WHO Regional Committee for South-East Asia

Report of the Fifty-ninth Session
Dhaka, Bangladesh, 22-25 August 2006
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Report of

the Regional Committee

Part I

Introduction

1. The Fifty-ninth session of the WHO Regional Committee for South-East Asia (SEA) was held in Dhaka, Bangladesh, from 22 to 25 August 2006. It was attended by representatives of all the eleven Member States of the Region, United Nations (UN) and other agencies, nongovernmental organizations (NGOs) having official relations with WHO, as well as observers.

2. A joint inauguration of the Fifty-ninth session of the Regional Committee and the Twenty-fourth Meeting of Ministers of Health was held on 20 August 2006. H.E. Begum Khaleda Zia, Prime Minister of the People’s Republic of Bangladesh, delivered the inaugural address.

3. The Committee elected H.E. Dr Khandaker Mosharraf Hossain, Minister of Health and Family Welfare, People’s Republic of Bangladesh, as Chairman and H.E. Lyonpo (Dr) Jigmi Singay, Minister of Health, Royal Government of Bhutan, as Vice-Chairman of the session.

4. The Committee reviewed the report of the Regional Director covering the period 1 July 2005 to 30 June 2006.

5. The Acting Director-General of WHO, Dr Anders Nordström addressed the business session of the Committee on 22 August 2006.

6. The Committee decided to hold its sixtieth session in Bhutan in 2007.

7. A drafting group on resolutions comprising a representative from each of the Member States was constituted with Dr Viroj Tangcharoensathien (Thailand) as Convener. During the session, the Committee adopted 10 resolutions.
Part II
Inaugural session

8. Inaugurating the Twenty-fourth meeting of Ministers of Health and the Fifty-ninth session of the Regional Committee for South-East Asia in Dhaka on 20 August 2006, H.E. Begum Khaleda Zia, Prime Minister of the People’s Republic of Bangladesh, called for stronger and more enduring cooperation among Member countries of the Region to ensure greater equity in delivery of health care. The Prime Minister urged delegates to introduce innovative financing methods to make health care affordable and within reach of all households.

9. The Prime Minister underlined the need for developing countries to be supported in evolving new technology and methods, including technology transfer and revision of patent laws, to ensure availability of cheap and high-quality medicines.

*Her Excellency Begum Khaleda Zia, Honorable Prime Minister, People’s Republic of Bangladesh, inaugurating the joint session of the Health Ministers’ Meeting and the Regional Committee.*
10. While recounting the steady progress in the health sector made by Bangladesh, H.E. Begum Khaleda Zia acknowledged the important contribution made by WHO in supporting the key national health programmes (for full text of the address, see Annex 1).

11. In his address, Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region, singled out the spread of avian influenza throughout the world as the most daunting health challenge. Stating that efforts to control it could not be made in isolation, without the cooperation of neighbouring countries and the international community, the Regional Director called for continued vigilance by all for every hint and sign of the virus changing its behaviour.

12. Dr Samlee emphasized the importance of addressing the Millennium Development Goals (MDGs) towards achieving poverty reduction. He underlined the importance of strengthening the public health infrastructure by producing a balanced health workforce, paying attention to health promotion and focusing on disease prevention and control. He emphasized that placing health services at the grassroots level would ensure that the health benefits reached the poor, the marginalized and the underprivileged (for full text of the address, see Annex 2).

13. In his welcome address, H.E. Dr Khandaker Mosharraf Hossain, Minister of Health and Family Welfare, Government of Bangladesh committed, on behalf of the health ministers, to advance regional cooperation in health, and to take steps to ensure that the health-related MDGs can be achieved by 2015.

14. H.E. Mr Nimal Sripala de Silva, Minister of Healthcare and Nutrition, Government of Sri Lanka also addressed the inaugural session in his capacity as the outgoing Chairman of the Fifty-eighth session of the Regional Committee for South-East Asia and as the Chairman of the Health Ministers’ Forum.

15. H.E. Lyonpo (Dr) Jigmi Singay, Minister of Health, Royal Government of Bhutan, proposed a vote of thanks on behalf of the health ministers.
Part III

Business session

Opening of the session

16. In the absence of Chairman and Vice-Chairman of the Fifty-eighth session of the Regional Committee, the fifty-ninth session was opened, in accordance with Rule 12 of the Rules of Procedure of the Regional Committee, by the Regional Director, Dr Samlee Plianbangchang. The Regional Director welcomed the participants and expressed the hope that countries of the South-East Asia Region, despite their social, cultural, political and economic diversities, would continue to work collectively with WHO’s technical support, towards improving the health status of the people in the Region. He further stated that Member States had made significant progress in health development. However, they needed to continue to direct their concerted efforts towards mobilizing additional resources, both internally and externally. He hoped that the deliberations of the Regional Committee would provide valuable guidance in this regard.

17. Dr Samlee expressed gratitude to H.E. Begum Khaleda Zia, Prime Minister of the People's Republic of Bangladesh for her inspiring address at the joint inaugural session of the Twenty-fifth Meeting of Health Ministers and the Fifty-ninth session of the Regional Committee. He also thanked the Government of the People's Republic of Bangladesh for hosting the Fifty-ninth session in Dhaka.

Sub-committee on credentials

(Agenda item 2.1)

18. A Sub-committee on Credentials, comprising representatives from Bhutan, Indonesia and Myanmar was appointed. It met under the chairmanship of the representative of Bhutan 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 all Member States of the Region were found to be in order, thus entitling the representatives to take part in the work of the Regional Committee.
**Election of Chairman and Vice-chairman**  
(Agenda item 3)  

19. H.E. Dr Khandaker Mosharraf Hossain, Minister of Health and Family Welfare, People’s Republic of Bangladesh, was elected Chairman and H.E. Lyonpo (Dr) Jigmi Singay, Minister of Health, Royal Government of Bhutan, as Vice-Chairman. Dr Hossain 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 representatives, the Committee would successfully cover the heavy agenda. He looked forward to the support of the Regional Director and the WHO Secretariat to accomplish the agenda in a meaningful manner.

**Adoption of agenda and supplementary agenda, if any, of the Regional Committee**  
(Agenda item 4, document SEA/RC59/1 [Rev.1])  

20. The Committee was informed that in accordance with Rule 8 of the Rules of Procedure of the Regional Committee, four items had been included in the agenda at the request of the Royal Thai Government. Following deliberations, the Committee decided to move up the agenda items on Regional Strategy for Health Promotion: Follow-up of the Sixth Global Conference on Health Promotion (Agenda item 10), and Alcohol Consumption Control – Policy options in the South-East Asia Region (Agenda item 11) to take them up before Agenda item 9.

21. The Committee also decided to drop the word “Public” from Agenda item 13 – “Strengthening Public Health Workforce in SEAR Countries”.

22. The Committee then adopted the revised Agenda (document SEA/RC59/1 [Rev.2]) incorporating the above-mentioned modifications (see Annex 3).

23. Subsequently the Committee decided, as per Rule 37 of the Rules of Procedures of the Regional Committee, to add item 21 “Representation of the South-East Asia Region on the Executive Board” to the Agenda.

**List of participants**

24. The list of participants is at Annex 4.

**Drafting group on resolutions**

25. The Committee constituted a drafting group on resolutions comprising one representative from each of the Member States of the Region. Dr Viroj Tangcharoensathien (Thailand) was nominated as the Convener by the group (for names of all members of the drafting group, see Annex 5).
List of official documents


Statements by representatives of UN and specialized agencies

27. Ms Harriet Torlesse (UNICEF) stated that there were many complex issues affecting children and women in the Region. She expressed satisfaction at the existing collaboration and cooperation among the United Nations Children's Fund (UNICEF), WHO, the Food and Agriculture Organization (FAO) and the World Food Programme (WFP) in tackling these issues effectively with the help and assistance of national governments. With reference to avian and human influenza, Ms Torlesse hoped that a strategy to develop communications resources and tools for tackling emergencies would be developed. She congratulated WHO on introducing new Child Growth Standards. She reiterated that UNICEF was committed to work with governments and WHO to solve the problems of children and women effectively and efficiently. One of the greatest challenges in doing this was to create the required human resource base in order to ensure that every delivery was conducted by a skilled birth attendant.

28. Mr Qaiser Khan (World Bank) said that the MDGs were linked closely to health. However, in the context of the fast-growing economies of South-East Asia, one had to think beyond the MDGs. Mr Khan also stated that the forthcoming World Development Report would highlight the second-generation issues such as HIV/AIDS, tobacco use and alcohol consumption among youth. He was happy to note that these issues would also be deliberated upon by the Regional Committee.

Address by the Director-General of the World Health Organization (Agenda Item 5)

29. Dr Anders Nordström, Acting Director-General, recalling his previous visit to Bangladesh in June 2003 lauded the country for the impressive achievements made in the health sector since then, particularly in terms of reducing maternal mortality and women's health.

30. Noting the exceptional challenges to health that the South-East Asia Region faced on account of its susceptibility to natural disasters such as tsunamis, floods and earthquakes, Dr Nordström commended the amazing progress and solidarity that neighbours in the Region had achieved and demonstrated. People had to cope with disruption of their lives and homes, and, at the same time, with the growing burden of diseases such as avian flu, polio, HIV, TB, malaria and other chronic diseases. Dr Nordström also commended Member States for having coped with the tsunami and its aftermath.
31. The Acting Director-General thanked the Committee for its valuable inputs and insights into the Eleventh General Programme of Work which was approved by the World Health Assembly in May 2006.

32. Referring to the Medium-term Strategic Plan (MTSP) 2008-2013 and the Proposed Programme Budget for 2008-2009, he said that the MTSP recommended five areas as the main focus of WHO during the period, namely: support to countries in moving towards universal coverage with effective public health interventions; strengthening global and local health security; action to modify behavioural, social, economic and environmental determinants of health; increasing institutional capacities to deliver core public health functions through the strengthening of health systems, and strengthening WHO’s coverage, at both global and regional levels, to support the work of countries.

33. To finance these plans, the Programme Budget for 2008-2009 had been pegged at $4.2 billion, an increase of 17% over the current biennium’s expected expenditure. For the South-East Asia Region, this meant an increase of 39%.

34. The $4.2 billion budget was proposed to be financed through an 8.6% increase in assessed contributions totalling $1 billion. The increase in the budget reflected the expectations of Member States and would target some of the core areas of WHO’s work.

35. The Acting Director-General lauded the progress made in the Region with regard to maternal and child health. He, however, pointed out that much more needed to be done for women’s health to keep up with the goals for 2015.
36. There was an urgent need to improve the prevention, treatment and care initiatives for women, and prevent HIV transmission to newborns in particular. Pointing out that one in 10 pregnant women lived in low-income countries, the Acting Director-General called for more comprehensive ARV treatment across the world. While the number of people with access to ARV treatment in these countries had increased four-fold in recent years, the existing gaps were still conspicuous.

37. Dr Nordström commended the Regional Framework on Noncommunicable Diseases since chronic diseases like cancer, cardiovascular ailments and diabetes accounted for 54% of all deaths in the Region. He also congratulated the nine Member countries of the Region who are Parties to the Framework Convention on Tobacco Control (FCTC).

38. Despite the alarm that it triggered, avian influenza did not culminate in a global pandemic largely on account of the thorough and constant vigil maintained by Member countries. But the threat of avian influenza was still a reality with half the countries of the Region having reported bird flu outbreaks. With support from WHO, almost all countries had preparedness plans in place to respond to a pandemic. Manufacturing capacity for antiviral drugs had improved considerably and licences had been granted in several developing countries to produce these. Attention was also being paid to the development of a vaccine: clinical trials had produced encouraging results.

39. With reference to polio, the Committee was informed that last year's outbreak in Indonesia showed that undetected circulation of the virus due to surveillance gaps could not be ruled out.

40. The Acting Director-General also reiterated the importance of continuing to strengthen health systems in order to scale up basic health services and achieve the MDGs. For this, policy options on how to finance health services and how best to organize the system and engage different stakeholders were needed. He underscored the importance of a strong health workforce to achieve this.

41. Responding to the Acting Director-General's observations on chronic diseases, the Committee proposed that the term chronic, noncommunicable diseases be used to replace the nomenclature of chronic diseases since some chronic diseases are communicable. The Committee also sought clarifications – in the light of the Eleventh General Programme of Work and revised guidelines with reference to voluntary contributions and an integrated budget – on how to reconcile national priorities with the donors' perspectives.

42. The Committee also elaborated on the new measures taken to combat polio in areas where fresh outbreaks had been reported. It also expressed the need for continued availability of resources even beyond the MDG target date (2015) as several countries may still need them.
43. In his response, the Acting Director-General spoke of WHO’s impending discussions with UNICEF on increasing the level of collaboration on child health. He appreciated the renewed initiatives to combat polio while clarifying that the word “chronic” was used to reflect the nature of noncommunicable diseases.

44. He also assured the Committee that the need to ensure availability of resources beyond the target dates of the MDGs will be considered while reminding Member States about the pressing need to achieve the targets in the first place.

45. On the concerns related to funding, Dr Nordström spoke of three sources of funding in an ideal scenario: assessed contributions, negotiated core contributions and voluntary contributions.

46. In conclusion, the Acting Director-General stated that the underlying goal was to make WHO more responsive to the needs of countries. He shared the appreciation for the work of WHO and its staff expressed recently by the UN Secretary-General. “We now need to look widely throughout the Organization at how we can further improve our work... We need to attract and retain the highest possible standard of competencies (and ensure) we have the right staff in the right place,” he concluded (for full text of the Director-General’s address, see Annex 7).

(Agenda item 5, documents SEA/RC59/2, Corr.1 and SEA/RC59/Inf.1)

47. Introducing his report, the Regional Director, Dr Samlee Plianbangchang, stated that the Region faced many health challenges during the last year. The response to these was influenced by a variety of factors. These included, among others, political concerns, capacity of health systems and availability of resources. He stated that success in health development did not result from efforts of the health sector alone, and other sectors had also to share responsibility and ownership in the process of such a development.

48. A strong political view and commitment of Member States had led to successful endeavours in tackling challenges. Complimenting the efforts of the governments, the Regional Director said that WHO had begun to ensure steady progress towards national health goals.

49. Communicable diseases continued to be important public health problems in the South-East Asia Region. There was a threat of potential pandemic caused by avian influenza. There were also the unchecked outbreaks of malaria, dengue fever, encephalitis and other diseases.
50. In this context, and in order to ensure prompt response, a Strategic Health Operations Centre (SHOC) had been set up at WHO’s Regional Office in New Delhi. Furthermore, to decentralize regional activities to countries, sub-units had been set up in New Delhi and Bangkok. And to promote collaboration among countries of the South-East Asia and Western Pacific regions, the Asia-Pacific Strategy for Emerging Diseases had been developed.

51. In the area of HIV/AIDS control, the coverage of antiretroviral treatment had increased from 37 000 cases to 162 000 cases between 2003 and 2005. During this period, 1.8 million new cases of TB had been put on DOTS and full coverage of treatment achieved in all countries.

52. The eradication strategy for polio was being modified to put an end to all new outbreaks. Apart from leprosy, three more diseases of poverty had been targeted for elimination in the Region. These were kala-azar, lymphatic filariasis and yaws.

53. Safety of blood and blood products continued to attract priority attention of WHO. A strategy for safe blood had been developed and its implementation started in all Member States.

54. Noncommunicable diseases (NCDs) continued to place an additional burden on health systems, accounting for about 54% of all deaths in the Region. The main risk factors for these conditions continued to be tobacco use, unhealthy diet, poor physical activity and high blood pressure. These risk factors continued to be addressed through integrated surveillance and population-based interventions.

55. All countries of the Region had developed national strategies for mental health promotion, specially targeting adolescents.

56. The Sixth Global Conference on Health Promotion, held in Bangkok, Thailand in August 2005 endorsed the Bangkok Charter for Health Promotion. The Charter was subsequently deliberated upon at the Fifty-ninth World Health Assembly. Countries had developed their action plans to implement the recommendations contained in the Charter. On tobacco use, of the five million deaths across the globe annually, 1.2 million were from this Region. Nine countries in the Region were Parties to the WHO Framework Convention on Tobacco Control. Global youth surveys were carried out in 10 countries to gather evidence for the development of tobacco control strategies (for full text of the Regional Director’s introductory remarks, see Annex 8).

57. The Committee reviewed the Report of the Regional Director in toto, and made the following observations after comprehensive deliberations:
58. The Committee was informed that Member States continued to overcome problems of injuries through multisectoral interventions. To restore the eyesight of the 15 million blind in the Region, eight countries had launched Vision 2020 – the Right to Sight programme which aims to eliminate the causes of avoidable blindness by 2020.

59. The Committee noted that countries continued to face serious public health challenges due to environmental degradation and pollution. Safe drinking water was becoming scarce in several countries. A guidance document on rainwater and health had been developed. These guidelines were being incorporated into the WHO Drinking Water Guidelines. Nearly 50% of the population did not have access to sanitation facilities. The Committee was informed that steps were being taken to promote workers' health as a basic human right.

60. Arsenic poisoning continued to be a serious health hazard in the Region. A field guide to tackle the problem had been developed. National integrated food safety programmes to tackle problems relating to food safety were developed in several countries. Tsunami and avian influenza highlighted the importance of food safety programmes, which had been developed in several countries.

61. The Committee recognized the vulnerability of the Region to natural disasters. The Tsunami of 2004 was followed by the earthquake in North-West India and in Indonesia and floods in these two countries. The need for strengthening emergency preparedness and response was therefore impressed.

62. With reference to an imported polio case of a 14-year old in one of the countries, the Committee noted that three National Immunization Days (NIDs) had been planned for the period September-November 2006. The Technical Advisory Group of WHO would review the situation concerning imported cases and would decide whether any further rounds of NIDs were required in 2007.

63. A review of the current immunization system confirmed it to be very good. It was decided to revive the process of holding cross-border meetings not only to curb polio, but also for malaria and other diseases.

64. The Committee was informed that the Country Cooperation Strategy (CCS) document spelt out the future health directions for countries and should be considered as the basis for areas which needed WHO's support. The WHO staff at headquarters, regional and country office level were fully involved in the CCS implementation.

65. Developing the health system framework was a priority for WHO. It was an important public health initiative aimed at infrastructure development and strengthening, review and analysis of human resources (HR), and training in
health system development. Training courses had been made available in countries through the WHO country offices.

66. Strengthening countries' capacities in managerial aspects was also a primary concern for WHO. Towards this end, Technical Advisory Groups had been constituted comprising experts from Member countries. The Agreement for Performance of Work (APW) mechanism had proved to be very useful in strengthening country capacities.

67. The Committee noted that WHO would undertake a review of its working and coordination mechanism at country level in order to make it more effective. WHO was committed to enhance its contribution towards strengthening the countries' capacities and improving their health systems. More specifically, the impact of WHO's work on reducing maternal mortality in countries could be one of the indicators. There was also a need to look at the process of collaboration from the point of view of utilizing countries' expertise, taking into consideration regional, cultural and country-specific contexts and requirements. Intercountry cooperation and sharing of experiences, knowledge and technology among the countries was also very important. The Committee noted that WHO would report in future the impact in measurable terms of its contribution in strengthening countries' health systems and in reducing their health problems.

68. The Committee urged WHO to take appropriate steps to protect and help the victims not only of natural disasters such as tsunami, but also the victims of man-made disasters such as civil wars. Man-made disasters led to the problems of social conflicts and domestic violence, increase in unwanted pregnancies, maternal mortality, and STDs. The need for enhanced focus on community-based health care to counter psychosocial problems was stressed. The Committee noted with appreciation that many countries had included the subjects of psychosocial health and adolescent health into the curricula for teachers.

69. With regard to the social problems arising from alcohol abuse, the Committee was informed that the social aspects would be taken into consideration. The Committee noted that WHO accorded high importance to working with partners in this regard.

70. The Committee requested the Regional Director to establish a Regional Emergency Fund on the lines of the one established by the Regional Office for the Eastern Mediterranean (EMRO).

71. The Committee, after discussing the Report, noted with satisfaction the progress made during the period under review in the implementation of WHO's collaborative programmes and activities in the Region. It congratulated the Regional Director and his staff for producing a lucid and comprehensive report.
Statements by representatives of nongovernmental Organizations (NGOs)

72. Dr Chandrakant S. Pandav (International Council for Control of Iodine Deficiency Disorders [ICCID D], South Asia), appreciated WHO’s support in the formation of the ICCIDD in 1985. He informed the Committee of the Council’s focus on activities aimed at sustainable elimination of iodine deficiency, as well as its role in policy formulation through interaction with the concerned policymakers. Highlighting the significant implications of iodine deficiency, Dr Pandav shared with the Committee ICCIDD’s success story pertaining to a country of the Region, and also offered the Council’s specific assistance and collaboration to other countries in strengthening the advocacy aimed at reducing IDD.

73. Prof Rabiul Husain (International Agency for the Prevention of Blindness [IAPB]), recalled IAPB’s long relationship with WHO, and reiterated the Agency’s resolve for prevention of blindness and elimination of preventable and curable/treatable blindness by 2020. In view of the magnitude of the problem of blindness in the Region, especially among children, due to glaucoma, diabetes and other reasons, the issue demanded urgent action. He appreciated the priority accorded by WHO to prevention of blindness at regional and country level and urged that this issue be included in WHO’s 11th GPW as well as in MTSP 2008-2013. He also made a request for a dedicated post for prevention of blindness in the Regional Office.

74. Dr Enamul Kabir (Sight Savers International, Royal Commonwealth Society for the Blind) informed the Committee that the goal of elimination of avoidable blindness by 2020 was achievable with technical support from WHO and cooperation of national governments and NGOs. He expressed the need for according high priority to this matter, and to include it in the MTSP for 2008-2013.

75. Mr Alain Aumonier (International Federation of Pharmaceutical Manufacturers and Associations [IFPMA]) informed the Committee about the IFPMA members' active contribution in discovering and developing medicines to meet major health needs. He suggested that there was no need for re-inventing a new framework to generate research and development for diseases primarily affecting the developing countries. Mr Aumonier also reiterated IFPMA’s commitment to continue to provide all possible inputs to the intergovernmental working group constituted by WHO.

76. Dr Bindeshwar Pathak (Sulabh International Social Service Organization) attributed the origin of Sulabh Sanitation Movement in 1970 to a WHO publication, “Excreta Disposal in the Rural Areas and Small Communities” published in 1958 which inspired him to modify, innovate and develop what
later became to be known as the Sulabh Toilet. This appropriate, affordable, indigenous and culturally-acceptable technology saved thousands of children from dying of diarrhoea. This technology was also offered to many countries in other regions. These efforts attracted the attention of many other UN agencies which included sanitation in their respective agendas. He requested WHO to consider documenting and disseminating similar initiatives implemented by different agencies and NGOs, in order to create awareness and wider application.

77. Mr Ajeet Bhardwaj (World Council of Optometry [WCO]) highlighted WCO’s commitment to public health imperatives. Referring to the initiative of 'Right to Sight' and implementation of Vision 2020, he hoped that increased budgetary resources would become available to address the problem of blindness by 2020.

Statement by representative of intergovernmental Organization

78. Dr Y. Oketani (Office International des Epizooties [OIE]) spoke about the highly pathogenic avian influenza (HPAI) viruses persistent and circulating in the environment. Describing the serious socio-economic consequences of the disease, he provided an update of the endeavours undertaken by OIE to address the situation. He informed the Committee about the other initiatives on the anvil and urged for closer collaboration with Member countries, WHO and other agencies in this regard.

Medium-term strategic plan (MTSP) 2008-2013

(Agenda item 7, document SEA/RC59/9 [Rev.1])

79. The Committee appreciated the efforts of the Secretariat in preparing this comprehensive document. The document provided the framework for the work of the entire Organization and was arranged in 16 Strategic Objectives, as compared to the 36 Areas of Work in the 2006-2007 Programme Budget. Within each Strategic Objective were three to eight Organization-wide Expected Results, each with its six-year targets and indicators. The Organization-wide Expected Results reflected the work to be achieved by the Secretariat at all levels.

80. The Committee was informed that it took six to eight months of wide-ranging consultations to draft the MTSP. The document would be used for preparing programme budgets of three bienniums.

81. The Committee noted that some governments had adopted results-based management frameworks in their medium and long-term plans. It was also
noted that it was sometimes difficult to identify appropriate indicators and targets to measure their work. The MTSP, therefore, provided a comprehensive model for use in the health sectors of the respective countries.

82. The Committee observed that even though MDGs were key indicators in the MTSP, the latter would be completed in 2013 while the timeframe for MDGs ran through 2015. This might make it difficult to determine appropriate targets for the MTSP.

83. The Committee sought clarifications on how specific budget figures in the document were determined. It asked if detailed budgets would be presented for the entire six-year period of the MTSP or for only the first biennium (2008-2009). Adequate financial analyses should also be provided in order to reflect the MTSP priorities. While region-wise figures had been provided in the document, county-wise breakdowns had not been included.

84. The Committee also enquired whether the MTSP would be flexible enough to match country needs and fit into respective national plans. The Committee was informed that the Strategic Plan would be flexible enough to reflect country priorities as presented in the Country Cooperation Strategy and to allocate resources to suit the needs of the country. The Country Cooperation Strategies had been used to develop the current MTSP and would continue to influence future MTSPs. At the same time, the MTSP will guide the work of the Organization in countries.

85. The Committee noted that the MTSP document had listed high-level indicators for Strategic Objectives to reflect health outcomes. Choosing appropriate indicators was a challenge in itself.

86. The Committee questioned the distribution of the WHO budget among regions. It expressed concern that the South-East Asia Region, which has the highest burden of disease, received less funds compared to other regions with lower disease burdens. However, it was noted that the SEA Region had received the largest proportional increase after the initial application of the validation mechanism.

87. The Committee expressed concern regarding unspecified voluntary contributions in the budget. It was necessary to ensure that priorities of the Member countries were not diluted by those of the donors.

88. Various specific issues in the MTSP document were brought to the attention of the Committee. It was stated that inputs from Member countries would make the document more comprehensive. The suggestions of all countries would be formally conveyed to WHO headquarters for preparation of the final draft which would be submitted to the 120th session of the Executive Board in January 2007 prior to its submission to the Sixtieth World Health Assembly. The Assembly
would review it and accord final approval to it, as well as to the 2008-2009 Programme Budget.

89. The Committee made detailed observations about specific indicators in the draft MTSP. It noted that information about some baselines was incomplete. These comments should be noted and forwarded to the global Strategic Objective Team for consideration in preparing subsequent drafts of the MTSP.

90. It was reconfirmed that the MTSP would be used to guide the work of WHO in the Region, and in the immediate context, would aid in further refining the country budgets and workplans in consultation with Member countries. The Committee was informed that a meeting of WHO and Member countries would be convened in September 2006 to discuss and determine the Proposed Regional Programme Budget at the Expected Result and country levels, in line with country and regional priorities.

91. The Committee noted the recommendations made by the 43rd meeting of the CCPDM as contained in its report (document SEA/PDM/Meet. 43/11, see Annex 9).

**Proposed regional programme budget 2008-2009**
(Agenda item 8, document SEA/RC59/10, [Rev.1])

92. The Committee reviewed the Proposed Regional Programme Budget for the 2008-2009 biennium developed in consultation with Member States. It commended the Regional Director for the efforts by the WHO Secretariat in developing the Regional Programme Budget and the background documentation.

93. The Committee was informed that the 2008-2009 proposed budget for the SEA Region included a 39% total increase over the previous biennium budget. This increase was more than the 29% rise in the budget for the entire Organization. The budget increase for the Region reflected a 9% increase for Assessed Contributions and a 50% increase for Voluntary Contributions (VC).

94. A brief visual presentation highlighting the salient features of the process of developing the proposed budget was made. The following were the highlights:

- The Proposed Regional Programme Budget document has been structured according to the 16 Strategic Objectives (SOs) contained in the MTSP, with regional indicators and targets reflecting the work of the WHO Secretariat and Member States for each SO.
- The total budget levels for each SO have been established through consultations between the regions and headquarters with inputs from country offices.
• Although the total Regular Budget for the Region has been established by headquarters, its distribution among SOs has been determined by the Region in consultation with countries.

• Increased reliance on VCs makes it difficult to ensure adequate funding for all areas. Scaling up of resource mobilization is, therefore, imperative to ensure adequate funds for regional priorities.

• The Regional Expected Results (RERs) are being developed for each Organization-wide expected result (OWER) – three to eight OWERs for each SO.

• The revised global programme budget which includes specific budget levels for regions, will be reviewed by the Executive Board in January 2007.

95. The Committee desired that indicators for Strategic Objectives should include priority diseases for the Region such as yaws and kala-azar. The Regional Programme Budget document should also reflect the current regional strategies such as the Revised Malaria Control Strategy which was discussed at the Twenty-fourth Meeting of Health Ministers.

96. The Committee expressed concern about the gaps between expected results and health outcomes and suggested that both these aspects be adequately correlated in the regional budget document. Furthermore, it was suggested that unit costs for individual objectives/indicators, where appropriate, should also be reflected.

97. The Committee pointed out that since the country plans would be based on country priorities, the total regional budget needed to be worked out from bottom upwards. It was important to match the country and regional priorities.

98. The Committee felt that the process of development of the regional budget figures should be flexible enough to reflect the changing conditions in countries.

99. Since the major part of the increase in the total budget was attributed to VCs, the Committee reiterated the importance of unspecified contributions to accommodate country priorities.

100. The Committee expressed its apprehension about meeting the polio-free certification targets set for 2009. It was felt that the proposed 22% reduction in the draft Proposed Regional Programme Budget for polio might be risky, especially since some countries in the Region still had new cases of polio. It also questioned the use of uniform percentage target indicators, noting that Member States of the Region were at varying stages of development. The indicators and targets should take into account country-specific conditions in
order to ensure that the proposed targets were appropriate to all countries in the Region. Furthermore, regional indicators and targets needed to be linked with global indicators in the MTSP.

101. The Proposed Regional Programme Budget document might have included some targets that were too ambitious and hence unachievable. Thus, targets should be reviewed to ensure that they are appropriate, relevant and achievable. Several representatives commented on specific indicators and targets that might be revised.

102. The Committee suggested that new and emerging realities in the health sector should be duly reflected in the process of building up the integrated budget. For instance, the private sector’s increasing role in the provision of health care should be duly taken into account. Towards this end, it was suggested that an expenditure analysis be carried out to show the effects of various funding options. In future this analysis should guide the distribution of budgetary resources to achieve maximum health outcomes.

103. The Committee perceived an imbalance in resource allocation vis-à-vis the burden of disease especially noncommunicable diseases, and reiterated the need to discuss this aspect thoroughly among the Member States.

104. The Committee noted that the Proposed Regional Programme Budget document was still open to refinement and fine-tuning. It, therefore, felt that there was need for discussions to continue in this regard. It suggested that a high-level group might be constituted to review further budget changes before presenting it to the Executive Board in 2007. Alternatively, this process of consultation might continue through emails and video conferences.

105. The Committee was assured that the comments and insights provided by it would be considered while finalizing the draft Regional Programme Budget for 2008-2009. The draft had been prepared after consultations by the Regional Office with countries of the Region. The Regional Director urged the Member States to depute a high-level representative to attend a consultation proposed to be held soon after the current session of the Regional Committee to look into the proposed changes before finalizing the draft for submission to headquarters. The specific country needs and requirements reflected in the Regional Programme Budget would eventually be appropriately incorporated in the Global Proposed Programme Budget after suitably factoring in the country needs, regional issues and local challenges, and will be presented to the Executive Board in January 2007.

106. Prioritization, feasibility, resource mobilization and appropriate planning were other equally important considerations. Countries would be actively
involved in developing the country-specific workplans beginning February 2007 based on the draft Regional Programme Budget. Using the mechanism of programme change, necessary adjustments could be made to reflect unforeseen developments in countries. The country cooperation strategies (CCS), currently in their second generation, would also be reviewed, in consultation with counties, to adequately accommodate relevant issues and priorities in preparing country workplans. The authority delegated to WHO representatives provided reasonable flexibility in this regard.

107. The Committee commented on its analyses of the percentage of assessed contributions vis-a-vis voluntary contributions. It noted the successive upward trend in donor support provided over the last few years, in addition to the funds received for tsunami relief. Of the total amount of voluntary funds, only 10% were unspecified and had been used for priority areas. During the last biennium, nearly 60 donor agreements had been signed and 800 projects implemented.

108. The Committee observed that only 22% of the total WHO Budget comprised assessed contributions. A clarification was provided to the Committee that the Budget was decided by the Executive Board and approved by the World Health Assembly. The voluntary funds received were usually earmarked for specific areas of work. Moreover, these funds were not received in full at the same time and it was difficult to anticipate the expected amount of voluntary contributions.

109. Although the polio eradication initiative was at an advanced stage, resources would continue to be needed to maintain regular monitoring systems and surveillance activities for the next few years. Thereafter, polio immunization would become part of the routine immunization which was a priority programme of WHO. Polio eradication being a high priority area received the largest share of funding. Apart from the resource mobilization efforts made by the Regional
Office, many donors and international agencies were expected to continue to provide support not only at the regional but also at country level. Bilateral donors, primarily the United Kingdom, the United States of America, Canada, Norway and Australia, and the Global Fund on HIV/AIDS, TB and Malaria provided the largest share of the funds. Other areas that attracted considerable voluntary funding were TB, HIV/AIDS and malaria, the priorities of allocation being decided by respective foreign ministries. Health care financing was another programme funded by donors such as GTZ.

110. The Committee noted that WHO recognized the importance of ensuring adequate funding and implementing priority programmes, as well as the importance of building technical capacity of countries in the area of programme development and management.

111. The Committee then adopted a resolution (SEA/RC59/R2) on the subject.

**Consideration of the recommendations arising out of the Technical Discussions on ‘Promoting Patient Safety in Health Care Institutions’**

(Agenda item 11.1, documents SEA/RC59/11 [Rev.1] and SEA/RC59/Inf.4)

112. H.E. Dr Abdul Azeez Yoosuf, Deputy Minister of Health, Maldives, in the absence of the Chairman and Rapporteur, presented the report and recommendations of the Technical Discussions on Promoting Patient Safety at Health Care Institutions, held in conjunction with the 43rd meeting of the Consultative Committee for Programme Development and Management (CCPDM).

113. The Committee felt that in addition to safety of patients, it was imperative to ensure safety of health care providers as well. It, therefore, urged that the recommendations of the Technical Discussions should be implemented as soon as possible. Health care infrastructure, quality of treatment as also the legal system needed to be strengthened to achieve this. The Committee, however, cautioned that regulatory measures might force health care providers to turn defensive in their work due to fear of litigation. It felt that such an approach would be counterproductive. Therefore, a systems approach comprising advocacy, consumer education, integration of ethics into health care practices, and capacity building of Member States would ensure that the goal of patient safety is achieved.

114. The Committee endorsed the report and recommendations of the Technical Discussions as contained in document SEA/RC59/11 (Rev.1), with added observations including the one to drop the term “Institutions” from the title of the agenda item (see Annex 10).
115. The Committee then adopted a resolution on the subject (SEA/RC59/R3).

**Selection of a subject for the Technical Discussions to be held prior to the Sixtieth session of the Regional Committee**

(Agenda item 11.2, document SEA/RC59/3)

116. Recognizing the importance of promoting nutrition and food safety in countries of the SEA Region, the Committee **decided** to hold Technical Discussions on “Nutrition and food safety” prior to the sixtieth session of the Regional Committee in 2007. The Committee also decided that from next year, prior consultations would be held with all Member States to select the topic for technical discussions. This would make the process more participatory. 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.

117. The Committee also noted that from next year, WHO would be undertaking an exercise to evaluate the usefulness of Technical Discussions. Such an evaluation would help determine the impact and contribution made by the Technical Discussions, especially in terms of sustainability of the positive health outcomes emanating therefrom.

**Regional strategy for health promotion: Follow-up of Sixth Global Conference on Health Promotion** (Agenda item 9, documents SEA/RC59/5 [Rev.1] and SEA/RC59/Inf.2 and Inf.3)) and **Alcohol consumption control-Policy options in the South-East Asia Region** (Agenda item 10, document SEA/RC59/15 [Rev.1])

118. The Committee was informed that the Sixth Global Conference on Health Promotion held in Bangkok in August 2005 had endorsed the “Bangkok Charter for Health Promotion in a Globalized World”. The Charter called for key commitments to make the promotion of health: (i) central to the global development agenda; (ii) a core responsibility for all governments; (iii) a key focus of communities and civil society, and (iv) a requirement for good corporate practice. As a follow-up action, WHO had facilitated the drafting of a Regional Strategy for Health Promotion through a consultative process involving regional experts.

119. The Committee appreciated the support received from WHO in health promotion and urged WHO to sustain its health promotion efforts in addressing communicable and noncommunicable diseases and new threats to health.

120. The Committee specifically called for multisectoral and multidisciplinary interventions regarding resource and social mobilization; capacity building;
lifeskills development for young people; establishing evidence of the effectiveness of health promotion; advocating for health; prevention and control of alcohol and tobacco use, and diet and other lifestyle-related health problems. The Committee urged WHO to undertake pilot projects/programmes in order to document best practices.

121. Establishing appropriate infrastructure and building capacity were crucial to health promotion. High levels of advocacy for appropriate regulation and legislations, and financial and human resources mobilization, as well as capacity building of both health and non-health professionals were other significant steps that needed to be taken for strengthening health promotion. There was also the need for primary prevention of noncommunicable diseases that contributed to cardiovascular diseases (CVDs) including diabetes and high blood pressure.

122. The Committee noted that the regional strategy document should have included a mention of resolution WHA57/16 on health promotion and healthy lifestyles adopted by the Fifty-seventh World Health Assembly in 2004.

123. The Committee adopted resolution SEA/RC59/R4 on the subject.

124. The Committee was informed that agenda item 10 – Alcohol Consumption Control: Policy Options in the South-East Asia Region – had been proposed by the Royal Thai Government.

125. Due to the varying stages of their growth and development, countries in South-East Asia were in transition and traditional practices were being gradually replaced by modern lifestyles, leading to new challenges, such as the increasing use and abuse of alcohol. A wide range of options were available for a policy that could lead to sustainable alcohol consumption control. Such a policy could be effectively attained through the active involvement of all stakeholders. The document SEA/RC59/15 (Rev.1) highlighted the various options available to Member States in reducing the public health problems caused by alcohol use.

126. The Committee noted the options available for an alcohol policy for Member States to choose from and adopt as appropriate. The Committee also urged WHO to provide technical assistance and resource allocation for this priority area.

127. The Committee was informed that health promotion had always been a priority concern of WHO, especially since it cut across various health programmes. It was not only multisectoral but multidisciplinary as well. The Committee noted that WHO was taking adequate steps to strike a proper balance between primary and secondary health promotion as well as collaborating with various stakeholders and partners by ensuring that the
Regional Health Promotion Strategy effectively integrated health promotion activities covering various health programmes.

128. The Committee noted that alcohol consumption had significantly increased in some countries of the Region. A policy on alcohol was a complicated public policy issue involving partnership of several stakeholders with conflicting interests. It was a critical issue and deserved high priority since it vastly affected the well-being of a large section of the population and accounted for more than 60 physical and mental diseases. It was noted that the proportion of alcohol programme expenditure was only a fragment of the already small budget for mental health and substance abuse which included alcohol consumption in its purview. Appreciating the comprehensive document prepared by WHO on alcohol consumption, the Committee sought to prioritize alcohol as a cross-departmental issue. Coordination with appropriate stakeholders; a multinational approach; a cost-effective policy highlighting implementation of interventions, and a Framework Convention on Alcohol Control were some of the actions suggested.

129. The issue of alcohol consumption should also be considered as one of the major identified risk factors in health promotion interventions. Apart from the social implications, the adverse effects of alcohol on health needed to be highlighted. Reduction in demand and harm alongside supply, the imposition of high taxes and appropriate legislation were among the key components recommended for dealing with the issue of alcohol consumption. The benefit to individuals arising out of curbs on alcohol consumption could also be estimated in monetary terms to offset the perceived gains from alcohol revenue generation.

130. The Committee also felt that the key approach to effectively prevent and control alcohol consumption was to expand the role of the health sector into that of a proactive agent. Health care professionals could screen and identify people abusing alcohol and provide treatment and rehabilitation services. Patient/client counselling, home visits/counselling and community organization were significant steps which could be taken in this regard. In some countries, prevention and control of alcohol consumption were part of the health promotion programmes. Information campaigns for community health education by household doctors at the primary health care level, and advocacy through the mass media were cited as important interventions.

131. A resolution (SEA/RC59/R8) was then adopted on the subject.

Regional initiatives for eradication/elimination of tropical diseases (Agenda item 12, document SEA/RC59/6 [Rev.1])

132. The Committee was informed that nearly one billion people in the developing world were affected by tropical diseases, which were “diseases of
poverty” affecting the marginalized population and the “poorest of the poor”. They were neglected in terms of policy support, priority attention, resource allocations and effective programme implementation in spite of the fact that these diseases had been significant public health problems for a long time.

133. The Committee noted that the tropical diseases that were targeted for elimination/eradication in the South-East Asia Region included leprosy, lymphatic filariasis, visceral leishmaniasis (kala-azar) and yaws.

134. The Committee appreciated WHO’s initiative in declaring these diseases regional priorities in view of the fact that safe, simple, cost-effective and operationally feasible interventions to tackle them were available. Since endemic countries in the Region faced difficulties in scaling up required interventions to the entire populations in need, additional support and resources were deemed necessary.

135. The Committee observed that these tropical diseases were “under the rubric of the neglected tropical diseases” which affected poor populations in remote rural areas where health services were inadequate or absent. However, cost-effective interventions were available – multidrug therapy (MDT) for leprosy, oral miltefosine for kala-azar, mass drug administration with two drugs (diethylcarbamazine and albendazole) for lymphatic filariasis and a single injection of long-acting penicillin for yaws.

136. The Committee acknowledged the strong political commitment for the elimination/eradication of these diseases. It reiterated that the target set for the elimination of kala-azar by 2015, and of lymphatic filariasis by 2020 was achievable in the Region. Nine countries in the Region had been successful in meeting the target for leprosy by 2005 and no cases of yaws had been reported from India for the past three years as a result of the yaws eradication programme launched in 1997.

137. The Committee's attention was drawn to the challenges faced in the elimination/eradication of these diseases. These included social and political commitment, capacity building at the local level, adequate supply of drugs, community participation and mobilization of adequate resources, etc. However, these programmes could be an entry point for provision of basic health care to the marginalized populations living in remote areas.

138. The Committee recognized that the key to success of elimination/eradication of tropical diseases was a high level of commitment and intensified and sustained action until the targets of elimination/eradication were achieved. Support in the form of additional human resources would be needed in this regard.
139. Special attention should be given to the countries neighbouring the affected ones and those with a potential disease burden since “communicable diseases do not require a passport to migrate across borders,” the Committee observed.

140. The Committee noted that countries affected by tropical diseases were satisfied with the pace and progress of various elimination/eradication initiatives. It lauded WHO’s efforts for setting specific targets for the elimination/eradication of tropical diseases. There was a need to mobilize resources and develop country initiatives to strengthen these programmes. The Committee called for greater focus on leprosy and lymphatic filariasis, given the magnitude of the problem.

141. The Committee was informed that WHO would provide full support to Member States to achieve the elimination/eradication targets set for these diseases. During the 2008-2009 biennium adequate provision of budgetary support would be made in the WHO plans of action to ensure adequate progress towards achievement of elimination/eradication targets in the Region.

142. The Committee adopted resolution SEA/RC59/R5 on the subject.

**Strengthening the health workforce in SEAR countries**
(Agenda item 13, documents SEA/RC59/12 [Rev.1] and SEA/RC59/Inf.7) and **Regional strategic plan for human resource development**
(Agenda item 14, document SEA/RC59/16)

143. The Regional Committee noted the close correlation between the presence of qualified health workers in a country and the key health outcomes. Health workforce was the backbone of the health sector. Human resources for health in all Member States of the Region faced certain common challenges, viz. shortages, maldistribution, compromised competency, inadequate management capacity and the like. WHO recognized the need to enhance its efforts in supporting Member States to strengthen their health workforce and align it with pro-poor health programmes.

144. The proposed ‘Regional Strategic Plan for Human Resource Development’ described the scope of the problem, the strategic areas as well as some key activities suggested for implementation by countries and WHO with the active participation and involvement of all stakeholders.

145. The Committee noted that efforts were being made by Member countries to update and standardize regulatory bodies and support operational HR research. The Committee sought WHO’s support for training of human resources in Member countries.
146. Keeping in mind the palpable dearth of competent health staff for public health programmes, the need to scale up and strengthen the health workforce in Member countries was reiterated. There was also the need to take care of health workers who provided health services in institutions, including hospitals and medical centres, with special attention to the workforce that could effectively carry out promotive and preventive health services in the community. Many Member countries had a paucity of such health staff who could effectively implement public health programmes such as maternal and child health, nutrition, malaria control, HIV/AIDS prevention, environmental health and others.

147. The Committee noted that the Fifty-ninth World Health Assembly in May 2006 deliberated on the issues relating to human resources for health and adopted two resolutions in that connection: WHA59.23 on rapid scaling up of health workforce production, and WHA59.27 on strengthening nursing and midwifery.

148. The Committee noted that the definition of public health workers should also encompass health professionals as they dealt directly with the patients. The Committee further noted that the development of a public health workforce was an important agenda for all Member countries. They adopted various measures to address the problem of maldistribution of doctors, nurses, dentists and paramedics, as well as the skill-mix and gender equity issues. Providing incentives and special training for opting to serve in rural and remote areas as had been initiated by some Member countries was one such step. Assurance of quality control and regulatory measures applicable to both the private and public sector contributed to maintaining the optimum standards in training. However, there remained other challenges faced by Member countries in the current scenario with emerging diseases and a changing economic situation wherein an increasing number of health professionals were entering the private sector. Conspicuous improvement in the availability of information on planning, management, monitoring and evaluation of the health workforce based on best practices and public-private partnership was crucial.

149. The Committee was informed that human resource development was a time-consuming process with no short-cuts. Therefore, training for the existing public health workforce to graduate to a pool of high-calibre professionals was considered essential. This would also help to improve the per capita ratio of availability of health workers to the entire population. Training programmes could be organized preferably at the workplace with minimal disruption of normal work. There was a strong felt need for human resources experts to address these issues. Such an investment was considered worthwhile in order to obtain the desired results in public health workforce management. The centres of excellence, business schools or WHO collaborating centres could be used to identify and deploy appropriate HR professionals to manage training programmes. Also, a decentralized approach to pool available manpower at
various levels by creating a viable partnership with private institutions engaged in public health management could also be useful. Apart from the need to create additional resources for the incentive schemes, a resource analysis was deemed to be essential.

150. The Committee endorsed the Dhaka Declaration and the Regional Strategic Plan while urging that the activities should be more country-oriented. Stronger collaboration was also sought among industrialized and developing countries in the Region, as well as with other partners.

151. Countries also faced the problem of lack of knowledge and competent skills, especially with regard to continuous professional development among the public health workforce in sectors other than health. Collaboration among medical schools and universities, exchange of health professionals and sharing of knowledge and information among countries could be viable tools to meet such challenges.

152. Technical self-sufficiency was vital to achieving the MDGs. Avenues to attract more donors and greater bilateral collaboration for investment in long-term human resource development in the health sector must be explored. Country offices could be delegated more authority to liaise with training institutions or the public health institutions network. Modern information technology and distance learning techniques could be put to good use in this context.

153. The Committee felt that there was a need for accreditation/recognition and validation of existing competent medical training institutions/colleges/schools by WHO. Standardization of curriculum quality with regard to training of the health workforce was also a pressing need.

154. The Committee noted that the lack of commitment on the part of governments to employ more health staff aggravated the current situation. Moreover, the compensation offered to the health workforce did not compare with that of their counterparts in other sectors, given the same levels of competence.

155. A resolution (SEA/RC59/R6) on the subject of Agenda item 13 was adopted.

**International trade and health**

*(Agenda item 15, document SEA/RC59/17)*

156. The Committee was informed that the subject of “Public Health, Innovation, Essential Health Research and Intellectual Property Rights: Towards a global strategy and plan of action” which formed part of agenda item 17.1 would be taken up in conjunction with agenda item 15.
157. The Committee emphasized the need for ministries of health to understand the implications of international trade agreements on public health and sensitize the ministries of trade in this regard before adopting international agreements.

158. It was recalled that the Fifty-ninth World Health Assembly, held in May 2006, had adopted a resolution on international trade and health (WHA59.26) recognizing the need for all relevant ministries – including those responsible for health, trade, commerce, finance and foreign affairs to work together constructively in order to ensure that the interests of international trade and health were appropriately balanced and coordinated.

159. The Committee also noted that the World Health Assembly at its Fifty-ninth session had adopted a resolution on “Public Health, Innovation, Essential Health Research and Intellectual Property Rights: Towards a global strategy and plan of action” (WHA 59.24) dealing with the key issue of health care needs of the developing world not being addressed by “market-driven” research in health care. The resolution also enunciated the establishment of an Intergovernmental Working Group (IWG) to formulate a global strategy and a global plan of action.

160. The Committee acknowledged that various international trade agreements and treaties were finalized without the involvement and input from the health sector due to lack of awareness on the part of trade negotiators that some of their actions may have important implications for public health. There was, therefore, need for capacity building in this area to understand the implications of trade agreements. WHO would support such efforts at the request of Member States.

161. The Committee was informed that India had established a World Trade Organization (WTO) Cell; Thailand had formed coordination committees that included academia, and professional and civil society organizations; and Thailand and Sri Lanka had established an Advisory Committee on Impacts of TRIPS1, GATS2, Globalization and Trade on Health. In this context the Committee appreciated that exchange of experiences among Member States in the Region would enhance and enrich their understanding and knowledge of issues related to trade and health. WHO would gather relevant data on lessons learnt and disseminate them to all Member countries.

162. It was brought to the notice of the Committee that pharmaceutical manufacturers were not keen to produce generic versions of drugs for fear of

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1 Agreement on Trade-Related Aspects of Intellectual Property Rights
2 General Agreement on Trade in Services
not earning profits. It was, therefore, suggested that generic pharma manufacturers should be encouraged, by way of granting them some incentives to produce generic drugs, especially to benefit people in the developing world.

163. The Committee was informed that an intercountry workshop on “Regional capacity building on the implications of TRIPS-Plus provisions on the expenses and access to ARVs and other essential new medicines” would be conducted in late 2006 in Thailand, in collaboration with the International Health Policy Programme (IHPP), and WHO headquarters. Five countries from the Western Pacific Region, all countries from the South-East Asia Region and staff from WHO headquarters would participate in the workshop. The workshop would assist countries to understand the implications of the introduction of TRIPS and “TRIPS-Plus” agreements to the access of ARV and essential medicines.

164. The Committee acknowledged the need for having a proper mechanism for the selection of affordable drugs. WHO would support Member countries in determining the best prices of essential medicines by providing data on different pricing patterns.

165. The Committee was informed that almost all developed countries were outsourcing the supply of drugs. WHO was urged to support Member countries by providing them with services of international Good Manufacturing Practices (GMP) experts. This would enable a greater number of pharmaceutical companies to derive appropriate benefits and thus compete in the international market.

166. The Committee also called for transfer of technology for the mutual benefit of countries in the Region. Countries should make better use of the flexibility provided under TRIPS, especially during public health emergencies, through imports and by enhancing local production capabilities.

167. The Committee was informed that price control was not forbidden under the TRIPS agreement. Countries could, therefore, negotiate the prices with companies before the drugs became available. Drug manufacturers usually applied different rates for different countries, depending upon the nature of demand. WHO could provide support to countries in this regard. A mechanism should also be developed to monitor the prices of patented drugs.

168. The Committee noted with satisfaction that Bangladesh, India and Thailand had made considerable progress in production of drugs. Sharing of knowledge and information in this regard among all Member countries would be beneficial for the whole Region.

169. A resolution (SEA/RC59/R9) on the subject was adopted.
Health information system development relating to millennium development goals (MDGs) and health metrics network (HMN) (Agenda item 16, document SEAIRC59/18 Rev.1)

170. The Committee was informed that WHO, together with Member States in the Region, had taken steps to strengthen national health information systems (HIS) primarily to improve the statistical database and information on mortality and morbidity and other vital parameters. A regional consultation on MDGs was organized by the Regional Office with emphasis on processes and mechanisms for data collection, collation and reporting. It was essential to address issues and challenges in health information systems and develop international standards for reporting. The Committee was also informed of the development of a regional strategic action plan for HIS implementation.

171. The Committee noted that while HIS and surveillance were being strengthened, planning and monitoring aspects also needed to be addressed. It also noted that the Health Metrics Network (HMN) could contribute in data duality, and thereby support HIS strengthening. It was imperative to mobilize resources for implementation of plans which cater to the need for delivering adequate and timely information to facilitate decision-making at all levels. Health information systems would be useful in tracking the progress of MDGs and improving health services within Member countries. In this context, the Committee underscored the importance of strengthening health management information systems through appropriate technology for policy management as well as decision-making. The importance of human resource development was also emphasized.

172. The Committee acknowledged that Member States were acutely constrained by the shortage of adequate capacity to analyse and disseminate the information collected. Decentralization of data collection and utilization was a step in the right direction. It was imperative to improve communication technology. Inconsistencies in data collected at global and local levels was another major bottleneck.

173. WHO had, over the years, sought to work with Member States to put an efficient health information system in place. The need for critical re-evaluation of the utility and functionality of HIS by WHO and Member States was also emphasized. A “sense of ownership” being essential in the context of HIS, it was imperative to allow information-gatherers to analyse the data so collected and thereby provide useful feedback. This, again, called for human resource development as also appropriate training.

174. The Committee was assured that the observations and recommendations arising out of the discussions would be appropriately acted upon.

175. A resolution (SEA/RC59/R10) on the subject was adopted.
Regional implications of the decisions and resolutions of the Fifty-ninth World Health Assembly and the 117th and 118th sessions of the Executive Board
(Agenda item 17.1, documents SEA/RC59/7 [Rev.1] and SEA/RC59/Inf.5)

176. The Committee noted that the 43rd meeting of the CCPDM held in the Regional Office in New Delhi from 14-16 June 2006 had extensively discussed the subject, a summary of which was available in its report SEA/PDM/Meet.43/8.

177. While observing that all resolutions adopted by the World Health Assembly and the Executive Board were important, the CCPDM recommended that 11 resolutions be elaborated specifically in terms of their regional implications for the SEA Region.

178. The Committee enquired into the ability of Member States to supply a sufficient quantity of monovalent oral polio vaccine for the eradication of polio and highlighted the need to develop a vaccine for avian influenza.

179. It was also important to strengthen the surveillance system and enforce tobacco control measures through appropriate legislation. The Committee reiterated the importance of all Member States becoming signatories to the WHO Framework Convention on Tobacco Control (FCTC). The Committee also requested for assistance in setting up diagnostic facilities for avian influenza in countries which did not yet have them in anticipation of a sudden outbreak. It also expressed concern over the fact that prevention and control of noncommunicable diseases remained marginal to the mainstream of public health activities.

180. The Committee recommended that WHO should address the question of emergency preparedness and response and consider with due importance the idea of establishing an emergency fund for natural disasters and calamities. It was stated that the creation of such a fund would require a resolution to be drafted to that effect. The Committee decided to establish a working group to draft such a resolution.

181. The Committee was informed that acute flaccid paralysis (AFP) surveillance was being undertaken in a systematic manner. The sentinel surveillance system was being used with regard to sexually transmitted infections (STIs). Attempts were also being made to reduce the chances of diseases crossing the borders of Member countries.

182. The Committee noted the regional implications of the resolutions and requested WHO to take appropriate action where necessary.
Review of the draft provisional agendas of the 120th session of the Executive Board and the Sixtieth World Health Assembly (Agenda item 17.2, document SEA/RC59/8[Rev.1])

183. The Committee noted the provisional agenda of the 120th session of the WHO Executive Board while being informed that the draft provisional agenda of the Sixtieth World Health Assembly had not been received till date.

184. The Committee opined that the agenda item No. 4.5 on rational use of medicines was particularly timely and had been deferred from the 119th session of the Executive Board.

185. The agenda item on Programme Budget was particularly crucial since a substantial increase in assessed contributions was being proposed.

186. The Committee was informed that agenda item 9.2F on Public Health, Innovation, Essential Research and Intellectual Property Rights (IPR): “Towards a Global Strategy and Plan of Action” was the outcome of an inter-government working group discussion. It was noted that a regional consultation on IPR had been planned to be held before the Inter-government Working Group meeting in Geneva on 4 December 2006.

UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases: Joint Coordinating Board (JCB) – Report on attendance at JCB in 2006, and nomination of a member in place of Myanmar whose term expires on 31 December 2006 (Agenda item 18.1, documents SEA/RC59/13 [Rev.1] and SEA/RC59/1nf.6)

187. The Committee was informed that representatives from Bangladesh and Myanmar attended the deliberations of the 29th session of the Joint Coordinating Board (JCB) held in June 2006 while India attended the session under the Contributors' category.

188. The Committee noted that this agenda item had been reviewed by the CCPDM at its 43rd meeting which had taken place before the 29th session of the JCB. The CCPDM had recommended that the update on activities and achievements of TDR be presented to this session of the Regional Committee along with the report of the latest session of the JCB.

189. The Committee noted the brief visual presentation made by Bangladesh on the report.

190. The Committee nominated Thailand as a member of the JCB for a period of three years effective 1 January 2007 and requested the Regional Director to inform WHO headquarters accordingly.
WHO Special Programme for Research, Development and Research Training in Human Reproduction: Policy and Coordination Committee (PCC) - Report on attendance at PCC in 2006, and nomination of a member in place of Sri Lanka whose term expires on 31 December 2006

(Agenda item 18.2, document SEA/RC59/14 [Rev.1]

191. The Committee was informed that representatives from India, Sri Lanka and Thailand attended the PCC session held in June 2006. The Committee noted that the CCPDM had reviewed this agenda item at its 43rd meeting held in June 2006 and had recommended that Member States disseminate information on HRP-related activities to reputed institutions and experts working on human reproduction. This, it was pointed out, would encourage the development of proposals from the Region for HRP funding.

192. The Committee noted the presentation made by the representative from Sri Lanka on the PCC session.

193. The Committee nominated Myanmar as a member of the PCC for a period of three years effective 1 January 2007 and requested the Regional Director to inform WHO headquarters accordingly.

Time and place of future sessions of the Regional Committee

(Agenda item 19, document SEA/RC59/4 Rev.1

194. The Committee decided to hold its sixtieth session in Bhutan in 2007 in conjunction with the Meeting of Ministers of Health. The exact dates will be confirmed later.

195. The Committee noted that its sixty-first session in 2008, being the year for nomination of the Regional Director, will be held in the Regional Office.

196. It also noted that Nepal having confirmed to host the Regional Committee session in 2009, the sixty-second session of the Committee would be held in Kathmandu in 2009.

Representation of the South-East Asia Region on the Executive Board (Agenda item 21)

197. The Committee felt that the decision on representation of the regions of WHO on the Executive Board should include population and burden of diseases as part of the criteria.
198. The Legal Counsel from WHO headquarters informed the Committee that taking into account Article 73 of the Constitution of WHO concerning the adoption and entry into force of amendments, the proposal seeking increased membership from the SEA Region on the Executive Board would need to be sent to the Director-General at least six months ahead of the World Health Assembly, following which it needs to be ratified by at least two thirds of the Member States, which is a minimum of 128 members.

199. The Committee thus decided to convene a working group of interested Member States of the Region to analyse various options of the proposal for enhanced representation of the regions of WHO on the Executive Board. It requested the Regional Director to report on the progress in this regard to the sixtieth session of the Regional Committee next year.

Adoption of Resolutions

200. The Committee adopted the following resolutions:

1. Resolution of thanks;
2. Regional programme budget 2008-2009;
3. Promoting patient safety in health care;
4. Regional strategy for health promotion;
5. Regional initiatives for eradication/elimination of tropical diseases;
6. Strengthening the health workforce in South-East Asia;
7. Public health, innovation, essential health research and intellectual property rights;
8. Alcohol consumption control – Policy options;
9. International trade and health, and
10. Health information system development relating to Millennium Development Goals (MDGs) and Health Metrics Network (HMN).

Adoption of the report of the Fifty-ninth session of the WHO Regional Committee for South-East Asia
(Agenda item 20, document SEA/RC59/21)

201. The Committee adopted the draft report of the Fifty-ninth session, as contained in document SEA/RC59/21, with minor modifications.
Closure of the session (Agenda item 22)

202. Representatives of Member countries attending the Fifty-ninth session of the Regional Committee congratulated the Chairman and Vice-Chairman for the smooth conduct of the meeting. They also expressed their deep sense of gratitude to the Government of Bangladesh for their warm hospitality and excellent arrangements. Appreciating the smooth and efficient conduct of the meeting, the representatives complimented Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region for his open-minded leadership, which made for productive deliberations.

203. The Regional Director expressed his gratitude to Dr Anders Nordström, Acting Director-General of WHO for helping to place global health in the right perspective. The discussions held during the meeting and resolutions adopted by the Committee provided clear directives to Member States and WHO to further strengthen their collaborative efforts in order to achieve common goals. However, the real success towards this end would depend on how purposefully the resolutions adopted by the Committee were implemented by all Member countries of the Region. The Regional Director expressed confidence that the desired goals could be achieved with collaboration, determination and commitment of all Member countries.

204. The Chairman expressed his sincere gratitude to H.E. Begum Khaleda Zia, Prime Minister of the People's Republic of Bangladesh for her inspiring address at the joint inaugural session of the Twenty-fourth Meeting of Ministers of Health and the Fifty-ninth session of the Regional Committee. He also thanked the distinguished representatives for their active participation and support, and the Vice-Chairman for chairing the sessions admirably in his absence.

205. The Committee had reviewed issues of vital importance for health development in the Region. The Chairman was confident that the valuable suggestions made during the deliberations and the important decisions taken would guide the work of Member States and WHO in their joint endeavours to achieve the best possible level of health for peoples of the Region.

206. The Chairman then declared the session closed.
Part IV
Resolutions and Decisions

Resolutions

SEA/RC59/R1 Resolution of thanks

The Regional Committee,

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

1. THANKS Her Excellency Begum Khaleda Zia, Prime Minister of the People's Republic of Bangladesh for graciously inaugurating the session and for her thought-provoking speech;

2. THANKS the Acting. Director-General, WHO, Dr Anders Nordström, for his inspiring address and participation;

3. CONVEYS its gratitude to the Government of the People's Republic of Bangladesh for hosting the session, and thanks the members of the National Organizing Committee and other national authorities for making the session a success, and

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

SEA/RC59/R2 Regional programme budget 2008-2009

The Regional Committee,

Having considered the regional Programme Budget for 2008-2009, which follows a significantly different approach as compared to previous bienniums and which is based on the six-year Medium-term Strategic Plan (MTSP), the regional Programme Budget statements containing strategic objectives; scope; regional indicators and targets, regional issues and challenges; strategic approach of the region and proposed resource requirement, and noting the report of the
43rd Meeting of the Consultative Committee for Programme Development and Management [CCPDM] (Document SEA/ PDM/Meet.43/11),

Welcoming the strong emphasis and focus on Organization-wide results-based, integrated budgeting, as well as the proposals for addressing the global public health challenges and strengthening WHO's country programmes,

Noting with appreciation the Director-General's proposal to increase the overall level of the budget by 17.2% which includes 8.6% increase in the Regular Budget, as compared to the previous biennium,

Acknowledging the decision WHA57(10), requesting the Director-General to draw up, in consultation with Member States and regions, guiding principles, based on objective criteria, to be applied in the allocation of funds from all sources, taking into account equity, efficiency and performance, and support to countries in greatest need, particularly the least developed countries,

Welcoming the proposed increase in the Regular Budget and Voluntary Contributions, and moreover, deeply concerned that the present share of the budget from such resources to the South-East Asia Region is not commensurate with its health needs and the burden of disease,

1. AUTHORIZES the establishment of a Working Group with representatives from all Member States in the Region to review the regional Programme Budget 2008-2009 with a mandate to endorse it on behalf of the Regional Committee;

2. URGES Member States:

   (a) To accelerate national priority programme implementation consistent with the target and indicators in the regional Programme Budget 2008-2009.

   (b) to work closely with the Secretariat to formulate workplans for the 2008-2009 biennium in a spirit of joint planning with ownership of all stakeholders, and

3. REQUESTS the Regional Director to take up with the WHO Director-General, the following for his consideration, while finalizing the regional Programme Budget for 2008-2009:

   (c) to allocate a greater proportion of the Organization's funds to the South-East Asia Region, based on the health needs and population size of countries of the Region,

   (d) to take actions at the headquarters level for enhancing resource mobilization in order to ensure that the allocations for the proposed
planned figures in the SEA Region for Voluntary Contributions are eventually met;

(e) to make all efforts that the Voluntary Contributions received are mostly unspecified funds so that they could be used for areas for which such contributions are normally not received, and

4. REQUESTS the Regional Director to enhance resource mobilization activities in the Region to ensure that the requirement of Voluntary Contributions to implement the regional Programme Budget 2008-2009 is met.

**SEA/RC59/R3 Promoting patient safety in health care**

The Regional Committee,

Recalling World Health Assembly resolution WHA55.18 relating to “Quality of care: Patient safety”,

Noting with concern the high human and financial toll of adverse events in both developed and developing nations,

Conceding that the problem is likely to be even greater in developing nations,

Recognizing that most of the harm to patients is due to failures in the design, organization and operation of systems,

Acknowledging that a large proportion of adverse events are therefore preventable,

Noting with concern the potential problems in the Region because of the vicious cycle of adverse events and malpractices, law suits and medical liability insurance, the practice of defensive medicines and the rising costs of health care,

Aware that no single stakeholder has the expertise or delivery capabilities to adequately tackle the full range of patient safety issues, and

Having considered the report and recommendations of the Technical Discussions on Promoting Patient Safety at Health Care Institutions in South-East Asia during the Forty-third Meeting of the Consultative Committee for Programme Development and Management,

1. ENDORSES the recommendations contained in the report (SEA/RC59/11 [Rev.1] and SEA/RC59/Inf.4);
2. **URGES Member States:**

   (f) to assess the scope and nature of adverse events in health care institutions as well as the contributing factors;

   (g) to establish or improve, with the involvement of all stakeholders, systems for the detection and reporting of adverse events with a primary focus on improving systems;

   (h) to develop national mechanisms to capture, share, respond, and learn from this information at all levels of the health system;

   (i) to promote interventions that have been shown to improve patient safety;

   (j) to support and enable health care institutions, both public and private, from the primary health care level through the referral level, to implement systems changes and practices conducive to patient safety;

   (k) to create, at all levels of the health care system, through awareness raising and enabling policies and legislation, an open environment receptive to the operational changes needed to deliver safer care in health care institutions;

   (l) to engage patients, consumer associations, health care workers, and professional associations, hospital associations, health care accreditation bodies and policy makers, in building safer health care systems, and creating a culture of safety within health care institutions;

   (m) to establish systems that respect the rights of both patients and providers, and

   (n) to allocate adequate resources to implement the above activities, and

3. **REQUESTS the Regional Director:**

   (a) to coordinate, through an inclusive consultative process, the development of a strategic framework and package of interventions for strengthening patient safety which builds on successful interventions and actions in the Region and worldwide;

   (b) to provide strong technical leadership and support to Member States in designing and implementing patient safety interventions and monitoring systems;

   (c) to ensure capacity building in different aspects of patient safety through training activities at the regional, subregional, and country levels;

   (d) to facilitate collaboration and the exchange of information and best practices between Member States and the World Alliance on Patient Safety;
(e) to coordinate and facilitate research on patient safety in the Region, including baseline surveys on adverse events, and operational research to assess the cost effectiveness of interventions;

(f) to contribute to the development of a patient-safety taxonomy, systems for reporting and learning from adverse events, and best practices to improve patient safety, and

(g) to monitor and report on progress in this area in the Region.

**SEA/RC59/R4 Regional strategy for health promotion**

The Regional Committee,

Recalling World Health Assembly and Executive Board resolutions WHA57.16 and EB117.R9 respectively, and its own resolutions SEA/RC32/R6 and SEA/RC40/R3, as well as the outcomes of the five international conferences on health promotion, all of which called for strengthening of health promotion through policies, strategies, legislation, partnership and allocation of resources, and by engaging communities,

Noting with satisfaction the active involvement of Member States of the Region during the Sixth Global Conference on Health Promotion held in Bangkok in August 2005, and having considered the follow-up on policy actions and commitments agreed to in the Bangkok Charter for Health Promotion in a Globalized World, and

Confirming the priority need to address social and other determinants of health and the major common risk factors associated with preventable causes of premature death and illness due to communicable and noncommunicable diseases among the people of the Region through health promotion,

1. **URGES Member States:**

(a) to consider health promotion as a core responsibility, central to the national and global development agendas; recognize the need for increasing investments in health promotion; establish mechanisms for concerted efforts and foster active engagement of civil society, professional bodies, the private sector and nongovernmental organizations;

(b) to strengthen capability for planning, coordination, management and implementation of comprehensive and multisectoral health promotion policies and programmes and to document evidence of effective health promotion interventions at national and local levels, in order to facilitate development of effective policies, and
(c) to adopt alternative, innovative and sustainable sources of financing for health promotion activities, with a firm institutional base for management, and

2. REQUESTS the Regional Director:

(a) to strengthen the capacity for health promotion across the Organization in the Region to provide better support to Member States;

(b) to facilitate the establishment of innovative and sustainable financing mechanisms with a firm institutional base for systematic and effective health promotion efforts;

(c) to support Member States with adequate human and financial resources to build capacity for developing policies, programmes, plans of action, guidelines and documentation of evidence, and

(d) to report on the progress of the implementation of the Regional Strategy to the sixty-first session of the Regional Committee in 2008.

SEA/RC59/R5 Regional initiatives for eradication/elimination of tropical diseases

The Regional Committee,

Recalling World Health Assembly resolutions WHA44.9 and WHA50.29 pertaining to elimination of leprosy and lymphatic filariasis, and Executive Board resolution EB118.R3 on control of leishmaniasis,

Appreciating the initiatives taken by the Regional Director in according high priority to eradition/elimination of tropical diseases, namely leprosy, kala-azar, lymphatic filariasis, and yaws,

Recognizing that these diseases are significant health problems in the Region and are poverty-related, affecting the poorest of the poor, and the most vulnerable and marginalized populations, often living in remote, hard-to-reach areas,

Further recognizing that these diseases are globally considered as “neglected” in view of the low priority to research and develop essential health technologies to address these diseases,

Noting that these diseases can cause disability and death, leading to social and economic consequences, and that their eradication/elimination has certain

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1 Diseases that are overwhelmingly or exclusively incident in developing countries. These diseases receive extremely little R&D and essentially there is no commercially-based R&D in the rich countries [Reference: Public health: Innovation and Intellectual Property Rights, Report of the Commission on Intellectual Property Rights, Innovation and Public Health, April 2006]
social and moral imperatives linked to alleviating the suffering of the poor and vulnerable groups, and

Noting further that some of these diseases such as leprosy, yaws and lymphatic filariasis, etc. are amenable to eradication/elimination in view of the availability of safe, simple and cost-effective interventions,

1. **URGES** concerned Member States:
   (a) to continue to accord high priority to these diseases and include them in their national development plans and allocate appropriate budgetary support;
   (b) to advocate with development partners and nongovernmental organizations to support intensification of efforts towards eradication/elimination of these diseases;
   (c) to intensify appropriate action by accelerating programme planning, implementation, monitoring and evaluation, and
   (d) to ensure that the safe and cost-effective interventions are scaled up and made accessible to all affected population, particularly the vulnerable groups, and

2. **REQUESTS** the Regional Director:
   (a) to increase technical support to Member States concerned in intensification of efforts towards eradication/elimination of these diseases;
   (b) to assist Member States concerned in planning, implementation and monitoring of the initiatives leading to eradication/elimination of these tropical diseases, and
   (c) to facilitate public-private partnerships in support of activities related to these diseases, including research contributing to new, safer and more effective diagnostics and drugs;
   (d) to mobilize funding from external sources to support national efforts towards eradication/elimination of these neglected diseases.

**SEA/RC59/R6 Strengthening the health workforce in South-East Asia**

The Regional Committee,

Recalling World Health Assembly resolution WHA59.23 and its own resolutions SEA/RC29/R6, SEA/RC29/R9, SEA/RC38/R10, SEA/RC42/R5, SEA/RC45/R5, and SEA/RC56/R7 relating to human resources for health,
Welcoming the Dhaka Declaration by the Health Ministers of Member States of the WHO South-East Asia Region on strengthening health workforce in countries of the South-East Asia Region to achieve an effective and well motivated health workforce,

Mindful of the fact that effective and efficient management of existing human resources for health, which is one of the most precious and important resources of the health system infrastructure, would lead to effective program delivery, and significant improvements in health system performance,

Noting with concern the unacceptable shortages, geographical and skill-mix imbalances in human resources for health in the Region,

Recognizing that these health workforce shortages and imbalances of skill-mix and geographical distribution are impeding the efforts to achieve the internationally agreed-health related development goals, including those contained in the Millennium Declaration, and those of regional priority programmes,

Aware of the global and regional alliances that are dedicated to health workforce development such as the Global Health Workforce Alliance (GHWA) and the Asia-Pacific Alliance on Human Resource for Health (AAAH), and

Having considered the document on Strengthening Health Workforce in South-East Asia (SEA/RC59/12 [Rev.1]),

1. **ENDORSSES** the South-East Asia Regional Strategic Plan for Human Resource Development (document SEA/RC59/16) along with the amendments made by members, to ensure equitable access to effective health services through an adequate and balanced distribution of sufficient, competent, and highly motivated health workforce.

2. **URGES** Member States:

   (a) to establish multi-stakeholder planning teams to develop multisectoral health workforce plans as committed in the Dhaka Declaration;

   (b) to develop and implement both short- and long-term national strategies and plans for the health workforce that take into account the full spectrum of health workers in both the public and private sectors, the largely untapped resource of community health workers, and the flows of migrant health workers;

   (c) to invest in the development of human resources for health in order to respond to population health needs through adequate, competent and motivated health workforce;
(d) to strengthen the capacity and quality of training institutions to better reflect local health situations and requirements with a particular emphasis on public health orientation and MDGs, nursing and midwifery;

(e) to revitalize the role of community health workers ensuring strong supervisory and support systems, and

(f) to strengthen national knowledge generation and management through increasing investment in human resources for health research and health information systems, and

3. REQUESTS the Regional Director:

(a) to coordinate, through an inclusive consultative process, the development of a package of interventions and tools for strengthening the health workforce based on the regional strategic plan;

(b) to provide technical support to Member States, as needed, in their efforts to revitalize and develop their health workforce planning and management;

(c) to strengthen regional and national training capacity through the introduction of innovative approaches to teaching with state-of-the-art teaching materials and continuing education through the use of the latest information and communication technology, and create longterm capacity in existing national institution;

(d) to support the existing regional partnerships and networks such as the Asia-Pacific Action Alliance on Human Resource for Health (AAAHH), in exchanging knowledge, and tools related to HRH planning and management, and in fostering south to south collaboration in health workforce development;

(e) to facilitate further collaboration between schools of public health and health workforce training institutes in the region such as the South-East Asia Public Health Educational Institutes Network (SEAPHEIN) as well as those in developed and other developing countries to improve training capacities and to promote innovations in educational practices;

(f) to develop and maintain, in collaboration with global and regional networks, a regularly updated regional database of health workforce both in the public and private sectors;

(g) to conduct research and document best health workforce practices with the aim to promote the exchange of management information
and best practices on human resources for health and promote center of excellence for public health management research in each country, according to its capacity and needs;

(h) to report to the Sixty-second Regional Committee in 2009 of progress made in the implementation of this resolution, and

(i) to support the quality assurance programme for accrediting public health training institutions.

SEA/RC59/R7  Public health, innovation, essential health research and intellectual property rights

The Regional Committee,


Having considered the report and recommendations of the Commission on Intellectual Property Rights, Innovation and Public Health,

Noting that an intergovernmental working group will be convened before the end of 2006 with a view to developing a global strategy and plan of action to provide the medium-term framework based on the recommendations of the WHO Commission on Intellectual Property Rights, Innovation and Public Health,

Aware of the emerging resistance to some of the currently available drugs and the need for affordable treatment for neglected diseases, and that insufficient research is being conducted in this area,

Considering the need to ensure appropriate incentives for research and development of treatments for neglected and the most neglected diseases\(^1\) predominantly affecting the Member States in the Region, and the need to address issues related to distribution, delivery and pricing of medicines at the end-user level,

Recognizing the importance of intellectual property rights in fostering research and development in innovative medicines but also acknowledging the necessity for alternative incentive systems,

\(^1\) Diseases that are overwhelmingly or exclusively incident in developing countries. These diseases receive extremely little R&D and essentially there is no commercially-based R&D in the rich countries [Reference: Public health: Innovation and Intellectual Property Rights, Report of the Commission on Intellectual Property Rights, Innovation and Public Health, April 2006]
Recalling that the agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) should not prevent member from taking other measures to protect public health in their efforts to promote access to affordable medicines,

Reaffirming the critical need to achieve the Millennium Development Goals to reduce poverty and promote human rights,

1. **URGES Member States:**
   
   (a) to actively participate in the work of intergovernmental working group;
   
   (b) to ensure an enabling environment including financial supports for health research in public and private settings to better respond to the pressing public health needs in the Region with particular emphasis on the new drugs, vaccines and diagnostics in order to address the high burden of neglected diseases in the Region;
   
   (c) to make full use of the flexibilities allowed in the TRIPS agreement;

2. **REQUESTS the Regional Director:**
   
   (a) to support the participation of Member States in the work of intergovernmental working group;
   
   (b) to convene a regional consultation of Member States to develop a regional perspective prior to the meeting of the intergovernmental working group;
   
   (c) to continue to provide technical support and mobilize financial resources to Member States in undertaking research capacities with particular emphasis on the neglected diseases, and
   
   (d) to report to the 62nd Regional Committee Meeting in the 2009 on progress made by this Resolution

**SEA/RC59/R8 Alcohol consumption control - Policy options**

The Regional Committee,

Recalling World Health Assembly resolutions WHA32.40; WHA36.12, WHA42.20, WHA55.10, WHA57.10, WHA57.16, WHA58.26 and its own resolutions SEA/RC54/R2 on public health problems caused by alcohol use,

Recognizing that the adult per capita alcohol consumption in the South-East Asia Region has almost doubled in the last decade and that the patterns, context and overall level of alcohol consumption has a negative impact on
health and cause serious social and economic consequences to the population, especially the poor,

Appreciating the continued efforts of Member States in adopting and implementing comprehensive national alcohol control policies and effective strategies for reducing public health problems caused by alcohol use,

Having considered the document SEA/RC59/15 which highlights various policy options to reduce public health problems caused by alcohol use, through concerted efforts by the government, public agencies, civil society and the private sector having no conflict of interest,

Noting the consequences of certain trade agreements that facilitate the free flow of and investment in alcohol, which boosts the consumption and negative impact of alcohol in the Region, and

Noting the unique characteristics of regional/national alcohol consumption and related problems e.g. linkage of alcohol to poverty, payday drinking, indigenous alcoholic beverages, which require context-specific policy and interventions,

1. ENDORSES the document Alcohol Consumption Control – Policy Options in South-East Asia Region (SEA/RC59/15) along the lines and amendments made by Members, to help reduce public health problems caused by alcohol use as a minimum framework for alcohol control policy and providing strategic guidance to Member States;

2. URGES Member States:

(a) to establish/strengthen institutional capacity, through multi-sectoral partnership, in order to generate information on consumption of alcohol and related problems based on socioeconomic strata, alcohol marketing strategies, commercial aspects and revenue generated from alcohol, to be used for policy, planning, monitoring and evaluation;

(b) to encourage appropriate participation of stakeholders having no conflict of interest, to develop comprehensive national alcohol control policies, action plans and programmes for reducing public health problems caused by alcohol use, based on the Regional Policy Options as a minimum framework;

(c) to assess the potential impact of certain trade agreements on alcohol consumption and related problems so that effective policy interventions could be formulated, and
(d) to establish/strengthen appropriate mechanism(s) for effective planning, implementation, monitoring and evaluation of national programmes, with adequate institutional capacity and funding, and

3. REQUESTS the Regional Director:

(a) to support Member States in building and strengthening institutional capacities for developing: information systems, policies, action plans, programmes, guidelines and monitoring/evaluation of programmes on prevention of harm from alcohol use;

(b) to hold a biennial regional forum of key partners from Member States and other international partners to share progress, experiences and lessons on alcohol control programmes, and

(c) to report on the progress on the implementation of the Alcohol Consumption Control – Policy Options to the sixty-first session of the Regional Committee in 2008.

SEA/RC59/R9 International trade and health

The Regional Committee,

Recalling World Health Assembly resolution WHA59.26 on “International Trade and Health” as well as resolutions WHA52.19, WHA53.14, WHA56.27, WHA57.14 and WHA57.19;

Recognizing that Member States of WHO’s South-East Asia Region are increasingly involved in international trade and agreements which have implications for public health in the Region,

Considering the need for coherence in health and trade policy, and mechanisms to secure better coordination among relevant ministries responsible for trade and health,

Recognizing that a sound policy on trade and health would secure balanced and coordinated interests between trade and health

Appreciating WHO’s initiatives to promote an effective health dimension to economic policies in a changing international context.

1. URGES Member States:

(a) to implement the World Health Assembly resolution WHA59.26;
(b) to ensure the involvement of health ministries in the processes of negotiating trade agreements in order to identify opportunities and mitigate the possible risks of these agreements with regard to public health;

(c) to develop capacity in relevant ministries in the assessment of the implications of international trade agreements on health of the population in order to effectively participate in the trade negotiations, and

(d) to improve the capacity of the National Regulatory Authorities, and

2. REQUESTS the Regional Director:

(a) to support Member States in their efforts to implement the World Health Assembly resolution WHA59.26;

(b) to continue to assist Member States in their efforts to build capacity, and identify and assess the public health implications of international trade agreements;

(c) to provide technical support and expertise to Member States to draft policies, laws and regulations or establish practices and to promote the exchange of information among Member States to address public health challenges and leverage opportunities to improve health in the context of international trade agreements;

(d) to mobilize resources to support the works related to Trade and Health;

(e) to assist Member States in developing necessary legal and economic frameworks within the country to avail of the flexibilities allowed in TRIPS Agreements, and

(f) to assist Member States in strengthening their National Regulatory Authorities.

**SEA/RC59/R10 Health information system development relating to Millennium Development Goals (MDGS) and Health Metrics Network (HMN)**

The Regional Committee,

Recalling the Executive Board resolution EB118.R4 and various regional and country activities relating to development and strengthening of health information systems,

Noting with concern the issues and challenges involved in strengthening health information systems, which are common to Member States in the Region,
Recognizing that Member States lack sufficient health information system capacity in terms of both human and other resources, particularly with regard to inadequately trained human resources for applying the latest analytical tools and methods including e-tools to synthesize and disseminate information for decision-making,

Acknowledging that there are other issues and challenges in identified areas of core indicators, data sources, data management, information products and their dissemination and use,

Having considered the commitment of Member States to achieve the Millennium Development Goals, and the availability of the Health Metrics Network partnership platform and Strategic Plan for Strengthening Health Information Systems in the Region, and

Recognizing the inconsistencies of published global and regional figures and estimates due to lack of reliable data,

1. **URGES Member States:**
   
   (a) to consider using the Health Metrics Framework as a tool for health information systems assessment and in enhancing harmonization of country efforts related to the strengthening of health information systems, drawing up and implementing action plans, and
   
   (b) to use the Regional Strategic Plan, the country action plan and Health Metrics Framework in the collection of data pertaining to MDGs and core health indicators, particularly disaggregated data, in order to track progress and measure achievements with regard to MDGs and the health status at national/sub-national levels, and

2. **REQUESTS** the Regional Director:
   
   (a) to assist Member States in drawing up and implementing their action plans to further strengthening country health information systems;
   
   (b) to assist Member States in implementing their plans for strengthening health information systems, particularly in supporting a comprehensive assessment of the countries' health information system and in drafting their action plans in the context of the Regional Strategic Plan for Strengthening Health Information Systems, and
   
   (c) to enhance technical support to Member States towards facilitating the collection of disaggregated data to help in tracking progress and measuring achievements with regard to MDGs and core health indicators at national/sub-national levels.
Decisions

SEA/RC59(1) Adoption of agenda and supplementary agenda, if any, of the Regional Committee

The Committee decided to drop the word "Public" from Agenda item 13 - "Strengthening Public Health Workforce in SEAR Countries". The Committee also decided, as per Rule 37 of the Rules of Procedures of the Regional Committee, to add item 21 'Representation of the South-East Asia Region on the Executive Board'


The Committee decided to revive the process of holding cross-border meetings not only to curb polio, but also for malaria and other diseases.

SEA/RC59(3) Selection of a subject for the Technical Discussions to be held prior to the sixtieth session of the Regional Committee

Recognizing the importance of promoting nutrition and food safety in countries of the South-East Asia Region, the Committee decided to hold Technical Discussions on "Nutrition and food safety" prior to the sixtieth session of the Regional Committee in 2007. The Committee also decided that from next year, prior consultations would be held with all Member States to select the topic for technical discussions. This would make the process more participatory. 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/RC59/(4) Regional implications of the decisions and resolutions of the 59th World Health Assembly and the 117th and 118th sessions of the Executive Board

The Committee recommended that WHO should address the question of emergency preparedness and response and consider with due importance the idea of establishing an emergency fund for natural disasters and calamities. The creation of such a fund would require a resolution to be drafted to that effect. The Committee decided to establish a working group to draft such a resolution.

SEA/RC59/(5) UNDP/World Bank/WHO special programme for Research and Training in Tropical Diseases: Joint Coordinating Board (JCB) - report on attendance at JCB in 2006, and nomination of a member in place of Myanmar whose term expires on 31 December 2006

The Committee nominated Thailand as a member of the JCB for a period of three years effective 1 January 2007 and requested the Regional Director to inform WHO headquarters accordingly.

SEA/RC59/(6) 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 Myanmar as a member of the PCC for a period of three years effective 1 January 2007 and requested the Regional Director to inform WHO headquarters accordingly.

SEA/RC59/(7) Time and place of future sessions of the Regional Committee

The Committee decided to hold its sixtieth session in Bhutan in 2007 in conjunction with the Meeting of Ministers of Health. The exact dates will be confirmed later.
SEA/RC59/(8)  Representation of the South-East Asia Region on the Executive Board

The Committee decided to convene a working group of interested Member States of the Region to analyse various options of the proposal for enhanced representation of the regions of WHO on the Executive Board. It requested the Regional Director to report on the progress in this regard to the sixtieth session of the Regional Committee next year.
Annexes
Annex 1

Text of address by the Prime Minister of Bangladesh

On behalf of the people and the Government of Bangladesh, I welcome you all to Bangladesh, and to the twenty-fourth Meeting of the Ministers of Health and the fifty-ninth Regional Committee Meeting of WHO’s South-East Asia Region. We are delighted that Bangladesh was selected to host this landmark event. We are also happy to have with us a number of international experts and leaders in the field of health from eleven countries of the Region. We look forward to gaining new insights in resolving many health issues through your deliberations.

Bangladesh, as you are all aware, has performed very well with regard to the health-related Millennium Development Goal (MDG) targets. In particular, I would like to highlight those related to maternal and child health, access to safe drinking water and sanitation, and affordable medicines for the people. Most of the goals are close to attainment and within-reach by 2015. Healthcare coverage has increased considerably, and this has meant tangible spill-over gains in many other sectors. The population growth rate has dropped from 3.0 percent in the 1970s to 1.48 percent in 2004. At the same time, the total fertility rate fell to 3.0 in 2004 from 6.3 in the 1970s.

Maternal mortality declined by about 22 percent over the last 15 years. Attitude to healthcare has shown signs of positive change. More and more expectant mothers are now seeking ante-natal and after-birth counselling. Life expectancy has shown remarkable improvement over the last 15 years, increasing from around 49 years in the 1970s to 64 years in 2004.

The Bangladesh Government has introduced a new Programme, with a view to achieving sustainable improvements in health, nutrition and reproductive health. It has a special focus on vulnerable groups, such as women, children, the poor, and the elderly. It is completely in harmony with the targets of our PRSP. The new Programme is build on a Sector-Wide Approach – which embodies a holistic focus on development rather than a project-specific outlook. With this new arrangement in place, I believe that implementation of programmes will be better coordinated and resources spent more efficiently.
On the whole, Bangladesh has made steady progress in the health sector. We express our deep appreciation to the WHO for providing unfailing support in these areas, particularly in making skilled attendance at birth available in both rural and urban areas. WHO contributed significantly to the enhancement of health service coverage and to increasing public awareness on many health aspects. In particular, we may mention the ill-effects of smoking tobacco products and the scourge of HIV-AIDS. WHO has also provided continued technical support and assistance towards capacity building in our health sector. Although a fruitful partnership exists between the Bangladesh Government and WHO, I believe that much more can and needs to be achieved.

I take this opportunity to affirm that Bangladesh, among other countries of this Region, will support the World Alliance for Patient Safety initiative and be a part of the First Global Patient Safety Challenge. The new theme, “clean care is safer care”, will put together concerted efforts to promote the highest standards of practice and behaviour. It will no doubt reduce the risks of healthcare associated infection.

In recent times, we have witnessed the prompt action of WHO in helping the Region contain and prevent Avian Influenza. The Government of Bangladesh has recently approved the National Plan of Action for Avian Influenza. Its implementation has just begun. I understand that WHO has enhanced its laboratory support for diagnostic tests for avian influenza. I express my sincere thanks to WHO for its prompt action in an important area of concern.

At this stage, I would like to raise a few issues for consideration of the distinguished Health Ministers and participants of the upcoming Regional Committee Meeting. First, the equity issues in health. Poverty and ill-health are inter-twined. We find that poor countries tend to have noticeably worse health outcomes than better-off countries. There still remain stark inequities in access to healthcare services within and among nations. This critical issue needs to be resolved, and we expect that your deliberations will produce solutions in this regard. We must introduce innovative financing methods, so that healthcare is affordable and within the reach of all households. Poor people have to be empowered to enjoy access to modern healthcare systems, more so because ill-health accentuates poverty.

Second, developing countries of the Region need support in evolving new technology and methods. This is particularly necessary to make drug prices cheaper and more affordable. I have learned that the WHO has just published the Report of the Commission on Intellectual Property Rights, Innovation and Public Health. It will go a long way in making good use of the flexibilities allowed under TRIPS. Bangladesh’s pharmaceutical manufacturing sector has grown remarkably and now exports medicines and vaccines to over 65 countries.
However, much more needs to be done by way of technology transfer and revision of patent laws in order to ensure cheap but high quality medicines in developing countries.

Third, our countries are faced with the unprecedented threats from emerging infectious diseases and the growing burden of chronic diseases. Thus, there is a critical need to develop a well-trained and dedicated public health workforce. At the same time, we must devise affordable methods to contain diseases, such as avian influenza, dengue, HIV/AIDS, malaria, TB and kala-azar. We also need to share best practices in the control of re-emerging diseases like polio.

All the member countries of the Region have rich experience to share. These meetings can serve as perfect platforms for discussing the fundamental health issues of the Region. I call for stronger and enduring cooperation, in order that healthcare can be made available to all without delay. We must find ways to make more efficient use of whatever resources we have for our health sector. Development partners and technical support agencies have a vital role to play in this regard.

A vital pre-requisite for an efficient healthcare delivery system is a nation’s pool of skilled healthcare personnel. Thus, capacity building and formal training stands at the core of any effort to develop a skilled health work-force in any country. I am pleased to learn that, during this meeting, a declaration on “Strengthening Health Work-force in SEAR Countries” is likely to be adopted. This initiative is timely, topical, and very significant for the Region as a whole. It will go a long way towards promoting efficiency of our health systems and improving human resource management capacity in countries of this Region.

I wish you all a comfortable stay in Bangladesh and a very productive meeting. Once again, I acknowledge the excellent support that Bangladesh has been receiving from WHO and all countries of this Region. I am certain this has richly contributed to the impressive health outcomes of our country.

I now declare the 24th Health Ministers’ Meeting and the 59th RC Meeting open.

Thank you all.
With great pleasure, I welcome you all to these important meetings. We are deeply honoured that Her Excellency, Begum Khaleda Zia, Hon’ble Prime Minister of the People’s Republic of Bangladesh is inaugurating the meetings.

Honourable Prime Minister, your presence reflects the high priority that you and your government accord to health of the people in this Region. This is indeed most inspiring.

I also extend my greetings to the Honourable Health Ministers, distinguished representatives and esteemed invitees. I very much appreciate that the Ministers have made it possible to attend the meetings. This is in spite of their busy schedule and important commitments at home.

Honourable Ministers, your presence here reflects your firm commitment to the regional solidarity. We very much look forward to your advice and guidance on the issues of our common concerns.

I would like to place on record our grateful thanks to the Government of the People’s Republic of Bangladesh for so graciously hosting these meetings; and especially to H.E. Dr Khandaker Mosharraf Hossain, the Minister for Health and Family Welfare.

During the recent past, we have witnessed significant changes in many spheres of health development. Lifestyle-related health problems are increasing and causing growing concern.

A longer life span reflects the success of health development efforts. On the other hand, this situation contributes to the increasing disease burden.

The daunting health challenges facing us today have evolved over time. Let me single out one of the most current concerns. That is Avian influenza, which has now spread throughout the world. Efforts to control it cannot be
made in isolation, without the cooperation of neighbouring countries and the international community.

Available data show that the total number of human deaths due to Avian Influenza this year up to now is more than the number reported during the whole of last year. Therefore, we should remain fully vigilant to every hint and sign that the virus may be changing its behaviour.

In the light of many difficult health issues, we have to courageously address them simultaneously. If not, the Millennium Development Goals and poverty reduction will remain an illusion.

To reach the targets of these goals, we need to really link health care services with actions on various dimensions of social and economic development. These include poverty reduction, women’s education and empowerment, and social harmonization.

The question that we need to urgently address is how can we meet these challenges together in the most efficient and effective manner? And, in the face of numerous constraints, how can we best protect and promote the health of all our people?

Strengthening public health infrastructure constitutes one of the core strategies for addressing these complex issues in health. This involves, among others, the production of a balanced health workforce; with due attention to health promotion, and disease prevention and control.

As much as possible, the emphasis of the health services must be placed on the work at the grassroots level. We have to ensure reaching the unreached, the poor, the marginalized and the underprivileged.

I am confident that the meeting of Health Ministers and the Regional Committee session will further enhance regional solidarity. This intercountry cooperation will be further strengthened to safeguard and promote health for all people.

I wish the meetings all success.

Thank you.
Annex 3

Agenda*

1. Opening of the session

2. Sub-committee on credentials:
   2.1 Appointment of the Sub-committee on credentials
   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

5. The Work of WHO in the South-East Asia Region – Report of the Regional Director,
   1 July 2005 – 30 June 2006

6. Address by the Director-General of the World Health Organization

7. Medium-term strategic plan (MTSP) 2008-2013


9. Regional strategy for health promotion: Follow-up of Sixth Global Conference on Health Promotion

10. Alcohol consumption control – Policy options in the South-East Asia Region

11. Technical Discussions:
   11.1 Consideration of the recommendations arising out of the Technical Discussions on ‘Promoting patient safety at health care institutions’
   11.2 Selection of a subject for the Technical Discussions to be held prior to the sixtieth session of the Regional Committee

* Originally issued as document SEA/RC59/1 (Rev.2) dated 23 August 2006
12. Regional initiatives for eradication/elimination of tropical diseases
   SEA/RC59/6 (Rev.1)

13. Strengthening the health workforce in SEAR countries
    SEA/RC59/12 (Rev.1) & SEA/RC59/Inf.7

14. Regional strategic plan for human resource development
    SEA/RC59/16

15. International trade and health
    SEA/RC59/17

16. Health information system development relating to Millennium Development Goals (MDGs) and Health Metrics Network (HMN)
    SEA/RC59/18 (Rev.1)

17. Governing Bodies:
   17.1 Regional implications of the decisions and resolutions of the Fifty-ninth World Health Assembly and the 117th and 118th sessions of the WHO Executive Board
    SEA/RC59/7 (Rev.1) & SEA/RC59/Inf.5

   17.2 Review of the draft provisional agendas of the 120th session of the WHO Executive Board and the Sixtieth World Health Assembly
    SEA/RC59/8 (Rev.1)

18. Special Programmes:
   18.1 UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases: Joint Coordinating Board (JCB) – Report on attendance at JCB in 2006 and nomination of a member in place of Myanmar whose term expires on 31 December 2006
    SEA/RC59/13 (Rev.1) & SEA/RC59/Inf.6

    SEA/RC59/14 (Rev.1)

19. Time and place of future sessions of the Regional Committee
    SEA/RC59/4 (Rev.1)

20. Adoption of the report of the Fifty-ninth session of the Regional Committee
    SEA/RC59/21

21. Representation of the South-East Asia Region on the Executive Board

22. Closure of the session
Annex 4

List of Participants*

1. Representatives, Alternates and Advisers

Bangladesh

Representative
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Minister of Health and Family Welfare

Alternate
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State Minister of Health and Family Welfare

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Secretary
Ministry of Health and Family Welfare

Prof Dr Shahadat Hossain
Director-General
Directorate-General of Health Services

Mr Md Shafiqul Islam
Joint Secretary (PH&WHO)
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Professor of Urology, DMCH and Dean
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Prof Mahmudur Rahman
Director, Institute of Epidemiology
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Prof Dr Md Habibur Rahman
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Dr Md Tajul Islam
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Directorate-General of Health Services

Prof Dr Mostaque Rahim
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* Originally issued as document SEA/RC59/19 (Rev.1) dated 23 August 2006
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Chairman, Department of Oncology  
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**Representative**  
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Minister of Health

**Alternate**  
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Secretary, Ministry of Health

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Personal Secretary to the Minister of Health

**DPR Korea**

**Representative**  
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Minister for Public Health  
Ministry of Public Health

**Alternate**  
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Director, Department of External Affairs  
Ministry of Public Health

**Advisers**  
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WHO Desk Officer  
Ministry of Foreign Affairs

Mr Choe Yong Su  
Official, Ministry of Public Health  
(Interpreter of the mission)

**India**

**Representative**  
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Secretary (Health and Family Welfare)  
Ministry of Health and Family Welfare

**Alternate**  
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Joint Secretary (International Health)  
Ministry of Health and Family Welfare

**Indonesia**

**Representative**  
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Head, Board of Health Human Resources Development and Empowerment  
Ministry of Health
Alternate

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Chief, Division of International Cooperation Bureau of Planning and Budgeting Ministry of Health

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Maldives

Representative

H.E. Dr Abdul Azeez Yoosuf
Deputy Minister of Health

Alternate

Ms Aminath Shenalin
Assistant Director
Ministry of Health

Adviser

Ms Mariyam Suzana
Assistant Undersecretary
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Myanmar

Representative

H.E. Prof Kyaw Myint
Minister of Health

Alternate

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Deputy Director-General
Ministry of Health

Advisers

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Mr Thet Lwin
Deputy Director, International Health Division Ministry of Health
Nepal

Representative  Dr Nirakar Man Shrestha  
Chief Specialist  
Policy, Planning International Cooperation Division  
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Sri Lanka

Representative  H.E. Mr V. Krishnamoorthy  
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Alternate  
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Global Alliance on Vaccine Initiative

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Report of the Fifty-ninth Session
Annex 5

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10. Dr S.M.Samarage (Sri Lanka)
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Annex 7

Text of Address by the Acting-Director-General, WHO

It is a pleasure to be back in Bangladesh. It was on the 6th of June, little over three years ago, the day before I was scheduled to travel to Dhaka, that JW Lee asked me if I would like to be part of his team. I delayed my trip here by a day to talk to my family, then came here. I spent several very interesting days discussing the Bangladesh Health Sector Programme. I also visited BRAC, an organization - or perhaps one should say movement - that impressed me a lot. Tim Evans - one of my “to be” ADG colleagues - was also at BRAC at the same time.

Another memory from that trip is the impressive achievement made in reducing maternal mortality ratios. We have seen progress in reducing child mortality in many countries, but few countries have, like Bangladesh, been able to save more mothers.

This is a Region that has faced some exceptional challenges. Countries have suffered Tsunamis, earthquakes and floods as well as continued conflicts. Communities that are struggling to cope with the effects of disruption to their homes have concurrently faced the burden of avian flu, polio, HIV, tuberculosis, malaria, as well as of a growing epidemic of chronic diseases.

The progress you have made, and the solidarity you have shown, provide lessons for us all. Your experiences, especially in coping with the Tsunami of December 2004, have provided lessons that are important not only for this Region, but also for other parts of the world.

Last year you gave us your very valuable insights and input to the draft Eleventh General Programme of Work (GPW) for WHO. This May, the World Health Assembly approved it.

Thank you for all that you have contributed to its strategic direction.

The title, “Engaging for health”, describes what we have to do now.

Together, we have to implement the shared vision of the global health agenda.
Shortly we will discuss the Medium-Term Strategic Plan (MTSP) for 2008 to 2013 and the Proposed Programme Budget for 2008 to 2009. Like the GPW it draws on countries’ practical experiences, challenges and needs.

The MTSP suggests that WHO should focus its work in five main areas:

1. Support for countries in moving to universal coverage with effective public health interventions;
2. strengthening global and local health security;
3. actions across sectors to modify the behavioural, social, economic and environmental determinants of health;
4. increasing institutional capacities to deliver core public health functions through strengthening of health systems;
5. strengthening WHO leadership, both at the global and regional levels, to support the work of countries.

To finance these plans, the Proposed Programme Budget for 2008-2009 has been costed at US$ 4.2 billion. This is an increase of 17% over the current biennium’s expected expenditure.

For the South-East Asia Region, this amounts to a total increase of almost 40% against the current biennium.

The share of the total budget for the South-East Asia Region, excluding polio and emergencies, is suggested to significantly increase as well, in line with the validation mechanism.

The US$ 4.2 billion budget is proposed to be financed through a 8.6% increase of assessed contributions amounting totally to US$ 1 billion; the introduction of negotiated core voluntary contributions aiming at US$ 600 million; and through specific voluntary contributions.

The share of the assessed contributions will, even with this increase, continue to decline (to 23%), which is unfortunate. We hope, however, that the introduction of negotiated core voluntary contributions will achieve better alignment and reduce transaction costs.

The increase of the budget is a direct reflection of the increased expectations from Member States and will target some core areas of need, namely:

• achieving the Millennium Development Goals for maternal and child health;
• increasing the focus on noncommunicable diseases;
- making health development sustainable through greater attention to the determinants of health;
- implementing the International Health Regulations;
- and strengthening of health systems.

A few more specific words about those areas:

We have made some good progress in child health, but much more remains to be done in addressing the underlying problems in mothers’ and women’s health. We are still far behind the goals set for 2015 and progress is too slow.

Globally, momentum is increasing to address sexual and reproductive health. WHO’s governing bodies have approved a series of strategies and measures aimed at tackling sexually transmitted infections and improving reproductive health, especially among adolescents.

I hope that this Region will follow with concrete action in all countries.

I note, for example, that excellent progress is being made in Bangladesh and India in addressing adolescent health, both through “adolescent friendly health services” and in increasing life skills among adolescents themselves.

I have personally made maternal and reproductive health a priority during my few months in this Office. In June I met with Thoraya Obaid and other senior colleagues from UNFPA, to coordinate action to reverse the global trend of deteriorating levels of sexual and reproductive health.

Now I have just come from the XVI International AIDS conference in Toronto. One clear message there was the vital need to improve prevention, treatment and care for women. In 2005, worldwide, fewer than one in ten pregnant women living in low and middle income countries received antiretroviral (ARV) treatment to prevent HIV transmission to their newborn infants.

Here in this Region, there has been a significant scaling up of access to treatment. More than four times as many people are now on ARVs than in 2003. But the treatment gap is still huge. Coverage for the most vulnerable and high-risk behaviour groups is still very low.

Another key message from that conference was that we need a balanced approach to prevention, treatment, care and support. The very strong call to address the health workforce was very encouraging.
This Medium-term strategic plan and Proposed programme budget suggest a substantial increased focus on noncommunicable diseases. Reduction of the impact of chronic diseases, such as cancers, cardiovascular disease, chronic respiratory disease, or diabetes is a major aim. Currently, more than half of all deaths (54%) in this Region are from chronic disease.

I believe that there is now a regional framework for NCD control. This is a vital step forward in mainstreaming chronic diseases into public health services.

As you know, last year’s publication of the first global report on chronic disease was an important step in raising the profile of these diseases and their huge contribution to global mortality.

With the WHO Framework Convention on Tobacco Control, 168 countries have now signed up to one of the most important interventions for control of the risk factors leading to chronic disease. I congratulate the countries of this Region that have become Parties to the Convention.

Linked to noncommunicable diseases is of course the importance of addressing the underlying determinants of health.

One of the seven items on the GPW global health agenda is “tackling the determinants of health”. The more we are able to influence and have control over the factors that influence health, the greater chance we have to improve the health and well-being of people.

The action required to tackle most of these determinants goes beyond the influence of ministries of health, and involves a large number of government and commercial responsibilities and a wide range of sectors.

The challenge is how to move from knowledge of the association of social and environmental determinants and health equity to specific policies that we can implement.

Last year the Bangkok Charter for Health Promotion explicitly called for policy coherence, investment, and partnering across governments, international organizations, civil society and the private sector.

I am pleased to see that this Committee’s active engagement in this process through the regional strategy for health promotion. The recognition of the threat to human health from emerging infectious diseases has catalysed action in many areas not previously viewed as a priority in public health.

Let me now turn to the implementation of the International Health Regulations and to avian influenza.
Those of you here who were involved in the careful negotiations involved in revising the International Health Regulations know first-hand how highly this instrument is regarded by Member States. We see no signs today that the threat posed by the H5N1 avian influenza virus is diminishing.

Today, more than 50 countries in central and southern Asia, Europe, Africa and the Middle East have reported outbreaks in birds. Human cases have now been reported in 10 countries. As at 17 August, there had been 239 confirmed cases and 140 deaths.

Forty-five of these were in Indonesia, where, earlier this year, the largest family cluster of cases on record was documented.

Fortunately, any possible human-to-human transmission reached a dead-end. Despite multiple opportunities for the virus to spread into the general community, it did not do so. Therefore, this experience did not result in a global pandemic alert phase change but did underscore the importance of constant vigilance and rapid and thorough investigation of any unusual events.

It also underscored the high level of global attention that any country affected by H5N1 must be prepared to face.

Too often, the first signal that this avian flu virus is present in a country comes with the confirmation of a human case. That is the wrong way round. Surveillance on the animal side needs to improve. With support from WHO, almost all countries now have preparedness plans for responding to a pandemic. The next step is to make these plans as realistic and operational as possible.

Manufacturing capacity of antiviral drugs has improved considerably. Licenses have been granted to produce these drugs in several developing countries.

Much attention is being given to the development of a vaccine, and finding ways to expand manufacturing capacity. These are difficult problems but much work has progressed and some clinical trials are now producing encouraging results.

We are all committed to polio eradication. Some challenges remain. In Indonesia, last year’s explosive outbreak which left 305 children paralysed for life appears to have been curbed. However, important subnational surveillance gaps means that undetected virus circulation cannot be ruled out.

Bangladesh is continuing to conduct high-quality immunization responses after having been re-infected this year. In Nepal, too, following re-infection last year, no new cases have been reported since March 2006.
Major challenges remain in India. Although polio has been beaten back to just a handful of key districts of Bihar state and western Uttar Pradesh state, a new outbreak in western Uttar Pradesh is increasing the risk of further national and international spread.

The challenge to India is clear: all efforts must be undertaken to rapidly stop the outbreak in and around Moradabad district. It is paramount that each and every child is reached during every immunization campaign.

Finally and perhaps most importantly, we need to continue strengthening health systems.

There is today a general agreement and understanding that, without functioning and efficient health systems, we will not be able to scale up basic health services nor achieve the MDGs.

We need policy options for how to finance health service, how to best organize the system, how to best engage different stakeholders and we need systems to provide us with data and evidence. But without a stronger health workforce we will fail.

Last month, in St Petersburg, I spoke on this to the G8. For universal coverage and access to become a reality, every country needs a motivated health workforce.

I have just made the same point very strongly in Toronto at the AIDS Conference, where we launched the “Treat, train, retain” initiative.

This joins wider global efforts to sustain and build through the Health Workforce Alliance.

We have to tackle this problem not just at the national and local level, but at the global level, to get the level of commitment that will see changes in employment and training policies, as well the broader fiscal issues related to human resources policies and strategies.
Annex 8

Text of Regional Director’s introductory remarks on his Annual Report

I am now submitting to the Regional Committee an annual report on the work of WHO in the Region. The Report is contained in document SEA/RC59/2, which is placed before the Committee. It covers the period from 1 July 2005 to 30 June 2006.

During the period under review we faced many health challenges in the Region. Response to those difficulties was very much influenced by a variety of factors. These included, among others, political concerns, capacity of health systems and availability of resources. Furthermore, success in health development does not come from efforts of the health sector alone. Other sectors have also to share responsibility and ownership in the process of such a development.

However, the strong political will and commitment of Member States led to successful endeavours in tackling the challenges. Complementing government’s efforts, WHO provided support to ensure the steady progress towards achieving national health goals.

Communicable diseases continued to be important public health problems in our Region. There was a threat of potential pandemic caused by avian influenza. There were also the unchecked outbreaks of malaria, dengue fever, encephalitis, and many others. To counter these problems, disease surveillance and investigation were further strengthened in the countries. Efforts were made to scale up national capacities in laboratory diagnosis of priority infectious diseases. Action was initiated to ensure adequate core capacity of Member States for implementing the revised International Health Regulations. Missions were fielded to help countries in the preparation of national influenza pandemic preparedness plans. To ensure prompt consultation during emergencies, a Strategic Health Operations Centre was established in the Regional Office. To decentralize regional activities to countries, a disease surveillance sub-unit was set up at the National Institute of Communicable Diseases, Delhi. A similar sub-unit is also being established in Bangkok. These sub-units are to serve our
and nearby WHO regions. To promote collaboration among countries in South-East Asia and the Western Pacific regions, the Asia-Pacific Strategy on Emerging Diseases was jointly developed.

In the area of HIV/AIDS control, the coverage of antiretroviral treatment increased from 37,000 cases to 162,000 cases between 2003 and 2005. As regards TB, 1.8 million new cases were put on DOTS (Directly Observed Treatment, Short-course). Full coverage with this treatment strategy has been achieved in all countries now. With regard to malaria control, the Regional Strategy was revised, with particular emphasis on using a multisectoral approach. The national policy on antimalarial drugs was updated in five countries.

The increase in the frequency of outbreaks of dengue fever and its geographical expansion were cause for serious concern. The Partners’ Meeting convened in March 2006 was to ensure sustained cooperation in resource mobilization for dengue control.

We expected to stop polio transmission in all countries in the Region. Unfortunately, we were not successful due to several reasons. To ensure future success, the eradication strategy was modified to include monovalent polio vaccine.

In the area of tropical diseases of low priority, apart from leprosy, three more diseases of poverty were targeted for elimination in the Region. These are kala-azar, lymphatic filariasis and yaws. Regional Technical Advisory Groups were formed to advise on the elimination strategies.

A meeting was held in Bangalore, India last year to advocate the inclusion of these strategies in the national action plans of the concerned countries.

The target for leprosy elimination was to be achieved globally at the end of 2005. But, not all countries in our Region could attain the target. However, commendable results from the elimination efforts were achieved.

The average regional prevalence rate of leprosy decreased to 0.87 per 10,000 population at the end of 2005. In another development, in July 2005, the Global Leprosy Programme was relocated from WHO headquarters to the Regional Office.

This is in line with bringing the global programmes to where the biggest burden of health problem exists.

As regards kala-azar, elimination plans were developed, and their implementation started by the three concerned countries.
In March this year, the Regional Office held a meeting with certain pharmaceutical companies to discuss the regional production of Oseltamivir for avian influenza. The outcome of the meeting was very positive and encouraging. A meeting with selected biologicals firms was also held in June this year to promote regional cooperation in vaccine production. The firms expressed their enthusiasm to pursue the challenge together.

During the period under review, safety of blood and blood products continued to attract our priority attention. Of the 15 million units of blood needed annually, less than two thirds could be collected. A strategy for safe blood was developed and its implementation started in all the Member States.

While combating communicable diseases, noncommunicable conditions placed additional burden on health systems. These conditions accounted for about 54% of all deaths in the Region. The main risk factors for these conditions continued to be tobacco use, unhealthy diet, poor physical activity and high blood pressure. These risk factors continued to be addressed through integrated surveillance and population-based interventions.

The regional network for information dissemination (SEANET-NCD) was developed and extended to cover most countries in the Region. Standardized NCD-risk factor surveys were carried out in nine countries to generate evidence-based information for intervention planning.

All countries of the Region have developed national strategies for mental health promotion, specially targeting the adolescent. These strategies emphasize, among others, the lifeskills approach and building community resilience.

The Sixth Global Conference on Health Promotion was held in Bangkok, Thailand in August 2005. It endorsed the Bangkok Charter for Health Promotion. The Charter was subsequently deliberated upon at the Fifty-ninth World Health Assembly. Countries have developed their action plans to implement the recommendations contained in the Charter. As regards tobacco use, out of five million annual deaths globally, 1.2 million were from this Region. Nine countries in the Region had signed the WHO Framework Convention on Tobacco Control. Global youth surveys were carried out in ten countries to gather evidence for the development of tobacco control strategies.

Concerning injuries, the regional death rate is very high, about 106 per 100 000 population as compared to the global average of 82.5. Of all deaths due to injuries in the Region, at least 23% were caused by road accidents. Member States continued to overcome problems of injuries through multisectoral interventions.
To restore eyesight of the 15 million blind in the Region, eight countries have launched the Vision 2020 - the Right to Sight programme. This programme aims to eliminate causes of avoidable blindness by 2020.

Maternal and child mortality continued to be grave concerns in the SEA Region. On the high side, maternal mortality ranges from 380 to 740 per 100 000 live births. The under-five mortality ranges from 69 to 125 per 1000 live births. To tackle this problem effectively, skilled birth attendance for every birth is critical. Yet, there are countries in the Region where such coverage is less than 50%. Member States have developed strategies to intensify their efforts to ensure adequate numbers of skilled birth attendants.

New child growth standards were released by WHO in April 2006. This is a technical tool for assessing the nutritional status of children. A regional workshop was held to brief all concerned nationals on the use of these standards.

Iodine deficiency disorders (IDD) is still an important public health problem in the Region. Only one country could reach the goal of elimination. IDD affects not only physical, but also mental and intellectual development, especially in children. To ensure effective programme development, IDD intervention must be viewed within the context of comprehensive human resource development. In the field of adolescent health, WHO continued to support countries in tackling related problems, especially in the area of HIV/AIDS, where about 50% of new HIV infections occurred among young people.

The countries continued to face serious public health challenges due to environmental degradation and pollution. Among many others, safe drinking water is becoming scarce in several countries. A guidance document on rainwater and health was developed. These guidelines are being incorporated into the WHO Drinking Water Guidelines.

Water safety plans were introduced as pilot exercises in several countries. Another important challenge is that nearly 50% of the population in the Region have no access to sanitation facilities. In spite of extensive efforts, this percentage has hardly improved, especially in the rural areas.

Concerning occupational health, the vulnerable population continues to work long hours in unsafe conditions. This includes women and the poor. Steps are being taken to promote workers’ health as a basic human right.

Arsenic poisoning continued to be a serious health hazard in the Region. A field guide to tackle the problem was developed. Training of 200 national staff in the affected countries in the use of this guide was completed. Experience in dealing with tsunami and avian influenza highlighted the importance of food safety in public health. National integrated food safety programmes to tackle problems relating to food safety were developed in several countries.
Our Region is disaster-prone. There was large-scale destruction caused by the tsunami of 2004. In October 2005, the north-western part of India was severely affected by a strong earthquake. Recently, there was a devastating earthquake in Yogyakarta, Indonesia. It killed about 7000 people, injured 45 000 and left 1.8 million displaced. There were severe floods in India, northern Thailand and Sulawesi, Indonesia. In addition, there were civil conflicts in Nepal and Timor-Leste that overloaded the already burdened health systems. Due to the occurrence of various emergencies, the need for improving emergency preparedness and response has become imperative.

Member States energetically updated their national plans with emphasis on capacity building, multisectoral involvement and empowerment of community and people. They also continued to monitor and report their progress towards achieving the Millennium Development Goals (MDGs). Ten countries in the Region have already submitted their progress reports on MDGs.

Due to the prevailing resource constraints, mobilization of extrabudgetary funds continued to be our priority strategy. To increase our capacity in resource mobilization, a number of training workshops were held for concerned national staff. A number of partners’ meetings to advocate for an increased inflow of funds were organized during the reporting period. As a result, 60 donor agreements were signed, and a sum of US$ 286.8 million was mobilized during the last biennium.

WHO collaborates with its Member States to provide support to their efforts in health development. The key strategy in such an endeavour is to strengthen the capacities of countries. This can lead to sustainability of countries’ achievements in their development endeavours and also promote self-reliance in the initiation and execution of their national health development agendas.

We, in this Region, are trying to work out the best way of strengthening the capacities of countries. Several initiatives have been undertaken to contribute to a more effective building up of these capacities. Among others, these are: (i) Decentralization of resources and delegation of authority to the country level; (ii) Strengthening of the countries’ public health systems, with special emphasis on public health workforce; and (iii) intensification of education and training in public health, with particular attention to work that covers the entire population.

During the period under review, the efficiency of WHO country offices was improved as the result of delegated authority; more budgetary resources were allocated to WHO country programmes; regional activities started getting decentralized to the country level; the Regional Office staff spent much more time performing WHO work in countries; there was an increase in intercountry cooperation under WHO country programmes; and WHO training activities in countries increased substantially.
In the coming years, we will double our efforts on strengthening countries’ capacities. Furthermore, a greater number of Regional Office staff will be located at the country level to ensure their proximity to problems on the ground. We will also continue to ensure that WHO country staff work harmoniously with their national counterparts. And, internally, we will continue improving the efficiency of our machinery at both country and regional levels.

What has been mentioned so far covers some of the noteworthy aspects of WHO’s work during the period under review, the detailed account of which may be found in the document SEA/RC59/2.

Whatever the health challenges may be, I wish to assure Member States of our best efforts to provide the required back-up. We will continue to intensify our work, and improve our efficiency to ensure speedy and effective service to our Member countries.

In these important endeavours, we need the unwavering political support from the Member States, and from all other partners. In future reporting, we will try to demonstrate, in more tangible terms, how WHO’s work is really impacting on the strength of national health systems, and on the health situations in countries. Only when the efficiency and effectiveness of its services become evident, can WHO be really proud of its work in the Member States.

Mr Chairman, I finally thank you, and I thank all, for your kind attention.

Thank You.
1. **Introduction**

The Forty-third Meeting of the Consultative Committee for Programme Development and Management (CCPDM) was held at the WHO Regional Office for South-East Asia (SEARO), New Delhi, from 14 to 16 June 2006. Government representatives and WHO representatives from Member countries of the South-East Asia (SEA) Region participated. The Agenda and List of Participants are attached as Annexures 1 and 2, respectively.

2. **Inaugural session**

*Opening remarks by the Regional Director*

Welcoming the participants, Dr Samlee Plianbangchang, Regional Director, WHO SEA Region, stated that CCPDM dealt primarily with WHO programme development and management. He said that he was glad that many of the participants of the Eleventh Health Secretaries’ Meeting had stayed on to attend the CCPDM meeting. This continuity was very important, especially in view of the direct role of health secretaries in the development and management of WHO programmes, particularly at the country level. He hoped that with the involvement of health secretaries, the meeting of the CCPDM would be more productive.

Dr Samlee informed the participants that the agenda for the three-day meeting was heavy. During the course of the meeting, the performance in implementation of the 2004-2005 biennial Programme Budget would be reviewed to identify strengths and weaknesses in that process. The lessons from this experience would then be used as the basis for improving the performance during the 2006-2007 biennium.

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In addition, some key issues in the process of programme implementation during 2006-2007 would be discussed in detail. These included Multi-country Activities (MCA); and the New Financial Regulations and Financial Rules.

Dr Samlee said that MCA was a mechanism to promote intercountry cooperation within the context of WHO collaborative programmes. It was an opportunity provided to countries to work together with WHO acting as a catalyst and facilitator.

Regarding the New Financial Regulations and Financial Rules, these had a significant implication on the way the biennial Programme Budget was planned and implemented. It was very important therefore to thoroughly discuss such implications and be ready to reorient the planning and implementation process. This was a major exercise since the new rules had become applicable effective the 2006-2007 biennium.

The CCPDM would also review once again the Medium-Term Strategic Plan (MTSP), covering the period 2008-2013. Very importantly, the Committee would deliberate upon the Proposed Programme Budget for the 2008-2009 biennium. This was the crucial element of the plan, from which actions will be identified and taken during the biennium concerned.

Dr Samlee said that MTSP and Programme Budget were not only linked, but also bound together; this was to ensure adequate implementation of WHO policy and direction as enunciated in the 11th Global Programme of Work. The MTSP and Programme Budget were crucial tools for the preparation of biennial workplans to be jointly implemented by Member countries and WHO.

The Regional Director requested the CCPDM members’ special attention, particularly at this point in time to the Programme Budget 2008-2009 to see whether the proposed global plan would adequately respond to the health development needs of countries in the SEA Region.

Dr Samlee also drew the attention of the CCPDM members to the topic of the Technical Discussions, viz. “Promoting Patient Safety at Health Care Institutions.” He informed them that the subject had been selected by the Regional Committee for South-East Asia at its session held last year. It was a very important subject, as far as the quality of health services was concerned. The conclusions and recommendations of the Technical Discussions would be submitted to the forthcoming session of the Regional Committee to be held in August 2006 in Dhaka.

The Regional Director further stated that there were two more items on the agenda of the CCPDM meeting, which the Regional Committee had requested the CCPDM to review and discuss.
The first item was on Regional Implications of Decisions and Resolutions of the recent World Health Assembly and the Executive Board sessions. Since, the time available to review and discuss all decisions and resolutions would not be enough, only a few important ones should be identified for deliberations.

The second item dealt with reports on meetings of the Joint Coordinating Board (JCB) of the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR); and the Policy and Coordination Committee (PCC) of the WHO Special Programme for Research, Development and Research Training on Human Reproduction (HRP). The two meetings of the special programmes had not been convened at the time of the CCPDM meeting. Therefore, the reports of both the meetings could not be presented. Instead, some useful information on the Special Programmes would be brought to the attention of the Committee.

The Regional Director stated that the outcomes from all agenda items of the CCPDM meeting would be submitted to the 59th session of the Regional Committee for its consideration in August 2006.

He informed the CCPDM members that there were several issues involved in the process of WHO programme development and management, which directly affected the work of WHO in the Region, the most important one being the mobilization of resources for implementing WHO collaborative activities in Member countries.

Dr Samlee further stated that during the current biennium, extrabudgetary resources from voluntary contributions constituted 72% of the total regional budget. This proportion of extrabudgetary resources might reach 75% during the next biennium. Extrabudgetary resources were playing an increasingly important role in WHO programme development and implementation.

Looking at it from another angle, most of the voluntary contributions for the 2006-2007 biennial budget were yet to be pledged or committed by funding agencies. Therefore, in the course of implementation of the current programme budget, WHO had to vigorously pursue resource mobilization. This was to ensure that there would be adequate funds for the implementation of all the planned activities.

In the process, it had to be kept in mind that extrabudgetary funds might be available to only certain priority areas, such as polio eradication, and HIV/AIDS prevention and control. It was difficult to mobilize these funds for other priority areas.

Dr Samlee said that funds were not easily available for some areas and stressed the need to mobilize funds. These areas include Noncommunicable
Diseases; Health and Environment; Health Systems Development and even Family and Community Health, which covered Making Pregnancy Safer, Nutrition, as well as Child and Adolescent Health.

Many pledges of funds had been received for the control of avian influenza and for Influenza Pandemic Preparedness and Response. But, the inflow to this area was still very slow, both for countries and for WHO’s work. This was in spite of the critically emergent situation of avian influenza, which had the potential to turn into an influenza pandemic that could have a devastating effect on human life and the world economy.

The Regional Director said that it was also important to recognize that activities funded by extrabudgetary resources were still largely determined by the policy of donor agencies. This trend had important implications on the implementation of WHO policy and strategy as decided by the Governing Bodies such as the World Health Assembly, the Executive Board and the regional committees.

This could lead to countries implementing the priorities of others, rather than their own. WHO would continue its efforts to persuade these agencies to provide funds according to the priority needs of countries as reflected in the Medium Term Strategic Plan (MTSP) and Programme Budget (PB). It was hoped that donors would use MTSP as the basis for them to provide funds for health development in developing countries.

Dr Samlee said that WHO was also trying to encourage donors to come forward with unspecified or unearmarked funds, so that these could be used flexibly in responding to the changing needs of countries. Member countries in the Region would be kept constantly informed and consulted on the issues and developments in this important area.

Dr Samlee stated that the WHO planning process was rather top-down and while reviewing MTSP and PB 2008-2009 during the meeting, it had to be made sure that the needs and priorities of countries in the region were clearly reflected. He mentioned that the SEA Region had always conveyed to headquarters such needs and priorities. This was done through various means, including direct dialogue with a view to ensuring the incorporation of those needs and priorities in the global documents. However, this action by the Regional Office might not be enough. The matter needed to be seriously followed-up by the Member States themselves at the Executive Board sessions and at the World Health Assembly. This was where the role of Member States became crucially important.

Dr Samlee also stressed the need for strong regional coordination and cooperation to protect the regional and country interests; and to ensure a fair
share of resources to the Region. The Regional Office would continue to provide full support to facilitate such a role of the countries at that level. Meanwhile, more frequent briefings and consultations would be ensured on this issue with the Member States.

The Regional Director concluded by wishing the CCPDM members fruitful deliberations. He also reminded that 14 June this year was World Blood Donor Day and the slogan was “Donate Blood Regularly - Save Lives”.

3. Election of Chairperson and Rapporteur

H.E. Dr Abdul Azeez Yoosuf, Deputy Minister of Health (Maldives) was elected Chairperson, Dr Tipvadee Bumpenboon (Thailand) was elected as Co-Chairperson and Mr Bhanu Pratap Sharma (India) was elected as Rapporteur for the CCPDM meeting.

H.E. Professor Mya Oo, Deputy Minister for Health (Myanmar) and Dr Bishnu Prasad Pandit (Nepal) were elected Chairperson and Rapporteur respectively for the technical discussion on Promoting Patient Safety at Health Care Institutions.

4. Establishment of Drafting Group

A Drafting Group, comprising Dr T. Marawan Nusri (Indonesia), Dr Thein Thein Htay (Myanmar), Dr S.M. Samarage (Sri Lanka) and Dr Sopida Chavanichkul (Thailand) was constituted to prepare the report of the meeting.


(Agenda item 2.1)

Dr Lin Aung, Programme Development Officer, WHO/SEARO, made a short presentation on the key technical aspects of the Programme Budget Performance Assessment of the 2004-2005 biennium for the SEA Region.

The presentation explained the purpose of these assessments and the innovative process followed. The assessment made by the Regional Office was based on detailed area of work-wise (AoW) reports up to the product level submitted by WHO country offices in the Region.

The major achievements and challenges during 2004-2005 were highlighted. The need for utilizing WHO Collaborating Centres and Centres of Excellence as well as the need for horizontal collaboration among countries of
the Region and WHO country offices to improve the technical quality of the work of WHO was also stressed. The technical feedback from the Regional Office could be utilized while implementing workplans for the Programme Budget 2006-2007. The need for more “proactive” technical monitoring was also highlighted.

It was stressed that the workplan formulation should be carried out with a “spirit” of planning, with the ownership of all stakeholders involved. Flexibility of programme changes would increasingly become more rigorous as the budget ceiling at the World Health Assembly would be at the lower planning element or the Organization-wide Expected Result (OWER) level.

Discussion points

- The Programme budget performance assessment report 2004-2005 from the Regional Office showed considerable improvement over the previous bienniums. However, there was scope for further improvement was still there which should be attempted in the next biennium.

- While the feedback reports from the Regional Office regarding many areas of work were complete, those concerning a few areas were lacking in detail. In future, the report should be made as comprehensive as possible.

- Based on the Millennium Development Goals (MDGs) and regional priorities, a few areas should be selected in each biennium for detailed evaluation. The exercise should also bring out clearly the contribution of the WHO biennial budget on the health outcomes of Member countries.

- For proper assessment of the programme budget performance in the context of WHO’s results-based management framework, performance should be measured on selected quantitative indicators against the baselines for those indicators as determined at the time of the inception of this framework. The exercise should keep in mind the quality aspects.

- From the next biennium, the planning process would become more stringent as the flexibility available to countries at the AoW level would be reduced to the OWER level. With the exercise thus becoming increasingly rigorous, it was necessary that adequate capacity be built at the level of National Programme Managers and other officers working at country and provincial levels.

- It was noted that the assessment for the 2004-2005 biennium was carried out by the Regional Office technical units. It was felt that the
involvement of National Programme Managers and their teams as well as WHO country offices in this exercise would lead to their capacity building as well as contribute to their sense of ownership of the programme.

**Recommendations**

(1) Member countries should draw suitable lessons from the programme budget performance assessment 2004-2005 which should guide them in better implementation of the Programme Budget from the 2006-2007 biennium onwards.

(2) Capacity building exercise of National Programme Managers and their teams in the areas of planning, implementation, monitoring and evaluation should be taken up seriously.

(3) WHO should develop guidelines for identification of three or four priority areas for assessment. Guidelines should also be framed for selection of areas for detailed evaluation.

6. Implementation of workplans for programme budget 2006-2007, including: *(Agenda item 2.2)*

6.1 Multinational activities (MCAs) *(Agenda item 2.2.1)*

Dr R.M. Brooks, Coordinator, Programme Planning and Coordination, WHO/SEARO, made a short presentation on Multinational activities (MCAs).

The presentation explained the rationale and background for moving from the Intercountry Programme (ICP)-II mechanism to the MCA mechanism. It was highlighted that intercountry activities were important even though the 2006-2007 funds for such activities had shifted to countries. A brief scope of MCAs was presented.

Ninety-one MCAs had been identified in country workplans and through a consultative process 11 MCAs had been finalized, while 27 others were being prepared.

It was emphasized that there was need to undertake an assessment of MCAs in early 2007, the results of which would be used to plan MCAs for Workplans of the 2008-2009 biennium.

**Discussion points**

- The scope of the MCA mechanism needed to be better understood. The mechanism was meant to promote intercountry cooperation.
through the use of the WHO biennial budget. The Member countries had the flexibility in the choice of areas of work as well as countries with which they wished to work. As a matter of fact, these activities could be finalized by country offices concerned directly without any reference to the Regional Office. However, it should be ensured that MCAs complemented the existing country workplans.

- While reviewing the list of MCAs identified for implementation during the current biennium, many countries expressed the desire to be more involved in the process of identification and implementation of those activities.

- The process of selection and implementation of the MCAs could be greatly facilitated if each country identified a focal point who was fully conversant with the concept of MCAs. A meeting of focal points could be convened by the Regional Office as quickly as possible to review the 91 activities currently on the list for improving the selection process as well as for their expeditious implementation. A meeting of the focal points could also be convened early next year to kick-start the process of selection of the MCAs for the 2008-2009 biennium as well as for a mid-term review of activities in 2006-2007.

- In the light of the new financial rules coming into effect whereby no carry-over was allowed from one biennium to the next, concerns were expressed about delays in financial clearance leading to non-utilization of funds. A need was therefore expressed for simplification of administrative procedures.

**Recommendations**

1. It was recommended that the respective governments should nominate focal points for MCAs immediately and that the focal points from countries should liaise with the respective planning focal points in the WHO country offices to review and facilitate the 2006-2007 MCAs.

2. The terms of reference of the group of focal points will be (i) to identify MCAs (ii) to assess the implementation status of MCAs and (iii) to recommend measures to accelerate the implementation of MCAs.

3. A meeting of the group of focal points should be organized by the Regional Office at the earliest.

**6.2 Implications of the new financial rules (Agenda item 2.2.2)**

Mr J.J. Kobza, Director, Administration and Finance (DAF), WHO/SEARO, made a presentation on the new financial rules effective 1 January 2006.
He explained that under the new rules for voluntary contributions, income would now be recorded at the time a donor agreement was signed, rather than waiting for deposit of funds. This would permit earlier implementation of activities upon signing of the agreement and would reduce no-cost extension requests to the donor due to administrative delays.

Expenditures would now be recorded on the ‘delivery principle’. Prior to this new policy an obligation was counted as expenditure. Now, implementation would take place when work had been actually delivered. Goods and services must be delivered before the end of the current financial period in order that the relevant costs could be charged against current funds. No reserves for unliquidated obligations would be allowed to be carried over to the next financial period, as mentioned above.

Obligations against which goods and services are not delivered before the end of the current financial period would be automatically cancelled and charged against the funds of the next financial period. This could be avoided by establishing obligations only for those activities which would be completed before the end-date, and through close monitoring of the pace and progress of implementation.

Discussion points

- It was noted that the revised rules had been mandated as part of the new accounting procedure adopted across the UN organizations to increase transparency in account keeping through the use of best practices in the area.

- While noting that the change in the recording of income would in general give WHO as well as Member countries more time for planning, there could be rare occasions where implementation problems could arise as a fall-out of a particular donor not fulfilling its pledge.

- While the change in the rules with regard to recognition of expenditure would lead to greater financial discipline, as a result of those changes, at least in the short term, the pace of expenditure would slow down. In this connection, the following points came up for discussion:
  - Early start to the planning and implementation process and close monitoring of the progress were absolutely necessary to ensure timely utilization of funds. Having rolling plans would also expedite the process.
  - In order to prevent large-scale surrender of funds at the end of the biennium on account of change in the policy, it was important to
improve the overall work efficiency. Particular mention was made of expediting the processes involved with recruitment of personnel and procurement of goods and services in the Regional Office.

— The capacity of WR offices to support programme implementation in respective Member countries required strengthening. The active involvement of the Regional Office in this exercise was necessary.

— While no carry-over of unliquidated amounts would be allowed from one biennium to the next starting from 2006-2007 onwards, it was clarified however that the principle of ‘due to be delivered’ would be accepted. This meant that expenditure would be recorded as long as goods and services were due to be delivered within the biennium, and when the actual date of delivery fell within a reasonable period from the close of the biennium.

**Recommendations**

1. The monitoring system at the country level needed to be improved in order to accelerate the implementation. It will be useful to have more frequent monitoring meetings between national programme managers and the WHO country office staff.

2. It would be useful to maintain a shelf of stand-by proposals related to country workplans so that in case any planned activity could not take place, it could be substituted by an activity from the shelf falling within the same AoW. The Member countries already had the flexibility to reprogramme funds within the same AoW.

7. **Medium-Term Strategic Plan (MTSP) 2008-2013**

(*Agenda item 2.3*)

Dr R.M. Brooks, Coordinator, Programme Planning and Coordination, WHO/SEARO, made a presentation on the subject.

The Medium-term Strategic Plan (MTSP) is a new document outlining the work of WHO over a six-year period (2008-2013). It is based on the 11th General Programme of Work (GPW), Governing Body resolutions and the Country Cooperation Strategies.

The MTSP is arranged according to 16 strategic objectives (SOs), each describing the scope of the SO, the indicators and targets, issues and challenges and the strategic approaches. Each SO includes five to eight OWERs that the Secretariat plans to accomplish.
The MTSP covers three bienniums. The Programme Budget attached to the MTSP covers only the first biennium (2008-2009). The format of the budget follows the 16 SOs and the OWERs in the MTSP.

The MTSP was formulated through extensive consultations between headquarters and the regions held over the last five months. It was noted that the process was still not complete, especially with regard to budgets.

**Discussion points**

- There was discussion about how the MTSP differed from the previous plans of WHO. It was explained that previous strategies of WHO were generally reflected in the GPW.
- Many expressed concern about the implications of the MTSP on country budgets and workplans. Work at country offices would have to fit within the overall framework of the MTSP and correspond to OWERs. Regional budgets would be shown at the Ower level (about 100 in total) instead of the 36 AoWs.
- The current draft of the MTSP does not have any budget figures. These have not yet been finalized but estimates would be included in the documents pertaining to the Regional Committee sessions.

**Recommendations**

1. Since the CCPDM did not have complete details and sufficient time to study the MTSP it was recommended that Member countries should examine the draft MTSP document for discussion at the 59th session of the Regional Committee for South-East Asia to be held in Dhaka in August 2006.

2. WHO should provide full details in time to facilitate Member countries’ preparations before the forthcoming session of Regional Committee.

8. **Proposed Programme Budget 2008-2009** *(Agenda item 2.4)*

Dr R.M. Brooks, Coordinator, Programme Planning and Coordination, WHO/SEARO, made a presentation on the subject.

While the MTSP outlines the budget framework and OWER, the Region and countries should reflect their specific priorities through appropriate budgets at the Strategic Objective and OWER levels.

The past budgets, workplans and actual expenditures were presented to the basis used for determining the Programme Budget 2008-2009 allocations for the Region.
The past expenditure figures showed that the Region provided a large proportion of funds to the areas of: Communicable Diseases; Immunization and Emergencies. Areas of Environment and Health; Noncommunicable Diseases and Health Systems received far lower allocations. Moreover, the expenditures recorded for these areas were also below budgeted amounts.

While the regions received voluntary contributions (VCs) beyond their budgeted amounts, these contributions were almost exclusively used for Communicable Diseases, Immunization and Emergency programme areas. Other programme areas received a low proportion of the budgeted amounts.

The preliminary estimates for the 2008-2009 biennium shows an increase in the overall budget of at least 10%, but most of this increase would be covered by voluntary contributions.

Under the new budget, the programme areas of Noncommunicable Diseases, Health Systems Development and Family and Child Health would receive substantial increases. However, increased funding for these programme areas would depend on increased mobilization of funds.

Discussion points

- With increasing reliance on voluntary contributions, the Organization had recognized that there were often mismatches between programme budgets and what was actually provided by donors to fund programmes.
- Integrating the Regular Budget and voluntary contributions complicated budgeting and implementation. There were no assurances that VC funds will be mobilized to complete the planned work.
- Donors tended to prefer certain programmes, such as Communicable Diseases Control, Polio Eradication and Emergencies, etc. WHO therefore needed to promote the funding of other programme areas that were also important to Member countries.
- Since the SEA Region had no donor country as its member, significant resources had been mobilized at the country level. Therefore, it was important that the Regional Office provided assistance to Member countries in mobilizing resources, both through WHO channels as well as through multilateral and bi-lateral support.

Recommendations

(1) WHO should urge donors to provide unspecified funds as far as possible. Where a donor is not willing to provide unspecified funds, WHO should urge that donor to contribute to under-funded areas in the workplans.
(2) The CCPDM urged the WHO Secretariat to put up a draft resolution before the Regional Committee highlighting the issue of funding of the integrated plan and specific actions to be taken in this regard.

(3) Since the CCPDM did not have complete details nor sufficient time to study the Regional Programme Budget document it was recommended that Member countries should examine the draft Regional Programme Budget document for discussion at the 59th session of the Regional Committee to be held in Dhaka in August 2006.

9. Regional implications of the Decisions and Resolutions of the Fifty-Ninth World Health Assembly and the 117th and 118th Sessions of the Executive Board (Agenda item 3)

Dr Lin Aung, Programme Development Officer, WHO/SEARO, provided a brief explanation of the arrangements made for group work. Three groups were formed comprising members of the CCPDM and the Secretariat, and concerned staff from the Regional Office. These groups were requested to review and identify the most relevant resolutions which had implications for the Region and to rank them in order of priority for further discussion at the 59th session of the Regional Committee.

Discussion points

- Group discussions to select appropriate resolutions needed to be done in a manner that would ensure a fair mix of resolutions with and without very significant implications for the Region.

- It was felt that all resolutions passed by the World Health Assembly and the Executive Board were important. Their relative importance may however vary in terms of their implications for a particular region.

- While selecting the resolutions for detailed examination at the 59th session of the Regional Committee, the groups had to keep in mind whether any of these resolutions had been discussed at the recent sessions of the Regional Committee.

- The CCPDM members appreciated the novel approach adopted by WHO to have extensive group discussions for a better understanding of the regional implications of the relevant resolutions.

Recommendations

(1) A precise note on the regional implications and action points for all resolutions should be provided as an information document at the 59th session of the Regional Committee (agenda item 13.1) to be held in August 2006.
(2) The following resolutions, which were identified after detailed deliberations, should be elaborated with regard to their implications for the Region and presented to the 59th session of the Regional Committee:

— WHA59.1 Eradication of poliomyelitis
— WHA59.2 Application of International Health Regulations (IHR-2005)
— WHA59.3 Nutrition and HIV/AIDS
— WHA59.17 Outcome of the first session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control (FCTC)
— WHA59.19 Prevention and control of sexually transmitted infections: draft global strategy
— WHA59.22 Emergency preparedness and response
— WHA59.23 Rapid scaling up of health workforce production
— WHA59.24 Public health, innovation, essential health research and intellectual property rights: towards a global strategy and plan of action
— WHA59.26 International trade and health
— EB118 R1 Thalassaemia and other haemo-globinopathies
— EB118 R4 Strengthening health information systems

10. Reports by Country Representatives on their attendance at the meetings of the Coordinating Bodies of WHO’s Global Programmes (Agenda item 4)

10.1 UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases: Joint Coordinating Board (JCB) (Agenda item 4.1)

The 43rd meeting of CCPDM preceded the meeting of the Joint Coordinating Board (JCB) of UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR) which was scheduled to be held from 19-21 June 2006 in Geneva. Therefore, the report by the country representatives on the proceedings and outcomes of the JCB meeting could not be presented.
Instead, Dr Chusak Prasittisuk, Regional Adviser, Vector Borne Diseases Control, WHO/SEARO, made a brief presentation on the scope of the programme. It was followed by another presentation by Dr Jan H.F. Remme from WHO/HQ. He explained the critical role played by health research in meeting the disease control priorities in developing countries. In order to meet the challenges of health problems of neglected populations, new knowledge and tools should be used extensively. Development assistance for health would be more effective if a larger share of it was devoted to research and development. The analytical framework involved in priority-setting for health research was also explained.

**Discussion points**

- The update provided on the activities and achievements of TDR was noted by the Committee. The report by country representatives on their attendance at the JCB meeting could not be presented since the JCB meeting was scheduled to be held after the CCPDM meeting.
- The activities of TDR, as well as the support provided by the Programme in the area of communicable diseases like kala-azar and research capacity strengthening through small research grants, were appreciated.
- The CCPDM members noted the proactive role played by TDR in drug development and clinical trials, and urged TDR to take measures for effecting early technology transfer to countries of the Region.

**Recommendation**

The update on the activities and achievements of TDR should be presented to the 59th session of the Regional Committee along with the report of the JCB meeting scheduled to take place from 19-21 June 2006.

**10.2 WHO Special Programme for Research, Development and Research Training in Human Reproduction: Policy and Coordination Committee (PCC) (Agenda item 4.2)**

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.

As the 43rd meeting of the CCPDM preceded the PCC meeting which was scheduled to be held from 29-30 June 2006 in Geneva, the report by country representatives on the proceedings and outcomes could not be presented.
Instead, Dr Dini Latief, Director, Family and Child Health, WHO/SEARO, made a brief presentation on the evolution of the Human Reproduction Programme since its inception in 1972 and its current scope and objectives.

Discussion points

- An update on the history of the Human Reproduction Programme and the status of its activities was noted by the Committee. The report by country representatives on their attendance at the PCC meeting could not be provided since the PCC meeting was scheduled to be held after the CCPDM meeting.
- The details of grants made by HRP such as long-term institutional development (LID); grants, and research training grants (RTG) to individual staff from centres in developing countries were noted.
- It was noted that in 2004-2005, HRP supported various research projects and research provided grants for capacity strengthening in five countries of the Region viz., India, Indonesia, Myanmar, Sri Lanka and Thailand.

Recommendation

As the HRP-related activities are not widely known in all countries, it was recommended that Member countries of the Region should disseminate this information to reputed institutions and experts working on human reproduction in their countries so that they may apply for funding.

11. Technical discussions on promoting patient safety at health care institutions (Agenda item 5)

The Technical Discussions on Promoting Patient Safety at Health Care Institutions were held on 16 June 2006. H.E. Professor Mya Oo (Myanmar) was elected Chairperson and Dr Bishnu Prasad Pandit (Nepal) was elected Rapporteur. The draft report and recommendations and/or draft text of the resolution arising out of the Technical Discussions will be submitted to the forthcoming session of the Regional Committee to be held in August 2006.

12. Adoption of report

The CCPDM reviewed the draft report of its forty-third meeting agenda by agenda, 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

The Regional Director, Dr Samlee Plianbangchang, in his concluding remarks, thanked all the CCPDM members for their deliberations. He expressed his particular appreciation to the Chairperson, H.E. Dr Abdul Azeez Yoosuf and Co-Chairperson Dr Tipvadee Bumpenboon, for the effective manner in which they chaired the meeting. Dr Samlee also thanked Mr Bhanu Pratap Sharma and other members of the drafting group for their excellent report. He appreciated the practical recommendations made by the Committee and assured the members that the Regional Office would take urgent action to implement all the recommendations made by the Committee.

Prof. Dr Mya Oo, Deputy Minister of Health, Myanmar, congratulated the members for the excellent and efficient manner in which the meeting had been conducted. He expressed his appreciation to the Rapporteur and members of the Drafting Group for preparing a concise report reflecting the discussions and recommendations. He congratulated members of the WHO Secretariat for their support, and for the excellent arrangements made for the meeting. He thanked the Government of India for providing the opportunity to visit the All India Institute of Medical Sciences and for the excellent arrangements made for their “field visit” to the Institute during the Eleventh Meeting of Health Secretaries of Member countries of the SEA Region.

The Chairperson H.E. Dr Abdul Azeez Yoosuf, in his closing remarks expressed the need for extensive actions to be taken both at country as well as the Regional Office level before the upcoming session of the Regional Committee in August 2006. He then declared the Forty-third meeting of the Consultative Committee for Programme Development and Management closed.
Annexure 1

Agenda

1. Opening session
2. Programme budget
   2.1 Programme budget performance assessment: 2004-2005
   2.2 Implementation of Workplans for Programme Budget 2006-2007, including:
      2.2.1 Multi-country Activities (MCAs)
      2.2.2 Implications of the New Financial Rules
   2.3 Medium-term strategic plan (MTSP) 2008-2013
   2.4 Proposed Programme Budget 2008-2009
3. Regional implications of the decisions and resolutions of the Fifty-ninth World Health Assembly and the 117th and 118th sessions of the Executive Board
4. Reports by country representatives on their attendance at the meetings of the coordinating bodies of WHO's global programmes, i.e.
   4.1 UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases: Joint Coordinating Board (JCB).
   4.2 WHO Special Programme for Research, Development and Research Training in Human Reproduction: Policy and Coordination Committee (PCC).
5. Technical Discussion on "Promoting Patient Safety at Health Care Institutions"
6. Concluding session
Annexure 2
List of Participants

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Mr Rajesh Bhushan
Director
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Mr Thinlay Dorji
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Ministry of Health

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Dr Salim J. Habayeb
WHO Representative to India

Dr Georg Petersen
WHO Representative to Indonesia

Dr Jorge M. Luna
WHO Representative to Maldives

Dr Adik Wibowo
WHO Representative to Myanmar

Dr Kan Tun
WHO Representative to Nepal

Dr Agostino Borra
WHO Representative to Sri Lanka

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Member from WHO/HQ

Dr Jan H.F Remme
Coordinator, Science Technology and Knowledge Management
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Annex 10

Consideration of the recommendations arising out of the technical discussions on “Promoting Patient Safety at Health Care Institutions”*

1. The Technical Discussions on Promoting Patient Safety at Health Care Institutions were held on 16 June 2006, in New Delhi, India in conjunction with the 43rd Meeting of the Consultative Committee for Programme Development and Management (CCPDM). H.E Prof. Mya Oo, Deputy Minister for Health, Ministry of Health, Myanmar, and Dr Bishnu Prasad Pandit, Chief Specialist, Ministry of Health and Population, Nepal, were elected Chairman and Rapporteur respectively. Special invitees, representing the local civil society, participated in the discussions in addition to the CCPDM participants.

2. Sir Liam Donaldson, Chair of the World Alliance for Patient Safety, had sent a video-presentation containing his remarks which was shown to the participants.

3. The detailed report of the Technical Discussions on Promoting Patient Safety at Health Care Institutions is provided in the document SEA/RC59/Inf.4.

4. In addition to the recommendation that the regional initiative be broadened from ‘Promoting Patient Safety at Health Care Institutions’ to ‘Promoting Patient Safety in Health Care’, the Group made the following recommendations:

Recommendations for Member countries

5. It is recommended that Member countries should:

   (1) Assess the scope and nature of adverse events occurring at health care institutions, as well as of the contributing factors;

* Originally issued as document SEA/RC59/11 (Rev.1) dated 20 July 2006
(2) Establish or improve, with the involvement of all stakeholders, systems for the detection and reporting of adverse events occurring at health care institutions with the primary focus to improve systems rather than attribute blame, and national mechanisms to capture, share, respond and learn from this information at all levels of the health system;

(3) Promote interventions that have been shown to improve patient safety;

(4) Support and enable health care institutions, both public and private, from the primary health care level through the referral level, to implement changes in systems and practices conducive to patient safety;

(5) Create, at all levels of the health care system, through awareness-raising and enabling policies and legislation, an open environment receptive to the operational changes needed to deliver safer care in health care institutions;

(6) Engage patients, consumer associations, health care workers, and professional associations, hospital associations, health care accreditation bodies and policy-makers, in building safer health care systems, and creating a culture of safety within health care institutions;

(7) Establish systems that respect the rights of both patients and providers, and

(8) Allocate adequate resources to implement the above activities.

Recommendations for WHO

6. It is recommended that WHO should:

   (1) Coordinate, through an inclusive consultative process, the development of a strategic framework and package of interventions for strengthening patient safety at health care institutions, which builds on successful interventions and actions, both in the Region and worldwide;

(2) Provide strong technical leadership and support to Member States in designing and implementing patient safety interventions and monitoring systems at health care institutions;

(3) Ensure capacity building in different aspects of patient safety through training activities at the regional, sub-regional and country levels;

(4) Facilitate collaboration and exchange of information and best practices between Member States and the World Alliance on Patient Safety;
(5) Coordinate and facilitate research on patient safety in the Region, including baseline surveys on adverse events, and operational research to assess the cost-effectiveness of interventions;

(6) Contribute to the development of a patient-safety taxonomy, systems for reporting and learning from adverse events, and best practices to improve patient safety, and

(7) Monitor and report on the progress made in the Region.

7. The Technical Discussions Group proposed that the 59th session of the Regional Committee may consider to adopt the resolution on this topic based on the above-mentioned recommendations.