REGIONAL COMMITTEE SEA/RC58/20

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DRAFT REPORT OF THE FIFTY-EIGHTH SESSION OF THE WHO REGIONAL COMMITTEE FOR SOUTH-EAST ASIA

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Part I

INTRODUCTION

THE FIFTY-EIGHTH session of the WHO Regional Committee for South-East Asia was held in Colombo, Sri Lanka, from 6 to 10 September 2005. It was attended by representatives of all the eleven Member States of the Region, UN and other agencies, nongovernmental organizations having official relations with WHO, as well as observers.

A joint inauguration of the fifty-eighth session of the Regional Committee and the Twenty-third Meeting of Ministers of Health was held on 4 September 2005. H.E. Mr Mahinda Rajapakse, Prime Minister of the Democratic Socialist Republic of Sri Lanka, delivered the inaugural address.

The Committee elected Mr Nimal Siripala de Silva, Minister of Healthcare Nutrition and Uva Wellassa Development, Government of the Democratic Socialist Republic of Sri Lanka as Chairman and Professor (Dr) Md Shahadat Hossain, Additional Director-General, Directorate General of Health Services, Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh as Vice-Chairman of the session.

The Committee reviewed the report of the Regional Director covering the period 1 July 2004 to 30 June 2005. It reviewed the detailed workplans for Programme Budget 2006-2007 and considered the recommendations arising out of the Technical Discussions on Skilled Care at Every Birth, held during the 42nd meeting of the Consultative Committee for Programme Development and Management in July 2005.

The Director-General of WHO, Dr LEE Jong-wook, addressed the session.

The Committee decided to hold its fifty-ninth session in Bangladesh in September 2006.

A drafting group on resolutions comprising a representative from each Member State was constituted with Mr B.P. Sharma, Joint Secretary (International Health), Ministry of Health and Family Welfare, Government of India as Convener. During the session, the Committee adopted six resolutions.

Part II

INAUGURAL SESSION

A JOINT INAUGURATION of the Twenty-third Meeting of Ministers of Health and the fifty-eighth session of the WHO Regional Committee for South-East Asia was held in Colombo, Sri Lanka, on 4 September 2005.

Welcome Address by the Minister of Healthcare, Nutrition and Uva Wellassa Development, Sri Lanka

H.E. MR NIMAL SIRIPALA DE SILVA, Minister of Healthcare, Nutrition and Uva Wellassa Development, Democratic Socialist Republic of Sri Lanka, extended a warm welcome to his fellow Ministers, the Regional Director and representatives to the 23rd Meeting of Ministers of Health and the fifty-eighth session of the WHO Regional Committee. He said that it was an honour that the Prime Minister, who was also the Chairperson of the National Health Council, the prime multi-sectoral body for health policies, had graced this occasion. His presence reflected the importance that he accorded to the health and well-being of the people. He thanked the Prime Minister for inaugurating the meeting.

The Health Minister said that though the SEA Region comprised only 11 countries, it was home to one-fourth of the world's population bearing 40% of the global disease burden of communicable diseases and growing noncommunicable diseases. The health systems were overburdened in all the countries. He welcomed WHO's role in strengthening the capabilities of Member States to meet global epidemics and disasters and expressed confidence in the leadership of the WHO Regional Director to provide the necessary thrust to achieve better health in the Region.

Sri Lanka had been able to make notable strides in health over the past few decades and had already reached several of the Millennium Development Goals. These achievements were the result of the long tradition of investment in the social sector, particularly health and education. Three years ago Sri Lanka had established a National Commission on Macroeconomics and Health to recommend policy directions. Last year he could convince the Cabinet that an increase in the health budget was not consumption, but a worthwhile investment that was critical for sustained socioeconomic development. Sri Lanka had also formulated a National Medicinal Drugs Policy and taken action to expand and strengthen nursing and other paramedical education programmes.

He hoped that the two meetings would be successful.

Inaugural Address by the Prime Minister of Sri Lanka

H.E. MR MAHINDA RAJAPAKSE, Prime Minister of the Democratic Socialist Republic of Sri Lanka, welcomed the participants on behalf of the President and people of Sri Lanka. He said that it was an honour for Sri Lanka to host the two important meetings. He was confident that these meetings would prove a major catalyst for further advances in health and medicine in the Region.

He thanked WHO and the UN Agencies for their support to Sri Lanka in the wake of the tsunami last year. He recalled that the WHO Director-General and the Regional Director had visited Sri Lanka immediately after the event and provided due support. He drew comfort

from the expression of solidarity amongst the countries of the Region, which significantly contributed to the response to the tragedy. He was pleased to note that the implementation of an early warning system for the Region would be extremely advantageous in preparing and responding to natural and man-made disasters, and in containing emerging communicable diseases.

The Prime Minister observed that Sri Lanka remained a high performer in respect of health indicators. Mortality continued to decline and life expectancy was projected to reach the current US levels by 2015–2020. Sri Lanka had been able to provide health care of technically acceptable quality and maintain reasonable equity despite the low expenditure on health. The wide coverage by the health services, good education, particularly of mothers, and social sector policies had contributed to impressive health outcomes in the country. Constructive partnership between the public and private sectors in health care had also contributed in this behalf. He hoped that the meetings of Ministers of Health and the Regional Committee would provide a platform for strong and enduring cooperation amongst the Member States (for full text of the address, see Annex 1).

Address by the Regional Director, WHO South-East Asia Region

DR SAMLEE PLIANBANGCHANG, Regional Director, WHO South-East Asia Region, stated that it was a matter of immense pride that the two highest level meetings of the Region were being inaugurated by the Prime Minister of Sri Lanka. He extended a warm welcome to the Health Ministers and representatives and thanked the Government of Sri Lanka for hosting the meetings.

The Regional Director recalled that since joining WHO in 1948, Sri Lanka had made remarkable progress in national health development. This was possible due to the sound and equitable health system prevalent in the country.

Dr Samlee observed that during the past decade, lifestyle-related conditions and diseases had increased, while infectious diseases continued to be responsible for a very large proportion of morbidity and mortality in the Region. Simultaneously, health risks relating to unhealthy lifestyles and environmental degradation had to be dealt with. The issue that needed to be urgently addressed was how to meet these challenges in the face of constraints in terms of resources and in other areas.

A comprehensive expression of governments around the world for achieving the most reasonable well-being of their people was clearly reflected in the Millennium Development Goals (MDGs). The MDGs identified a set of inter-related targets for addressing extreme poverty and its many related dimensions, with health being placed at the centre. There were effective technical interventions to attain these goals. However, innovative strategies and more effective approaches were needed for implementation of these interventions.

He was confident that the deliberations at the meeting of Health Ministers and the Regional Committee would be very productive. WHO was ready to provide the necessary support to governments for health development (for full text of the address, see Annex 2).

Part III

BUSINESS SESSION

OPENING OF THE SESSION

IN THE ABSENCE of the Chairman and Vice-Chairman of the fifty-seventh session, the fifty-eighth session of the WHO Regional Committee for South-East Asia was opened, in accordance with Rule 12 of the Rules of Procedure, by the Regional Director, Dr Samlee Plianbangchang, on 6 September 2005.

The Regional Director welcomed the participants and said that he was pleased that some of the Health Ministers had stayed on to participate in the deliberations of the Regional Committee. He looked forward to their valuable contributions and guidance. Since the last session, the Region had made significant progress in health development. Referring to the emergence of avian influenza and the devastating earthquakes and tsunami in December 2004 that severely affected some Member States, he deeply appreciated the spontaneous and unstinted support extended by various UN and other international agencies, Member States, NGOs and the local communities whose efforts helped to prevent any outbreak of communicable diseases. WHO was proud to be a part of the emergency exercise along with other partners. He reiterated WHO's continued support to Member States in their health development efforts.

SUB-COMMITTEE ON CREDENTIALS *(Agenda item 2)*

A SUB-COMMITTEE on Credentials, consisting of representatives from the Democratic People's Republic of Korea, Maldives and Thailand was appointed. The Sub-committee met under the chairmanship of Dr Sopida Chavanichkul, representative from Thailand, and examined the credentials submitted by Bangladesh, Bhutan, DPR Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste. The credentials submitted by the representatives of all the Member States were found to be in order, thus entitling them to take part in the work of the Regional Committee.

ELECTION OF CHAIRMAN AND VICE-CHAIRMAN *(Agenda item 3)*

MR NIMAL SIRIPALA DE SILVA (Sri Lanka) was elected Chairman. On assuming the chair, Mr de Silva thanked the representatives for electing him Chairman, which he considered an honour for himself and his country. He was confident that with the cooperation and support of all concerned, the Committee would successfully cover the heavy agenda in a meaningful manner. He hoped that the deliberations would lead to sound directions for strengthening health development in the Region.

Professor (Dr) Md Shahadat Hossain (Bangaldesh) was elected Vice-Chairman.

ADOPTION OF AGENDA AND SUPPLEMENTARY AGENDA, IF ANY

(Agenda item 4, document SEA/RC58/1 (Rev.2))

THE COMMITTEE was informed that the Royal Thai Government had proposed avian flu for inclusion as an agenda item. However, this subject would be taken up for discussion under Agenda item 12 "Asia-Pacific strategy on emerging diseases". The Committee then adopted the Agenda as contained in document SEA/RC58/1 (Rev.2) (Annex3).

LIST OF PARTICIPANTS

The list of participants is at Annex 4.

DRAFTING GROUP ON RESOLUTIONS

THE COMMITTEE constituted a drafting group on resolutions comprising one representative from each Member State.

LIST OF DOCUMENTS

The list of documents is at Annex 5.

THE WORK OF WHO IN THE SOUTH-EAST ASIA REGION: REPORT OF THE REGIONAL DIRECTOR: 1 JULY 2004 – 30 JUNE 2005

(Agenda item 5, document SEA/RC58/2 and SEA/RC58/Inf.1(Rev.1) and Inf.2)

INTRODUCING HIS report for the period 1 July 2004 – 30 June 2005, the Regional Director stated that health development needed stronger multisectoral and multi-disciplinary actions. Globalization and trade liberalization played a vital role in the field of health. He highlighted the significant developments in the different areas of WHO's collaborative programmes, the constraints as well as the steps taken to overcome them. In order to tackle challenges more effectively, WHO's global policy on decentralization and delegation of authority had been intensified and an increasing number of activities had moved from the Regional Office to the countries. During the reporting period, the Region further strengthened its collaborative efforts with other partners resulting in increased external resources for supporting health development in the Region. In future increased attention would be paid to identifying country-specific needs for WHO response (for full text of the Regional Director's introductory remarks, see Annex 6).

Following the introduction of the Regional Director's Annual Report, the Committee discussed it chapter by chapter.

With regard to Communicable Diseases, the Committee noted the all-round achievements made in TB control in the Region. The DOTS programme was a classic example of partnerships with the public sector, NGOs, the community and the corporate sector, as was the case with leprosy elimination and polio eradication for which final intensified efforts were being made. The Committee stressed the need for WHO's increased technical assistance for elimination of malaria.

The Committee noted that WHO was working concertedly with Member States to achieve the respective targets for leprosy elimination and polio eradication. Efforts were also being intensified for elimination of kala-azar and filariasis. TB/HIV co-infection was being addressed as a priority area both by HIV as well as TB programmes.

Regarding noncommunicable diseases, the Committee noted that rapid demographic changes had led to lifestyle-related diseases such as obesity, cardiovascular diseases and diabetes. Some countries had initiated integrated disease surveillance programmes for monitoring the risk factors. A telemedicine network was also being developed in India to provide out-reach services for early detection of cancer.

WHO was playing a pivotal role in tackling arsenicosis in some countries of the Region. Technical assistance was being provided to train health professionals on how to detect arsenic in water.

The Committee recognized the urgent need to make policy-makers and politicians aware of the adverse effects of iodine deficiency disorders especially related to mental

health of children. In this connection, it was informed that an advisory group had been established to refine the regional action plan and the regional strategy towards meeting the IDD challenges.

The Committee stressed the imperative need for an effective nutrition programme in view of the strong link between health promotion and nutrition. In regard to diabetes, attempts were being made to review the modalities with the focus on adopting a healthy lifestyle and diet.

The Committee emphasized the urgent need for WHO to work closely with governments for monitoring the risk factors related to health. In this connection, it was noted that WHO had recently launched a Commission on Socio-economic Determinants of Health. This was in recognition of the fact that in order to effectively tackle noncommunicable diseases, it was necessary to identify health determinants.

On the issue of Family and Community Health, the Committee was informed of some recent initiatives taken by Member States to reduce maternal mortality by providing incentives such as maternal transport allowance, free delivery services and helicopter ambulance, etc. There was also a felt need to upgrade neonatal care through refresher courses for paramedical staff. Efforts were being intensified towards increasing immunization coverage in all Member States. The Committee noted with appreciation that increased provision would be made in WHO's budget for child and maternal health in order to enhance technical assistance to Member States. The Committee reiterated the need to have skilled care at birth and family welfare advisers.

The Committee appreciated the support provided by WHO to Member States in the development of adolescent health policy. There was a need to introduce a programme on adolescent health at the secondary school level.

With regard to Sustainable Development and Healthy Environment, the Committee was informed that health being multi-faceted and multi-dimensional, there was a need to pay attention to rural health, sustainable sanitation, safe drinking water and food safety. Based on the report of the Commission on Macroeconomics and Health, increased allocation to the health sector had been made by some countries. A number of initiatives were being taken such as management of waste, food hygiene laws being updated and new regulations being framed on bottled water. Food safety programmes needed to be strengthened in many countries. National workshops had been organized to train health professionals, with the focus on creating awareness and capacity building.

The Committee noted that for achieving a healthy environment and to improve sanitation, there was a need to ensure adequate water supply and sanitation facilities and to strengthen institutional capacity in these areas. WHO had supported countries by building capacity and creating awareness. The Region was striving to achieve Goal 10 of Target 7 of MDGs by focusing efforts on the concerns of some countries in this area. The third revision of the WHO Guidelines on Drinking Water had been made available to Member States. Regarding the provision of adequate sanitation, the Committee noted that the Region was depending on the South Asia Conference on Sanitation (SACOSAN) process.

In the area of Health Systems Development, the Committee stressed the need to reduce poverty. The importance of linking it to sustainable development was also stressed.

The Committee noted the limited availability of health care facilities in remote areas; the importance of deployment of human resources for health care services; the need to reduce the price of laboratory tests and essential medicines, and the need to inform the poor about their right to receive health services. It was imperative to provide enough monetary incentives, especially for people living in remote areas, and to implement new laws on decentralization. WHO was urged to continue to provide strong support for health systems development in countries. It was important to have reliable information systems to monitor progress of MDGs, and to ensure the provision of quality drugs keeping in view WTO

regulations. The need for human resource development and training of personnel for capacity building was also emphasized.

The Committee emphasized the need to have a separate chapter in future reports of the Regional Director devoted to poverty alleviation and MDGs as they were crucial subjects cutting across many areas.

The Committee urged WHO to look into the aspect of incomplete, incorrect or incompatible basic health data, especially MDG indicators, as it would affect fair allocation of resources to countries. Better data were needed to formulate strategies to improve health.

The Committee was informed that WHO was continuing to promote traditional medicine in primary health care. The aspect of socio-cultural heritage of traditional medicines was also highlighted. In this context, it was stressed that countries should share information on traditional medicines with a view to promoting intercountry collaboration. The Committee emphasized the importance of traditional medicines as well as incorporation of these programmes in national health plans.

The Committee noted the importance of health financing, as highlighted by the Commission on Macroeconomics and Health. Many aspects of human resources for health required additional efforts and should, therefore, be the focus of WHO work in future. The Committee recognized that knowledge management was a subject of increasing importance. A new global knowledge management strategy was, therefore, being developed by WHO.

The Committee recognized the importance of providing detailed advance briefing to members representing the South-East Asia Region at meetings of the Executive Board and other governing bodies. This would prepare them better to present issues effectively in a regional rather than a country-specific perspective. The Committee urged the development of a mechanism whereby all issues to be taken up at EB sessions could be discussed. Participation of representatives from all Member States should be ensured through this mechanism.

The Committee noted that while delegates of Member States attending the meetings of governing bodies had constitutional roles, most of them representing developing countries invariably sought more assistance. There was, therefore, a need to appropriately brief the members on their roles and responsibilities.

The Committee was informed that while the Executive Board, the World Health Assembly and the Regional Committee were governing bodies of WHO, meetings of Health Ministers and Health Secretaries helped to draw up policies and rules for collaborative purposes in the Region.

The Committee appreciated the role of the Regional Office and the Regional Director in providing briefing to Member States prior to and during the World Health Assembly and desired that this practice be continued.

The representative from the International Diabetes Federation (DF) said in his statement that Type 2 diabetes mellitus was spreading in epidemic proportions, with 330 million people estimated to suffer from it by the year 2025. Genetics, foetal origins, lifestyle and stress were identified as etiological factors. A primary prevention strategy had been formulated to minimize the burden of disease in the Region and reduce end-stage complications and mortality.

The representative from the International Council for Control of Iodine Deficiency Disorders (ICCIDD) said that his organization had pledged its technical expertise for tracking progress towards sustainable elimination of iodine deficiency disorders (IDD). The ICCIDD had the mandate to promote collaboration with stakeholders and national governments to end iodine deficiency which was the most common preventable cause of mental handicap

affecting the learning abilities of children. Ensuring mental health for all was not achievable without elimination of iodine deficiency-induced psychomotor retardation, he added.

The Committee **noted** with satisfaction the progress made during the period under review and congratulated the Regional Director and his staff for bringing out a clear and concise report.

ADDRESS BY THE DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION *(Agenda item 6)*

DR LEE JONG-WOOK, Director-General, recalling his visit soon after the tsunami, commended the Government of Sri Lanka for achieving significant progress in reconstruction and rehabilitation in a short time. The key lesson from the tsunami for the Region was the importance of strengthening health systems to detect and deal with disease at a very early stage. The lessons learnt had to be taken seriously.

The threat of avian influenza was looming large in parts of Indonesia, Thailand, Viet Nam, Cambodia, China and Laos. Over 140 million birds had been culled by farmers which had effectively helped to control the situation. However, those who lost their livelihood had little or no financial compensation. Further culls might well affect a multitude of farmers who cannot afford to lose their flocks. So far, the virus had not crossed from birds to humans, but the geographical range of the virus increased the opportunity for human cases to occur. WHO had recently developed guidelines to help countries to prepare effectively. What was now required was to reduce chances of human infection and strengthen the early warning system.

Rapid deployment of resources contained outbreaks at an early stage. Therefore, the availability of health care workers, vaccines, quarantine measures, and vaccine production needed to be scaled up. This also implied rapid technology transfer to expand vaccine manufacturing sites. International cooperation had to be mobilized to contribute towards global antiviral stockpiles and pandemic vaccine development to limit the scale of avian influenza outbreak and reduce the risk for humans.

The Director-General referred to some success stories from the Region which included the development by India of a monovalent oral polio vaccine type 1 and using it with great success, vaccination of 24 million children across Indonesia in two days, and prevention of re-infection by polio virus among the population in Bangladesh and Nepal. Sharp vigilance and an efficient warning system had enabled quick response. In some parts of the Region, the surveillance networks already included other vaccine-preventable diseases such as measles and neonatal tetanus.

WHO's common vision for the next decade recognized the influence of non-medical factors such as poverty and education. Social determinants such as environmental, economic and political issues as well as intellectual property rights and trade agreements played an important part in health outcomes. Other important equity issues would have to be dealt with boldly in view of the scarcity of resources. Universal access to treatment for people living with HIV was not only absolutely necessary but entirely feasible. Nearly one million people were on antiretroviral treatment by June 2005 in low and middle-income countries. Overall, prices of antiretroviral drugs were falling. WHO had pre-qualified 63 antiretroviral drugs including 29 generic formulations. The agreement between WHO and the US Food and Drug Administration would further support the pre-qualification programme in speeding up the availability of lower-priced generic antiretroviral medication. Facilities for testing and counselling needed to be further expanded. Universal access was also a key to tuberculosis control. The SEA Region still had the highest disease burden of tuberculosis and, while good progress had been made, much more needed to be done to reach the MDG

targets for 2005. In the area of maternal and child health too, financial barriers to access needed to be reduced and an effective workforce built.

Adoption of the International Health Regulations 2005 by the Fifty-eighth World Health Assembly was a historic step towards building improved health security and improving global coordination. Necessary steps needed to be taken to build mechanisms for disease detection, alert response and information sharing, both within and between countries.

Noncommunicable diseases also posed a grave threat to the health of the people. Cancer and cardiovascular diseases were now the leading cause of deaths worwide. The global report on preventing chronic disease, to be released in October 2005, stressed the importance of taking steps to curb the rise of cancer, cardiovascular diseases, chronic respiratory diseases and diabetes. He thanked the nine Member States of the Region for ratifying the Framework Convention on Tobacco Control. In conclusion, Dr LEE said that there was a great potential for progress and the decisions taken by the Regional Committee during its current session would accelerate positive trends and bring equitable, life-saving interventions to many people in the Region (for full text of the Director General's address see Annex 7).

The Committee commended the achievements made by WHO under the leadership of Dr LEE. Particular mention was made of the increase in the Regular budget which had seen zero growth for the past many years. Serious concern was expressed, however, regarding the low proportion of extrabudgetary funds allocated to the SEA Region.

The Committee noted that Member States were gearing up to implement the International Health Regulations 2005. WHO's technical support was sought for implementation of those regulations. The mechanism and strategy contained in the guidelines issued by WHO to respond to the threat of pandemic influenza would be implemented. However, the lack of stockpiling of antivirals in this Region was a cause for serious concern. The Committee sought WHO support in this regard.

Member States reaffirmed their commitment to fully eradicate polio from the Region. In this context it was suggested that vaccination against polio virus be made obligatory for all international travellers to places of pilgrimage. The need for monovalent vaccines and strengthening regional capacity in vaccine production was stressed.

Progress had been achieved in regard to the "3 by 5" initiative. However, this raised the issue of second-line treatment at an affordable cost for which WHO support was sought. Following the tsunami, countries had moved to reconstruction, but there were some aspects that still needed to be addressed such as management of financial resources, improving the coordinating mechanism etc.

The Committee noted the peculiar health concerns faced by certain countries in high altitude areas and sought WHO's technical guidance in resolving them.

The Director-General, responding to some of the observations made by representatives, stressed the need to eradicate polio. and urged the countries not to get discouraged by recent importations. As regards the increase in WHO's Regular budget allocation, he said that this had been achieved because of the joint efforts of WHO and Member States.

REVIEW OF WHO COLLABORATIVE PROGRAMMES IMPLEMENTED DURING THE 2004-2005 BIENNIUM *(Agenda item 7.1, documents SEA/RC58/16)*

THE COMMITTEE noted that while financial monitoring and evaluation of programmes was being carried out satisfactorily, there was a need to improve the technical aspects. This would ensure sound programme implementation and produce a positive and tangible impact on health

development in countries. WHO was reviewing the technical aspects of programme implementation in order to make it more efficient and effective. It was also optimistic in being able to mobilize additional resources to respond to the priority needs of Member States.

The Committee placed on record its appreciation for the improvement made in programme implementation, and in the optimum utilization of the Regular budget during the current biennium.

The Committee expressed satisfaction with the increase in the flow of funds from other sources and noted that the targets projected for the 2004-2005 biennium had since been exceeded as of 31 March by 22%. This was despite the fact that there was a 100% increase in the target for 2004-2005 as compared to 2002-2003. The Region had been successful in attracting US$ 220 million as against the projected figure of US$ 191.4 million for the biennium. This was due to the intensified efforts of the regional and country offices. The tsunami had also generated US$42 million.

The Committee noted with concern that the tsunami had significantly affected the implementation of WHO country programmes in some countries. It had delayed progress in high priority areas, such as health system strengthening and control of noncommunicable diseases. It was informed that due to the tsunami, a relaxation for obligation of funds had been made for the current biennium. Now 100% obligation of funds could be effected by the end of the year instead of by 31 August 2005.

The Committee was informed that staff from the Regional Office would be deputed to provide technical support and improve programme implementation at country level. This would not result in parallel implementation mechanisms being adopted, nor would it result in any financial burden on the countries.

The Committee noted with concern that the Regional Office was faced with a deficit of US$ 3 million in staff costs due to devaluation of the US dollar, cost increases and increase in salaries of staff. The same trend was expected to continue in the 2006-2007 biennium.

The Committee **noted** the recommendations made by the 42nd CCPDM as contained in its report (document SEA/PDM/Meet.42/11).

REVIEW OF DETAILED WORKPLANS FOR PROGRAMME BUDGET 2006-2007 *(Agenda item 7.2, document SEA/RC58/12)*

THE COMMITTEE was informed that the total budget for the biennium 2006-2007 for the Region was US$ 357 million as compared with US$ 285 million for the 2004-2005 biennium. This represented a 25% increase. However, 72% of the total budget would come from voluntary contributions. The Supplementary Intercountry Programme would cease to exist at the end of the current biennium. As a successor arrangement to ICP II, CCPDM had recommended that 5.35% of the country budget be earmarked for multi-country activities, to be identified and carried out by Member States at their own initiative. Detailed workplans for 2006-2007 had been prepared after consultation among the Regional Office, WHO country offices and national counterparts for review by the Committee.

The Committee **noted** the detailed regional and country workplans.

The World Health Assembly had, **after many years**, approved a 4% increase in the Regular budget for 2006-2007, out of which the South-East Asia Region would receive US$5.8 million. It was felt that this opportunity should be utilized to help Member States in greatest need, many of whom had been getting a disproportionately low share of the Regular budget. This would also help to correct the existing imbalances. It was reiterated that the

existing RB allocation would not be reduced for any Member State but that, while distributing the increased RB allocation, Member States in greatest need would be given preferential treatment, in the spirit of regional solidarity. The proposal presented would also address the issue of equity, especially as far as the least developed Member States were concerned. The following table indicating country-wise allocation of additional RB funds was presented to the Committee.

Table. *Proposed distribution of additional Regular budget funds to countries of the SEA Region*

(in thousands US$)

Country	2004-2005	Increase	% of distribution	2006-2007
Bangladesh	11 096	423	9.0	11 519
Bhutan	2 167	564	12.0	2 731
DPR Korea	3 237	564	12.0	3 801
India	13 731	235	5.0	13 966
Indonesia	9 892	235	5.0	10 127
Maldives	2 064	564	12.0	2 628
Myanmar	7 260	423	9.0	7 683
Nepal	8 427	423	9.0	8 850
Sri Lanka	4 814	423	9.0	5 237
Thailand	5 530	235	5.0	5 765
Timor-Leste	1 500	611	13.0	2 111
Total	69 718	4 700	100.0	74 418

Additional RB funds for 2006-2007 $ 5 797
Distribution to countries $ 4 700 81.1%
Distribution to the Regional Office $ 1 097 18.9%

The Committee noted that as per the proposal of the Regional Director, the increase from 2004-2005 to 2006-2007 was as follows:

Country	Percentage
Bangladesh	3.8
Bhutan	26
DPR Korea	17.4
India	1.7
Indonesia	2.4
Maldives	27.3
Myanmar	5.8
Nepal	5
Sri Lanka	8.8
Thailand	4.2
Timor-Leste	40.7

The Committee sought to know the basis on which the allocation was proposed. The Regional Working Group (RWG), which had looked into the aspect of distribution, had recommended two options as the basis for allocation: (a) disease-burden, and (b) Millennium Development Goals (MDGs). The Committee further noted that RWG had recommended that the option of using the Human Development Index (HDI) as a basis for making allocations was not acceptable since it did not reflect the health needs of Member States. Option 2 of the recommendations of RWG had been endorsed by CCPDM.

The Committee further noted that as per the information given in the working paper (SEA/RC58/12), a mix of indices such as HDI, IMR and MMR had been used for the proposed allocations. It was clarified to the Committee that MDG indicators were either not available or were unreliable and could not be used for this purpose. The Committee was informed that HDI was not used as a basis for allocation. The Committee was however not given any definite information about the basis of allocation. It therefore requested the Regional Director to urgently provide written information about the basis for distribution of the incremental RB funds.

In the absence of any clarifications to the point raised about the criteria adopted by the Regional Office for allocation of additional RB funds, the Committee noted as follows:

1. **Some countries felt that the recommendations of RWG, which were endorsed by the 42nd CCPDM, were implemented partially.**
2. **The criteria mentioned in the working paper regarding the use of HDI were not in line with the recommendations of CCPDM.**
3. The allocations 2006-2007were made in an ad hoc manner without getting the basis of allocation approved by the Regional Committee in advance. It was noted with concern that the use of such ad hoc mechanisms could become a wrong precedent not only for allocations for the countries but could also be used by headquarters for regional allocations.

However, despite the above infirmities and keeping in view the need to maintain regional solidarity, the Committee agreed to the proposal of the Regional Director as a one-time exception.

The Committee requested the Regional Director to convene a meeting of RWG immediately so that it could deliberate on the steps needed to be taken to implement its earlier recommendations. The Committee desired that in future allocation should be made on a set of transparent criteria.

The Committee further noted that the key issue was not the distribution of funds between countries of the Region but overall funding to the SEA Region compared to other regions. It stressed that although the SEA Region had 25% of the world's population and carried 40% of the disease burden, it had received only 11% of the total budget. Therefore, attempts should be made to increase the share of the budget of the Region. Unless appropriate criteria for allocation were adopted, the Region might not succeed in this endeavour.

The Committee noted that the budgetary allocations under the Regular budget for the Region had remained static over the years, while the health situation in some countries had even deteriorated. Thus, in real terms, the budgetary allocation had decreased. Furthermore, a large share of the RB funds went to meeting the expenses of WHO country offices, particularly in smaller countries.

It was noted that increased amounts were proposed for knowledge management and information, which placed a considerable burden on small countries.

The Committee noted that frequent changes in the workplan process often affected programme implementation. There was a need to ensure flexibility in programme changes based on the needs of individual Member States. The Committee was informed that efforts in joint planning and a thorough review of workplans at CCPDM had resulted in high quality workplans for 2006-2007 and that this practice would continue. However, programme changes would be allowed to address unforeseen situations in the countries.

The Committee was informed that future increases in the Regular budget were difficult since this would result in increased assessed contributions by Member States. For that reason, efforts were made to mobilize extrabudgetary resources. However, 90% of the EB resources were usually earmarked for specific areas such as polio, ERP, HIV/AIDS, TB etc while only 10% was unspecified. The Committee was assured that WHO would try to secure additional resources to support the critical needs of countries. Attempts would also be made to streamline the WHO country offices to reduce costs relating to information technology and security, thus reducing the burden on country budgets.

GUIDING PRINCIPLES FOR STRATEGIC ALLOCATION OF WHO'S RESOURCES TO REGIONS AND COUNTRIES

(Agenda item 7.3, document SEA/RC58/13)

THE COMMITTEE was informed that the 116th session of the Executive Board had requested the regional committees to comment on the proposed approach for strategic allocation of resources. The CCPDM at its 42nd meeting held in July 2005, had noted the guiding principles for strategic allocation of WHO's resources. The comments made by the Regional Committee would facilitate preparation of the draft to be discussed by the Executive Board at its 117th session in January 2006.

The Committee supported the proposed overall principles and procedures. It emphasized that these principles applied to allocation of WHO's resources to regions. Each region would subsequently determine the distribution of funds to its Member States. The Committee noted that the South-East Asia Region was receiving resources that were not commensurate with its disease burden as well as the population living in poverty.

With reference to allocations to different levels of the Organization, the Committee stressed the need to ensure that at least 70% of the Organization's budget be allocated to regions and countries, with a maximum of 30% to WHO headquarters.

The proposed validation mechanism would ensure that resources were needs-based and would accord due consideration to countries in greatest need. The Committee also recognized that the Results-based Management Framework emphasized expected results and the performance of the Region in achieving these results as factors determining the allocation of resources.

The Committee was informed that the guiding principles would be revised and presented to the 117th session of the Executive Board in January 2006 and probably to the Fifty-ninth World Health Assembly. It also noted that appropriate models were being designed for a needs-based validation mechanism. However, there was insufficient information on how these would affect the allocation of resources to the Region. Therefore, the Committee recommended that the Regional Director take specific steps to ensure that Member States were informed of the key developments related to such models, and to the draft paper to be presented at the 117th session of the Executive Board. Furthermore, since the Region had already established a Regional Working Group on budget development, this group should be reconvened when information about the models is available to consolidate the regional response to be presented to the Executive Board.

11TH GENERAL PROGRAMME OF WORK OF WHO COVERING THE PERIOD 2006-2015: REVIEW OF PROCESS AND DRAFT CONTENTS *(Agenda item 8, document SEA/RC58/15)*

THE COMMITTEE was informed that the 42nd CCPDM had reviewed the draft Executive Summary of the 11th General Programme of Work (GPW), and that a summary of its deliberations was contained in the report of the meeting (SEA/PDM/Meet.42/11).

The Committee, having reviewed the Executive Summary of the 11th GPW, felt that the document articulated the global health agenda which was broad in scope and content, and that it should therefore focus on concrete activities to achieve this agenda. The Committee noted that GPW was similar to the Bangkok Charter adopted by the Sixth Global Conference on Health Promotion attended by 125 countries, development partners and NGOs, held in Bangkok in August 2005. The Committee noted the need to strengthen implementation of the Charter by Member States.

Concern was expressed that the MDGs were not adequately reflected in the document. Given the fact that other UN agencies and development partners were proactively directing their programmes towards the realization of MDGs, WHO should make a strong commitment to those goals in the 11th GPW in order to clearly define its own role.

The Committee was informed that realizing the MDGs was crucial for WHO. The 11th GPW coincided with the period covered by MDGs and the ten action areas which underpinned the strategies to reach the MDGs showed WHO's commitment.

The Committee suggested that WHO revise the document by incorporating more specific and concrete proposals on WHO's work into the 11th GPW to achieve the global health agenda. The issues outlined in the agenda were well known but WHO should assist Member States in finding solutions, possibly through sharing of best practices among countries. The Committee recognized the need for a sharper focus on priorities. In addition, WHO should strengthen its core competencies in those areas towards supporting Member States in meeting these challenges.

The Committee noted that the present document was still a draft. It would be refined and shared with Member States before it was presented to the 117th session of the Executive Board and the Fifty-ninth World Health Assembly for final approval.

CONSIDERATION OF THE RECOMMENDATIONS ARISING OUT OF THE TECHNICAL DISCUSSIONS ON SKILLED CARE AT EVERY BIRTH, HELD ON 6 JULY 2005 *(Agenda item 9.1, document SEA/RC58/5)*

DR GUNAWAN SETIADI, Rapporteur of the Technical Discussions on Skilled Care at Every Birth, presented the report and recommendations of the group (document SEA/RC58/5).

The Committee felt that the title of the subject suggested that the focus was on skilled care at birth only and therefore its scope should be expanded to cover skilled care subsequent to birth as well. There was a need to strengthen the referral system as maternal deaths occurred because of a weak referral system.

The need to strengthen national and sub-national planning and programming to ensure equitable access and quality of skilled care at birth was stressed. The Committee felt that gaps in human resources should be reviewed and appropriate policies relating to skilled care at birth developed. Barriers to equitable access and utilization of skilled care at birth should be identified and evidence-based actions taken to overcome them. Appropriate improvements in health systems should be instituted to strengthen programme management and improve health care delivery. The Committee sought WHO's assistance in this regard.

The Committee endorsed the report and recommendations of the technical discussions as contained in document SEA/RC58/5 and adopted a resolution on the subject (SEA/RC58/R2).

SELECTION OF A SUBJECT FOR THE TECHNICAL DISCUSSIONS TO BE HELD PRIOR TO THE FIFTY-NINTH SESSION OF THE REGIONAL COMMITTEE

(Agenda item 9.2, document SEA/RC58/4)

CONSIDERING the need to promote patient safety in countries of the South-East Asia Region, the Committee **decided** to hold Technical Discussions on "Promoting patient safety at health care institutions" during the 43rd meeting of the Consultative Committee for Programme Development and Management, to be held prior to the fifty-ninth session of the Regional Committee in 2006. It urged Member States to participate fully in the Technical Discussions and requested the Regional Director to take steps for the preparation and conduct of the discussions.

HEALTH ACTION IN EMERGENCIES, INCLUDING RESPONSE TO EARTHQUAKES AND TSUNAMIS OF 26 DECEMBER 2004

(Agenda item 10, document SEA/RC58/6)

THE COMMITTEE was informed that this subject had been discussed at the Tenth Meeting of Health Secretaries and the 23rd Meeting of the Ministers of Health.

The Committee thanked WHO for rendering all possible assistance immediately after the tsunami and in post-tsunami rehabilitation work.

The Committee noted that there had been cases of violence and unsocial activities during disasters in certain parts of the world. It was, therefore, felt that disaster plans should also address such problems in collaboration with concerned law enforcement authorities.

The Committee recognized the need to strengthen the physical infrastructure in order to mitigate the impact of disasters and to facilitate rapid and effective response. It stressed the importance of preparedness and response capacity at community and local levels. A prepared health sector could mitigate the impact of disasters by reducing avoidable deaths, injuries and illnesses; anticipating population displacements; establishing disease surveillance systems; managing and preventing psychological and psychosocial problems; planning for food shortages and nutritional deficiencies; monitoring for diseases due to environmental health hazards; preventing damage to health facilities and other infrastructure; and anticipating and minimizing disruption of routine health services.

The Committee felt that incorporating Emergency Preparedness and Response (EPR) programmes within ministries was essential to making disaster management in the health sector sustainable. Furthermore, for preparedness response, recovery and rehabilitation efforts to be effective and better coordinated, the various units of EPR should be placed under the management of high level offices in view of the many cross-cutting issues. In this context, multisectoral, regional and intercountry collaboration was essential. Relations with national and international media should be strengthened and health sector professionals trained, including in risk communication, to enable them to deal with the media and to help journalists to report more accurately on health issues during emergencies. The Committee requested WHO to support Member States in exchanging expertise and information, increasing partnerships with other UN agencies and facilitating mobilization of resources.

The Committee noted the observations and recommendations of the meetings of Health Secretaries and Health Ministers and adopted a resolution on the subject (SEA/RC58/R3).

INTERNATIONAL HEALTH REGULATIONS (2005)

(Agenda item 11, document SEA/RC58/7)

THE COMMITTEE noted that the International Health Regulations (2005) marked a major milestone in collaborative efforts between Member States in the Region and WHO. The regulations were the result of the collective efforts of all Member States. The efforts made by the SEA Region in this regard had been appreciated.

Since the revised IHR would come into force in June 2007, very limited time was available to Member States to prepare for its implementation. The Committee stressed the urgency to address the following important concerns and issues: upgrading the existing health infrastructure; building core capacities; establishing surveillance mechanisms for developing early warning systems; strengthening existing laboratory services for immediate diagnosis; strategic stockpiling of drugs and vaccines and mobilizing political commitment.

The Committee urged WHO to mobilize additional resources and provide technical expertise to ensure effective and timely implementation of IHR. It also requested the Organization to assess and build core capacity in Member States in detecting, verifying and responding to public health emergencies of international concern.

Support was also sought to help Member States enact appropriate legislation and make administrative arrangements for effective implementation of IHR. The Committee emphasized that it was important to implement these regulations simultaneously across the globe.

The Committee was informed that WHO was working closely with Member States in the assessment of surveillance systems and laboratory services. It was also developing a roster of experts, institutions and services available in the Region which could be mobilized in emergencies. The Committee noted that WHO would be developing action plans for IHR implementation, in close collaboration with Member States to facilitate mobilization of additional resources for this purpose.

The Commmittee noted the observations and recommendations of the Tenth Meeting of Health Secretaries and adopted a resolution on the subject (SEA/RC58/R4).

ASIA-PACIFIC STRATEGY ON EMERGING DISEASES

(Agenda item 12, document SEA/RC58/8 and SEA/RC58/Inf.3)

THE COMMITTEE was informed that this subject had been discussed at the Tenth Meeting of Health Secretaries and that a summary of the discussion was available in the report of that meeting.

Tracing the background to the Asia-Pacific Strategy on Emerging Diseases, the Committee emphasized the need to strengthen national capacity in the area of surveillance and public health laboratories for diagnosis of emerging diseases. It also noted that the Asia-Pacific Strategy and International Health Regulations (2005) were complementary.

The Committee stressed that the immediate point of concern for the Region was the pandemic threat of avian influenza. The Asia-Pacific Strategy had opened the way not only for international cooperation but also for collaboration with the Western Pacific and the Eastern Mediterranean regions.

Learning from the SARS experience, the Committee acknowledged that diseases knew no national boundaries. Besides impacting the health of people, they had implications also for international travel and trade and for the economies of the affected States.

The Committee recognized the shortage of drugs and vaccines to deal with emerging diseases as well as problems encountered in producing antivirals, especially due to patent rights. It was therefore important for Member States to establish risk communication mechanisms so that public health measures could be initiated immediately to protect populations should the need arise.

The Committee highlighted the need to establish a panel of experts, and to identify regional centres of excellence for laboratory services so that Member States could use their services for timely diagnosis. The need to develop mechanisms to facilitate timely transport and testing of samples by laboratories, and to assess the regional capacity for production/manufacture of antivirals and influenza vaccines was also noted.

In addition to the concerns related to avian influenza, urgent efforts were also needed for the prevention and control of Japanese encephalitis and dengue. The Committee highlighted the need for an action plan and to mobilize resources, with particular emphasis on vaccines, to tackle the problem of Japanese encephalitis affecting some Member States.

The Committee requested WHO to support Member States in strengthening their capacity for communicable disease surveillance and outbreak alert and response, and to establish a regional mechanism to coordinate and advise on the effective implementation of the Asia-Pacific Strategy on Emerging Diseases. WHO was also requested to assist in the mobilization of technical, logistic and financial resources for facilitating the implementation of the strategy.

The Committee was informed that WHO was collaborating closely with Member States in preparing pandemic influenza preparedness plans and in mobilizing the necessary resources. The Organization was requested to stockpile and immediately supply antiviral drugs to affected countries, should the need arise.

The Committee noted the observations and recommendations of the Tenth Meeting of Health Secretaries and adopted a resolution on the subject (SEA/RC58/R5).

POLIO ERADICATION: FINAL STRATEGY *(Agenda item 13, document SEA/RC58/9)*

THE COMMITTEE was informed that this subject had been discussed at the Tenth Meeting of Health Secretaries and that a summary of the discussion was available in the report of that meeting.

The Committee noted that India was favourably placed to eradicate poliomyelitis transmission in 2005. Surveillance sensitivity was near certification standards. A new monovalent oral polio vaccine (mOPV1) had been used in the highest risk areas during the mass campaigns. The high transmission season had not yet resulted in an increase in cases. After eradication, the risk of polio, though small, could be from the chance introduction of wild-type poliovirus from inactivated polio vaccine (IPV) manufacturing sites, from laboratory accidents, or deliberate introduction. OPV cessation was therefore essential for maintaining eradication.

The regional priorities included interruption of wild-type poliovirus transmission, polio outbreak response planning, regional certification, appropriate bio-containment of all polioviruses, highly sensitive AFP surveillance, increasing routine OPV3 coverage, mechanisms for synchronous OPV cessation, national long-term routine immunization policy, and regional stockpiling of mOPV1.

In developing their national immunization policy for post-OPV cessation, Member States may be confronted with the issue of inactivated polio vaccine (IPV). Major programmatic implications of IPV use include a need for increased cold chain capacity, injection safety and waste disposal, changing the pertussis component of combination vaccines, using a different preservative, and marginal reduction of the small risks associated with OPV cessation. It would also increase costs significantly.

The Committee recognized that the outbreak of polio in Indonesia was a timely reminder that no country was safe until transmission had been completely stopped. In order to achieve eradication, high routine polio immunization, substantial financial

and technical resources, strong surveillance and adequate response plans were essential. Member States should, therefore, coordinate among themselves in order to sustain the achievements of eradication. The Committee was optimistic in cutting the polio transmission in the Region in spite of the situation in Indonesia. Efforts in mobilizing technical and financial resources would continue. In addition, efforts would continue to facilitate adequate procurement and supply of adequate quantities of vaccine.

Polio eradication was the highest and immediate priority that would be accomplished by the end of 2005. However, OPV cessation would occur once polio eradication was achieved. The certification process would take three years. Guidelines were available on immunization of travellers; further guidelines, if required, could be developed.

The Committee urged Member States where poliovirus transmission was endemic or where wild poliovirus importations had occurred, to further intensify their eradication strategies and implement innovative strategies to interrupt wild poliovirus transmission in 2005. It urged all Member States to implement the strategies outlined in the Global Immunization Vision and Strategy (GIVS) framework, and to establish an action plan for responding to any polio outbreak caused by importation of wild poliovirus vaccine-derived polioviruses. The Committee urged WHO to collaborate with partners in ensuring the highest political support for polio eradication and in mobilizing financial and technical resources necessary to implement GIVS.

The Committee noted the observations and recommendations of the Tenth Meeting of Health Secretaries and adopted a resolution on the subject (SEA/RC58/R6).

REGIONAL IMPLICATIONS OF THE DECISIONS AND RESOLUTIONS OF THE FIFTY-EIGHTH WORLD HEALTH ASSEMBLY AND THE 115TH AND 116TH SESSIONS OF THE WHO EXECUTIVE BOARD

(Agenda item 14.1, document SEA/RC58/14 and SEA/RC58/Inf.4)

THE COMMITTEE noted that the 42nd Meeting of CCPDM, held in Dhaka from 5-7 July 2005, had discussed the subject and a summary of the discussion was available in its report SEA/PDM/Meet.42/11.

During the discussion, CCPDM made a special reference to World Health Assembly resolution WHA58.17 concerning international migration of health personnel: A challenge for health systems in developing countries.

The CCPDM highlighted the need to address not only international migration but also internal brain drain. It was noted that globalization had increased mobility of personnel and trade in health services. The migration of skilled health workers from developing countries needed to be addressed urgently. WHO support was required to develop strategies to mitigate the adverse effects of migration of health personnel.

The Committee recommended that WHO should address the issue of migration of health personnel from developing countries, and support strategies for effective deployment and retention of health personnel.

The Committee expressed the need for guidance to Member States in drafting resolutions for meetings of governing bodies. The Committee was assured that the Regional Office would ensure greater coordination among Member States and provide the necessary information to optimize their inputs.

In regard to the proposed resolution on “Globalization, Travel, Intellectual Property Rights and Health” proposed by Thailand, the Committee requested the Regional Director to obtain and send the latest version to Member States to get their comments well in time for the 117th session of the Executive Board.

The Committee **noted** the observations of CCPDM on the subject.

REVIEW OF THE DRAFT PROVISIONAL AGENDAS OF THE 117TH SESSION OF THE WHO EXECUTIVE BOARD AND THE FIFTY-NINTH WORLD HEALTH ASSEMBLY *(Agenda item 14.2, document SEA/RC58/17)*

THE COMMITTEE noted the draft provisional agenda of the 117th session of the WHO Executive Board and was informed that the draft provisional agenda of the Fifty-ninth World Health Assembly had not been received so far. The same would be forwarded to Member States as soon as it was received for their comments. The three members of the Executive Board from the Region would then be invited to formulate the Region's stand for forwarding to the Executive Board.

UNDP/WORLD BANK/WHO SPECIAL PROGRAMME FOR RESEARCH AND TRAINING IN TROPICAL DISEASES: JOINT COORDINATING BOARD (JCB) – REPORT ON ATTENDANCE BY REPRESENTATIVES OF BANGLADESH AND MYANMAR AT JCB IN 2005 *(Agenda item 15.1, document SEA/RC58/10)*

THE COMMITTEE was informed that representatives from Bangladesh and Myanmar had attended the deliberations of the 28th session of JCB, held in June 2005, and presented their report to the 42nd CCPDM held in July 2005.

The Committee **noted** the observations and recommendations of the 42nd CCPDM on the subject.

WHO SPECIAL PROGRAMME FOR RESEARCH, DEVELOPMENT AND RESEARCH TRAINING IN HUMAN REPRODUCTION: POLICY AND COORDINATION COMMITTEE (PCC) – REPORT ON ATTENDANCE AT PCC 2005 AND NOMINATION OF A MEMBER IN PLACE OF THAILAND WHOSE TERM EXPIRES ON 31 DECEMBER 2005 *(Agenda item 15.2, document SEA/RC58/11)*

THE COMMITTEE was informed that representatives from Sri Lanka and Thailand had attended the deliberations of the 18th meeting of PCC, held in July 2005, and presented their report to the 42nd meeting of CCPDM.

The Committee **noted** the observations and recommendations of the 42nd CCPDM on the subject.

The Committee **nominated** Bangladesh as a member of PCC for a period of three years effective 1 January 2006, and requested the Regional Director to inform WHO headquarters accordingly.

The Committee was assured that henceforth the information exchanged at these meetings would be communicated and shared among Member States immediately upon conclusion of the meeting.

TIME AND PLACE OF FUTURE SESSIONS OF THE REGIONAL COMMITTEE *(Agenda item 16, document SEA/RC58/3 (Rev.1))*

THE COMMITTEE **decided** to hold its fifty-ninth session in Bangladesh in 2006 in conjunction with the Meeting of Ministers of Health. The exact dates would be confirmed later.

The Committee **noted** the invitations of the Governments of Bhutan and Nepal to host the Regional Committee sessions in 2007 and 2009 respectively. It further noted that the sixty-first session in 2008, being the year for nomination of the Regional Director, would be held in the Regional Office. The Meeting of Ministers of Health in 2008 would be hosted by the Government of India.

The Committee suggested that it was important to evaluate the working of a number of meetings, such as Meeting of Health Secretaries, and the Meeting of Ministers of Health. It was also suggested that the duration of the Regional Committee meeting be reduced.

ADOPTION OF RESOLUTIONS

The Committee adopted the following resolutions:

1. **Resolution of thanks**
2. **Skilled care at Every Birth**
3. **Health Action in Emergencies**
4. **Polio Eradication: Final Strategy**
5. **Asia-Pacific Strategy on Emerging Diseases**
6. **International Health Regulations**

ADOPTION OF THE REPORT OF THE FIFTY-EIGTH SESSION OF THE WHO REGIONAL COMMITTEE FOR SOUTH-EAST ASIA

(Agenda item 17, document SEA/RC58/20)

The Committee adopted the draft report of the fifty-eighth session, as contained in document SEA/RC58/20, which certain modifications.

CLOSURE OF THE SESSION

(Agenda item 18)

The representatives of Member States congratulated the Chairman and the Vice-Chairman for their smooth conduct of the session. They expressed their deep gratitude to the Prime Minister of Sri Lanka for graciously inaugurating the session and for his thought-provoking speech. The representatives expressed their sincere appreciation for the excellent arrangements and the warm hospitality extended to them throughout their stay by the Government of Sri Lanka. The representatives also thanked the Regional Director and the WHO Secretariat for their technical inputs and excellent preparations made for the meeting. They expressed their deep appreciation to the WHO Director-General, Dr LEE Jong-wook for attending the session and for his inspiring address.

The Committee expressed concern that GFATM had not approved the financial proposals submitted by countries of the South-East Asia Region. It was suggested that a letter be sent to the Executive Director, GFATM, expressing the collective concern of the Region on the issue.

The Regional Director thanked the representatives and expressed satisfaction that despite the heavy agenda, the meeting could be concluded in time due to the able guidance and leadership provided by the Chairman and Vice-Chairman and the cooperation extended by all representatives. He expressed appreciation for the direction provided by the representatives in strengthening collaborative efforts in Member States. The Regional Director reiterated the need to redouble the efforts to fight the formidable health challenges being faced by the Region. He was confident that the discussions on Health Action in Emergencies would help Member States to strengthen their preparedness and response mechanisms. The discussions and the resolutions adopted on the technical subjects would provide the necessary guidance, both to WHO and Member States, to initiate suitable measures to achieve the targets. Dr Samlee appreciated the spirit of solidarity shown by the Region. He reiterated that it was essential to ensure that health care was available to all those in need, especially the vulnerable and the marginalized populations.

The Chairman, in his closing remarks, thanked the representatives for their constant support and guidance in organizing the session and for their active participation. He thanked the Director-General for his stimulating and thought-provoking address. He also thanked the Vice-Chairman for sharing his task during his absence. He hoped that the deliberations and important decisions taken by the Regional Committee would guide the work of Member States and the Organization in their joint endeavours. He stressed the need to enhance knowledge and implement the programmes effectively so that people at the periphery get the required benefits.

The Chairman then declared the session closed.