124th session of the Executive Board, due to extraneous matters as well as dissatisfaction with the definition, information papers were requested for the Sixty-second World Health Assembly in May 2009. However, due to the shortened session, it was deferred to the Sixty-third World Health Assembly.

185. The Committee noted that medicines play a crucial part in health-care systems; the discussions at the HLP meeting emphasized that strengthening national regulatory authorities is the means of achieving quality, safety and efficacy of medicines. A teleconference had subsequently been held to update Member States on the issues. WHO would continue to provide countries with technical advice on various issues related to quality, safety and efficacy of medicines; rational use of medicines; and public health, innovation and intellectual property.

186. The Committee noted that there were a number of important questions of continuing interest to Member States, including the composition of IMPACT, ensuring access to affordable generic medicines, and clarifying and standardizing terms and definitions.

187. The Committee emphasized that a firm distinction should be maintained between substandard and counterfeit medical products. Relevant international agreements should be taken into account, and there could be a need for international agreement on issues affecting the import and export of medicines. It was pointed out that there may be a need for further discussion of technical issues related to the definition.
188. It was also stressed that there is a need to ensure access to generic medicines that are safe, efficacious and of good quality. The public health risk of substandard medicines was recognized; Member States were ready to take action against medicines that do not meet the standards of quality, safety and efficacy.

189. The Committee endorsed the recommendations of the HLP meeting and adopted resolution SEA/RC62/R6 on this agenda item.

Strategies to reduce harmful use of alcohol (Agenda item 14.6, document SEA/RC62/19)

190. The Committee was informed that there was substantial evidence that alcohol use was a major determinant of ill-health and of economic and social disempowerment. Unfortunately, the totality of the harm from alcohol use is not widely recognized. Alcohol use and its related harm depend on the sociocultural milieu in which it is used. Thus, the basis for the prevention of alcohol-related harm in the context of the South-East Asia Region should not only be disease prevention but reduction of poverty, disempowerment, violence, prevention of injuries and improvement of well-being and social capital. Initiatives to reduce harm from alcohol use in the Region have to take into account the role and interests of diverse sectors involved in addressing issues related to alcohol. Two parallel programmes are needed: a strong policy for prevention of harm from alcohol use, and community action to reduce harm from alcohol use.

191. The Committee noted with concern the increasing incidence of harm from alcohol use including “binge drinking” and drunken driving resulting in accidents and loss of lives. It was felt that community involvement combined with country-specific policies would prove highly effective in controlling harm from alcohol use. A global strategy would go a long way in complementing national actions in this regard.

192. The Committee urged WHO to provide support to increase country capacity to effectively mitigate the harmful use of alcohol. It was also suggested that effective control measures such as increasing taxation to restrict the use of alcohol and enforcing legal mechanisms would help in mitigating the harmful effects of alcohol. It would be in the interest of Member States to collaborate with each other and share relevant information on surveys/studies conducted on this subject, which would help them develop suitable national strategies to counter this grave problem.

193. The Committee endorsed the recommendations made by the HLP meeting on this agenda item.
Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits (Agenda item 14.7, document SEA/RC62/20)

194. The Committee noted that viruses had been shared freely between national influenza centres and WHO collaborating centres for many years. In 2007, Indonesia proposed that sharing of H5N1 influenza viruses should be tied to benefits of affordable and available vaccines. This led to a halt in the practice of freely sharing viruses.

195. A number of unsuccessful attempts have since been made to resolve this impasse, starting with a meeting organized by WHO headquarters in Jakarta (March 2007), followed by a series of technical and intergovernmental working group meetings, the last of which took place in Geneva in May 2009. Consensus was reached on most issues, but a number of issues remained unresolved, such as data-sharing and intellectual property rights.

196. The Committee noted that in the present world of interdependence and interconnectivity, sharing of virus and other biological instruments in a transparent, free and fair manner would assist Member States in taking early steps for pandemic preparedness as no country in the world was immune to pandemic influenza. It urged WHO to continue to provide assistance to facilitate virus-sharing among Member States in order to facilitate vaccine production in the Region.

197. The need to derive fair, equitable and concrete benefits from virus sharing was stressed, especially in Member States affected by H5N1 and other viruses of pandemic potential.

198. The Committee was informed that, building on the broad regional consensus, issues that are still unresolved would be discussed at the inter-governmental meeting scheduled to be held next year.

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

Special Programmes:


200. The Committee noted that the report of the Thirty-second meeting of the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases: Joint Coordinating Board (JCB) held in Geneva, Switzerland, from 15 to 17 June 2009 was presented to the HLP meeting held in the Regional Office, New Delhi from 29 June to 2 July 2009.
201. The Committee nominated Indonesia as member of the JCB for a period of four years effective 1 January 2010 and requested the Regional Director to inform WHO headquarters accordingly.


202. The Committee noted that the report of the Twenty-second Meeting of PCC held in Geneva, Switzerland, on 18-19 June 2009, was presented to the HLP meeting held in the Regional Office, New Delhi from 29 June to 2 July 2009.

203. The Committee nominated Thailand as member of the PCC for a three-year term starting 1 January 2010 and requested the Regional Director to inform WHO headquarters accordingly.

Time and place of future sessions of the Regional Committee (Agenda item 16, document SEA/RC62/23)

204. The Committee formally accepted the invitation from the Royal Thai Government to host its Sixty-third Session in 2010.

205. The Committee also noted with appreciation the invitation of the Government of India to host its Sixty-fourth Session in 2011.

Closure of the session (Agenda item 18)

206. Representatives of Member States congratulated the Chairman and Vice-Chairman for the smooth and successful conduct of the meeting. They thanked the Government of the Federal Democratic Republic of Nepal and its Ministry of Health and Population for their warm hospitality and excellent arrangements made for the session.

207. The representatives expressed their great appreciation for the participation of the Right Honourable Mr Madhav Kumar Nepal, Prime Minister of Nepal at the joint inaugural session and for his thought-provoking speech. They expressed their gratitude for the encouraging presence, dynamic leadership and active participation of Dr Margaret Chan, Director-General, WHO, and for her valuable guidance on important technical issues. They also conveyed their deep appreciation to the Regional Director, Dr Samlee Plianbangchang, for his able leadership and congratulated him on his reappointment as Regional Director for the South-East Asia Region for a second term.
208. The Chairman thanked the representatives for their active participation and wholehearted support for the smooth functioning of the session. He also expressed his appreciation for the inspiring speech made by Dr Margaret Chan, WHO Director-General. The Committee reviewed several important issues and made valuable suggestions, which the Chairman hoped would be implemented. He also thanked the UN agencies and NGOs for their active participation and valuable contributions on important agenda items that were discussed by the Committee.

209. The Vice-Chairperson thanked H.E. Dr Uma Kant Chaudhary, Minister for Health and Population, Government of the Federal Democratic Republic of Nepal and all staff of the Ministry of Health and Population, for their warm hospitality, and for making the representatives’ visit to Kathmandu a memorable one. She thanked the dignitaries for giving her the opportunity to chair the meeting during different sessions. She congratulated the Director-General, the Regional Director and WHO staff for their active participation, and for the excellent arrangements made for the conduct of the meeting.

210. The Regional Director, Dr Samlee Plianbangchang, thanked the Honourable Ministers and their distinguished representatives for their active participation and for the cordial and fruitful conclusion of the Sixty-second Session of the Regional Committee. He thanked the Honourable Chairman, Dr Uma Kant Chaudhry, ably assisted by the Vice-Chairperson, H.E. Dr Aminath Jameel, for the smooth conduct of the session and for covering the heavy agenda within the short time that was available. The Regional Director, while thanking all the distinguished representatives for their cooperation and understanding, expressed his appreciation for the spirit of solidarity and cohesiveness displayed by Member States. He expressed his deep appreciation to H.E. Dr Nelson Martins, Minister of Health, Government of the Democratic Republic of Timor-Leste for pledging financial contribution for the South-East Asia Regional Emergency Fund, on behalf of his government. Speaking about the important issues discussed and the resolutions adopted by the Committee, Dr Samlee assured the Member States that WHO would provide full technical support to implement those resolutions.

211. The Regional Director also thanked the Director-General for addressing both the Health Ministers’ meeting as well as the Regional Committee session, and expressed his deep appreciation for her valuable guidance and comments on matters of priority interest. He expressed his sincere thanks and appreciation for the presence of the Right Honourable Mr Madhav Kumar Nepal, Prime Minister of Nepal, at the joint inauguration. The Regional Director also thanked all staff of the Ministry of Health and Population, Nepal, members of the Organizing Committee, WHO staff in the Country Office, and from headquarters and the Regional Office, for their efforts towards the successful conduct of the session.

212. The representatives expressed great satisfaction at the successful and smooth conduct of deliberations on subjects of vital importance to the health of the peoples of the SEA Region.
They desired that resolutions adopted and/or recommendations made during the session be actively pursued and implemented.

213. The Chairman declared the session closed.