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WHO Regional Committee for South-East Asia

Report of the Fifty-eighth Session
Colombo, Sri Lanka, 6-10 September 2005


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ANNEXES

Report of the Regional Committee*

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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 (In-charge of 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 (Bangladesh) 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) *(Annex 3)*.

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 OFFICIAL DOCUMENTS

The list of official documents is at Annex 5.

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

(Agenda item 5, documents 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 outreach 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 Environments, 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 Target 10 of Goal 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 cost 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 for a separate chapter devoted to poverty alleviation and MDGs in future reports of the Regional Director 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 from Member States attending the meetings of governing bodies had a constitutional role, most of them representing developing countries invariably sought more WHO assistance. There was, therefore, a need to appropriately brief the delegates 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, document 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 in 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 for 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 consultations 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 more than a decade without any increase in the Regular budget, approved a 4% increase 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 had been endorsed by the 42nd CCPDM, were implemented partially.

(2) The criteria mentioned in the working paper regarding the use of HDI were not in accordance with the recommendations of CCPDM.

(3) Allocations for 2006-2007 were 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 set a wrong precedent not only for allocations to the countries but it 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 at the earliest so that it could deliberate on the steps needed to be taken to implement its earlier recommendations. The

Committee desired that in future allocations 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 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 allocations had decreased. Furthermore, a large share of the RB funds went into 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 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 42nd meeting of CCPDM, 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 was available so as to present a consolidated regional response 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 meeting of 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, and that there was a 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 the document be revised by incorporating more specific and concrete proposals on WHO's priorities 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 practical solutions. 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.

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 the 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 *(SEA/RC58/(1))*.

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 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, strengthened 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 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 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 might be confronted with the issue of inactivated polio vaccine (IPV). Major programmatic implications of IPV use included 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 so far. The Committee was optimistic in cutting polio transmission in the Region in spite of the situation in Indonesia. Efforts would continue to mobilize technical and financial resources and also to facilitate 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 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 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 meeting of CCPDM.

The Committee **noted** the observations and recommendations of 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 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 *(SEA/RC58/(2))*.

The Committee was assured that henceforth 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 *(SEA/RC58/(3))*.

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 Meeting of Ministers of Health. It was also suggested that the duration of the Regional Committee session 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) International Health Regulations (2005)

(5) Asia-Pacific strategy on emerging diseases

(6) Polio eradication: Final strategy

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, with certain modifications.

CLOSURE OF THE SESSION

(Agenda item 18)

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 discussion 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 got the required benefits.

The Chairman then declared the session closed.

Part IV

RESOLUTIONS AND DECISIONS

RESOLUTIONS

SEA/RC58/R1 RESOLUTION OF THANKS

The Regional Committee,

Having brought its fifty-eighth session to a successful conclusion,

1. THANKS His Excellency Mr Mahinda Rajapakse, Prime Minister of the Democratic Socialist Republic of Sri Lanka, for graciously inaugurating the session and for his thought-provoking speech;

2. THANKS His Excellency Mr Nimal Siripala de Silva, Minister of Healthcare, Nutrition and Uva Wellassa Development, Democratic Socialist Republic of Sri Lanka, for gracing the occasion;

3. THANKS the Vice-Chairman, Professor (Dr.) Md Shahadat Hossain, Additional Director General (In-charge of Director General), Directorate General of Health Services, Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh, for the smooth conduct of the session during the absence of the Chairman;

4. THANKS the WHO Director-General, Dr LEE Jong-wook, for his inspiring address and participation;

5. CONVEYS its gratitude to the Government of the Democratic Socialist Republic of Sri Lanka for hosting the session, and thanks the members of

the National Organizing Committee, the staff of the Ministries of Healthcare, Nutrition and Uva Wellassa Development and Foreign Affairs and other national authorities for making the session a success, and

6. CONGRATULATES the Regional Director and his staff on their efforts towards the successful conclusion of the session.

SEA/RC58/R2 SKILLED CARE AT EVERY BIRTH

The Regional Committee,

Recalling World Health Assembly resolution WHA58.31 and its own resolutions SEA/RC53/R9 and SEA/RC56/R9 relating to health of mothers and newborns,

Noting with concern the unacceptably high maternal and neonatal mortality in the Region,

Recognizing that most maternal and neonatal deaths arise from complications during childbirth or immediately after birth and that almost all of these deaths are preventable considering the availability of skilled care at birth,

Acknowledging that a large proportion of women and newborns in the Region do not receive skilled care at birth, and

Having considered the report and recommendations of the Technical Discussions on Skilled Care at Every Birth (document SEA/RC58/5) during the Forty-second Meeting of the Consultative Committee for Programme Development and Management at Dhaka in July 2005,

1. URGES Member States:

(a) to strengthen national and sub-national planning and programming so as to give due attention to the need for long-term plans and strategies to ensure skilled care at every birth;

(b) to identify barriers to equitable access and utilization of skilled care at birth, and to develop evidence-based actions to overcome these;

(c) to review the gaps in human resource for skilled care at birth and, as appropriate, to develop or modify human resource policies for skilled care at birth which includes planning, production, placement, retention and career development;

(d) to institute appropriate improvements in their health systems to strengthen programme management, health care delivery and quality of care including an effective referral system, and to increase financing, and

(e) to improve the demand for continuum of skilled care with special attention to ante- and post-natal care of mothers and their newborns, and

2. REQUESTS the Regional Director:

(a) to enhance technical support to Member States in reviewing and revising their human resource policies, strategies and plans and assist in their implementation to achieve skilled care at every birth;

(b) to assist Member States in strengthening their health systems and provide evidence-based norms and standards to ensure skilled care at every birth, and

(c) to advocate for increased funding from national and international sources to support national efforts to ensure skilled care at every birth, and assist in the development of a mechanism for global pooling of funds for maternal and child health.

SEA/RC58/R3 HEALTH ACTION IN EMERGENCIES

The Regional Committee,

Recalling World Health Assembly resolutions WHA34.26, WHA42.16, WHA44.41 and WHA46.6, and its own resolutions SEA/RC44/R5 and SEA/RC57/R3 relating to emergency health preparedness and response, and

Having deliberated on the subject and considered the recommendations on health action in emergencies, including response to earthquakes and tsunamis of 26 December 2004, as contained in the background document (SEA/RC58/6),

1. ENDORSES the recommendations contained therein;

2. URGES Member States:

(a) to further strengthen risk management mechanisms in the health sector;

(b) to incorporate Emergency Health Preparedness and Response programmes in ministries of health;

(c) to promote intersectoral collaboration to improve emergency preparedness and response, and

(d) to engage communities and other sectors in preparedness, response and rehabilitation efforts, and

3. REQUESTS the Regional Director to support emergency health preparedness, response, recovery and rehabilitation, mitigation and prevention activities in Member States through:

(a) promoting interregional and intercountry cooperation and exchange of expertise and information;

(b) facilitating prompt mobilization of technical and financial resources;

(c) strengthening WHO regional and country offices in their preparedness and response capacities to support Member States, and

(d) fostering increased partnerships with UN agencies and other partners.

SEA/RC58/R4 INTERNATIONAL HEALTH REGULATIONS (2005)

The Regional Committee,

Recalling World Health Assembly resolutions WHA48.7, WHA54.14, WHA55.16 and WHA56.28 relating to global public health, and welcoming the adoption by the World Health Assembly of resolution WHA58.3 on the International Health Regulations (2005),

Concerned about the growing threats of emerging and re-emerging communicable diseases such as SARS and avian influenza,

Mindful of other potential global health security issues arising from accidental or deliberate use of biological, chemical and radionuclear agents and their implications to Member States of the Region in terms of human suffering and socioeconomic implications,

Appreciating the technical support and guidance provided to Member States by WHO in the revision process of the International Health Regulations,

Taking note of the recommendations of the Ninth Meeting of Health Secretaries of Member States of the WHO South-East Asia Region regarding the revision process of IHR and the need to strengthen the core capacity required for its implementation, and

Keenly aware of the enormous challenges faced by Member States in terms of building the necessary core capacity, including human resources and health systems development essential for the implementation of the International Health Regulations (2005) in the limited time available,

1. URGES Member States:

   (a) to take all necessary steps to implement the International Health Regulations (2005) in accordance with the purpose and scope of the Regulations, and

   (b) to fulfil all administrative and legal requirements that may be necessary for effective implementation of the International Health Regulations (2005), and

2. REQUESTS the Regional Director:

(a) to facilitate the implementation of the International Health Regulations (2005) through technical guidance and support to Member States, as necessary;

(b) to facilitate resource mobilization and to develop and maintain core capacities in Member States, and

(c) to promote intercountry and interregional collaboration.

SEA/RC58/R5 ASIA-PACIFIC STRATEGY ON EMERGING DISEASES

The Regional Committee,

Recalling World Health Assembly resolutions WHA48.13; WHA54.14; WHA56.19; WHA56.28; WHA56.29, and WHA58.5 relating to prevention and control of communicable diseases,

Recalling its own resolutions SEA/RC53/R11 relating to cross-border collaboration on control of communicable diseases, and SEA/RC57/R3 relating to emergency health preparedness,

Considering the complementarity of the International Health Regulations (2005) to the Asia-Pacific Strategy on Emerging Diseases,

Recognizing that emerging diseases such as SARS and avian influenza pose serious threats to public health and to economic and social stability in the Asia-Pacific Region and beyond, and

Appreciating WHO's initiatives to promote intercountry and interregional collaboration and the actions taken to develop the Asia-Pacific Strategy on Emerging Diseases,

1. URGES Member States:

(a) to strengthen their capacity for surveillance and response to detect, verify, report and respond to communicable disease outbreaks as a public health emergency;

(b) to consider implementation of the Strategy to further strengthen surveillance and response to emerging infectious diseases;

(c) to increase cooperation among themselves through appropriate mechanisms in surveillance, preparedness and outbreak investigation of emerging diseases;

(d) to strengthen collaboration and coordination between the health, veterinary and agricultural sectors, including surveillance systems, to enhance early detection of zoonotic diseases such as avian influenza, Nipah infection and SARS, and

(e) to develop, share and implement national preparedness and response plans as soon as possible, with special emphasis on avian influenza, and

2. REQUESTS the Regional Director:

(a) to continue support to Member States in strengthening their capacity for communicable disease surveillance, outbreak alert and response, including facilitating timely transportation and testing of samples;

(b) to facilitate establishment and networking of regional centres of excellence to coordinate and advise on effective implementation of the Asia-Pacific Strategy on Emerging Diseases;

(c) to facilitate stockpiling of essential medicines, vaccines and personal protection equipment at appropriate locations;

(d) to support Member States in developing and implementing national influenza pandemic preparedness plans;

(e) to support Member States in mobilizing technical, logistic and financial resources for facilitating implementation of the Asia-Pacific Strategy on emerging diseases and the influenza pandemic preparedness plans, and

(f) to explore the possibility of extending cooperation in this area to the WHO Eastern Mediterranean Region.

SEA/RC58/R6 POLIO ERADICATION: FINAL STRATEGY

The Regional Committee,

Recalling resolutions SEA/RC34/R2, SEA/RC38/R9 and SEA/RC49/R6,

Reaffirming WHO's commitment to the global goal of eradication of poliomyelitis,

Recognizing that substantial progress has been made in the Region towards the achievement of the goal of polio eradication in 2005,

Noting that as of August 2005, poliomyelitis remains endemic only in a few districts in India, but that all countries remain at risk, as exemplified by Indonesia where a large outbreak of polio is occurring,

Realizing that such outbreaks resulting from importations of wild poliovirus and funding shortfalls are major obstacles to achieving the goal of eradication in the Region, and

Affirming that poliomyelitis eradication will result in far-reaching humanitarian and economic benefits to all countries,

1. URGES Member States where poliovirus transmission is endemic or where wild poliovirus importations have occurred, to further intensify the implementation of their eradication strategies to interrupt wild poliovirus transmission in 2005;

2. URGES all Member States, particularly those which are free from poliomyelitis:

(a) to implement the strategies outlined in the Global Immunization Vision and Strategy (GIVS) framework, including the Reach Every District (RED) approach, to achieve and maintain high levels of routine immunization coverage uniformly across all administrative units until global certification of polio eradication;

(b) to allocate adequate resources for enhancing and maintaining AFP surveillance at sub-national level, achieving high and uniform quality across all sections of communities;

(c) to develop an action plan with adequate resources to respond effectively to a polio outbreak caused by an importation of wild poliovirus or circulating vaccine-derived polioviruses (cVDPVs);

(d) to fully implement and verify appropriate containment of wild and vaccine-derived polioviruses, and prepare for eventual containment of vaccine viruses, and

(e) to analyse and consider the risks, benefits and opportunity costs while developing national mechanisms for eventual cessation of the use of OPV in the routine immunization programme and destruction of remaining stocks of trivalent OPV, and

3. REQUESTS the Regional Director:

(a) to advocate with Member States in ensuring the highest political support for polio eradication, including maintenance of high quality surveillance;

(b) to coordinate with partners and all Member States in mobilizing financial and technical resources necessary to implement GIVS;

(c) to collaborate with all partners in mobilizing the required resources for polio eradication and in ensuring adequate supply of vaccine, and

(d) to promote and support the international certification scheme for polio eradication in the Region.

DECISIONS

SEA/RC58/(1) Selection of a subject for the Technical Discussions to be held prior to the fifty-ninth session of the Regional Committee

CONSIDERING the need to promote patient safety in the 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.

SEA/RC58/(2) Nomination of a member to the Policy and Coordination Committee (PCC) of the WHO Special Programme for Research, Development and Research Training in Human Reproduction

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.

SEA/RC58/(3) Time and place of future sessions of the Regional Committee

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.

Annexes

Annex 1

TEXT OF ADDRESS BY THE PRIME MINISTER OF SRI LANKA

On behalf of our President, Her Excellency Chandrika Bandaranaike Kumaratunga, and the people of Sri Lanka, I would like to welcome you all warmly to Sri Lanka and to the 23rd Meeting of Ministers of Health. It is an honour for all of us that Sri Lanka has been selected this year to host this important event, and we can look forward to your collective wisdom, knowledge and inspiration. We are sure that this event will provide a major catalyst for further achievements in the area of health and medicine in our Region.

I would also like to take this opportunity to thank the World Health Organization and its partner UN agencies for their prompt and consistent support to Sri Lanka in the wake of the Asian tsunami of last year, which tragically affected many countries within our region. Dr Lee, the WHO Director-General, and the Regional Director visited us immediately after this heartbreaking event and inspired us, advised us, and supported us in numerous ways to come to terms with the tragedy. Despite the catastrophic effects suffered by all in this disaster, we can draw some comfort from the expression of solidarity that the affected countries of this region displayed in their response to the victims and each other – this significantly contributed to the immediate response actions, both extensively and effectively.

The implementation of an early warning system for the region will be extremely advantageous in the preparation and response to national and man-made disasters, and for the containment of emerging communicable

diseases throughout providing an essential step in ensuring our countries possess mutual preparedness in light of impending adversities.

Your Excellencies are of course aware that Sri Lanka has been, and remains a high performer in health status terms, with relatively good indicators than other similar low and middle-income countries. Mortality is low and continues to decline, fertility is already below replacement level, and is expected to reach 1.4 – 1.6 by 2015 by current trends. Life expectancy is high and projected to reach current US levels by 2015–2020.

We have also seen that despite low expenditures on the health sector, we have been able to provide health care of technically acceptable quality, free of user charges in Sri Lanka. We have with great care been able to maintain reasonable equity under the current difficult circumstances. The wide coverage by the health services, the good education, particularly of the mothers and the social sector policies that have been adopted for over five decades, have all contributed to the impressive health outcomes that are seen in the country. Further, there is a constructive partnership between the public and private sectors in health care, although undoubtedly much more needs to be achieved. The private sector has been able to cater to a segment of the population that can afford consumer quality and responsiveness, and thereby relieved to a certain extent the pressure on the public sector services.

Both this gathering of Health Ministers, and the forthcoming WHO Regional Committee meeting, where our teams take the opportunity to meet and further discuss the fundamental health issues of the region, provide a strong platform whereby we can continue to unite, share and advance our knowledge and can only lead us to stronger and enduring cooperation. All our countries are so rich in knowledge and wisdom,

possess immense resources and goodwill, we have so much to learn from, and to share with each other, not only in health but in each and every field of human endeavour. We must make use of all available opportunities to optimize these gains and to realize our collective potential. I am confident that this meeting will become a landmark event in the health development history of our South-East Asia Region. Sri Lanka will be very pleased to make its contribution to this effort.

I have no doubt that my colleague, the Hon'ble Minister of Health, with his customary efficiency and organization skills, has made sure that all of you have a very productive meeting and a wonderful time in our country. Please let his team know if there is any little thing that we could do to make your stay comfortable and happy.

I wish all of you every success.

Thank you.

Annex 2

TEXT OF ADDRESS BY THE REGIONAL DIRECTOR, WHO SOUTH-EAST ASIA REGION

It is a great pleasure that the Hon'ble Prime Minister of Sri Lanka is graciously inaugurating these two highest-level regional meetings of WHO in South-East Asia. I extend my heartiest greetings and a very warm welcome to the Hon'ble Health Ministers and distinguished representatives. On behalf of the World Health Organization, may I thank the Government of the Democratic Socialist Republic of Sri Lanka, and especially H.E. Mr Nimal Siripala de Silva, for hosting these meetings.

Sri Lanka joined WHO in 1948. We have witnessed remarkable progress in her national health development, as mentioned by the Hon'ble Health Minister, Mr de Silva, in his welcome address. For example, life expectancy at birth, which stood at 67 years for males and 72 for females in 1980, increased to 72 and 76 respectively in 2001. The infant mortality rate decreased significantly from 34 per 1000 live births in 1980, to 11.1 in 2003. The country has been polio-free since 1993. Leprosy has been eliminated since 1995. We must congratulate the Government of the Democratic Socialist Republic of Sri Lanka for these impressive achievements that were contributed, among others, by a sound health system, based on equitable access to health care by all people.

During the past decade, we have observed significant changes at all levels of development in the health area. However, infectious diseases

continue to cause a very large proportion of morbidity and mortality in South-East Asia. Simultaneously, we have to deal with the health risks relating to unhealthy lifestyles and environmental degradation. The issue that needs to be urgently addressed is how to effectively meet these challenges in the face of resource and other constraints.

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

The deliberations at the Meetings of Health Ministers and the Regional Committee will be productive, as usual. All of us will stand to benefit from the wisdom and guidance of the Hon'ble Health Ministers on topical health issues.

WHO, as an Organization of Member States, always stands ready to provide any required support to governments in their efforts to pursue the development of health for all people.

Thank you.

Annex 3

AGENDA*

1.	Opening of the session	–
2.	Sub-committee on Credentials:	
	2.1 Appointment of the Sub-committee on Credentials	SEA/RC58/19
	2.2 Approval of the report of the Sub-committee on Credentials	
3.	Election of Chairman and Vice-Chairman	–
4.	Adoption of Agenda and Supplementary Agenda, if any, of the Regional Committee	SEA/RC58/1 (Rev.2)
5.	The Work of WHO in the South-East Asia Region – Report of the Regional Director covering the period 1 July 2004 – 30 June 2005	SEA/RC58/2 and SEA/RC58/Inf.1 (Rev.1) and Inf.2
6.	Address by the Director-General of the World Health Organization	–
7.	Programme Budget:	
	7.1 Review of WHO collaborative programmes implemented during the 2004-2005 biennium	SEA/RC58/16
	7.2 Review of the detailed workplans for Programme Budget 2006-2007	SEA/RC58/12
	7.3 Guiding principles for strategic allocation of WHO's resources to regions and countries	SEA/RC58/13

* Originally issued as document SEA/RC58/1(Rev.2) dated 6 September 2005

8.	11th General Programme of Work of WHO covering the period 2006-2015: Review of process and draft contents	SEA/RC58/15
9.	Technical Discussions:	
	9.1 Consideration of the recommendations arising out of the Technical Discussions on Skilled Care at Every Birth, held on 6 July 2005	SEA/RC58/5
	9.2 Selection of a subject for the Technical Discussions to be held prior to the fifty-ninth session of the Regional Committee	SEA/RC58/4
10.	Health action in emergencies, including response to earthquakes and tsunamis of 26 December 2004	SEA/RC58/6
11.	International Health Regulations (2005)	SEA/RC58/7
12.	Asia-Pacific strategy on emerging diseases	SEA/RC58/8 and SEA/RC58/Inf.3
13.	Polio eradication: Final strategy	SEA/RC58/9
14.	Governing Bodies:	
	14.1 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	SEA/RC58/14 and SEA/RC58/Inf.4
	14.2 Review of the draft provisional agendas of the 117th session of the WHO Executive Board and the Fifty-ninth World Health Assembly	SEA/RC58/17

15.	Special Programmes:	
	15.1 UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases: Joint Coordinating Board (JCB) – Report on attendance by representatives from Bangladesh and Myanmar at JCB in 2005	SEA/RC58/10
	15.2 WHO Special Programme for Research, Development and Research Training in Human Reproduction: Policy and Coordination Committee (PCC) – Report on attendance at PCC in 2005 and nomination of a member in place of Thailand whose term expires on 31 December 2005	SEA/RC58/11
16.	Time and place of future sessions of the Regional Committee	SEA/RC58/3 (Rev.1)
17.	Adoption of the report of the fifty-eighth session of the Regional Committee	SEA/RC58/20
18.	Closure of the session	-

Annex 4

LIST OF PARTICIPANTS*

1. Representatives, Alternates and Advisers

Bangladesh

Representative	Professor (Dr.) Md Shahadat Hossain Additional Director General (In-charge of Director General) Directorate General of Health Services
Alternate	Dr Md Tajul Islam Director (Planning and Research) Directorate General of Health Services

Bhutan

Representative	H.E. Lyonpo (Dr) Jigmi Singay Minister Ministry of Health
Alternate	Dr Gado Tshering Officiating Secretary Ministry of Health

DPR Korea

Representative	Dr Kim Su Hak

* Originally issued as document SEA/RC58/18 (Rev.2) dated 8 September 2005

Minister of Public Health

Alternates

Mr Choe Il
WHO Focal person
International Organizations Department
Ministry of Foreign Affairs

Dr Sok Yong Guk
Officer
External Affairs Department
Ministry of Public Health

Mr Choe Yong Su
Officer
Ministry of Public Health

India

Representative

Mr Deepak Gupta
Additional Secretary
Ministry of Health and Family Welfare

Alternate

Mr B.P. Sharma
Joint Secretary (International Health)
Ministry of Health and Family Welfare

Indonesia

Representative

Dr Sri Astuti Suparmanto
Director-General of Community Health
Ministry of Health

Alternates

Dr Gunawan Setiadi
Chief

Bureau of Planning and Budgeting
Ministry of Health

Dr Mulya Hasjmy
Chief
Centre for Health Emergency and Response
Ministry of Health

Mr Imam Subekti MPH
Chief
Division of International Cooperation
Bureau of Planning and Budgeting
Ministry of Health

Maldives

Representative Mr Iliyas Ibrahim
Minister of Health

Alternates Dr Abdul Azeez Yoosuf
Deputy Minister of Health

Ms Shehenaz Fahmy
Deputy Director
Ministry of Health

Mr Yoosuf Naleez
Assistant Under Secretary
Ministry of Health

Myanmar

Representative Prof. Dr Kyaw Myint
Minister for Health
Ministry of Health

Alternates	Mr Than Aung Deputy Director-General Ministry of Health
	Dr San Shway Wynn Director (Public Health) Department of Health
	Mr U Thet Lwin Deputy Director, International Health Division Ministry of Health

Nepal

Representative	Mr Lava Kumar Devacota Secretary Ministry of Health and Population
Alternate	Dr Babu Ram Marasini Deputy Health Administrator Policy, Planning and International Cooperation Division Ministry of Health and Population

Sri Lanka

Representative	Hon. Mr Nimal Siripala de Silva Minister of Healthcare, Nutrition and Uva Wellassa Development
Alternates	Mr Ranjith Maligaspe Secretary Ministry of Healthcare, Nutrition and Uva Wellassa Development
	Dr Y.D.N. Jayatilaka Additional Secretary

Ministry of Healthcare, Nutrition and
Uva Wellassa Development

Dr H.A.P. Kahandaliyanage
Director-General of Health Services

Dr H.M. Fernando
Deputy Director-General (Public Health Services)
Ministry of Healthcare Nutrition and
Uva Wellassa Development

Dr H.S.B. Tennakoon
Deputy Director-General of Health Services
(Planning)

Dr S.M. Samarage
Director (Organization Development)

Thailand

Representative — Dr Supachai Kunaratanapruk
Deputy Permanent Secretary

Alternates — Dr Siripon Kanshana
Inspector-General

Dr Sopida Chavanichkul
Director, International Health Group

Mrs Piyachat Chelintrakool
Administrative Officer

Timor-Leste

Representative	Mr Basilio Martins Pinto Director Health Policy and Planning

2. Representatives from United Nations and Other Specialized Agencies in the SEA Region

United Nations Children's Fund (Regional Office for South Asia)	Dr Aberra Bekele Head of Early Childhood Programme UNICEF Sri Lanka Country Office Colombo – 3, Sri Lanka
United Nations Population Fund (UNFPA)	Ms Malathi Weerasooriya 202, Bauddhaloka Mawatha Colombo-7, Sri Lanka

3. Representatives from Inter-governmental Organizations

Office International de Epizooties (World Organization for Animal Health)	Dr Sri Kamal Ranjith Amarasekara Director-General Department of Animal Production and Health P.O. Box 13 Getambe Peradeniya, Sri Lanka
Asian Development Bank	Mr Alessandro Pio Country Director Sri Lanka Resident Mission ADB Sri Lanka Resident Mission 49/14-15, Galle Road Colombo, Sri Lanka Mr G. Amarasena

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The World Bank	Ms Kumari Navaratne Public Health Specialist World Bank 73/5 Galle Road Colombo-5, Sri Lanka

4. Representatives from International Nongovernmental Organizations

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	IUCN Asia Programme No. 53, Horton Place Colombo-7, Sri Lanka
International Diabetes Federation	Dr Mahen Wijesuria Chairman of the IDF South-East Asia Region and Member of the IDF Board of Management c/o Diabetes Association of Sri Lanka National Diabetes Centre 50 Sarana Mawatha Rajagiriya, Sri Lanka
South Asia Cooperative Environment Programme	Dr A.A. Boaz Director-General 10, Anderson Road Colombo-5, Sri Lanka
International Council for Control of Iodine Deficiency Disorders	Prof. M.G. Karmarkar Senior Adviser ICCIDD, Centre for Community Medicine All India Institute of Medical Sciences Ansari Nagar New Delhi – 110029, India
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	Dr Tulsi Basu

	10, Pratapaditya Road Kolkata – 700026, India
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International Paediatric Association	Professor Manouri Senanayake Department of Paediatrics University of Colombo Kynsey Road Colombo-8, Sri Lanka
International Pharmaceutical Federation	Prof. Tuley De Silva General President Sri Lanka Association for the Advancement of Science President, Pharmaceutical Society of Sri Lanka 451/75, Thimbirigasyaya Road Colombo-5, Sri Lanka
International Planned Parenthood Federation	Ms Chandrika Subasinghe South Asia Regional Office 12/2A Salmal Mawatha Nedimala, Dehiwala, Sri Lanka
The World Confederation	Mrs Theeravati Fernando

for Physical Therapy	Representative Asia-Western Pacific Region World Confederatoin for Physical Therapy 174A, Castle Street, Borella Colombo-8, Sri Lanka
Rotary International	Mr K.R. Ravindran Governor 1991-92 77, Nungamugoda Road Kelaniya, Sri Lanka

Annex 5

LIST OF OFFICIAL DOCUMENTS*

SEA/RC58/1 Rev.2	Agenda
SEA/RC58/2	The Work of WHO in the South-East Asia Region: Report of the Regional Director covering the period 1 July 2004 – 30 June 2005
SEA/RC58/3 (Rev.1)	Time and place of future sessions of the Regional Committee
SEA/RC58/4	Selection of a subject for the Technical Discussions to be held prior to the fifty-ninth session of the Regional Committee
SEA/RC58/5	Consideration of the recommendations arising out of the Technical Discussions on Skilled Care at Every Birth, held on 6 July 2005
SEA/RC58/6	Health action in emergencies, including response to earthquakes and tsunamis of 26 December 2004
SEA/RC58/7	International Health Regulations (2005)
SEA/RC58/8	Asia-Pacific strategy on emerging diseases
SEA/RC58/9	Polio eradication : Final strategy
SEA/RC58/10	UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases: Joint Coordinating Board (JCB) - Report on attendance by representatives from Bangladesh and Myanmar at JCB in

* Originally issued as document SEA/RC58/22 dated 13 September 2005

	2005
SEA/RC58/11	WHO Special Programme for Research, Development and Research Training in Human Reproduction: Policy and Coordination Committee (PCC) - Report on attendance at PCC in 2005 and nomination of a member in place of Thailand whose term expires on 31 December 2005
SEA/RC58/12	Review of detailed workplans for Programme Budget 2006-2007
SEA/RC58/13	Guiding principles for strategic allocation of WHO's resources to regions and countries
SEA/RC58/14	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
SEA/RC58/15	11th General Programme of Work 2006-2015: Review of process and draft contents
SEA/RC58/16	Review of WHO collaborative programmes implemented during the 2004-2005 biennium
SEA/RC58/17	Review of the draft provisional agendas of the 117th session of the WHO Executive Board and the Fifty-ninth World Health Assembly
SEARC58/18	List of participants
SEA/RC58/19	Report of the Sub-committee on Credentials
SEA/RC58/20	Draft report of the fifty-eighth session of the Regional Committee for South-East Asia
SEA/RC58/21	Decisions and list of resolutions
SEA/RC58/22	List of official documents

SEA/RC58/23	Report of the fifty-eighth session of the Regional Committee for South-East Asia

Information Documents

SEA/RC58/Inf.1 (Rev.1)	List of meetings organized and list of technical reports and advocacy material issued in the South-East Asia Region during the period 1 July 2004 – 30 June 2005
SEA/RC58/Inf.2	List of workplans in operation during 2004-2005 (Regular Budget)
SEA/RC58/Inf.3	Asia-Pacific strategy on emerging diseases
SEA/RC58/Inf.4	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 WHA resolution WHA 58.26: Public health problems caused by harmful use of alcohol

Resolutions

Annex 6

TEXT OF REGIONAL DIRECTOR'S INTRODUCTORY REMARKS ON HIS ANNUAL REPORT

It is a requirement for me to submit to the Regional Committee an annual report on the work of WHO in the Region.

The report (SEA/RC58/2), which is placed before the Committee, covers the period from 1 July 2004 to 30 June 2005. It elaborates the work of WHO during the past year covering areas from Communicable Disease Control to Health Systems Development.

During the period under consideration, there were many factors that contributed to the already formidable health challenges in the Region. Natural calamities of an unprecedented scale struck many countries. These increased the burden on the already overloaded health systems. Local conflicts in several places made it more difficult for health activities to be delivered. Political considerations played a major role in health development processes at all levels. In particular cases, this made it more difficult to mobilize resources for health in certain countries. Increasingly, health issues became public and political concerns. As such, health development needed much stronger multisectoral and multidisciplinary actions. Globalization and trade liberalization played a clearly visible role in the area of health. In spite of all these factors, the overall morbidity and mortality in the Region were kept well under control. Workforce still contributed positively to the growing economy of countries.

In a more specific context, the Region was still overwhelmed with communicable diseases. In addition, noncommunicable and chronic conditions kept emerging. To a larger extent, and of a bigger magnitude, the countries really faced a double burden of diseases.

These are only a few challenges among many that we are facing. Within this scenario, WHO in the Region needs constant reform to ensure that it lives up to the expectations of Member States.

During the period under review, implementation in the Region of WHO's global policy on decentralization and delegation of authority was intensified. More and more WHO activities moved from the Regional Office to the countries. Country-focus approach became our principal means to better serve the Member States. Country-specific needs and requirements were identified for WHO response. We hope that this reform initiative would be made more effective in the years to come.

Now, let me briefly touch on some of the noteworthy features of our work during the period under review. To effectively combat emerging infectious diseases, the Regional Office developed a vision paper to be used as a policy and strategy guide for programme development.

On international control of disease outbreaks, Member States were closely involved in the revision process of the International Health Regulations. For certain communicable diseases of high priority, Regional Advisory Groups were formed. These technical groups will provide advice on policies, strategic directions, as well as technical and operational aspects in the concerned areas.

Assessment of surveillance and response capacity was concluded in a number of countries. Support was provided for the development of national plans for epidemic preparedness and response, including the

case of influenza pandemic. Vigorous actions were undertaken to help affected countries in the prevention and control of outbreak of avian influenza in humans.

Polio transmission in our Region continued to decline. In India, in 2004, only 134 cases were detected, the lowest ever for this country. This year, only 26 cases were reported as of 22 August. However, the recently-imported cases of polio in Indonesia demonstrated that all countries continued to be at risk until wild poliovirus is completely eradicated from the world.

Leprosy is to be eliminated as a public health problem by the end of this year. The Global Leprosy Programme was transferred from WHO headquarters to the Regional Office. This change, it is hoped, will greatly augment our efforts in leprosy elimination.

On tuberculosis, over 90 per cent of the population in the Region now lives in areas accessible to DOTS service. Three countries in the Region have already achieved the global targets of 70% case detection, and 85% treatment success among reported cases.

In addition, the Region embarked on two new initiatives in the area of communicable disease: kala-azar elimination by 2015 in the three endemic countries: Bangladesh, India and Nepal; and yaws eradication by 2010 from India, Indonesia and Timor-Leste. For kala-azar elimination, a strong political commitment was shown through the signing of a Memorandum of Understanding in May by the three affected countries.

Significant progress was made by countries in mainstreaming HIV prevention, care and treatment into their ongoing national health programmes. The number of people on ART increased from 37 500 in January to 90 000 in April this year. However, it was still too low

compared to the target of 400 000 by the end of 2005. Whatever efforts we have devoted to the prevention and control of this scourge, HIV epidemic continued in the Region.

The emergence and possible spread of drug-resistant malaria parasite is causing grave concern. With WHO technical support, national treatment policies in endemic countries were revised. Malaria morbidity and mortality showed a declining trend. But the proportion of a more severe type of malaria (Plasmodium falciparum) had increased significantly over the past many years.

Eighty-six percent (1.3 billion) of the population in the Region are at risk for dengue. Among others, WHO provided support for investigation and control of the dengue outbreak through integrated measures.

Nine endemic countries in the Region accounted for 64% of the global burden of lymphatic filariasis. Under the programme on elimination of lymphatic filariasis by 2020, all those countries commenced mass drug administration.

Public health laboratories continued to provide critical support to public health programmes, especially in disease surveillance and outbreak control. National networks of laboratories were strengthened through the utilization of expertise available within the Region.

Noncommunicable diseases accounted for 44% of the disease burden and 51% of deaths in the Region. In nine countries, WHO assisted in the development of a national NCD information base on risk factors. Epidemiological surveillance of major NCDs was undertaken with the focus on a systematic collection and utilization of data. A regional network for prevention of chronic diseases, SEANET-NCD, was established to facilitate exchange of information and promote the application of strategic approaches in this area.

As part of the Global Information System on Tobacco Control, a regional online database was developed. National action programmes for reduction of tobacco use among youth were initiated. Vigorous support was also provided for strengthening national capacities in the implementation of the WHO Framework Convention on Tobacco Control.

Development and implementation of a strategy on mental health promotion had been advocated as part of community and population-based mental health care. Also, capacity building in existing health care facilities was pursued to reduce the huge treatment gap for common neuropsychiatric conditions.

Last year, the tsunami struck the coastal areas of six countries in the Region. It caused unprecedented devastation to livelihood and the life of a large number of population in those countries. There was large-scale mobilization of forces and resources to help the concerned governments. WHO, among many other agencies, came forward in a big way to support those governments in emergency relief operations. Technical guidelines and manuals for use in emergency operations were widely disseminated and used in the fields. There were no major disease outbreaks in the affected areas in the aftermath of the tsunami. This was due to the commendable work done by public health workers in those countries.

In the areas of Family and Community health, nine of the 11 Member States continued to implement the Integrated Management of Childhood Illness (IMCI) programme. Guidelines for emergency management of common diseases in young children were developed and made available to all Member States.

Neonatal survival is a major challenge in the Region. The death toll of newborns accounts for 1.4 million annually. A regional strategy for

promoting neonatal health was used as a framework for the development of national programmes.

Universal use of evidence-based norms and standards for maternal and newborn care was promoted to ensure quality services. In the area of reproductive health, efforts were focused on ensuring skilled care at every birth. A regional training module for Reproductive Health Library (RHL) was published and widely used in countries.

The adverse impact of gender inequities on women's health is an area of concern for the Region. Reorientation of medical and public health education programmes was encouraged to ensure the integration of gender issues in the planning and delivery of health services.

Arsenic poisoning continued to be a problem of public health importance in several countries of the Region. Support to the countries was continued in the management and surveillance of arsenicosis. WHO field guidelines for arsenic detection and mitigation were widely disseminated and used.

The implementation of a policy on management of health care wastes, in line with international agreements, was promoted. Through this policy, the Regional Office, in collaboration with an educational institution in the Region, initiated a six-month certificate course on the subject.

In the area of Health Systems Development, the 'South-East Asia Public Health Initiative' was launched. To support the development in this initiative, a network of South-East Asia Public Health Educational Institutes (SEAPHEIN) was formed and became operational. The focus of this development during the past year was to support countries in

strengthening public health education programmes to ensure the availability of a competent public health workforce.

For our Region, resource mobilization for health is important indeed. A strategic action plan for resource mobilization during the period 2004-2005 was developed and implemented.

Resource flow to the Region during the period under review reached the highest level ever. As of 29 August 2005, the total voluntary contributions was US$ 208.5 million – well over the target of US$ 191.5 million projected for the 2004-2005 biennium.

During the period under review, the Regional Office further strengthened its collaboration with other partners, both within and outside the UN system. The fruit of this stronger partnership was that more external resources became available for supporting health development in the Region.

To repeat, these are only some of the noteworthy points in the report under consideration. A detailed account may be found in the document SEA/RC58/2.

I wish I could have reflected the impact of WHO's response to country needs in much clearer terms. To be able to do so, we should have pursued a more in-depth assessment of such response. In future, we will pay much more attention to such assessment in WHO's collaborative programmes with countries.

Whatever be the overall climate of health development, Member States should be assured that WHO in the Region would continue its best to serve them. We will continue to intensify improvements in our performance, to ensure improved quality of our services to the countries.

Certainly, to be able to effectively fulfil our mandated role, we really need the unwavering support of Member States in the Region, particularly, support at policy and political levels.

Annex 7

TEXT OF ADDRESS BY THE DIRECTOR-GENERAL, WHO

It is good to be back here in Sri Lanka. Eight months ago (4-8 January) I was in Kalmunai and Galle in Sri Lanka, and Aceh in Sumatra; critical arenas of the tsunami crisis. You have achieved so much in this short time. Those scenes of devastation and distress - broadcast worldwide - have changed. You have moved from disaster to reconstruction. There is still much more to do, but essential progress has been made.

The key legacy of the tsunami for the public health of the Region is the importance of strengthening health systems to be capable of detecting and dealing with disease at a very early stage. This is a lesson that must be taken very seriously. As we saw on television in the United States, there are other emergencies waiting to happen. You have to be prepared to cope with them. We will give you our full support to do this.

We are closer to a pandemic of flu than at any time since 1968. It is not a question of whether the pandemic will come, but "when" it will come. In this Region, avian flu virus is already firmly entrenched in poultry in parts of Indonesia and Thailand. It is also known to be present in many parts of Viet Nam, some areas of Cambodia, China, and possibly Laos. In late July this year the virus was carried beyond Asia, being also found in Russia and Kazakstan.

The known bird reservoirs have been decisively handled. Over 140 million birds have been culled. This was an essential contribution to control pandemic flu by poor farmers. This sacrifice is very much appreciated, especially because those who lost their livelihood had little

or no financial compensation. This needs consideration in future. Further culls may well affect a multitude of small farmers who cannot afford to lose their flocks and may need an incentive to comply. The associated economic losses from the first cull are estimated at between 9.7 and 14.6 billion dollars. It is impossible to know or to guess how much higher the cost of inaction would have been. Based on this, culling was justified.

Inaction is not an option now. We know that influenza is coming. We must prepare for it now.

So far, a total of 112 human cases have been confirmed in four countries: Cambodia, Indonesia, Thailand and Viet Nam, with 57 fatalities. Fortunately, so far the virus has not crossed easily from birds to people, nor has it spread easily among humans. But the geographical range of the virus increases opportunities for human cases to occur. These in turn increase opportunities for the virus to become more contagious.

WHO has recently prepared guidelines to help countries prepare effectively for a pandemic. They have been sent to all Member States and copies are here for you today. The guidelines detail the strategic actions to take, in three phases. What we have to achieve now, in the pre-endemic phase, is the reduction of opportunities for human infection and a strengthening of the early warning system. This tactical response goes together with taking the best medical precautions available.

Rapid deployment of assets and resources contain outbreaks at an early stage. That means availability of health care workers, antiviral medicines like Tamiflu, vaccines against influenza, and quarantine or other measures. Scaled up vaccine production requires rapid technology transfer. We know that the demand far outstrips supply. We have therefore to find a way to avoid this bottleneck and expand vaccine manufacturing sites. Currently fewer than 10 countries have domestic vaccine companies engaged in work on a pandemic vaccine. Trained

health workers are needed to deal with the pandemic and educate the public in epidemic response. This may involve the need to create quarantine sites and close schools and other public places. We must also keep firmly in mind that the threat of a pandemic has political and social dimensions. Poorer countries will not be able to protect themselves as effectively as the wealthy.

In the past, developing countries usually received vaccines after the pandemic has passed. This should not be the case this time.

Massive international cooperation is needed now to contribute towards global antiviral stockpiles and pandemic vaccine development. Decisive action is needed now by donors and international partners to help the countries affected to limit the scale of the bird flu outbreak and to reduce the risk for humans. Clearly, if we had known a year ago that the tsunami is going to strike, we would have been prepared. This is another kind of tsunami, which we know will come. Now we have the time and the will to be prepared for it.

Turning to polio. In just four months India developed a monovalent oral polio vaccine type 1 and is using it with great success. There have been no further type 1 cases in India for two months. There is a real chance that transmission of indigenous virus can be stopped by the end of this year. And it must be stopped. Conclusively.

Polio eradication is a priceless gift for the whole world. We must protect the progress we have made so far. Indonesia is doing this with its massive response to an imported poliovirus, vaccinating 24 million children across the country in just two days. These activities have an immediate local focus, but global implications for polio eradication. Previously there was some debate over whether it was wiser to focus resources on polio eradication single-mindedly or to use these resources more broadly for EPI or building the infrastructure. Now, at this stage, our

only option is to finish the job. The many lessons we have learnt can be applied in the future, At this point, we must complete thie polio eradication campaign.

The populations of Bangladesh and Nepal have been able to prevent reinfection by poliovirus. Sharp vigilance and efficient early warning systems allow for quick response. In some parts of the Region the surveillance networks already include other vaccine-preventable diseases including measles and neonatal tetanus. The people working in them are a vital workforce not just for polio but for all disease outbreaks.

While we must be able to cope with crises, the long-term work towards health for all is a measured, planned process. Our common vision for the next decade recognizes that health is influenced by a wide range of non-medical factors like poverty and education. Social, environmental, economic, and political issues, such as intellectual property rights and trade agreements play a part in health outcomes. Their consequences are clear in the accumulating burden of chronic disease and the continuing death toll from infectious diseases like HIV/AIDS, tuberculosis and malaria. However, the question of how to apportion responsibility for reducing or stopping their causes is a complex one. Your discussion later on the draft general programme of work will make an important contribution to this.

There are important equity issues we have to face boldly in looking at the resources needed to deal with a flu pandemic. Those issues, of making life-saving measures available to all, equally, are already pressing. Two years ago I talked to this Regional Committee about getting 3 million people onto antiretroviral treatment by the end of 2005 as a first step towards universal access. Many people thought that "3 by 5" was too ambitious. Good. We should set aggressive targets. But it was a lot to achieve in the time-frame. Reaching 3 million people will take

a little longer than originally anticipated. But the principle of universal access remains a key objective.

Much has been achieved in a short space of time. Close to 1 million people were on antiretroviral treatment at the end of June in low and middle-income countries. Based on this progress, universal access is now increasingly recognized worldwide as a moral and social imperative, and as a practical necessity. The commitment made by Member States to increase access to treatment has become a movement which now cannot be turned back. This has inevitably led to the G8 recently setting an even more ambitious target. This was to get "as close as possible to universal access to treatment for all those who need it by 2010". Access for everyone to the treatment they need is now recognized as not only absolutely necessary for people who live with HIV, but entirely feasible.

Overall, antiretroviral drug prices are falling as more products become available and the market expands. WHO has already prequalified 63 antiretroviral drugs, including 29 generic formulations. The recent confidentiality agreement between WHO and the US Food and Drug Administration will further support the prequalification programme, speeding up the availability of lower-priced generic antiretroviral medication.

By making treatment more widely available, more people are now motivated to come forward for testing. This is especially important to avert the spread of HIV infection among young people in the Region. The availability of testing and counselling must be further expanded for the more than 7 million people living with HIV in this Region. Treatment and prevention go hand in hand, each supporting the other's ability to save lives.

Over the years of the polio eradication effort, we have together made progress towards almost universal vaccine coverage in polio-endemic

countries. Universal access is also a key to tuberculosis control. India and Indonesia have made major progress in the area of tuberculosis control. But this Region still has the highest burden of tuberculosis globally and there is much more to be done to reach the targets for 2005 and for the Millennium Development Goals. Indeed, if this Region does not meet its goals, the world will not, since one third of all cases are found here.

"Make every mother and child count" was the theme of this year's World Health Day. Here too, financial barriers to access need to be reduced and an effective workforce built.

Let's look at the story of one person, Renu Sharma from Delhi. At the time this photograph was taken she was five months' pregnant with her third child and still working hard to look after the family's livestock and fields. She had not yet had her first antenatal checkup, although she is lucky in having a clinic just one km away. Almost half of all pregnant women in India never attend an antenatal clinic and in 2000, 136 000 Indian women died in childbirth. Four months later in hospital, Renu successfully delivered little Monica, who weighed 3 kg. She was lucky to get one of the nine beds; there were 25 other women waiting. Yet less than half of deliveries in India are assisted by a skilled birth attendant. Within her first week of life, Monica has been vaccinated against polio, TB and hepatitis, substantially improving her chances of survival. In India, 33 out of every 1000 babies die in their first 7 days of life from preventable disease and one in 12 die before they reach the age of five.

These are the figures that we have to change. All the Monicas of this world must have the best possible chance of health - equally. We need to keep those individuals firmly in our minds as we consider the large-scale plans of public health.

The adoption of the International Health Regulations 2005 by the Health Assembly this year was a historic step towards building improved health security and improving global coordination. No effort must be

spared to build the necessary mechanisms for disease detection, alert response and information-sharing, both within countries and between them.

Despite the many challenges for controlling infectious diseases, we cannot afford to ignore NCDs. Cancer and cardiovascular diseases are now the leading cause of death worldwide. The global report on preventing chronic disease, coming out in October, will stress the importance of taking steps now, in all developing countries, to curb the rise of cancer, cardiovascular disease, chronic respiratory disease and diabetes, among others.

I thank all of you whose countries have signed the Framework Convention on Tobacco Control and especially those nine countries that have ratified it in this Region. I urge the two countries that have not yet ratified to do so in order to become Parties to the Convention, In February 2006, the first meeting of the Conference of the Parties to the FCTC will be held. The Convention is an excellent example of how international cooperation can provide strong support for national efforts to tackle the root causes of many cancers and heart disease.

There is great potential for progress here. The main problems are known, recognized, and are being tackled. There are tools on hand to deal effectively with disease epidemics. The decisions you will be making this week can speed up these positive trends, and bring equitable, life-saving interventions to the many people who count on your support.

I wish us all success in the important discussions of this week.

Thank you.

Annex 8

REPORT OF THE FORTY-SECOND MEETING OF THE CONSULTATIVE COMMITTEE FOR PROGRAMME DEVELOPMENT AND MANAGEMENT*

1. Introduction

The Forty-second Meeting of the Consultative Committee for Programme Development and Management (CCPDM) was held at the Pan Pacific Sonargaon Hotel, Dhaka, Bangladesh, from 5-7 July 2005. Government representatives and WHO representatives from all Member States of the South-East Asia (SEA) Region participated.

2. Inaugural Session

Opening Remarks by the Regional Director

Welcoming the participants to the Forty-second Meeting of the CCPDM, Dr Samlee Plianbangchang, Regional Director, WHO SEA Region, thanked the Government of the People's Republic of Bangladesh and its Ministry of Health and Family Welfare for hosting the meeting.

* Originally issued as document SEA/PDM/Meet.42/11, August 2005

The Regional Director pointed out that those who were familiar with the CCPDM meeting might be surprised to see the big gathering at this year's meeting. This was because there would be a detailed review and finalization of workplans for the 2006-2007 biennium in the parallel sessions to be conducted during the meeting. All WHO representatives and senior staff members of the Regional Office and country teams would review and finalize the workplans. He requested the country representatives to split themselves into appropriate groups to cover all the sessions.

The Regional Director stated that the CCPDM was serving as the executive arm of the Regional Committee, which was the only constitutional body of WHO at the regional level. In this role, CCPDM was dealing particularly with matters relating to programme development and management of the Organization's work in the SEA Region.

Dr Samlee informed the gathering that the highlight of the CCPDM agenda this time was the biennial Programme Budget (PB) for 2006-2007. In addition, review and finalization of biennial workplans and other issues, such as criteria for distribution of additional Assessed Contributions (Regular budget) among countries in the Region, and ICP-II successor arrangement would also be discussed.

The participants were also informed that the World Health Assembly this year had approved a 4% increase in Assessed Contributions (AC) for the PB 2006-2007. As a result of this increase, USD 5.797 million will accrue to the SEA Region. After allocating a little more than one million US dollars to the Regional Office intercountry project, the rest would be distributed among

Member States. Dr Samlee further stated that the Secretariat had completed an exercise on criteria to be used in distributing this budget increase among countries in the Region, and that this matter would be presented and discussed during the course of the meeting.

The Regional Director stated that the supplementary intercountry programme or ICP-II will cease to exist from the next biennium onwards. The Regional Working Group on Programme Budget Development established by the Regional Committee last year recommended, among others, the procedures for multicountry activities to replace ICP-II. The Regional Director recalled that the purpose of ICP-II was to promote cooperation among countries in the Region, and that it had served this purpose very well during the past many years. However, in developing ICP-II, the country budgets at the Regional level had to be pooled. This was against the principle of decentralization of resources in WHO. Therefore it had been decided to stop ICP-II. At the same time, there was still the necessity to have a certain arrangement for promoting such intercountry cooperation without taking away WHO country funds from countries. Therefore, the idea of multicountry activities had been planned within the individual WHO country programmes.

The Regional Director also stated that the total budget for the SEA Region for the 2006-2007 biennium was USD 357 million compared with USD 285 million for the 2004-2005 biennium, thereby representing a 25% increase. However, 72% of the total budget for 2006-2007 would come from Voluntary Contributions (VC) or extrabudgetary resources. He further said that VCs were mostly earmarked for specific purposes by donors; only about 10%

of these were unspecified. Therefore, the implementation of biennial workplans which integrated Regular budget and VCs together would face a limitation in terms of financial flexibility.

Dr Samlee mentioned that as part of WHO's country focus and country-specific approach, the Regional Office staff were constantly encouraged to work with country offices, and get involved in the implementation of country programmes. In order to promote the involvement of the Regional Office staff, joint planning between countries and the Regional Office had been pursued in the course of developing the WHO country workplans. This mechanism had proved very effective in promoting joint efforts and activities between staff at these two levels. WHO had applied the principle of results-based management in developing and managing its programmes. The joint planning between countries and the Regional Office had reinforced the formulation of expected results, which were the prime concern in the programme budgeting process. These expected results will also be used to drive the Organization's efforts in resource mobilization for supporting the implementation of workplans.

The Regional Director drew the attention of the participants to the topic of Technical Discussions, viz. Skilled Care at Every Birth, to be discussed during the meeting. He mentioned that several countries of the Region continued to have high maternal and neonatal mortality and stressed the need to do much more to improve the care for mothers and newborns during birth. He expressed the hope that these discussions would help identify new initiatives that could lead to the development of a more effective programme for the reduction of maternal and neonatal mortality.

The Regional Director informed the participants that the CCPDM had originated from a “Small Committee” established by the Regional Committee in 1980. The role and functions of the CCPDM had evolved during these years. In 1998, the Regional Committee decided that the CCPDM should take over the functions of its Sub-Committee on Programme Budget. Since then, the CCPDM had been serving as the executive arm of the Regional Committee in matters relating to programme development and management. It comprised high-level country representatives at decision-making level from all countries in the Region. It met once a year to prepare, as mandated by the Regional Committee, the technical materials for consideration of the Committee. In order to further strengthen the work of the Regional Committee through this mechanism, the Regional Director urged for more involvement of CCPDM. This may be in the form of its sub-committees on various specific issues relating to programme development and management. To do so effectively, there was a need to have an annual workplan for CCPDM, so that the Committee members would know in advance when to do what.

Dr Samlee also pointed out that roles of the Health Secretaries meeting and the CCPDM meeting were very much related to each other, and therefore the work of these two important Regional bodies needed to be well coordinated. They also needed to be organized back-to-back. As a lot of effort from members of the WHO Secretariat was required for the organization and conduct of these meetings, from the next year onwards, these back-to-back meetings were planned to be held at the Regional Office in New Delhi.

The Regional Director concluded by thanking the Government of the People's Republic of Bangladesh and its Ministry of Health and Family Welfare for hosting this meeting and for the excellent arrangements made. He wished the meeting a grand success.

3. Election of Chairperson and Rapporteur

H.E. Prof. Dr Mya Oo, Deputy Minister for Health (Myanmar) was elected Chairperson, for both CCPDM and Technical Discussions on Skilled Care at Every Birth. Dr Gado Tshering (Bhutan) was elected as Rapporteur for CCPDM meeting.

Dr Gunawan Setiadi (Indonesia) was elected Rapporteur for the Technical Discussions on Skilled Care at Every Birth.

4. Establishment of Drafting Group *(Agenda item 2)*

A Drafting Group, comprising Dr Khandaker Rashedul Haque (Bangladesh), Mr Bhanu Pratap Sharma (India), Dr Imam Subekti (Indonesia), Ms Shehnaz Fahmy (Maldives), Dr Nirakar Man Shrestha (Nepal) and Dr Nipunporn Voramongkol (Thailand) was constituted to prepare the report of the meeting.

5. ICP-II Successor Mechanism *(Agenda item 3.1)*

Dr R.M. Brooks, Planning Officer, WHO/SEARO, made a short presentation on the key technical aspects of the ICP-II successor mechanism, highlighting the fact that the supplementary intercountry programme (ICP II) would cease to exist at the end of the 2004-2005 biennium. In the coming biennium, i.e. 2006-

2007, ICP-II funds will be retained in respective country budgets. On recommendation of the 41st meeting of the CCPDM, the Regional Director, in August 2004, established a Regional Working Group (RWG) on Programme Budget Development and Management comprising representatives from all Member States in the Region. The terms of reference of the RWG were confirmed by the 57th session of the Regional Committee. It included recommending ways and means of replacing the existing ICP-II mechanism while, at the same time, protecting the ability of the Regional Office to discharge its normative functions, and to continue its technical cooperation vis-à-vis Member States in the Region.

The RWG recommended that multicountry initiatives should continue even after ICP-II was phased out at the end of the 2004-2005 biennium. The RWG further concluded that future multicountry initiatives would be managed by WHO's country offices, through joint planning and workplan development with Member States.

Dr Brooks emphasized that the challenge now was to see how WHO country offices identified the multicountry activities (MCAs) through joint planning with Member States in order to reflect them in country workplans for the 2006-2007 biennium. The Secretariat, based on the recommendations of the Working Group, had developed guidelines for the ICP-II successor mechanism to generate ideas for multicountry activities, and for their planning and monitoring.

The highlights of Dr Brook's presentation were:

- The workplans for PB 2006-2007 were being finalized, while the mechanism for planning and implementation had already been developed.

- The RWG recommended that MCAs be continued despite the end of the ICP-II mechanism. The MCAs will provide clear benefits to countries of the Region. Funds for MCAs should be as large or even higher than the ICP-II level, i.e. 5.35%.

- Countries should be incharge of joint planning of MCAs and should be free to use technical services from various sources. Implementation of MCAs could either be in countries or in the Regional Office, depending upon willingness and capacity.

- MCAs are meant to benefit two or more countries, as it is more efficient for countries to implement some activities together rather than separately. Countries should participate in MCAs and provide funds for them in country budgets.

- Former ICP-II funds would be reverted to country budgets. However, these funds would be used for MCAs only.

- Both country offices and the Regional office needed to be proactive in planning MCAs. However, the final decision about participation in MCAs will be determined by country offices. As the Regional Office had a better knowledge of overall country interests, it could facilitate the planning of MCAs.

- Countries can propose that MCAs be included in their workplans. MCAs should be indicated in workplans at activity, product or office-specific expected result (OSER) level.

- There are two options of coordinating the MCAs. The first option would be at the country level and the second at the Regional Office level.

- Implementation of MCAs could either be at the country or regional level. Administrative arrangements need to be established to simplify implementation and ensure transparency. There must be an agreement of all involved countries on implementation procedures and monitoring.

- A group comprising staff from the Regional Office and country offices needs to be formed to undertake assessment of MCAs at the end of the biennium.

Discussion Points

- The idea behind ICP-II was to address the issues of multicountry nature. Since ICP-II mechanism would cease to exist at the end of the 2004-2005 biennium, the respective allocations from country Regular budget will now be available at the country level. Since the problems requiring multicountry collaboration would still remain, Member States should continue to set apart a minimum of 5.35% of RB for MCAs. The experience with implementation of MCAs in the 2006-2007 biennium should be reviewed in

early 2007 and depending on the outcome of this review, suitable adjustments should be made in the programme.

- The High-level Task Force (HLTF) mechanism may be needed to facilitate MCAs.

- MCAs would have two components. First, the programme content in respective countries and, secondly, the intercountry meetings. As far as the first component was concerned, there may not be any difficulties in sharing of expenditure as the cost relating to any individual country's participation in MCAs can be worked out precisely. The share of costs pertaining to an individual country can be apportioned accordingly. The second issue however offers difficulties in terms of equity for working out the principle of sharing. It would be desirable to refer this issue to HLTF for advice.

- Funds for MCAs should not be used to support attendance at international conferences and for study tours. However, these could be used to finance participation in meetings related to MCAs.

- Funds for MCAs should be supplementary and should not be used for large programmes like International Health Regulation (IHR). Such large programmes would be funded from other sources through the Regional Office workplans.

- While it was advisable to limit the MCAs within the SEA Region, at times it would require collaboration with other countries outside the Region. There should be sufficient

flexibility to implement such MCAs. However, in such instances, the Regional Office should be consulted.

Recommendations

(1) The CCPDM recommended that both the options set out in the agenda be used, depending on the nature of MCAs. As per the first option, the WHO Representatives (WRs) are to take proactive role in coordinating MCAs proposed by national authorities with concerned WHO counterparts of participating countries. As per the second option, participating Member States could approach the Regional Office directly, to organize MCAs. The Regional Office in such cases would assign a Regional Adviser for this purpose to provide technical advice and coordination.

(2) The CCPDM requested the Regional Office to draw up and disseminate guidelines regarding MCAs. It was also requested to identify and disseminate the list of MCAs which could be taken up in the 2006-2007 biennium.

(3) For planning, implementation and monitoring of MCAs, there will be a need for close coordination between countries involved and the Regional Office.

(4) The Regional Office should get an evaluation of the MCA mechanism used for 2006-2007 done at the beginning of 2007 itself. The outcome of the evaluation should be shared with all Member States of the Region so that appropriate decision on the continuance of MCAs could be taken.

(5) At least 5.35% of country budget should be earmarked for MCAs.

6. Programme Budget 2006-2007 *(Agenda item 3.2)*

Dr R.M. Brooks made two presentations, first on the general introduction of the Programme Budget 2006-2007, and second on the distribution of increased assessed contribution (Regular budget) funds to countries under the 2006-2007 Programme Budget. The highlights of his presentations were:

General Information

- In general, the country workplans showed appropriate Regular budget but the workplans under-budgeted the VCs. The shortfall of VCs was about USD 50 million and mainly in the six Areas of Work (AoW), namely Communicable Disease Prevention and Control; Epidemic Alert and Response; HIV-AIDS; Child and Adolescent Health; Immunization and Vaccine Development, and Emergency Preparedness and Response.

- It was observed that in country workplans for priority programmes, there was a gap in the amount of USD 8.3 million in the Regular budget. The Areas of Work were: Epidemic Alert and Response; Making Pregnancy Safer; Child and Adolescent Health, and Noncommunicable Disease and Tobacco.

- There was need to apportion more Regular budget funds to priority programmes. More needed to be done to monitor the distribution of VCs to all AoWs.

- Much more was required to balance the distribution of VCs to all AoWs.

Increased RB allocation

- For the Programme Budget 2006-2007, Regular budget will be increased for the first time in a decade. The World Health Assembly in May 2005 approved a 4% increase in Regular budget. The budget for SEA Region will be increased by USD 5.8 million which represents 6.2% increase over the previous biennium.

- Countries in the SEA Region would receive over 80% of the Region's increased Regular budget allocation for PB 2006-2007. The RWG recommended that regular budgets should in no case be reduced, and that it be ensured that countries in greatest need are protected. The recommendations of the Working Group should be considered by the Regional Committee meeting in September 2005.

- The proposed criteria for distributing the increased RB funds to countries are: current health situation of countries – emphasizing primary health care and equity; countries in greatest need, and correction of imbalances in basic allocations. This would ensure that WHO's core presence in countries will support all national governments.

- The decision on distribution of additional Regular budget funds shall be taken at the Regional Committee meeting in September 2005.

Discussion Points

- In future, the estimated figures for OS/VCs in respect of the Programme Budget should be conveyed to countries on time so as to achieve better planning.

- With regard to the budget gap between approved figures and planned figures pertaining to priority areas, it was noted that the gap might have been far less if the estimated figures had been conveyed to countries on time. It also needed to be appreciated that some priority areas were already receiving substantial funding from other donor agencies and as a consequence, some countries had not used the scarce WHO biennium funds for those areas.

- In respect of the increase in the Regular budget allocations which will be available for 2006-2007, it was noted that on the recommendation of the fifty-seventh session of the Regional Committee, a regional working group on resource allocation had been formed. The draft recommendations of the RWG were considered by the CCPDM. The RWG had given two options for distribution of additional resources:

Option 1

(i) Burden of Disease;

(ii) Poverty, and

(iii) Health system indicators (e.g. skilled birth attendants ratio, measles immunization coverage).

Option 2

(i) A selection of 10 MDG indicators, i.e. poverty gap ratio, prevalence of underweight children, primary education enrolment ratio, literacy rate of 15-24-year olds, infant mortality rate, under-five mortality rate, maternal mortality ratio, measles immunization coverage, HIV/AIDS prevalence, skilled birth attendants ratio; and access to urban/rural safe water, and

(ii) Population adjustment factors

- Most Member States were in favour of Option 2. A view was also expressed that the distribution formula should be flexible enough to accommodate any emergent needs of a country.
- Priority should still be given to countries in greatest need.
- Indonesia offered to donate their share of the increased allocation under RB 2006 – 2007 biennium to Timor-Leste.
- If the second option was to be adopted, the population adjustment factor should be such that it would give the same result as the population factor under the previous formula.
- Technical support provided to the countries for mitigating the adverse effects of food contaminated by chemical agents should be included in the Regional Office workplans.

Recommendations

(1) Countries should increase planned activities (both under RB and OS) for priority areas so as to reduce the budget gap to the extent possible, and

(2) For allocation of additional RB funds, the CCPDM recommended that RWG's second option be adopted, and emphasized that support be provided to countries in greatest need.

RD's Remarks on Distribution of Increased RB Funds

On the issue of distribution of increased RB funds to countries, the Regional Director stated that most countries of the Region were facing funding constraints in tackling their health problems. A few Member States were facing acute financial problems and they also happened to be countries in greatest need of funds. As WHO had always been conscious of the funding constraint being faced by some countries in tackling their health problems, it was trying to mobilize voluntary funds for them.

The Regional Director further stated that as the Region had received a small increase in RB funds, this opportunity should be used to help countries in the greatest need as these countries had received a disproportionate share in the basic RB allocation in the first place.

He urged and invited all Member States to join hands in the spirit of regional solidarity to help countries in the greatest need.

7. Review of WHO Collaborative Programmes Implemented During the 2004-2005 Biennium

(Agenda item 3.3)

Ms Ann T. Van Hulle-Colbert, Director, Administration and Finance (DAF), WHO/SEARO, presented the financial aspects of WHO collaborative programmes implemented during the biennium, as well as the lessons learnt. The highlights of her presentation were:

- The financial resources available to the SEA Region were: Regular Budget (RB) US$ 91 million and Other sources (OS) US$ 192 million

- India, Myanmar, Thailand and Timor-Leste had met the first year's target of 75% implementation (RB) at the end of the first year (31 December 2004).

- In respect of OS funds, the PB 2004-2005 figure of US$ 191 million was nearly double the OS funding received in the previous biennium. While the target appeared to be overambitious, it had already been achieved. The tsunami of 26 December 2004 was the main cause of the unexpected and unprecedented influx of donor funds into the Region.

- The new approaches proposed for 2006-2007 are: no financial implementation targets, rather, the quality of programme delivery would be emphasized. There will be no more ICP-II and the Regular budget funding would remain with countries for MCAs.

- The new financial rules that would take effect from the start of the 2006-2007 biennium would eliminate reserves. The new rules would require all RB funds to be fully utilized during the biennium – funds representing unliquidated obligations i.e. ULOs would not be allowed to be carried forward into the subsequent biennium for unfinished work.

- Expenditures would not be recorded until the particular work was completed and products delivered, instead of being recorded at the time of obligation itself as was the current practice. This would help align the second year workplan timeframe with the period of funding availability.

- The next biennium would experience higher costs for staff and local expenditures, due mainly to the decline in the relative value of the US dollar. This had already led to the post-adjustment for professional staff increasing by at least 30% in all but two countries, and by more than 200% in four countries, since 2003. Local staff salaries had also increased by more than 10% in seven countries over the same period.

Discussion Points

- It was noted that RB implementation had been delayed in some tsunami-affected countries. Nonetheless, it was felt that the target of 100% obligation could still be achieved by the deadline of 31 August 2005.

- Continuous progress had been made in reducing “reserves” and “surrenders”. Greater emphasis should now, therefore,

be placed on ensuring quality, as well as in meeting the financial targets.

- The new financial rules that would take effect from the beginning of the 2006-2007 biennium would no longer allow ULOs for incomplete work to be carried over as "reserves" into the subsequent biennium. However, for the current biennium, "reserves" can still be established at the end of the 2004-2005 biennium.

- Under the new financial rules, costs of activities spanning more than one biennium (e.g. fellowships) must be split and apportioned appropriately to the relevant bienniums.

- Starting from 2006-2007, the commitment of funds (i.e. obligation) alone will no longer amount to incurring of expenditure. Instead, expenditure would only be deemed to have been incurred once the particular work has been completed and the product delivered.

- The current practice of providing only 80% (instead of 100%) advance for local costs had led to difficulties with implementing activities requiring full payment to be made before the start of the activity.

Recommendations

(1) The Quality Of Programmes Should Not Be Compromised For The Sake Of Meeting Financial Implementation Targets;

(2) The Workplans For 2006-2007 Must Take Into Consideration The Need To Complete All Activities Within The Biennium Since Ulos As Well As Unutilized Funds Will Have To Be Surrendered, And

(3) In Order To Discourage Over-Budgeting Of Local Costs, Full Advances Can Be Approved By Daf For Activities Of A Short Duration, Provided That Expenditure Reports Are Received For Advances Made Earlier.

8. Regional Implications of the Decisions and Resolutions of the Fifty-Eighth World Health Assembly and the 115th and 116th Sessions of the Executive Board

(Agenda Item 4)

Dr Lin Aung, Programme Development Officer, WHO/SEARO, made two presentations – first highlighting the key information on the decisions and resolutions adopted by the fifty-eighth World Health Assembly and the 115th and 116th sessions of the Executive Board of particular concern, relevance and implications for the Region. These were placed before the CCPDM for its review and recommendations for consideration by the fifty-eighth session of the Regional Committee. Dr Lin Aung also informed the delegates that the regional implications of each decision and resolution had been highlighted, with actions proposed to be taken, both by countries and the Regional Office.

The second presentation was on guiding principles for strategic resource allocations, highlighting:

- Strategic resource allocation was an integral part of WHO's managerial process.
- The Regional Office had established a formal mechanism for the consultative process, i.e. the RWG comprising representatives from all Member States. The RWG

examined the previous model based on the human development index (HDI) and examined the proposed guiding principles for strategic resource allocation.

- There was high degree of consistency between the "guiding principles" set out in the document and recommendations of the RWG.
- If fully implemented, this may result in changes in SEA Region's budget and distribution of RB funds between various levels of the Organization.
- The distribution of funds among country offices was determined by the Regional Office. However, the same needs-based formula could be applied to redistribute WHO funds to country offices.
- This paper was submitted to EB the 116th session of the Executive Board in May 2005 and Regional Committees have been requested to comment on the proposed approach of Strategic Resource Allocation. The Regional Committee's guidance will therefore facilitate the preparation of a draft for the 117th session of the Executive Board to be held in January 2006.

Discussion Points

- The CCPDM took note of the regional implications of the decisions and resolutions of the fifty-eighth World Health Assembly and the 115th and 116th sessions of the Executive Board.

- There was need to address not only international migration but also internal brain drain. It was noted that globalization and GATS had increased the mobility of personnel and trade in health services. The migration of skilled health workers from developing countries needed to be addressed urgently. Monetary incentives would not be the only solution for this. WHO support was required to develop strategies to mitigate the adverse effects of migration of health personnel. It was noted that the theme for World Health Day 2006: "Human Resources for Health" also underlined the importance of this issue.

Recommendation

WHO should address the issue of migration of health personnel by developing and supporting strategies for effective deployment and retention of health personnel.

9. Reports by Country Representatives on their Attendance at the Meetings of the Coordinating Bodies of WHO's Global Programmes *(Agenda Item 5)*

9.1 UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases: Joint Coordinating Board (JCB) *(Agenda item 5.1)*

The Joint Coordinating Board was established by the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR), to coordinate the interests and

responsibilities of the parties cooperating in this Special Programme. UNICEF is one of the co-sponsors of the Special Programme. Representatives from the SEA Region from Bangladesh and Myanmar participated in the twenty-eighth session of the Joint Coordinating Board (JCB) held from 23-24 June 2005 in Geneva.

Dr Khandaker Rashedul Haque, representative from Bangladesh presented the report on the deliberations of the JCB meeting on behalf of representatives from the SEA Region.

The Director of TDR in his report explained the strategic changes brought about in TDR's international infrastructure and explained the technical achievements and impacts of the TDR programme on various diseases. The plan for elimination of visceral leishmaniasis (kala-azar) from the Indian sub-continent had been formalized, based on new drugs, diagnostic tests and vector control methodologies, cross-cutting disease activities and cross-cutting capacity-building activities.

Speaking on the strategic outlook for TDR, it was highlighted that the technical output from TDR continued to have high impact and was of high quality. It was clarified that while the strategic outlook for TDR was focused on health, a long-term vision of goals and activities for the emerging new environment of international health research and human development needed to be developed in collaboration with partners and key stakeholders. In this context, TDR's 10-year vision would elaborate the proposed approaches for closer engagement with regions and countries. The vision aimed to focus itself appropriately on international health research in the coming years.

The proposed projected budget for 2006-2007 was US$ 100 million. The Standing Committee encouraged resource mobilization efforts aimed at approaching newly industrialized countries, and emphasized the need for TDR to move closer to regions where some important donors were active and were likely to commit themselves.

The CCPDM noted the report.

9.2 WHO Special Programme for Research, Development and Research Training in Human Reproduction: Policy and Coordination Committee (PCC) *(Agenda item 5.2)*

The Policy and Coordination Committee (PCC), the governing body of the Special Programme for Research, Development and Research Training in Human Reproduction (HRP), is responsible for its overall policy and strategy. The PCC reviews and decides upon the planning and execution of the Special Programme, including its budget, to ensure that interests and responsibilities of parties cooperating in the Special Programme are coordinated. Representatives from Sri Lanka and Thailand from the SEA Region participated in the 18th meeting of the PCC, held in Geneva from 30 June to 1 July 2005.

The representative from Thailand, Dr Nipunporn Voramongkol reported on the proceedings of the meeting.

The draft recommendations presented to the PCC emphasized the important role of family planning and preventing unsafe abortion; adolescent reproductive health; prevention of maternal morbidity and mortality, and achievement of the MDGs. They also

stressed that the Programme's work in these areas should be given greater support, as well as the importance of further developing and strengthening research capacity in the area of health systems research while maintaining a strong involvement in basic and clinical research. The PCC recommended that research capacity strengthening should be featured as a key component of the Programme's strategies to assist developing countries, in particular the least developed countries, to improve sexual and reproductive health. It noted with concern the trends, within WHO, towards verticalization of elements of sexual and reproductive health and emphasized the importance of integrated approaches, particularly with regard to strengthening the integration of sexual and reproductive health programmes into HIV/AIDS prevention and treatment activities. It also noted with concern the reduction in funding of the Programme and urged WHO to demonstrate its support for sexual and reproductive health and the central role it plays in the MDGs by allocating more resources to the Programme. It approved the Proposed Programme Budget 2006-2007 and urged Member States to highlight sexual and reproductive health, including research, at the September 2005 World Summit. The outcome of the Summit would be essential to the attainment of the agreed health-related development goals including those contained in the Millennium Declaration.

The CCPDM noted the report.

10. Technical Discussions on Skilled Care at Every Birth

(Agenda Item 6)

Technical Discussions on Skilled Care at Every Birth were held on 6 July 2005. H.E. Prof. Dr Mya Oo (Myanmar) Chaired the session, while Dr Gunawan Setiadi (Indonesia) was the Rapporteur. The report and recommendations arising out of the Technical Discussions will be submitted to the 58th session of the Regional Committee.

11. Review of the Draft of WHO's 11th General Programme of Work for the Period 2006-2015 *(Agenda Item 7)*

Dr Lin Aung, Programme Development Officer, WHO/SEARO, made a short presentation and emphasized that the General Programme of Work (GPW) was the policy guide to WHO's programme development covering a specific period and formed the basis for its programme budget for that period. He recalled that the Tenth GPW 2002-2005 was set to conclude next year and steps had been initiated to formulate the 11th GPW which would cover a ten-year period 2006-2015. This was in line with the decision of the Director-General.

The highlights of Dr Lin Aung's presentations on the 11th GPW were:

- "The Scenarios": Health issues were often global, not just national (SARS, avian flu, polio, ART drugs). Health and development were recognized as interdependent. WHO was not the only player in global health; several other international bodies, such as the Global Fund, GAVI,

development banks and bilaterals, as well as other UN agencies were increasingly getting involved. How was global health expected to change over the next ten years? "Scenarios" were used to look into the future. The world was getting increasingly complex and the future was quite impenetrable. Scenarios were plausible, challenging and relevant stories about the future, that allowed summarizing what was known; anticipating and exploring what may happen, and clarifying what was expected to happen.

- The latest draft of the GPW introduced the *concept of gaps* to describe global health issues viz. gaps in synergy; gaps in implementation; gaps in social justice; and gaps in knowledge.
- Global Health Agenda: In order to improve global health, there needed to be a specific agenda for the next 10 years. The Global Health Agenda was limited to around ten action areas. The agenda should be comprehensive, in that it should identify all key areas for improvement, and it should be applicable and relevant to the international community and national governments, and not just to WHO.
- The current position of WHO was based on historical developments, and its mandate was for the health of all people with special attention to the needs of the poor. Based on the action areas of the Global Health Agenda, WHO may need to re-position itself now. The first step in this direction was to look at the current work of WHO and identify its comparative advantages, and then to identify

priorities for positioning WHO accordingly in the next ten years.

- The Organization and its Member States together with UN agencies, the civil society and the private sector should all see themselves as drivers of change as reflected in WHO's 11th General Programme of Work.
- **The 11th GPW should also call for action to improve health over the next decade. In collaboration with partners, it should propose a *global health agenda* that:**
  - Articulates the main global health challenges and opportunities for the next 10 years;
  - Outlines through consultations the most strategic directions and ways of working which the international community should adopt to improve health in the world;
  - Focuses on the actions and responsibilities of WHO as the world's specialized health agency and its role in global health;
  - Serves as a tool for continuous dialogue between and within WHO, Member States, partner agencies, civil society, the private sector and the WHO Secretariat;
  - Emphasizes that health is increasingly of a multi-dimensional nature and a central component of human and economic development, global security, and social justice;
  - Recognizes that gaps in terms of health outcomes and access to basic services must be identified and addressed;

– States that significant improvements in global health are the responsibility of multiple sectors and partners all acting responsibly, and

– Underlines the need for WHO to embrace its leadership role in technical and policy-setting areas of global health.

Within this agenda item, a brief introduction on Medium Term Strategic Plan (MTSP) for 2008-2015 was made by Dr Lin Aung, which was followed by a brief presentation by Dr Eigil Sorensen, WR DPR Korea, who is the reference group member from the SEA Region for MTSP.

The highlights of presentations on MTSP were that it:

- Provided visible linkage between the Organization's long-term vision and its medium-term strategic planning;
- Analysed the problems, issues and challenges related to themes and strategic directions emerging from GPW;
- Provided an idea of the impact of the work of WHO in the next six years;
- Stated the issues and challenges linked to implementation of decisions of Governing Bodies and WHO's long-term agreements with external partners and other UN agencies;
- Supported the definition of draft "Strategic Objectives" which shall assess strengths, limitations, and opportunities affecting WHO in relation to its roles, responsibilities and strategic choices established in the 11th GPW;

- Analysed critical issues which WHO as an organization needed to address in terms of the GPW themes for WHO, and
- Provided a strategic approach:
  - Concise statements of approaches – the means- to programme delivery that will be adopted and applied in achieving the Strategic Objectives;
  - Provided set of parameters for formulating the Organization-wide expected results (OWERs);
  - Reflected long-term strategic plans that have been developed in response to decisions/recommendations of Governing Bodies, and
  - Distinguished between Member States and the Secretariat, noting the specific approaches that the Secretariat will pursue based on GPW that will allow for determination of resource indication for each Strategic Objective.

Discussion Points

- The title “Closing the Gaps” was more appropriate than the new one “Together Towards Healthier Future”.
- The strengths and weaknesses of WHO as identified during country-level workshops were discussed. While the leadership of WHO in technical matters was undisputed, concerns had been expressed on its diminishing role in the light of the fact that many international bodies were now playing an active role in the health sector. WHO must retain its pre-eminent position. WHO also needed to

advise Member States on measures to contain the adverse fallouts of globalization. Human resource development would also be an area requiring urgent attention in the coming years.

- Several planning processes and documents were now available viz. 11th GPW for 10 years (2006-2015); Medium Term Strategic Plan for six years (2008-2015) as a bridge between GPW and country biennial planning; Country Cooperation Strategies (CCS), and county workplans. While strategic plans were also important, focus needed to be placed on country biennial workplans which were of direct relevance to the country.

Recommendation

The CCPDM recommended that the Executive Summary of the 11th GPW, after the necessary modifications to include the points emerging out of discussions at the meeting, be placed before the 58th session of the Regional Committee in September 2005.

12. Adoption of Report

The CCPDM reviewed the draft report of its forty-second meeting page by page, concentrating on the discussions and observations made by members, and the recommendations arrived at on each agenda item, and adopted it with minor modifications.

13. Closure

In his concluding remarks, Dr Samlee Plianbangchang, Regional Director, WHO SEA Region, stated that the arrangement for this

meeting had been rather complex, since many things had to be completed in a short time. However, the goal had been achieved in that all agenda items had been covered, which produced useful outcomes. The conclusions and recommendations of the meeting would be submitted to the 58th session of the Regional Committee in September this year.

The Regional Director once again thanked the Government of the People's Republic of Bangladesh and its Ministry of Health and Family Welfare for hosting this meeting and for the excellent arrangements made. He also thanked them for their generous and courteous hospitality. He appreciated the dedicated and untiring efforts of local staff, from both the Ministry of Health and Family Welfare and the WHO Country Office in Bangladesh. He thanked His Excellency Professor Mya Oo for his able leadership in chairing both the CCPDM meeting and the Technical Discussions, and also thanked His Excellency Mr Luis M R F Lobato for so efficiently playing the role of Co-chairperson of the CCPDM meeting.

Dr Samlee also expressed his appreciation to Dr Gado Tshering and Dr Gunawan Setiadi for their hard work as rapporteurs of the CCPDM meeting and Technical Discussions respectively. He remarked that the Drafting Group certainly deserved special thanks and appreciation for their commendable work in preparing the report of the CCPDM meeting.

He hoped that most delegates would also be attending the forthcoming session of the Regional Committee in September 2005, when there would be an opportunity to follow up on the conclusions and recommendations of the CCPDM.

He expected the CCPDM members after returning to their respective countries, to brief their national representatives to the

58th session of the Regional Committee on the deliberations of the meeting of CCPDM. This would greatly facilitate the discussions on the conclusions and recommendations of the CCPDM, during the Regional Committee session.

The Chairperson, Prof. Dr Mya Oo, in his closing remarks congratulated the members on the successful completion of the meeting. He expressed his appreciation to the Rapporteurs and members of the Drafting Group for preparing a concise report reflecting the discussions and recommendations. He also congratulated members of the WHO Secretariat for their support, and for the excellent arrangements made for the meeting.

The Chairperson then declared the Forty-second Meeting of the Consultative Committee for Programme Development and Management closed.

Annex 9

CONSIDERATION OF THE RECOMMENDATIONS ARISING OUT OF THE TECHNICAL DISCUSSIONS ON SKILLED CARE AT EVERY BIRTH, HELD ON 6 JULY 2005*

1. INTRODUCTION

Technical Discussions on Skilled care at every birth (Agenda item 6 of the 42nd Meeting of the Consultative Committee for Programme Development and Management) were held in Dhaka on 6 July 2005. H.E. Prof Dr Mya Oo, Deputy Minister for Health, Myanmar, and Dr Gunawan Setiadi, Chief, Bureau of Planning, Ministry of Health, Indonesia, were elected as Chairman and Rapporteur respectively. All the CCPDM participants, local/special invitees and WHO staff concerned participated in the discussions.

1.1 Opening Remarks by the Chairman

The Chairman, in his opening remarks, said that it was opportune that this year the subject for the Technical Discussions was Skilled care at every birth as he considered it critical for achieving two of the eight Millennium Development Goals (MDGs). He reminded the audience that MDG 5 calls for a reduction of the maternal mortality ratio by three quarters between 1990 and 2015 and MDG 4 for a reduction in the under-five mortality by two thirds during the same period. He emphasized that skilled care at birth is recognized as an

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important input for improving maternal health and reducing child mortality.

Evidence from all over the world, including from within the South-East Asia Region, indicates that it is indeed possible to institutionalize skilled attendance at birth with positive outcomes for maternal health. He quoted the positive experiences of Thailand, Sri Lanka and Kerala state in India in this regard.

The Chairman was of the view that the subject would merit a multi-dimensional deliberation. This included policy issues related to human resource development, health sector financing, attention to equity, legal issues and attention to prevailing societal norms and customs for community involvement, and several others.

The Chairman hoped that active deliberations during the session would result in practical recommendations that could be implemented in different country scenarios. He then invited Dr P.T. Jayawickramarajah, Acting Director, Family and Community Health, WHO/SEARO, to deliver his remarks.

Dr Jayawickramarajah explained that the topic of the Technical Discussions is very relevant as the theme of the World Health Day 2005 is Maternal and child health: Make every mother and child count. The working paper has been produced through teamwork involving external experts. He hoped that the group could discuss key policy issues and challenges as well as the way forward to countries and WHO.

Next, the Chairman gave the floor to Dr Ardi Kaptiningsih, Regional Adviser, Reproductive Health and Research, WHO/SEARO, to introduce the working paper.

1.2 Introductory Remarks

In her presentation, Dr Kaptiningsih stated that timely access to skilled care at birth is the most crucial factor for the survival of pregnant women and their newborns. Skilled care at birth is defined as the essential care for childbirth and the immediate postpartum period that every woman and her newborn need. It includes: (a) routine care for all women and their newborns, (b) special care for those who need integrated interventions, and (c) management of complications of pregnancy and childbirth and problems in newborns. Such care should be provided as a continuum at primary health care level by health care providers with midwifery skills (skilled attendants) and, when complications occur, at secondary health care level that requires additional health care providers with obstetric, anaesthetic and paediatric skills supported by appropriate services.

A brief overview of skilled care at birth in the South-East Asia Region was provided. The South-East Asia Region (SEAR) accounted for 174 000 maternal and 1.4 million neonatal deaths in 2000, representing 33% and 35% of the global figures respectively.

Several useful lessons learnt from within the Region have contributed to achieving high levels of skilled care at birth. One of the key factors that contributes to success in this regard is the availability of skilled attendants at community level with a referral back-up, providing emergency obstetric care and special care for newborns with problems, in a functioning health system. All countries with a low maternal mortality ratio and neonatal mortality rate have high access to skilled care at birth.

Countries in the SEA Region are at different stages of development of skilled care at birth. For countries with a very low level of skilled care at birth, the major problem is the lack of skilled attendants at community level. Even when existing health care providers are given the responsibility to provide maternal and newborn care, they often do not have the required skills, essential equipment and support and back-up referral services. A few countries that have succeeded in deploying adequate number of skilled attendants at community level face other challenges. These countries need to ensure that the technical quality of care provided is adequate; supervision and referral back-up services are effective, and basic supplies and equipment and outreach services for the poor and disadvantaged groups are in place. Countries with high coverage of skilled care at birth may still have areas with low access. Such countries often face problems related to overuse of ultrasound screening and high rate of caesarean sections.

Ensuring universal access to skilled care at birth requires a composite set of interventions. Member States face a number of challenging policy issues related to human resources; inadequate health sector financing; reaching the poor and the disadvantaged; low status of midwifery as a profession, and the need for sustainable referral networks and services, as well as effective leadership and management.

It is the responsibility of governments to ensure skilled care at every birth as it is the right of all pregnant women and their newborns. Countries will need to make a number of strategic decisions with a long-term vision. Critical among these will be: human resource development and management; capacity to manage long-term, phased-in interventions; mobilizing funds for universal access to maternal and newborn health services;

improving the referral system, comprehensiveness, integration and quality of services; working effectively with individuals, families and communities, and ensuring multisectoral and intercountry collaboration.

2. DISCUSSIONS

The following sections provide the highlights and conclusions of the discussions on various issues relevant to skilled care at every birth. All countries expressed their commitment to achieve the MDGs related to maternal and newborn health and shared their policies and interventions carried out in this regard. It was considered that the time was opportune to discuss the topic in the CCPDM since the theme of the World Health Day 2005 relates to maternal, newborn and child health.

Many interventions, such as efforts to train basic health workers in midwifery, strengthening accreditation system for training institutions, improvement of referral services, policy decisions on safe abortion services, financing scheme for poor women for childbirth and emergency obstetric and newborn care, NGOs' involvement, have been implemented in different countries of the Region. It was also recognized that some countries had a long way to go to scale up these interventions across the country so that skilled care at birth can be accessed by all.

Some constraints were identified in scaling up these interventions, i.e. investment in the health sector in many countries is still less than 5%, and only a small proportion of it is allocated to maternal and newborn health; limited equipment, drugs and supplies; difficulties in deployment of skilled attendants at community level and relevant specialists at first referral level. The

issue of brain drain was also raised by DPR Korea and Nepal. Low educational status was also identified as one of the factors that influenced demand for professional care during pregnancy, childbirth and postpartum period. The issue of pre-service training of skilled attendants at primary health care level is clearly a major issue in many countries of the Region, especially those with a low proportion of childbirth attended by skilled attendants.

A number of important issues were raised by participants from countries. Among others:

- Although the focus should be on skilled care at birth and during the immediate postpartum period since most deaths occur during this period, there is a need to promote a continuum of care throughout pregnancy and life-cycle. Issues such as the need for family planning, improvement of nutrition status, prevention of unwanted pregnancies and teenage pregnancies, prevention and management of unsafe abortion, as well as prevention and management of common diseases in pregnant women, such as malaria and anaemia should be addressed adequately.
- Community involvement in taking care of pregnant women and newborns, and in timely referral of pregnant women and their newborns when complications and problems arise.
- There should be a global fund for maternal and newborn health to allow countries to achieve the MDGs in respect of maternal and child health, including newborn health.

The country participants then divided themselves into three working groups: (1) countries with a proportion of births by skilled

attendants less than 50%, i.e. Bangladesh, Bhutan, India, Nepal and Timor-Leste; (2) those with a proportion between 50 and 80%, i.e. Indonesia, Maldives and Myanmar; and (3) those with a proportion more than 80%, i.e. DPR Korea, Sri Lanka and Thailand. The groups discussed issues related to human resources and health systems in order to achieve universal skilled care at birth, as well as way forward for Member States and the role of WHO. The outcomes of the group work can be summarized as follows.

(1) Human resources development

- All countries with a proportion of births by skilled attendants less than 50% agreed that there is a need to have a long-term plan for human resource development for maternal and newborn health that includes plans for production, placement, retention and career development.

- The category of health professionals with midwifery skills at community level (skilled attendants) may differ in each country as country situations and needs are different; however, there should be no compromise in quality relating to skilled care. The needs and competencies should be identified by each country and training on midwifery tailored according to their needs.

- Strengthening of training institutions in midwifery is a major issue, and mechanisms should be in place to ensure quality of training.

- The Chair of the SEA Regional Multi-disciplinary Advisory Group on Nursing and Midwifery, who was specially

invited to this meeting, stated that the Task Force would identify these competencies in consultation with countries at its next meeting.

(2) Health systems

- Strengthening district programme management is a major concern. This would include management of human resources, including optimization of their performance; organizing health services, as well as programme monitoring and fostering community involvement.

- Adequate financing for expanding access to and improving quality of skilled care at birth should be available. A mechanism for global pooling of funds for maternal and child health should be established. Special attention should be given to the poor and the disadvantaged, as well as underserved areas in countries.

- The private sector should be on board, together with the government initiative, to achieve universal skilled care at birth.

Place of delivery should not be a problem as long as skilled care is provided. There are examples in some countries that can manage safe delivery at home by skilled attendants.

3. CONCLUSIONS AND RECOMMENDATIONS

After reviewing the country situations in the SEA Region and key issues and challenges in achieving universal skilled care at birth, the group made the following recommendations:

3.1 To Member Countries

(1) National and sub-national planning and programming needs should be strengthened to give due attention to the need for long-term plans and strategies to ensure equitable access and quality of skilled care at birth.

(2) Gaps in human resources for skilled care at birth should be reviewed and appropriate human resource policies for skilled care at birth developed or modified to include planning, production, placement, retention and career development.

(3) Barriers to access and utilization of skilled care at birth should be identified and evidence-based actions to overcome these developed and implemented.

(4) Appropriate health system improvement should be instituted to strengthen programme management, health care delivery and financing.

(5) Demand for skilled care at birth should be improved.

3.2 To WHO

(1) Technical support should be provided to Member States to review and revise their human resource policy, strategy and plans as well as in their implementation so to ensure skilled care at every birth.

(2) WHO should assist Member States in strengthening their health systems and provide evidence-based norms and standards in ensuring skilled care at every birth.

(3) WHO should advocate for increased financial resources from national and international agencies to support national efforts in ensuring skilled care at every birth as well as facilitate a mechanism for global pooling of funds for maternal and child health.

The Technical Discussions Group proposed that the fifty-eighth session of the Regional Committee adopt a resolution on the subject. A draft resolution was accordingly prepared for consideration by the Regional Committee.