Regional Input into Organization-wide Priorities for the 2004-2005 biennium
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1. INTRODUCTION

The General Programme of Work (GPW) for the period 2002-2005 was approved by the Fifty-fourth World Health Assembly in May 2001 with its Resolution WHA54.1. WHO has identified the specific priorities for the proposed Programme Budget for 2002-2003. It also indicated that these priorities will be reviewed in consultation with Member States when the proposed Programme Budget for 2004-2005 biennium is prepared.

The Executive Board, at its 109th session in January 2002, will consider the elaboration of the WHO Programme Budget for 2004-2005. The Director-General has advised the Regional Directors to elaborate a process to elicit the regional inputs into the development of the Organization-wide priorities for 2004-2005, while preparing the Organization’s biennial budget.

As an initial step in this process, the Regional Director would like to propose to the health ministers of WHO South-East Asia that at their 19th meeting at Maldives in August 2001, that they should review the regional health and development situation and identify broad regional priorities for 2004-2005. The Regional Director will then convey the observations and recommendations of the health ministers, to the 54th Session of the WHO Regional Committee to be held in Yangon in September 2001. The recommendations will subsequently be conveyed to the Director-General for her consideration for preparing the discussion and debate at the Executive Board in January 2002.

2. BACKGROUND

Annex 1 provides an updated document containing the regional issues and challenges on health development for 2004-2005. It illustrates the summary of updated regional health development, strategies and priority action for each specific priority health issue, with some detailed facts and figures.

The foremost challenges for WHO collaboration with Member States in the Region are to: (a) articulate and advocate evidence-based policies and strategies; (b) maintain a high-level of technical expertise for catalyzing change; (c) enhance national and regional partnerships; (d) sustain national and regional health development capability; and (f) resource mobilization.

Specific regional health priorities for 2004-2005, as outlined below, are an amalgamation of global, regional and national priorities. In view of the burden of particular diseases faced by certain groups of countries of the Region, a regional perspective has been added to supplement global priorities.

(1) Malaria,
(2) HIV/AIDS,
(3) Tuberculosis,
(4) Dengue fever and Dengue haemorrhagic fever,
(5) Maternal health,
(6) Nutrition
(7) Tobacco,
(8) Other major communicable diseases (Filariasis, Kala-azar, Poliomyelitis and other EPI diseases, Leprosy),
(9) Environmental health risks,
(10) Noncommunicable diseases (CVD, Cancer, Diabetes, Blindness and deafness, Injuries),
(11) Mental health,
(12) Food safety,
(13) Safe blood, and
(14) Health systems

Annex 2 is the abstract of the GPW 2002-2005 as approved by the Fifty-fourth World Health Assembly. The abstract contains nine Organization-wide priorities for 2002-2003 that have been identified keeping in view the strategic directions and core functions stipulated in the WHO Corporate Strategy and the global health situation and trends. These are incorporated in the General Programme of Work (GPW) 2002-2005. At present, the focus of the priorities would be Programme Budget 2002-2003, and those for 2004-2005 will be identified during the process for preparation of the budget in 2002. In addition to the orientation provided by the strategic directions and core functions of the Organization, more specific areas of emphasis still need to be defined. Based on an analysis of major challenges in international health, these priorities would reflect strategic choices, with regard to areas in which WHO has the advantage compared to others, or where there is a need to build up capacity. The following criteria are to be used for identifying priorities:

- Potential for significant change in burden of disease with existing cost-effective interventions;
- Health problems with major impact on socioeconomic development and a disproportionate impact on the lives of the poor;
- Urgent need for new technologies;
- Opportunities to reduce health inequalities within and between countries;
- WHO’s advantages, particularly in relation to provision of public goods, building of consensus around policies, strategies and standards, initiation and management of partnerships, and
- Major demand for WHO support from Member Countries.

Using the above criteria, the following nine Organization-wide priorities for WHO for the 2002-2003 biennium were listed as below:

(1) Malaria, tuberculosis and HIV/AIDS;
(2) Cancer, cardiovascular disease and diabetes;
(3) Tobacco;
(4) Maternal health;
(5) Food safety;
(6) Mental health;
(7) Safe blood;
(8) Health systems; and
(9) Investing in change in WHO.

Annex 3 of the document highlights the matrix on the common national priorities for WHO collaboration for 2002-2005, as identified by WHO Country Cooperation Strategy for each country.

Annex 4 of the document provides the list of the 14 technical content areas, identified by the High Level Task Force on Intercountry Collaboration, for support through the supplementary intercountry programme (ICP-II) for 2002-2003.

Annex 5 of the document provides the matrix of high priority technical subject areas, based on the resolutions or decisions of the 48th Regional Committee in 1990 to its 53rd session in 2000, from the 13th to 18th meetings of the health ministers and also from the first to sixth meetings of health secretaries.

3. POINT FOR CONSIDERATION

The Honourable Health Ministers are requested to identify the broad regional priorities, taking into consideration the background as provided in Annexes, as an initial step, in the provision of regional inputs into the development of the Organization-wide priorities for 2004–2005.
Annex 1

REGIONAL ISSUES AND CHALLENGES

1. INTRODUCTION

The Region comprises 10 Member Countries with one-fourth of world population residing in one-sixth of the global land area. Most countries have passed through rapid demographic and epidemiological transitions resulting in double burden of diseases. A few countries still have larger proportion of younger aged population and higher disease burden from communicable and other preventable diseases and conditions. The overall population of the Region continues to grow rapidly and has crossed 1.5 billion by the end of 2000. While communicable diseases are still the major killers and cripplers, noncommunicable diseases are also emerging as leading causes of morbidity, disability and mortality. In addition, the Region has nearly half of the world's poor and elderly. The economic crisis in the late 1990s has also affected health development in the Region.

Despite these problems, the Region has made significant progress: increasing life expectancy, reducing infant and child mortality, as well as preventing and controlling communicable diseases. There has been considerable reduction in morbidity and mortality due to vaccine-preventable diseases such as polio, measles, tetanus, whooping cough and diphtheria. With the expansion of coverage with multi-drug therapy, leprosy cases have declined and seven countries have achieved the elimination target. Three remaining countries have accelerated their programme in order to reach elimination target by 2005. A regional strategy for eliminating lymphatic filariasis in eight endemic countries was developed and elimination was envisaged by 2005. Similar attempts were also made to eliminate kala-azar. Many epidemics and outbreaks were handled quickly and effectively through proper surveillance systems and efficient integrated control mechanisms.

The Region still bears a heavy share of the global burden of many priority diseases. This is due in part to the very large population, difficult terrain and communication, and low economic status of the countries of the Region. Worldwide, nearly 40% of all maternal deaths, 41%, of all deaths due to infectious diseases, 40% of tuberculosis cases and 70% of poliomyelitis cases occur in this Region. Similarly, the Region accounts for 25% of hepatitis B, over 15% of HIV/AIDS infections and about 35% of blindness.

Infant mortality rates in some countries are still high, ranging between 80 and 100 per 1000 live births. An analysis of under-five mortality rates shows a similar pattern. Protein-energy malnutrition and deficiencies of micronutrients such as iodine, vitamin A and iron are also major public health problems.

All countries are striving to ensure universal access to health care by initiating reforms in their health systems. These initiatives include strengthening the health infrastructure with appropriate mix of human resources including volunteers, equitable health care financing,

* An updated version of regional issues and challenges prepared on similar lines of text appeared as part of the Proposed Programme Budget 2002-2003 Part II (SEA/RC53/13 (Rev.1).
decentralized decision-making and governance, promoting private sector participation and increasing the involvement of the nongovernmental sector.

Rapid expansion of international trade in the wake of liberalization has affected health care in the Region, especially in countries with deficient trade practices and legislation. In most countries, quality drugs are not accessible to a large proportion of people. On the other hand, there is the challenge of irrational and indiscriminate prescribing practices, often leading to multi-drug resistance and adverse drug reactions. The adverse effects of increasing tobacco and alcohol consumption on overall morbidity and mortality, especially among poor families, are also a cause for serious concern.

WHO collaborative programmes during the last decade made significant contributions in supporting health development efforts in the countries of the Region. The following lessons learnt from these efforts would guide the formulation and implementation of future collaborative programmes in the Member Countries. These include among others:

- High-level advocacy for the development of sound national policies and strategies resulted in bringing health to the centre of development. Promotion of technical cooperation among countries brought about general health development, development of joint disease control operations, and the establishment of training programmes.
- Partnerships with regional organizations such as ASEAN and SAARC, and other regional and intergovernmental groupings like Mekong-basin development, helped in strengthening health development efforts in communicable disease control, nutrition, and providing access to essential drugs. These partnerships also helped in disease reduction, improvement in the quality of services, and overall health sector development, including human resources.
- Strengthened partnerships with governments, nongovernmental organizations and leading technical institutions promoted national capacity development.
- Maintaining a high level of child immunization coverage against vaccine-preventable diseases contributed to a substantial reduction of mortality and morbidity due to these diseases.

Increased coverage of immunization and strengthened immunization networks for other vaccine-preventable diseases are the outcome of organizing a series of national immunization days (NIDs) synchronized among neighbouring countries. WHO’s role in mobilizing partners for this crucial phase has been critical.

All countries of the Region prepared national strategies for control of HIV/AIDS. The resources, however, are grossly insufficient, requiring greater coordination among UN co-sponsors to ensure enhanced and sustained political commitment. Surveillance needs to be expanded to include STI and behavioural aspects.

The Region made efforts to expand the coverage of DOTS strategy for tuberculosis control. The experience of successful partnership with the private sector and mobilizing bilateral and multilateral funding for TB control will be useful in future collaboration. The Region is beginning to develop capacity to monitor multi-drug resistance. The Roll Back Malaria initiative received political commitment at the highest level. Bi-regional cooperation helped in strengthening cross-border surveillance of communicable diseases, and in achieving consensus on technical issues and in developing case definitions, milestones and key indicators.
Tobacco consumption among women and youth is rising in the Region. The Tobacco Free Initiative and World No Tobacco Days are used to draw public attention to the dangers inherent in tobacco use. There is a need to intensify media campaigns to counter the promotional activities of tobacco manufacturers, including their extensive advertising and sponsorship of sports and cultural activities.

As a tool of health sector reform, country health profiles and national health accounts were developed. The main features of the country profile are: the evolving health systems infrastructure including decentralization, the health expenditure pattern including mechanism of health financing, public-private mix, regulatory mechanism, etc. WHO’s support through the provision of technical expertise, training of primary health care workers, development of infrastructure, and strengthening of medical institutions resulted in a substantial reduction in the incidence of preventable blindness in several countries.

The newly-developed standards of midwifery practice for safe motherhood helped countries in enhancing and ensuring the quality of midwifery care. They also facilitated increased accessibility to selected life-saving interventions for women in the rural and remote areas. These standards were well received internationally. Actions were being taken by WHO/HQ to further refine them for global application. In promoting gender mainstreaming in health policy and programmes, WHO/SEARO, through country collaboration, developed a database disaggregated by sex, age, and other variables, employing the life-span approach, and this data was shared with all partners.

The joint planning and management of WHO collaborative programmes by Member Countries and the WHO Secretariat, through the Regional Committee and the Consultative Committee on Programme Development and Management (CCPDM), played a significant role in improving the implementation of programmes. The joint Government/WHO coordination mechanisms continued to play a key role in guiding the planning, implementing and evaluating WHO programmes and those supported by other development partners, in the national health development efforts.

2. REGIONAL STRATEGIES AND PRIORITY ACTION

2.1 Regional Framework

All countries of the Region are developing nations facing the daunting challenges of poverty, lack of sanitation and a high prevalence of infectious diseases. The basic and essential health services, particularly for the vulnerable sections of population, are inadequate. The Declaration on Health Development in the South-East Asia Region in the 21st Century, adopted by Health Ministers of the Region in 1997, reaffirmed the unwavering commitment of the Member Countries, inter alia, to ensure universal access to quality health care; to accord the highest priority to alleviate the burdens of disease, disability, premature death and suffering afflicting people, especially the poor; to invest in women's health and development to eliminate gender discrimination and disparities; to strengthen existing partnerships and to forge new ones for health development at all levels, and to develop regional self-reliance.

At their meetings in 1997 through 2000, the parliamentarians from the Region, noting the gaps in health status between the countries and among population groups within countries, pledged to reduce the negative implications on health status by the globalization phenomenon including economic crisis; advocate and take appropriate legislative measures to enhance the social safety net; find alternative ways of health care financing in both the private and public sectors, including the establishment of trust funds for the poor and vulnerable, and promote a smooth transition of the decentralization process.
Regional Conference on Public Health in South-East Asia in the 21st Century held at Kolkuta in November 1999 noted the progress as well as the considerable gaps in public health practice, education, training and research in the Region. The Conference adopted a Declaration, with a view to enhancing health development in the Region, endorsing the promotion of public health as a discipline and as an essential requirement for health development; recognizing the leadership role of public health in formulating and implementing evidence-based healthy public policies; strengthening and reforming public health education and training, and research as supported by the networking of institutions, and using information technology for improving human resources development.

Keeping in view the continuity of work done during 2002-2003, the "Regional Framework for WHO Collaborative Programme for 2004-2005" would focus on the above strategic approaches, reflecting the WHO Corporate Strategy and its core functions. WHO would continue to contribute through its technical expertise, where it has a comparative advantage and can respond meaningfully to support health development efforts of the countries of the Region.

2.2 Issues and Challenges

The foremost challenges for WHO collaboration with Member Countries in the Region are to:

- Articulate and advocate evidence-based policies and strategies: It is imperative to ensure that policy and decision makers have access to evidence-based information for formulating and implementing strategies to improve the health care delivery system. Steps will be taken to further develop regional and national capacity to critically analyze, organize and disseminate information on epidemiological surveillance and other health information to support decision-making.

- Maintain high-level of technical expertise for catalyzing change: The existing concerns and the emerging complex challenges in the field of public health demand a high level of technical expertise and support to Member Countries in improving the health status of their people. WHO would, therefore, address these challenges by strengthening its collaboration with the network of WHO Collaborating Centres and national institutions as well as with other development partners. Through this collaboration, WHO would provide technical solutions suited to the needs of specific countries. Action to exchange expertise among countries and facilitate rotation of staff between the WHO Country Offices, the Regional Office and WHO Headquarters would be promoted.

- Enhance national and regional partnerships: The determinants of ill health cover multisectoral concerns. It is therefore, imperative to strengthen existing partnerships and forge new ones for health development at all levels. Efforts will be made to foster interaction between health planning, policies and actions with other government and nongovernmental sectors. These sectors will be urged to include health concerns in their agendas.

- Sustain national and regional health development capability: Strategies will be formulated to further develop and strengthen the capacity of each Member Country in the Region in health development, through the development of health and medical sciences, medical technology and health care services. Regional self-reliance in health development will be promoted through regional solidarity and intercountry cooperation.
• Resource mobilization: WHO will enhance its efforts to support countries in their efforts to mobilize resources internally and from existing and potential development partners for their health development efforts.

As the healthy life expectancy in the Region has risen steadily, the proportion of elderly people in the population is also growing rapidly. The Region, with its high population, also accounts for a major proportion of the global disease burden. WHO would concentrate on reducing excess mortality, morbidity and disability, due to both communicable and noncommunicable diseases, especially among the poor and vulnerable population (the youngest and the older). The major determinants and appropriate interventions for the prevention and control of such diseases will be identified and implemented widely.

3. SPECIFIC PRIORITY AREAS FOR 2002-2005

Specific priorities for 2004-2005, as outlined below, are an amalgamation of global, regional and national priorities. In view of the burden of particular diseases faced by certain groups of countries of the Region, a regional perspective has been added to supplement global priorities.

In determining regional priorities, each country of the Region provided a list of country priorities. These priorities were reviewed to ensure consistency with respect to the WHO “Core Functions” and “Strategic Directions” and then aggregated into regional priorities, thus ensuring a regionally appropriate programme in the context of “One WHO”. The focus during the biennium 2004-2005 would, therefore, be on the following main areas:

Malaria

Figure 1: Trend of P. falciparum Proportion in Selected Countries of SEA Region, 1997-1999

*Note: Relates to Java & Bali only

Source: Country Reports
The situation in the Region has not improved very much over the last few years. It is estimated that there are about 17-21 million malaria cases in the Region each year and about 30 000 deaths. Malaria is a major cause of poverty and decreased productivity. The increasing number of people infected with Plasmodium falciparum is a cause for serious concern. Almost all deaths due to malaria resulted from this species of the parasite. This issue is further aggravated by the development and spread of multi-drug resistance to the available first and second line antimalarial drugs. The development of resistance by the disease vector to insecticides considerably impeded malaria control. Migration of population within countries and across international borders also posed major constraints.

The Roll Back Malaria (RBM) Initiative was implemented in 24 pilot districts in seven countries. The RBM Mekong Initiative and the SAARC Initiative brought the concerned countries together to tackle effectively the problem of cross-border malaria and other important communicable diseases. From the regional perspective, priority will be given to address the problem of multi-drug resistance through the Mekong delta project and through partnerships. Using intercountry mechanisms, the problems relating to border malaria will be tackled. Biological control of vectors and comprehensive control of vector-borne diseases will be intensified.

HIV/AIDS

The HIV/AIDS epidemic continues to cause concern to the Region. According to WHO and UNAIDS estimates, there are nearly 36 million people in the world living with HIV infection at the end of the year 2000 and nearly 6 million are in this Region. By March 2001, 173 299 cases of AIDS were reported by Member Countries. All Member Countries agreed that HIV/AIDS is one of the major priority health and development problems. All concerned sectors together with nongovernmental organizations and the community are implementing national strategic plans in each country. A syndromic approach for case management of sexually-transmitted diseases had been adopted. The priority issues that need to be addressed to control HIV/AIDS include application of successful interventions; sustained commitment at the highest level with adequate resource allocation; mobilization of and maintaining sustainable partnerships among the public and private sectors, and donor agencies, NGOs, community groups and affected persons; providing uninterrupted care to persons with HIV/AIDS, improving access to anti-retroviral drugs, including their use to prevent mother-to-child transmission, and reducing risk behaviour among those with high risk sexual behaviour and drug users.

Global efforts will be fully supported through collaboration with UNAIDS for sustaining political commitment and for mobilizing resources. The programme will further strengthen technical support for STI syndromic management, blood safety, disease surveillance and research, prevention of mother to child transmission, and care of people living with HIV/AIDS, including management of opportunistic infections and counselling.

Regional priorities will include emphasis on surveillance, especially of behaviour surveillance and STI, to help refine the plans of action and monitor the epidemic. Operational research will be promoted to focus on priority areas including behavioural and social interventions. Partnerships will be developed to encourage the private sector to participate in syndromic management of STI. The HIV/AIDS control programme will develop partnerships with other programmes to address numerous social and medical problems.
Tuberculosis

It is one of the major killers in the Region and is a serious impediment to human development. Every year around 8 million people develop TB worldwide, of whom 3 million are in this Region. This represents 38% of the global burden. An estimated three quarters of a million people in the Region died of TB in 1999. More women are killed from TB than from all causes of maternal mortality aggregated together. TB has mainly affected the 20-45 aged population, which is the most economically productive group. This has an adverse effect on national economies.

The rapid spread of HIV/AIDS infection in the Region worsened the situation of TB control, as TB was the most life-threatening opportunistic infection associated with HIV/AIDS. Around 60-75% of AIDS patients developed TB. Another emerging problem was the development of resistance to anti-TB drugs, which had serious implications in the management of TB patients. All countries in the Region adopted the DOTS strategy for TB control, and almost 45% of the people in the Region had access to DOTS. Over 5 million patients had so far been treated with a success rate of around 80% under programme conditions. A few countries expected to achieve universal DOTS average by the end of 2001 while a few others, having the largest burden of the disease, were expected to achieve this goal by 2005. WHO support would be provided to sustain political commitment to achieve the global targets through expansion of DOTS. Capacity building through in-depth country reviews, improvement of laboratory diagnosis and strengthening of programme management would enhance the quality of DOTS implementation. Specific attention would be paid to the problem of HIV/TB co-infection. Monitoring of drug resistance would be established. Partnerships with NGOs and the private sector would be further strengthened. Operational research would be promoted and the findings used through development of linkages between researchers and the programme.

![Figure 2: Trends in tuberculosis incidence in the Region](image)


Dengue Fever and Dengue Hemorrhagic Fever (DF/DHF)

There was a dramatic increase in DF/DHF globally over the last two decades. In South-East Asia Region, the number of cases had been increasing during the last five years. Seven
countries in the Region had a series of DHF problem. DHF was a leading cause of hospitalization and death among children in these countries, and its geographic distribution spread within the countries and also to new countries. Major outbreaks occurred in India, Indonesia, Myanmar, Sri Lanka and Thailand in the recent years. Of great concern was the increase in the severe form of the diseases (DHF), particularly in India, Myanmar and Sri Lanka, with relatively high case fatality rates (CFR).

Table 1: DF/DHF cases, deaths and case fatality rates in SEAR countries, 1995-1999

<table>
<thead>
<tr>
<th>Year</th>
<th>Country</th>
<th>India</th>
<th>Indonesia</th>
<th>Myanmar</th>
<th>Sri Lanka</th>
<th>Thailand</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>Cases</td>
<td>7,847</td>
<td>35,102</td>
<td>2,477</td>
<td>440</td>
<td>59,911</td>
<td>105,777</td>
</tr>
<tr>
<td></td>
<td>Death</td>
<td>10</td>
<td>885</td>
<td>53</td>
<td>11</td>
<td>183</td>
<td>1,142</td>
</tr>
<tr>
<td></td>
<td>CFR (%)</td>
<td>0.13</td>
<td>2.52</td>
<td>2.14</td>
<td>2.50</td>
<td>0.31</td>
<td>1.08</td>
</tr>
<tr>
<td>1996</td>
<td>Cases</td>
<td>16,517</td>
<td>44,650</td>
<td>1,655</td>
<td>1,298</td>
<td>38,109</td>
<td>102,229</td>
</tr>
<tr>
<td></td>
<td>Death</td>
<td>545</td>
<td>1,192</td>
<td>18</td>
<td>54</td>
<td>114</td>
<td>1,923</td>
</tr>
<tr>
<td></td>
<td>CFR (%)</td>
<td>3.30</td>
<td>2.67</td>
<td>1.09</td>
<td>4.16</td>
<td>0.30</td>
<td>1.88</td>
</tr>
<tr>
<td>1997</td>
<td>Cases</td>
<td>1,177</td>
<td>30,730</td>
<td>3,993</td>
<td>980</td>
<td>99,150</td>
<td>136,030</td>
</tr>
<tr>
<td></td>
<td>Death</td>
<td>36</td>
<td>681</td>
<td>76</td>
<td>17</td>
<td>227</td>
<td>1,037</td>
</tr>
<tr>
<td></td>
<td>CFR (%)</td>
<td>3.05</td>
<td>2.22</td>
<td>1.90</td>
<td>1.73</td>
<td>0.27</td>
<td>0.76</td>
</tr>
<tr>
<td>1998</td>
<td>Cases</td>
<td>717</td>
<td>47,235</td>
<td>666</td>
<td>1,275</td>
<td>29,577</td>
<td>79,470</td>
</tr>
<tr>
<td></td>
<td>Death</td>
<td>18</td>
<td>999</td>
<td>14</td>
<td>8</td>
<td>85</td>
<td>1,124</td>
</tr>
<tr>
<td></td>
<td>CFR (%)</td>
<td>2.51</td>
<td>2.11</td>
<td>2.10</td>
<td>0.63</td>
<td>0.29</td>
<td>1.41</td>
</tr>
<tr>
<td>1999</td>
<td>Cases</td>
<td>944</td>
<td>14,651</td>
<td>5,828</td>
<td>1,699</td>
<td>24,900</td>
<td>48,022</td>
</tr>
<tr>
<td></td>
<td>Death</td>
<td>17</td>
<td>291</td>
<td>88</td>
<td>14</td>
<td>56</td>
<td>466</td>
</tr>
<tr>
<td></td>
<td>CFR (%)</td>
<td>1.80</td>
<td>1.99</td>
<td>1.51</td>
<td>0.82</td>
<td>0.22</td>
<td>0.97</td>
</tr>
</tbody>
</table>

Source: Country Reports.

Other Communicable Diseases

Collaboration with Member Countries will focus on the adoption of an integrated approach to control priority communicable diseases among the poor, vulnerable and inaccessible populations. Efforts to control the increasing epidemics of dengue/DHF and the outbreak of filariasis will be intensified. Enhancing the regional and national capacity to reduce case fatality will be emphasized. Control efforts against kala-azar, a re-emerging problem, will also be intensified. Promotion of the use of treatment schedules based on research findings was necessary. Use of intercountry mechanisms to address the cross-border problem of kala-azar will be further promoted. Poliomyelitis will continue to remain a priority, as some countries would try to eradicate it by 2005. Leprosy elimination efforts in a few highly endemic countries might still need to be intensified, to reach global target.

Maternal Health

The large number of maternal deaths occurring in this Region was of grave concern to all the countries. As accurate information was often lacking, WHO and UNICEF developed a
methodology to estimate the burden of maternal deaths in the world (see Figure 3). According to the latest estimates (1995), 31% of global maternal deaths occurred in this Region. It was estimated that India had the highest number of maternal deaths (110,000) in the world. The estimated maternal ratios in the Region ranged from 830 (Nepal) to 35 (DPR Korea) per 100,000 live births. The estimated lifetime risk of a maternal death in the Region ranged from 1 in 21 pregnancies in Nepal to 1 in 1,100 pregnancies in DPR Korea and Thailand.

Figure 3: Estimated maternal mortality ratio in SEAR countries, 1995

One area of continuing concern in the Region was the low status of women. The health consequences of the low status of women were reflected in every aspect of their lives, and in their inadequate access to health promoting and life-saving interventions. The Region had very low coverage of attendance of deliveries by trained personnel, as compared to other Regions. All of these factors led to higher maternal mortality in some countries of the Region.
WHO will continue to address the problem of high maternal mortality ratios through the national, regional and global Making Pregnancy Safer (MPS) programmes, within the overall Reproductive Health Strategy. The standards of midwifery practices for safe motherhood will be refined for wider application. In addition, reduction of morbidity and mortality of children will remain an important strategy within the maternal and child health programmes.

Nutrition

Malnutrition was a serious problem in the Region for several decades. Though improvements were noted in some countries, the Region still accounted for a significant percentage of the world’s malnourished children. Protein-energy malnutrition and micronutrient deficiencies constituted the major forms of nutritional disorders. Iron deficiency was the most common cause for anaemia in the Region, with over 600 million people affected. Predominant among those affected were young children, adolescent girls, and women of reproductive age.

The South-East Asia Region accounted for a large proportion of the world's cases of iodine deficiency disorders. More people were affected with higher levels of severity compared to any other WHO Region. It was estimated that almost 600 million persons lived in iodine-deficient areas and were at risk, and about 172 million of them were likely to suffer from goitre. Vitamin A deficiency was a public health problem in many countries of the Region. It was estimated that 125 million children under five years were currently at risk, and 1.3 million were reported to be vitamin A deficient. They were therefore, at 20 times greater risk of death from severe infections like measles, diarrhoea and pneumonia. The countries were taking various public health measures, including health education, to encourage the intake of carotene-rich foods, particularly green, leafy and yellow vegetables.

Over the years, WHO supported countries in their efforts to strengthen national nutrition programmes. Ensuring the safety of food and water, through multisectoral action and community involvement, was the key to success of these programmes. The results of the countries’ sustained efforts could now be seen. The incidence of iodine deficiency disorders, for example, the most important and preventable cause of mental retardation, showed a remarkable decline in some countries of the Region. This was possible by, among other measures, making iodized salt readily available to the people.

Another nutritional aspect that merited attention was obesity. With new urban-based lifestyles, “fast food” diets, and low levels of physical activity, a higher occurrence of obesity was seen, as well as of related chronic disorders including coronary heart diseases, diabetes mellitus and hypertension. According to recent reports, 9-19% of children aged 19 years or less in Thailand were obese, and 20-30% of adults had a body mass index7 (BMI) of more than 25 - indicative of overweight. Surveys in India recently showed that 6.6% of adult women were overweight.

Tobacco

Tobacco consumption was increasing in the Region, with diseases and deaths attributable to tobacco use becoming a cause for serious concern. Alerted to the health dangers, most countries were making significant progress in promoting tobacco control measures. Technical support will be provided to strengthen national capacity for comprehensive tobacco control programme management including involvement in the Framework Convention for Tobacco Control (FCTC) process. Tobacco Free Initiative (TFI) advocacy activities both at the regional and country levels will be further enhanced. Priority areas for
operational research will be identified and supported for the improvement of programme implementation. Community-based anti-tobacco and cessation intervention programmes will be expanded.

Environmental Health Risks

Through the Health and Environment Initiative, eight countries of the Region developed national health and environmental plans of action. Since 1992, the Regional Office had been promoting the concept of healthy cities to address priority health and well-being issues. Environmental problems, resulting from rapid population growth and urbanization were challenging the ability of governments to provide adequate services to the increasing number of urban residents, posing a serious challenge to health development. The delivery of basic services such as water supply and sanitation, were straining national resources. Arsenic poisoning in drinking water remained a major health problem in certain geographical areas of the Region. WHO supported the countries in their efforts to strengthen institutional capacity to assess and manage health hazards due to air, water and land pollution and to ensure the quality of drinking water. Other areas in which WHO provided support included the management of wastes from medical facilities and the promotion of chemical safety.

Noncommunicable Diseases

Noncommunicable diseases in this Region in 1999 accounted for 22% of the global NCD related mortality and 25.2% of the global NCD burden. In the Region itself, nearly 52% of all deaths and 38% of the disease burden were due to noncommunicable diseases. There were clear signs that these diseases were assuming serious proportions. There was a sharp increase in the incidence of cardiovascular diseases. Mortality from cancer was also on the increase. Another lifestyle-related disease, diabetes mellitus, emerged as an important public health problem in the Region. Blindness was also a serious problem. One third of the world’s 45 million and half of the world’s 1.5 million blind children lived in this Region. Further, an additional 45 million persons in this Region had low vision and different grades of visual impairment. The Region was thus estimated to have 60 million blind and visually impaired persons.

Figure 4: Estimated prevalence of diabetes mellitus by WHO Region 1995-2025

Member Countries will be supported in developing national NCD control programmes. Emphasis will be given to the establishment/strengthening of surveillance of cardiovascular diseases, cancer, diabetes mellitus, blindness and their risk factors. Initiation of integrated community-based prevention projects will be supported, initially in three countries. Regional
networks of NCD prevention will be established for sharing experience and improving strategies and later expanded to cover more areas and countries.

Mental Health

Support will be provided to develop/implement national mental health policies with emphasis on community-based programmes in mental health and substance dependence, including prevention of ill-effects from alcohol. A regional profile of the burden from neuropsychiatric disorders will be developed. Innovative and culturally sensitive community-based management programmes, reaching out to all sections, including marginalized groups, will be developed.

Food Safety

The World Health Assembly called upon all Member States to address concerns that food-borne illnesses associated with microbial pathogens, bio-toxins and chemical contaminants in food represented a serious threat to the health of millions of people in the world. It was recognized that food-borne diseases significantly affected people’s health and well-being and had economic consequences for individuals, families, communities, businesses and countries. Ensuring the safety of food and harmonizing the efforts of all stakeholders in the food chain required effective food safety systems. In most developing countries, however, these systems remained weak. The Assembly urged Member States to integrate food safety as one of their essential public health and nutrition functions, and to provide adequate resources to establish and strengthen systematic and sustainable food safety programmes at all levels of the food chain. Furthermore, this should be carried out in close collaboration with national applied nutrition and epidemiological surveillance programmes.

Safe Blood

Blood safety in the Region was of major concern since there was limited access to safe blood. Blood transfusion services in most countries faced problems that hampered the availability of safe blood. Lack of a national policy or lack of effective implementation and inadequate trained human resources to undertake transfusion services were primarily responsible for this situation. The development of health laboratory services and the integration of quality assurance parameters in the functioning of these laboratories were carried out in all countries. Technical support in the development of laboratory programmes, training of personnel and provision of supplies and equipment was provided by WHO.

WHO will provide technical support in formulating and implementing national policies on blood safety for safe blood transfusion. Strengthening of blood transfusion services, quality assurance programmes in health laboratory services, and advocacy for accreditation of laboratories will also be supported.

Health Systems

Strengthening the provision of primary health care (PHC) remained a priority for the Region ever since its enunciation in the Alma Ata Declaration. WHO’s assistance to Member Countries to restructure their health systems based on PHC helped to achieve equitable, affordable, accessible, sustainable and good quality health care. Through decentralization and community participation, district health systems were strengthened. WHO undertook a number of steps directed at enhancing intercountry cooperation and collaboration in the Region.
WHO’s support will be aimed at strengthening national capacity on health policy formulation, health planning and management for the provision of effective and efficient health services that are responsive to the community’s needs, particularly the poor and vulnerable. Strengthening national capacity for health sector reform that leads to equity in health care and developing capacity to plan, produce and manage a cost-effective mix of human resources for health to provide equitable, integrated and quality health care will also be supported.
Annex 2

GENERAL PROGRAMME OF WORK 2002-2005

The changing context of international health

1. The latter part of the twentieth century saw a transformation in human health unmatched in history. Despite the remarkable achievements of health and other socioeconomic development in recent decades, more than one thousand million people were excluded from the benefits of economic development and the scientific advances that increased the length and quality of life of so many others throughout the world. Health is a fundamental human right and still, it has been denied to more than one-fifth of humankind.

2. The past decade has been a time of significant change in international health.
   • Understanding of the causes and consequences of ill-health is changing. It is increasingly evident that achieving better health depends on many social, economic, political and cultural factors, in addition to health services. Moreover, there is a growing recognition of the role that better health can play in reducing poverty.
   • Health systems are becoming more complex. In many countries, the role of the State is changing rapidly, and the private sector and civil society are emerging as important players. In the developing world, a growing number of development organizations, international financial institutions, private foundations and nongovernmental organizations are active in the health sector. Worldwide, people’s expectations of health care services are rising.
   • Safeguarding health is gaining prominence as a component of humanitarian action. A significant increase in the occurrence and impact of conflict and of natural disasters has highlighted the need to protect health in complex emergencies.
   • The world is increasingly looking for greater coordination among development organizations. Reform in the United Nations system aims to make organizations more responsive to the needs of Member States, and to provide a rallying point for achievement of international development goals. A greater emphasis on effectiveness through collective action and partnerships is necessary to rise to this challenge. This, in turn, will require more dynamic, and less bureaucratic, approaches to management.

3. Given the magnitude of the global health agenda, it is evident that WHO cannot do everything. Defining WHO’s particular role in world health is therefore fundamental. It has required, among other efforts, greater concentration on areas in which WHO can

* An abstract of the Original Document on WHO General Programme of Work 2002-2005, as approved by WHA54.1
demonstrate a clear advantage in comparison to other actors at international and national levels.

4. If WHO is to respond effectively to a changing international context, several new ways of working are called for that include:
   - adopting a broader approach to health within the context of human development, humanitarian action, equity between men and women, and human rights, with a particular focus on the links between health and poverty reduction;
   - assuming a greater role in establishing wider national and international consensus on health policy, strategies and standards – through managing the generation and application of research, knowledge and expertise;
   - triggering more effective action to promote and improve health and to decrease inequities in health outcomes, through carefully negotiated partnerships and by making use of the catalytic action of others; and
   - creating an organizational culture that encourages strategic thinking, prompt action, creative networking, innovation and accountability, and strengthens global influence.

5. These overarching lines require WHO to devise new processes and modalities, which draw on the respective and complementary strengths of headquarters, and of regional and country offices. They encompass the functions of WHO as set out in Article 2 of its Constitution, and build on the principles and values articulated in the Global Strategy for Health for All.

STRATEGIC DIRECTIONS

6. WHO’s goals are to build healthy populations and communities, and to combat ill-health. To realize these goals, four strategic directions will provide a broad framework for focusing WHO’s technical work.

   Strategic direction 1: Reducing excess mortality, morbidity and disability, especially in poor and marginalized populations.
   Strategic direction 2: Promoting healthy lifestyles and reducing risk factors to human health that arise from environmental, economic, social and behavioural causes.
   Strategic direction 3: Developing health systems that equitably improve health outcomes, respond to people’s legitimate demands, and are financially fair.
   Strategic direction 4: Framing an enabling policy and creating an institutional environment for the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.

7. The four strategic directions are interrelated. Real progress in improving people’s health cannot be achieved through one direction alone. Success in reducing excess mortality will depend on more effective health systems, and a reduction in exposure to risks and threats to health - many of which lie outside the reach of the health system itself. The effectiveness of work on health systems and risk reduction will in turn depend on the broader policy and institutional environment – globally and nationally – in which countries work to improve the health of their populations.
CORE FUNCTIONS

8. In carrying out its activities WHO’s Secretariat will focus on the following six core functions:

- articulating consistent, ethical and evidence-based policy and advocacy positions;
- managing information by assessing trends and comparing performance; setting the agenda for, and stimulating, research and development;
- catalyzing change through technical and policy support, in ways that stimulate cooperation and action and help to build sustainable national and intercountry capacity;
- negotiating and sustaining national and global partnerships;
- setting, validating, monitoring and pursuing the proper implementation of norms and standards, and
- stimulating the development and testing of new technologies, tools and guidelines for disease control, risk reduction, health care management, and service delivery.

9. WHO’s functions have often been described as falling into two categories: normative work and technical cooperation. Implicit in this division has been the idea that normative functions are carried out primarily at headquarters, and that technical cooperation describes the work of regional and country offices. Yet the six core functions describe the most important activities carried out at all levels of WHO. Technical cooperation does not appear as a single category. Rather, it is better described as a summary term covering many different combinations of the core functions carried out in specific countries. In this sense, technical cooperation (including between developing countries) will include advocacy, development of partnerships, encouragement of local research and development, and policy advice. Depending on the needs of the specific country, technical cooperation may involve staff from headquarters, as well as from regional and country offices.

10. This approach to describing WHO’s core functions also recognizes that regional and country offices too play a role in normative work. Some regional offices may take on global leadership in a particular technical area. In addition, both regional and country offices will be involved in drawing up guidelines on best practice, and in testing new technologies or approaches to service delivery.

11. WHO’s core functions provide a focus for planning the work of the Secretariat. They have been helpful in thinking about where WHO’s advantages lie, and are particularly useful in appraising whether the balance of functions is right in relation to specific areas of work. The core functions also played a part in formulating expected results.

ORGANIZATION-WIDE PRIORITIES

12. Despite the orientation provided by the strategic directions and core functions, more specific areas of emphasis still need to be defined. Based on an analysis of major challenges in international health, they also reflect strategic choices with regard to areas in which WHO has comparative advantage, or where there is a need to build up capacity.

13. Criteria for identifying priorities include:
potential for significant change in burden of disease with existing cost-effective interventions;

health problems with major impact on socioeconomic development and a disproportionate impact on the lives of the poor;

urgent need for new technologies;

opportunities to reduce health inequalities within and between countries;

WHO’s advantages, particularly in relation to provision of public goods; building of consensus around policies, strategies and standards; initiation and management of partnerships, and

major demand for WHO support from Member States.

14. WHO’s overall Organization-wide priorities are set out below.

Malaria, tuberculosis and HIV/AIDS:

• three major communicable diseases, which pose a serious threat to health and economic development and have a disproportionate impact on the lives of poor people;

• all three urgently need new and affordable diagnostics, drugs and vaccines, requiring intervention by a global body such as WHO, capable of influencing private sector research and development in an area which would otherwise receive limited attention;

• tackling the three diseases requires not only cost-effective technologies, but also sustained efforts and effective mechanisms which bring together and mobilize the resources of diverse players – in the public and private sectors, within and beyond the health system.

Cancer, cardiovascular disease and diabetes:

• a growing epidemic in poor and transitional economies; a major threat, not least because of escalating costs of treatment, in the industrialized world;

• needs cross-national surveillance, and better epidemiology of risk factors.

Tobacco:

• a major killer in all societies and a rapidly growing problem in developing countries;

• not just a health issue – the economic case for tobacco control is strong;

• powerful vested interests have to be overcome if consumption is to be reduced, which argues for leadership from a global organization that unites the strength of its Member States.

Maternal health:

• the most marked difference in health outcomes between developed and developing countries shows up in maternal mortality data;
closely linked to development of health systems – it is difficult to cut down maternal mortality without a well-functioning health system.

Food safety:
- a growing public concern, with potentially serious economic consequences;
- new developments in biotechnology pose increasingly difficult technical and ethical questions; problems may affect several countries when food is traded internationally;
- demand is increasing from Member States for impartial technical and scientific advice;
- consistent with WHO’s broader approach to health: opportunities for working across sectors and in partnership with several other bodies.

Mental health:
- five of the 10 leading causes of disability are mental health problems; major depression is the fifth contributor to the global burden of disease, and may be second by 2020;
- needs greater technical consensus in a highly contested and politicized field, and better epidemiological information; potential for public-private partnerships (new treatments) and public voluntary partnerships (provision of service and continuity of care) – all areas in which WHO has advantages compared to other organizations.

Safe blood:
- both a potential source of infection and a major component of treatment: crucial in the fight against HIV/AIDS and for dealing with the growing disease burden among women (as a consequence of pregnancy), children, and accidents and trauma victims;
- a neglected area in many countries, requiring work not only on technical standard setting, but also on legislation, development of health systems, and creation of public, private and voluntary partnerships;
- major opportunity to establish a partnership with the International Federation of Red Cross and Red Crescent Societies and other nongovernmental organizations competent in blood safety.

Health systems:
- development of effective and sustainable health systems underpins all the other priorities;
- WHO’s work on tools and methods for assessing and comparing health systems will provide much needed evidence on the determinants of performance;
- demand is substantial from Member States for support and advice on health sector reform;
- different approaches to health financing have major implications for equity and efficiency;
• workforce management is a neglected area in many health systems and needs a more comprehensive approach;

• more effective mechanisms for resource allocation, budgeting and financial management are a key to ensuring successful implementation of priority programmes.

Investing in change in WHO:

• a prerequisite for WHO to become a more efficient and productive organization – and one capable of response within an increasingly complex international environment;

• development of new skills, systems and processes is central to the effective management of WHO’s core functions;

• gender considerations are to be incorporated in the planning and achievement of expected results in all areas of work.

15. These specific priorities are identified in the proposed programme budget 2002-2003. They will be reviewed in consultation with Member States, when the proposed programme budget for the 2004-2005 biennium, is prepared.
## Annex 3

### COUNTRY COOPERATION STRATEGY

**COMMON PRIORITIES IDENTIFIED BY SEAR CCS TEAMS**

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Bangladesh</th>
<th>Bhutan</th>
<th>DPR Korea</th>
<th>India</th>
<th>Indonesia</th>
<th>Maldives</th>
<th>Myanmar</th>
<th>Nepal</th>
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<td>Human resource development</td>
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<td></td>
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<td>Improve medical education and training, epidemiological surveillance</td>
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<td>HRH policy, SDT, curriculum development</td>
<td>HR development and management, staff deployment.</td>
<td>HR development, skills mix, productivity/performance, quality assurance.</td>
<td>Capacity building, professional development, participation in international health activities.</td>
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<td>Priority Area</td>
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<td>Bhutan</td>
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<tr>
<td>Health promotion</td>
<td>+</td>
<td>Integration of HP</td>
<td>+ Rehabilitation of persons with disability.</td>
<td>+ Integration of HP into health programmes.</td>
<td>+ Sust. dev. of health programmes.</td>
<td>Tobacco, substance abuse.</td>
<td>+</td>
<td></td>
<td>+ Anaemia, IDD.</td>
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<td>Nutrition</td>
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<td>+ Anaemia, IDD.</td>
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<td>+ Water quality, healthy settings, hospital waste, health of internally displaced persons.</td>
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<td>Reducing abortion, infertility management, AH, IMCI</td>
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<td>Standards, legislation.</td>
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<td>Blood safety policy, quality assurance in blood services</td>
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<td>Strengthen health laboratory services.</td>
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<td>EPI</td>
<td>New vaccine development, Disease surveillance</td>
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<td>Impl. of polio eradication, strengthen EPI coord. committee, cold chain systems, essential drugs policy.</td>
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<td>New vaccine development</td>
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<td>IMCI, strengthening of surveillance system, dev. Of monitoring and supervision system.</td>
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+ = Priority stressed by CCS Team. ++ = High priority stressed by CCS Team.
Annex 4

CONTENT AREAS FOR INTERCOUNTRY COLLABORATION
DURING 2002-2003 AS IDENTIFIED BY THE HIGH LEVEL
TASK FORCE ON INTERCOUNTRY COLLABORATION

Content Area

1. Strengthening blood transfusion programmes and promotion of quality assurance in public and private sectors for prevention of HIV/AIDS, and Hepatitis B

2. Intensification of cross-border collaboration in polio eradication, HIV/AIDS, tuberculosis, malaria, kala-azar, and dengue

3. Multi-disease surveillance and response, including health hazards and risk behaviour surveillance, through intercountry and interregional collaboration and use of regional mechanisms such as ASEAN, SAARC, Mekong Basin Project, and Intercountry Cooperation in Health Development

4. Development of regional networks to enhance national capacity in human resources for public health

5. Making essential drugs, vaccines and commodities (bednets, condoms) affordable and accessible through the use of intercountry mechanisms addressing policy, quality, and supply issues


7. Regular reviews and monitoring to improve the coverage and quality of maternal health care for making pregnancy safer

8. Mainstreaming gender perspective into health policies and programmes with focus on women’s health issues and their access to quality health care throughout their life-span

9. Increasing the use of information technology


11. Development of strategies for implementing community-based approaches for mental health problems and substance abuse

12. Development of strategies for implementing national nutrition policies and plans to prevent reduce and eliminate malnutrition

13. Prevention and control of accidents and injuries

14. Arsenic poisoning
Annex 5


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<th>Subject area</th>
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<th>Health Secretaries’ Meeting Discussions and Recommendations</th>
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<td>14th, 16th &amp; 17th HMMs</td>
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<td>14th &amp; 15th HMM</td>
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<td>10. Intercountry Cooperation in Health Development</td>
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