REGIONAL COMMITTEE

Agenda item 18

Fifty-sixth Session
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DRAFT REPORT OF THE FIFTY-SIXTH SESSION OF THE WHO REGIONAL COMMITTEE FOR SOUTH-EAST ASIA

CONTENTS

Part I

INTRODUCTION

THE FIFTY-SIXTH session of the WHO Regional Committee for South-East Asia was held from 10 to 12 September 2003. It was attended by representatives of all the eleven Member Countries of the Region, UN and other agencies, nongovernmental organizations having official relations with WHO, as well as observers.

The session was opened by Dr Achmad Sujudi, Minister of Health, Indonesia, and Chairman of the fifty-fifth session.

The Committee elected Ms Sushma Swaraj, Minister of Health and Family Welfare and Parliamentary Affairs, India, as Chairperson and Professor Mya Oo, Deputy Minister of Health, Myanmar, as Vice-Chairman of the session.

The Committee reviewed the report of the Regional Director for the period 1 July 2002 to 30 June 2003 and considered the recommendations arising out of the Technical Discussions on Social Health Insurance, held during the 40th meeting of the Consultative Committee for Programme Development and Management.

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

The Committee nominated Dr Samlee Plianbangchang as Regional Director of the South-East Asia Region of WHO for a five-year term from 1 March 2004. The Committee also adopted a resolution declaring Dr Uton Muchtar Rafei as Regional Director Emeritus.

The Committee reconfirmed its decision to hold its fifty-seventh session in Maldives in September 2004.

A drafting group on resolutions comprising representatives from Bangladesh, Bhutan, India, Indonesia, Myanmar and Timor-Leste was constituted with Prof Dr Azrul Azwar (Indonesia) as Convener. During the session, the Committee adopted nine resolutions.

Part II

OPENING OF THE SESSION

THE FIFTY-SIXTH session of the Regional Committee for South-East Asia was opened by Dr Achmad Sujudi, Minister of Health, Indonesia, and Chairman of the fifty-fifth session.

Dr Achmad welcomed the Health Ministers and the representatives of all SEAR Member Countries and said that the countries of the Region were collaborating with WHO to improve the health of their people, citing the example of effective containment of SARS. He added that countries had stood up to face the challenges posed by poverty, illiteracy, unchecked population growth and severe financial constraints. While mobilization of additional resources was required, equally important was the effective and efficient use of available resources.

Address by the Regional Director, WHO

DR UTON MUCHTAR RAFEI, Regional Director, WHO South-East Asia Region, said that over the years countries of the Region had made impressive gains in health development. There had been notable progress in reducing the burden of both communicable and noncommunicable diseases. The Region had made steady progress towards leprosy elimination and in expanding DOTS coverage for the control of tuberculosis. While old scourges such as kala-azar and malaria were widespread, vaccine-preventable diseases like diphtheria, pertussis, measles, poliomyelitis and hepatitis B had been dramatically reduced.

WHO was working closely with Member Countries to address the problem of HIV/AIDS, which was assuming grave proportions, with more than 6 million people affected.

Countries had strengthened community action for health, in collaboration with national, regional and international organizations. As a result, they had accelerated targeted programmes such as “making pregnancy safer” and “integrated management of childhood illnesses” in order to reach the hitherto unreached.

Dr Uton said that an effective disease surveillance system was vital for early detection and control of any new disease or any threatening disease outbreak. He commended the collaborative strength of Member Countries which had enabled them to swiftly contain the recent global epidemic of SARS.

Health for all, using the primary health care approach, continued to be the major policy thrust of Member Countries in improving equity, quality and effectiveness of their health systems. While recognizing the need to generate more resources for health, it was necessary to protect the financial and health risks of the poor and vulnerable. The rapid liberalization of international trade had affected health systems development. While a large proportion of the population did not have access to quality essential medicines and vaccines, there was an increasing trend of irrational and indiscriminate prescribing practices, often leading to multi-drug resistance and adverse reactions.

The increasing trend of tobacco and alcohol use was having a serious impact on overall morbidity and mortality. Mental disorders and substance abuse, diabetes and cardiovascular

diseases continued to be major problems accounting for nearly one-fourth of the burden from noncommunicable diseases.

Countries of the Region had a long and rich tradition of technical cooperation, as reflected in the initiatives such as highest-level policy meetings of Health Ministers and Health Secretaries as well as the high-level task forces and meetings of experts organized to deal with specific technical issues(for full text, see Annex 4).

Address by the Minister of Health and Family Welfare and Parliamentary Affairs, Government of India

H.E. MS SUSHMA SWARAJ welcomed the representatives of the Member Countries and said that the SEA Region, inhabited by 1.5 billion people and carrying 40 per cent of the global disease burden, was one of the most important regions of WHO. While known diseases such as TB, malaria and HIV/AIDS were being dealt with, new challenges such as SARS had emerged. SARS was not an ordinary disease but one which adversely affected the economy, trade and tourism in the countries. She acknowledged the guidance and support given by WHO in effectively and efficiently containing SARS, and called for continuous vigilance and increased surveillance.

Underlining the importance of the Framework Convention on Tobacco Control as an important milestone, she said that India would soon be signing the Convention.

Highlighting the importance of traditional systems of medicine in the Region, Ms Swaraj said that it was not just an alternative system of medicine but a scientifically documented and validated system being practised for thousands of years. She urged WHO to make SEARO the headquarters for traditional systems of medicine.

She said women's health, which had been a major area of concern, should be taken up as a theme for action by WHO. Considering the high rates of infant mortality and maternal mortality in the Region, which had a direct bearing on women's health, she suggested the constitution of a global alliance focusing on reducing IMR and MMR.

Ms Swaraj commended Dr Uton Muchtar Rafei for his leadership, particularly during the SARS epidemic, and expressed appreciation for the role played by him in health development during his tenure as Regional Director.

Part III

BUSINESS SESSION

1. Sub-committee on Credentials *(Agenda item 2, document SEA/RC56/18))*

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

2. Election of Chairman and Vice-Chairman *(Agenda item 3)*

MS SUSHMA SWARAJ (India) was elected Chairperson. Ms Swaraj thanked the representatives for electing her Chairperson, which she considered an honour for herself and her country. She was confident that with the cooperation and support of all concerned, the Committee would successfully cover the agenda in the next three days.

Professor Mya Oo (Myanmar) was elected Vice-Chairman.

3. Adoption of Agenda and Supplementary Agenda, If Any *(Agenda item 4, document SEA/RC56/1 Rev. 1)*

THE COMMITTEE adopted the Agenda as contained in document SEA/RC56/1 (Annex 1).

4. Drafting Group on Resolutions

THE COMMITTEE constituted a drafting group on resolutions comprising representatives from Bangladesh, Bhutan, India, Indonesia, Myanmar and Timor-Leste.

5. List of Participants

THE LIST of participants is at Annex 2.

6. List of Official Documents

THE LIST of Official Documents is at Annex 3.

7. Statements by Representatives of UN Agencies

DR EMELIA TIMPO (Team Leader, UNAIDS South Asia Intercountry Team), referred to the UNGASS declaration of commitment on HIV/AIDS which had been endorsed by most governments. She called for the intensification of regional and sub-regional cooperation and coordination in support of expanded country-level efforts for HIV/AIDS control. In its development work, the United Nations had adopted an approach based on human dignity and the right to development. It had also shown commitment towards the empowerment of HIV/AIDS patients, taken gender issues into consideration, developed and strengthened networks and partnerships and used innovative technologies for enhanced response and coverage.

The key areas of interventions by UNAIDS in South Asia included leadership and advocacy, capacity building for a sustained multisectoral response, involvement of civil society in support of networks of people living with HIV/AIDS and resource mobilization. The other areas of collaboration concerned support to governments at national, state and provincial levels in their surveillance and estimation processes. Community-based care, use of anti-retrovirals in all the countries of the Region, and development of a national database of secondary data on HIV/AIDS in five countries were also supported. UNAIDS supported the efforts of WHO in developing a regional strategy for TB and HIV/AIDS.

8. The Work of WHO in the South-East Asia Region: Report of the Regional Director – 1 July 2002 – 30 June 2003

(Agenda item 5, documents SEA/RC56/2 and Inf.1 and Inf.2)

THE REGIONAL DIRECTOR, introducing his report for the period 1 July 2002 to 30 June 2003, said that the past year had seen fruitful collaboration with Member Countries. Despite the far-reaching political and socioeconomic changes, the South-East Asia Region was able to effectively tackle many disease outbreaks, including the prevention and control of severe acute respiratory syndrome (SARS). It highlighted the solidarity and collaboration that WHO maintained with its Member Countries in strengthening comprehensive disease surveillance, networking and information sharing.

The Region had an estimated 6 million HIV-infected people and over 300 000 reported AIDS cases. The rapid spread of AIDS to the general population was a major cause for concern. Tuberculosis continued to cause concern, with nearly 3 million new cases and 750 000 deaths annually. Countries were strengthening their national TB control programmes through rapid expansion of the DOTS strategy. The emergence of multidrug-resistant strains of tuberculosis and the rising trend of TB amongst HIV-infected cases in some countries posed an additional threat.

The re-emergence of malaria as a major killer highlighted the need for more concerted efforts. Currently there were around 3 million reported cases. Control efforts focused on integrated vector management, including use of insecticide-treated bednets and improved case finding.

Progress continued in leprosy control with eight Member Countries having achieved the leprosy elimination target. The remaining three endemic countries were expected to achieve the elimination target by 2005. In all countries, leprosy elimination activities were being integrated within basic health services.

Following a spurt in polio cases in 2002 and 2003 in some states in India, the

government had renewed its focus on providing high quality immunization and on effective sentinel surveillance. Countries were now using the polio immunization infrastructure to strengthen services for other vaccine-preventable diseases. Fresh initiatives for EPI launched across the Region in 2003 included the phased introduction of hepatitis B vaccine and auto-disable syringes.

Eight of the eleven countries in the Region were endemic to dengue/dengue haemorrhagic fever. However, the number of reported cases and case-fatality rates were now declining. The revised regional strategy for prevention and control of dengue/DHF focused on social mobilization and communication for behavioural change.

Dr Uton said that WHO's sustained efforts over the past four years had resulted in the adoption by the Fifty-sixth World Health Assembly of the WHO Framework Convention on Tobacco Control (FCTC). This was another example of building trust and forging solidarity.

Three countries had developed national policies on injury prevention with WHO support. Training courses on injury surveillance and road safety were organized and advocacy material on violence and health disseminated in the Region.

In regard to prevention of blindness, the focus of WHO support was on management of corneal ulcers and on capacity building. Guidelines were being developed for formulating national programmes for prevention of deafness. A regional profile on care of the elderly was being finalized with a view to strengthening information on the ageing population in the Region. Measures were also undertaken for strengthening community-based rehabilitation.

A number of activities had been initiated to promote mental health. These included the development of a community-based programme on identification, management and stigma removal in epilepsy and psychosis; promotion of mental health among adolescents, a study on suicide prevention, and assisting countries in developing/updating modern mental health policies and services.

WHO was advocating the Integrated Management of Childhood Illnesses (IMCI) strategy to reduce high child mortality. The strategy was currently being implemented in seven countries of the Region. In the field of adolescent health, progress was achieved in advocacy and policy and strategy development.

WHO supported Member Countries in strengthening the processes and mechanisms for monitoring and evaluation of quality, access to and utilization of maternal and neonatal health services. Member Countries had strengthened their programmes relating to maternal and neonatal health, focusing on emergency obstetric care. Promotion of evidence-based practices had been strengthened through the introduction of the WHO Reproductive Health Library CD-ROM.

Although progress had been achieved in regard to women's health and gender mainstreaming, the implications of gender difference on public health were not yet well understood. While attention was given to reproductive aspects, the social, economic and cultural factors that affected women's health continued to be neglected. There was therefore an urgent need to broaden the global agenda for women's health.

Recognizing the need for sustainable development and healthy environments, WHO assisted Member Countries in developing national strategies on health and poverty reduction. The report of the Commission on Macroeconomics and Health (CMH) had motivated Member Countries to carry forward its recommendations within national health reforms.

Malnutrition continued to be a major health problem with high levels of moderate-to-severe stunting. Iron deficiency affected more than 60 per cent of women of child-bearing age and millions of young children. There was an urgent need to develop nutrition programmes that addressed not only undernutrition, but also diet-related diseases such as diabetes and obesity.

WHO assisted Member Countries in identifying and assessing health hazards in various sectors. Draft surveillance guidelines and a comprehensive regional strategic plan for occupational health, including risk management, infrastructure support and capacity building were developed.

Seven countries of the Region had completed assessments of water supply and sanitation coverage. The reports indicated that most countries would require increased levels of investment in order to meet the Millennium Development Goals.

Following the resolution adopted by the Regional Committee in 2002 endorsing WHO's medicines strategy, efforts were being made to identify areas needing improvement. Implmentation of innovative approaches was being supported while mechanisms for bulk purchase were being further explored with relevant partners and Member Countries.

In the area of blood safety, emphasis was laid on quality assurance in clinical and public health laboratory services. Technical material and guidelines were provided to address the problem of bacterial resistance to commonly-used antibiotics which had emerged as a major problem.

National capacity on management of health information systems was strengthened with the focus on quality improvement in statistics, knowledge of methods and issues related to health and systems performance assessment.

In the area of health research, WHO assisted countries in the development of national guidelines on ethics in research and in strengthening institutional ethics review boards.

Development of human resources for health continued to be an important concern in Member Countries. WHO provided support in strengthening public health-related training institutions and establishment of regional networks. Guidelines were developed for countries to effectively manage their nursing and midwifery workforce.

The Regional Office continued to play an active role in the mobilization of resources for health. By the end of 2002, extrabudgetary funds totalling US$ 95 million had been mobilized for implementing WHO collaborative programmes. WHO continued to sustain and strengthen its partnership with other UN agencies, and intergovernmental and nongovernmental organizations.

The surrender of funds to the miscellaneous income decreased from US$ 3.4 million in 1998-1999 to US$ 1.5 million in 2000-2001. Eight countries and the RO/ICP programmes had achieved 85 per cent implementation in respect of the first year of the 2002-2003 biennium.

The Committee reviewed and discussed the report of the Regional Director. The following points emerged:

The Committee commended the crucial role played by WHO in combating the SARS epidemic, particularly in terms of providing information support to the countries of the Region.

The Committee appreciated the technical support provided by WHO to the countries in finalizing their proposals for submission to the Global Fund for AIDS, Tuberculosis and Malaria (GFATM.) It felt that there was a need to intensify efforts to mobilize more extrabudgetary resources.

Childhood diseases like acute respiratory infection continued to cause high morbidity in the countries of the Region. Appreciating WHO's efforts and support through the Integrated Management of Childhood Illness (IMCI) programme, the Committee stressed the need for innovative mechanisms to address the issue. The Committee called for WHO support in the area of essential drugs and medicines as some countries were in the process of enacting legislation to establish such a mechanism.

In the area of malnutrition, the Committee noted that countries still faced the problem of anaemia, particularly among children, and hoped that concerted efforts by and support from WHO would help in controlling this problem. The Committee also stressed the need for further collaboration and assistance from WHO to strengthen programmes for prevention and control of diseases like iodine deficiency disorders.

Noting that dengue was still widely prevalent in some countries and that a dengue vaccine would not be available in the near future, the Committee called upon WHO to focus control efforts on anti-larval measures. It also urged WHO to periodically report on the progress made in the development of the dengue vaccine.

The Committee stressed the need to identify and strengthen more institutions in the Member Countries for being designated as WHO collaborating centres. Noting the lack of training institutions in public health, the Committee urged WHO to strengthen this aspect.

The Committee highlighted the importance of cross-border collaboration since most communicable diseases like SARS, dengue, malaria, Japanese encephalitis etc. were largely due to population movement in the border areas. The Committee stressed the need to establish a health intelligence system across the Region to facilitate an early warning mechanism.

The Committee noted that Member Countries were in the process of signing the Framework Convention on Tobacco Control (FCTC) and were putting necessary regulations in place. The Committee, however, noted with concern that because of socioeconomic aspects the process of tobacco control in some countries might take longer. It emphasized the importance of ratifying the Convention, taking into consideration cultural as well as economic impacts.

The Committee expressed satisfaction at the mobilization of extrabudgetary resources. It was also noted that some of these resources were used to combat SARS. It, however, stressed the need to improve the implementation of extrabudgetary funds. The Committee noted that 70 per cent of the extrabudgetary funds was still uncommitted which could hamper the Region's claim for more funds. The Committee suggested that the Regional Director's report should include an analysis of how the funds were expended. The Committee also stressed the need for a mechanism to monitor whether decisions and recommendations arrived at important meetings had been implemented.

Countries of the Region were in the process of attaining self-sufficiency in the manufacture of cost-effective drugs for major life-threatening diseases like AIDS. The Committee noted that even though the countries were governed by patent laws, the TRIPS agreement restricted the export of these drugs to neighbouring countries. The Committee urged WHO to extend its support in making these drugs available at cheaper rates to countries which needed them most.

The Committee noted that results of injuries and violence constituted a major disease burden for the countries of the Region. WHO could play a pivotal role in injury prevention. The Committee urged the establishment of a regional forum for intensifying efforts in this regard and for greater budgetary allocation for this area. Countries were also requested to implement the recommendations contained in the World Report on Violence and Health 2002.

The Committee was informed that the number of WHO collaborating centres in the countries depended on the readiness and capabilities as well as the number of institutions of national excellence in the countries. The Committee noted WHO's policy of designating collaborating centres initially for a period of four years, and WHO's efforts in the networking of collaborating centres, such as nutrition-research-cum action centres, involving several countries in the Region.

The Committee noted WHO's efforts in networking of public health institutions capable of imparting training for upgrading the skills of both clinicians and public health professionals through the mechanism of intra-country and regional fellowships.

The Committee was informed that since the resources from the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) was based on the quality of proposals submitted, WHO representatives in countries joined a meeting in Beijing to familarize themselves with the preparation of proposals. The countries, however, needed to have concrete plans and infrastructure for absorbing the huge amounts to be received from the Fund. The Committee appreciated WHO's technical assistance to Bhutan and Maldives in preparing proposals for submission to the Global Fund for the third round.

In the area of care of the elderly, the Committee was informed that several ESCAP countries preferred the more cost-effective home-based treatment and care to hospital-based treatment. Referring to globalization and privatization, the Committee emphasized the need to focus on research in health care financing and health systems rather than on disease-oriented research, realizing that investment in the health of the poor would result in increased economic gain.

The Committee noted that eight countries of the Region had achieved leprosy elimination targets and efforts were ongoing towards elimination at the sub-national level in respect of countries that had achieved elimination at the national level. It noted WHO's offer of assistance to countries in assessing the prevalence and elimination of leprosy.

The Committee noted the concerns expressed regarding mobilization and utilization of EB funds. Out of US$95 million, US$81 million had been utilized for technical support, mostly for polio eradication, followed by tuberculosis, emergency and humanitarian assistance, HIV/AIDS and malaria. The Committee called for equitable distribution of EB resources based on population and disease burden.

Noting that Member Countries had strengthened traditional systems of medicine as part of their national health development, the Committee called upon them to promote efforts to ensure the safety, efficacy and quality of traditional medicines, including herbal medicines, in the light of WHO's strategy. The Committee further urged WHO to assist Member Countries in developing/ strengthening national policies, strategies and plans of action in this regard. A resolution on Traditional Systems of Medicine was adopted (SEA/RC56/R6).

The Committee was informed that arsenic control would receive adequate support through the ICP II mechanism.

The Committee noted that a regional strategic plan for integrated disease surveillance had been developed, based on which countries were in the process of developing multi-disease surveillance and response for preventing and responding to epidemic-prone diseases.

The Committee was informed that a regional strategy on injury prevention had been developed and appreciated WHO's assistance to Member Countries in the formulation of national strategies. The theme for World Health Day 2004 was Road Safety.

The Committee noted that some countries had the capacity to manufacture drugs and wished to provide them to other countries in the Region, and requested WHO assistance in this regard.

The Committee, after discussing the report of the Regional Director on the Work of WHO, **noted** with satisfaction the progress made during the period under review in the implementation of WHO's collaborative programmes and activities in the Region, and congratulated the Regional Director and his staff for bringing out a clear and comprehensive report.

9. Address by the Chairman, SEA/ACHR

PROF N.K. GANGULY, Chairman (South-East Asia Regional Advisory Committee for Health Research), presented the gist of discussions, conclusions and recommendations of the 28th session of SEA-ACHR, held in Maldives in August 2003, which was attended by research managers and scientists from both the SEA and Eastern Mediterranean Regions of WHO. While discussing the updates of research work at regional, country and WHO/HQ levels, ACHR recommended wider use of the regional health research management modules and implementation of capacity strengthening in health research through funding small-grant research activities, particularly to institutions and individuals from countries with limited capacity for health research. The ACHR noted the draft Regional Vaccine Policy and recommended wide advocacy and dissemination and in-depth country case studies on specific key issues for its implementation. Member Countries were urged to develop their own national immunization policies and establish technical advisory groups, along with national regulatory authorities.

The ACHR recommended that WHO should provide and facilitate technical and financial support to Member Countries to strengthen their epidemiological surveillance and health research capability, both in the basic and operational aspects, for effective control of TB with a view to reducing the disease burden. On thalassaemia, ACHR recommended the establishment of a regional technical expert group, consisting of various disciplines, to update and disseminate information on the development of knowledge and technology related to its prevention and control.

The ACHR underlined the need to follow up its previous recommendations and emphasized WHO's role in providing a strategic framework to promote and improve utilization of research findings. In order to obtain political support, it was suggested that the recommendations of ACHR be brought to the attention of health ministers.

10. Statements by Nongovernmental Organizations

PROFESSOR D.H. DASTOOR (World Confederation for Physiotherapy – WCP) said that physiotherapy helped to reduce morbidity and mortality in noncommunicable diseases like chronic pulmonary diseases, diabetes mellitus, cardiovascular diseases etc. which were

assuming serious proportions in the Region. Occupational/lifestyle-related hazards causing musculoskeletal dysfunctions and pain, especially involving the neck, back and the knees, were also on the increase. Industrial medicine and musculoskeletal specialization among physiotherapists needed to be promoted to prevent and tackle these growing problems. Early intervention was necessary during mass accidents and earthquakes, which were also a cause of injuries to the musculoskeletal system. The Indian Association of Physiotherapists collaborated extensively with Oxfam India during the earthquakes in Latur and Kutch.

DR NINA PURI (International Planned Parenthood Federation - IPPF) said that IPPF had pioneered a movement in the area of sexual and reproductive health for over five decades. It had now redefined its mission with the focus on five challenging areas of worldwide concern, viz. sexual and reproductive health; unsafe abortion; HIV/AIDS; adolescents and youth, and advocacy in these areas. Within IPPF, South Asia was one of the most deprived and complex regions and IPPF was committed to pursue these issues in close partnership with WHO. She commended WHO for focusing attention on reducing maternal mortality, fighting HIV/AIDS and documenting the impact of unsafe abortion.

DR CHANDRAKANT S. PANDAV (Regional Coordinator, South-East Asia Region, International Council for Control of Iodine Deficiency Disorders [ICCIDD]) said that ICCIDD was a non-profit nongovernmental organization dedicated to sustainable elimination of IDD throughout the world. It had the mandate to collaborate with stakeholders and pledged its technical expertise to assist Member Countries in tracking progress towards sustainable elimination of iodine deficiency disorders. There had been significant achievements in the SEA Region in sustaining the elimination of iodine deficiency disorders and the situation with regard to availability of adequately iodized salt to the population had been encouraging. He said that it was essential to ensure the provision of daily iodine requirements to every mother and child. ICCIDD looked forward to close collaboration with the Member Countries along with partner agencies towards sustainable elimination of iodine deficiency disorders.

DR A.G. HARIKIRAN (Commonwealth Association for Mental Handicap and Development Disabilities – CAMHADD) said that the key elements of the global strategy that targeted important lifestyle-related risk factors were surveillance, preventive activities and strengthening of health care with support to health sector management. A centre for preventive cardiology focusing on the prevention of hypertension and diabetes had been established in Bangalore. He referred to a proposed global consultative workshop in November 2003 on population-based cost-effective strategies to prevent hypertension and diabetes with WHO technical support. He hoped that this activity would mark the beginning of a new initiative for promoting prevention of hypertension and diabetes at a global level in general, and at the national level in India, in particular.

DR SUCHITRA PRASANSUK (International Federation of Otolaryngological Societies [IFOS] and Hearing International [HI]) said that the majority of hearing impaired people were children in deprived communities in the developing world where poverty, illiteracy, malnutrition, poor hygiene and infection abounded and resources were either limited or non-existent. IFOS and HI appreciated WHO's support in promoting deafness prevention programmes and efforts to focus global attention on the increasing burden of deafness on society. There was, however, a need to mobilize greater political, technical and financial inputs for deafness prevention in the countries of the Region. Networking and partnership efforts should be intensified to open avenues for promotion of hearing and prevention and control of deafness.

DR DIPIKA MOHANTY (Institute of Immunohaematology - IIH) congratulated WHO on developing the haemoglobin colour scale which provided a simple method of detecting anaemia and assessing its severity. She said that it was an invaluable adjunct to diagnosis

in clinics that had no facilities for laboratory tests. The scale had been found to be useful and clinically reliable but, unfortunately, its price was rather high in India and other countries of the Region. She urged WHO to provide the scale and the test strips at low cost to the countries of the Region.

MS SHOBHA TULI (Thalassaemia International Federation - TIF) appreciated WHO's work in the area of safe motherhood and the health of the newborn. She strongly felt that the issue of screening of genetic and blood disorders too should form an integral part of the programme in order to eliminate unwanted births of children afflicted with genetic diseases such as thalassaemia. Apart from the suffering caused to the patient, this deadly blood disorder created an extremely miserable situation not only for the mother, but also for the whole family in terms of costly treatment in the face of a losing battle to save children's lives. Against this backdrop, there was a very strong need for screening pregnant women as part of WHO's programmes on safe motherhood and health of the newborn. She urged WHO as well as Member Countries to include the screening for thalassaemia as a mandatory test for all pregnant women and to dedicate a year to thalassaemia in order to create awareness.

In a written statement, DR CHOK-WAN CHAN (International Pediatric Association – IPA) said that millions of children continued to suffer from diseases that were either preventable or readily treatable. This was not acceptable and the world community must insist and support progress in child health. The comprehensive strategy on Health of the Newborn, as contained in the working paper, provided a broad and important agenda for WHO. IPA had established a Newborn Survival Committee, to work jointly with its child health care partners, including WHO, for optimal management of newborns with consequent improvement in the quality of their survival. Child health was a basic right of every child and taking good care of children was one of the soundest investments that society and governments could make. He urged WHO to consider the needs of newborns and children and appropriately include them in the WHO programme.

11. Address by the Director-General, WHO *(Agenda item 6)*

DR LEE Jong-wook, Director-General, WHO, congratulated the SEA Region on its successful efforts to control the recent SARS epidemic. He said that health development in the Region had a great deal at stake, particularly in the continuing fight against HIV/AIDS, TB and malaria, and in the eradication of polio.

It was opportune to recall, on the occasion of the 25th anniversary of the Alma-Ata Declaration on Primary Health Care, that health was for all; everyone equally needed health. However, when society failed, through negligence, to meet that need, it was in very serious trouble.

The greatest challenge facing mankind was the catastrophe of HIV/AIDS with more than 42 million HIV-positive cases globally. Prevention and control efforts in some countries of the Region had been effective but in others the danger of continued increase persisted. WHO was working with its partners to design the necessary programmes. A comprehensive strategy to put three million people on anti-retrovirals by the end of 2005 (3 by 5) was expected to be announced on 1 December, World AIDS Day.

TB continued to be a threat in the Region. It was essential to ensure that those suffering from the disease received effective DOTS treatment.

Member Countries must press home the hard won advantage gained in their efforts towards polio eradication. Likewise, efforts towards leprosy elimination had built up an extremely valuable network of support, collaboration and training.

Protection during pregnancy, child-bearing and motherhood formed the core of the health system. Skilled attendants were needed in pregnancy and childbirth, with access to emergency obstetric care whenever complications arose. Nearly 10 million children in low- and middle-income countries died every year before reaching the age of five. Of these, almost seven million deaths were from five preventable and treatable conditions like pneumonia, diarrhoea, malaria, measles and malnutrition. This toll could be substantially reduced by developing strategies such as Making Pregnancy Safer and Integrated Management of Childhood Illnesses.

Surveillance systems were a key for eradicating polio and for controlling new and re-emerging infections. In this context, the revision of the International Health Regulations was significant. Malaria continued to be a serious problem all over the world. The need to stabilize the incidence of malaria and work towards reducing it could hardly be overemphasized.

Noncommunicable diseases and injuries accounted for almost 60 per cent of the disease burden worldwide. The Fifty-sixth World Health Assembly adopted the Framework Convention on Tobacco Control, which was a global achievement in the fight against tobacco-related diseases.

Unbalanced nutrition, affecting all societies, posed a major challenge for health. WHO's objective was integrated approaches that worked against malnutrition – from deficiencies and excesses.

In the context of increasing traffic accidents and resultant deaths, it was essential to raise awareness and strengthen WHO's response.

In regard to the problem of brain drain, the Director-General said WHO would be working closely with countries on innovative methods to train, deploy and supervise health workers, with particular reference to nurses and midwives, at community and primary health care levels.

WHO's work depended on partnerships. Over the years, the Organization had built strong and effective working relations with governments, foundations, nongovernmental organizations, the private sector and fellow multilateral organizations.

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The representatives congratulated Dr LEE on his assumption of office as Director-General of the World Health Organization and offered him their cooperation and unstinted support. Member Countries looked forward to his leadership and guidance.

The Committee expressed the need for a code of conduct for the advertising industry with a view to projecting and promoting healthy life styles, and looked forward to WHO's intervention in the matter. The topic of Global Strategy on Diet, Physical Activity and Health, to be presented at the World Assembly in May 2004, was a clear indication of the significance attached to this important subject by WHO.

In response to the observations made by the representatives, the Director-General said that EB funds now constituted 60 per cent of the total WHO funds and the remaining 40 per cent was Regular Budget funds. It was rather difficult and a big challenge to allocate

additional EB resources since there was no guarantee of these funds flowing into WHO. An increase in the allocation could be considered only when there was an overall increase in the flow of funds to WHO. The expectation with regard to making essential drugs and vaccines available at affordable prices had to be viewed in the light of investments made by the pharmaceutical companies in research and development, research-based trials, licensing and other related activities. Regarding FCTC, he said that there might be lobbying in some countries when the process of ratification was debated. In regard to SARS, the Director-General said that it was better to proceed on the assumption that it would come back and be prepared for it (for full text, see Annex 5).

12. Nomination of Regional Director *(Agenda item 7)*

IN ACCORDANCE with Rule 49 of the Regional Committee's Rules of Procedure, the Director-General read out the resolution adopted by the Committee in its private meeting nominating Dr Samlee Plianbangchang as Regional Director, WHO South-East Asia Region (SEA/RC56/R1). The Committee requested the Director-General to propose to the Executive Board the appointment of Dr Samlee for a period of five years from 1 March 2004.

Representatives congratulated Dr Samlee on his nomination as Regional Director. They were confident that, having served WHO for several years in various capacities and being familiar with the Region, Dr Samlee would bring to his office rich experience not only of working with the Organization but with countries as well. They felt that with his dedication and deep commitment to improving the health status of the people in the Region and, with the collaboration of the Member Countries, the South-East Asia Region would indeed emerge as one of the healthiest in the world. The representatives were confident that he would steer the Region very effectively and efficiently. Reposing complete confidence in his technical competence, integrity and leadership, they pledged him their full support and sincere cooperation in carrying forward the legacy of his predecessors.

The Committee noted that the South-East Asia Region had seen significant progress in health development under the leadership of Dr Uton Muchtar Rafei who had shouldered his responsibility with such care and dedication. Dr Uton had provided visionary direction to the countries and reinforced and restored WHO's credibility and technical leadership among the Member Countries and other UN agencies. He had been passionately pursuing his dream of making health care accessible to all, particularly the vulnerable and marginalized sections of society. The Committee thanked the Regional Director for providing mature leadership and support to the Member Countries in their health development efforts and adopted a resolution declaring Dr Uton Muchtar Rafei as Regional Director Emeritus (SEA/RC56/R2).

The Regional Director thanked the Committee and said he was honoured to have been declared Regional Director Emeritus, joining the group of his illustrious predecessors who had laid strong foundations which greatly facilitated his work. The unstinted support offered by the Member Countries was equally valuable. He expressed satisfaction at the joint initiatives taken in the areas of disease prevention and control, resource mobilization and advocacy, and bringing health to the centrestage of the development agenda. He would cherish memories of the cooperation and support that he received from Member Countries during his long association with WHO.

Dr Samlee Plianbangchang, the Regional Director nominee, stated that he was overwhelmed by the trust and confidence reposed by the Member Countries. He assured the Committee that he would do his best and try to carry forward the work initiated by Dr Uton. He would also endeavour to accelerate the development process to ensure timely, equitable and adequate response to the changing needs of the Member Countries. Development in new

areas would be started and effective utilization of existing resources ensured. Strengthening capabilities and promoting intercountry cooperation and collaboration would be the other areas of thrust. The work of WHO would be further decentralized with more authority being delegated to the country offices for effective implementation of WHO's collaborative programmes. He assured the Director-General that the SEA Region would continue to work with WHO headquarters as well as with country offices in unison. He looked forward to receiving guidance and political support from Member Countries in order to be more responsive and provide support relevant to their needs.

13. Detailed Work Plans for Programme Budget 2004-2005

(Agenda item 8, documents SEA/RC56/16 and Inf.4)

THE COMMITTEE was informed that the model underlying resolution WHA51.31 would be discussed at the 113th session of the Executive Board in January 2004 pending a thorough evaluation of the same to be presented to the Fifty-seventh World Health Assembly in May 2004.

The Committee recalled the discussion that had taken place at its 55th session in September 2002 and the view expressed at that time of the need to find a common position among Member Countries of the Region on the future application, if any, of resolution WHA51.31. It was further recalled that the Regional Committee for the Western Pacific, in 2002, had expressed strong reservations on the continuation of this resolution beyond the 2004-2005 biennium.

The paper presented by WHO headquarters had demonstrated the net decrease of some US$ 6.5m in the Regular Budget allocation for the South-East Asia Region from the baseline figure of the 1998-1999 biennium. The resolution adversely affected the Western Pacific, South-East Asia, Eastern Mediterranean and American Regions, while it benefited the European and African Regions.

The Committee expressed serious concern on the reduction in the regional allocation since the Region carried 40 per cent of the global disease burden. In order to achieve equitable distribution of funds the Committee suggested that the indicators should be linked to health statistics, life expectancy, infant and maternal mortality rate etc. It also stressed that since more than 50 per cent of the countries in the Region belonged to the category of least developed countries (LDC), there was a need to protect their interest.

On a related issue, the Committee was informed that WHO proposed to organize a regional consultation on regional and country allocations and country work plans for the 2004-2005 biennium in the last quarter of 2003.

A resolution relating to programme budget was adopted (SEA/RC56/R4).

The Committee took note of the detailed work plans (country, Regional Office/ICP and supplementary intercountry programme) for the 2004-2005 biennium, which had been reviewed by the 40th meeting of CCPDM. It observed that detailed consultations among national counterparts, WHO country offices and the Regional Office had gone a long way in ensuring that the work plans were complementary and mutually supportive, and used a logical framework approach for result-based management of WHO's collaborative programmes. The Committee also noted the CCPDM's recommendation that the Regional Director might consider setting the target of programme implementation at 75 per cent by the end of the first year, and to 100 per cent by 31 August of the second year of the biennium.

14. Joint Evaluation of a Specific Intercountry Programme – Multi-Disease Surveillance and Response *(Agenda item 9.1, document SEA/RC56/14)*

THE COMMITTEE was informed that in accordance with the recommendations of its fifty-third session to evaluate one supplementary intercountry programme (ICP II), the fifty-fifth session selected "Multi-disease surveillance and response, including health hazards, risk behaviour surveillance, through intercountry and inter-regional collaboration and use of regional mechanisms like ASEAN, SAARC, Mekong Basin project, and Intercountry cooperation in Health development" as the content area for in-depth evaluation in 2003. Joint Teams comprising staff from WHO headquarters and the Regional Office and officials from Member Countries visited India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand and assessed the programme in terms of appropriateness of mechanisms and approaches, adequacy of resources, relevance, efficiency, effectiveness, complementarity, sustainability and replicability.

The Committee noted that there was a lack of adequate understanding about the operational linkages between intercountry and country programmes and the role of nationals, staff of WR's office and the Regional Office in implementation. It requested the Regional Office to compile a comprehensive information booklet which would help address this need. It also highlighted the need to focus not only on the process of implementation but also on the outcome of the programme. This could be achieved by arranging formal meetings involving staff from the Regional Office, country offices and national officials in creating awareness about ICP II mechanisms. The Committee agreed on the need to sustain strong partnerships among countries, UN agencies, NGOs and other sectors for effective multi-disease surveillance. Networking of laboratories in the Region was also of vital importance in this regard. The Committee urged WHO to develop a regional strategy for integrated surveillance and also develop a network for noncommunicable disease control.

Recognizing the importance of maternal and child health and women's health, it agreed that this be part of the 14 priority programme areas of WHO.

The Committee, having reviewed and discussed the report of the 40th meeting of the Consultative Committee for Programme Development and Management (CCPDM) on "Joint evaluation of programme on multi-disease surveillance and response", **noted** with satisfaction and endorsed its recommendations to continue joint evalutions/reviews of not only supplementary intercountry programmes but also other regional priority programmes.

15. Selection of an Intercountry Programme or Content Area for Evaluation and Reporting to the Fifty-seventh Session of the Regional Committee *(Agenda item 9.2, document SEA/RC56/13)*

THE COMMITTEE considered the on various programme/content areas for evaluation and suggested the following areas in order of priority:

(1) Intensification of cross-border collaboration in priority communicable diseases (e.g. HIV/AIDS, polio, tuberculosis and malaria, kala azar, dengue, SARS etc.

(2) Development of regional networks to enhance national capacity in human resources for public health

(3) School health

The Committee, after deliberating on the subject, selected "Intensification of cross-border collaboration in priority communicable diseases (e.g. HIV/AIDS, polio, tuberculosis

and malaria, kala-azar, dengue, SARS etc.)" as an intercountry programme or content area for evaluation in 2004.

The Committee also urged Member Countries and the Regional Director to continue the joint evaluation process, as done earlier, with the full involvement and representation of Member Countries and requested the Regional Director to report on the evaluation to the 57th session of the Regional Committee in 2004.

16. Consideration of the Recommendations Arising Out of the Technical Discussions on "Social Health Insurance"

(Agenda item 10.1, document SEA/RC56/17)

DR GADO TSHERING Chairman of the Technical Discussions, presented the report and recommendations contained in document SEA/RC56/17. He said that countries were in different stages of health care reforms. While some countries had laid more emphasis on development of social health insurance (SHI) with the aim of achieving universal coverage, most had some experience of health insurance programmes either through the private sector or community-based financing schemes.

The Committee felt that all countries needed WHO technical support to review country situations on social health insurance, providing evidence-based research findings, developing policy options, providing models for consideration and facilitating policy debates among the stakeholders. While in-depth studies on possible options for alternative health care financing within the context of national socioeconomic and development policies should be carried out, experiences of countries already having wider social health insurance coverage needed to be documented. It was also important to make an assessment in the countries of the prerequisites for introducing SHI. A policy framework had to be developed for introducing or expanding social health insurance providing, at the same time, for an increased public expenditure.

The Committee noted that nongovernmental organizations could play a vital role in providing health insurance coverage to communities, particularly in a rural setting. It requested WHO support for implementing SHI in Member Countries and in developing a national framework for expanding social health insurance or adopting national legislation for introducing SHI as alternative health care financing, involving WHO collaborating centres and national centres of excellence.

The Committee noted that exchange of experiences, partnerships with other organizations, and community mobilization were needed for expanding SHI schemes. It had also to be realized that in most countries of the Region, health care was inadequate and ineffective. While there had been an expansion in the health infrastructure, quality of care had not been maintained. Public health expenditure in the countries of the Region had been well below the expected 5 per cent of GDP and there was a need to allocate more funds for ensuring effective and efficient health care.

The Committee discussed the report of the Technical Discussions and endorsed the recommendations. A resolution on the subject was adopted (SEA/RC56/R5).

17. Selection of a Subject for the Technical Discussions to be Held Prior to the Fifty-seventh Session of the Regional Committee

(Agenda item 10.2, document SEA/RC56/11)

IN VIEW of the significance of the recent emergency scenario posed by the SARS outbreak and the need to strengthen response to natural disasters, the Committee **decided** to hold Technical Discussions on "Emergency Health Preparedness" during the 41st meeting of CCPDM, to be held prior to the fifty-seventh session of the Regional Committee in 2004. It urged the Member Countries to actively participate in these discussions.

18. Strengthening of Nursing and Midwifery Workforce Management

(Agenda item 11, document SEA/RC56/6)

THE COMMITTEE was informed that a skilled and competent nursing and midwifery workforce was essential for a well-functioning health system and to scale up responses for achieving the Millennium Development Goals. A well-managed nursing and midwifery workforce was vital to ensure the provision of competent, equitable and quality health care.

The Committee noted that different terminologies, standards of education and skill mix have been used by Member Countries in the nursing and midwifery workforce. The Committee was concerned that most countries of the Region were experiencing a shortage of skilled nursing and midwifery personnel. The problems were compounded by maldistribution of personnel, inappropriate skill mix in many settings and the lack of status of nurses and midwives. This had an impact on the ability of a country to provide equitable and accessible quality health services. The nursing and midwifery profession had not received sufficient attention of health planners. The lack of motivation and recognition, coupled with social stigma and other socioeconomic issues attached to the profession, needed to be urgently addressed at the planning stage. The countries of the Region faced common challenges such as low status of nurses and midwives, poor working conditions, unsatisfactory patient-nurse ratios, lack of training institutions for specialized nursing care, motivating men to join this profession, and brain drain - both international as well as from the public to the private sector. Issues confronting nursing and midwifery workforce needed to be addressed in a broader context of the health system as they required system changes.

The Committee appreciated WHO's efforts and initiative in providing technical support in this crucial area which needed to be strengthened at the national level.

The Committee urged Member Countries to adapt the Guidelines for Nursing and Midwifery Workforce Management and to develop a national action plan to address priority issues in this area. The Committee also urged Member Countries to establish or strengthen national nursing and midwifery focal points, associations and councils to take the lead in implementing national plans, strengthen integrated national information systems on nursing and midwifery services and workforce, and improve capacity for leadership and management training and education of nursing midwifery personnel.

The Committee urged WHO to provide effective and adequate training support to Member Countries through intercountry and inter-regional training opportunities for nursing care and promote institutional linkages between Member Countries. It felt that efforts should be made to improve the living conditions of nursing and midwifery personnel and establish a social environment where they would be recognized and respected by society. It also urged WHO to intensify support to countries in adapting the newly-developed guidelines according to country situations and to develop and implement national and regional action plans, and to facilitate intercountry collaboration for strengthening capacity development and management of nursing and midwifery workforce in the Region. The Committee further

urged WHO to continue to support the work of the Regional Advisory Group on nursing and midwifery.

A resolution on the subject was adopted (SEA/RC56/R7).

19. International Health Regulations – Revision Process

(Agenda item 12, document SEA/RC56/4)

THE COMMITTEE was informed that the SARS epidemic highlighted some of the major concerns in terms of international health regulations (IHR). These needed to be addressed to protect against the spread of serious risks to public health and unnecessary restrictions in travel or trade for public health purposes.

The Committee was informed of the main changes proposed to IHR. The global outbreak of SARS earlier in 2003 was used as a concrete example to illustrate the application of some of the changes proposed. The Committee noted the increasing trend of reporting of outbreaks at an early stage by the Member Countries and seeking WHO's assistance in mobilizing and coordinating appropriate international support.

The Committee noted that the proposed revisions would incorporate all diseases of international concern. The four key changes included: (a) early notification on international public health emergencies and response mechanisms; (b) definition of core capacities; (c) identification of national focal points, and (d) recommended measures for public health emergencies of international concern and acknowledged risks.

The Committee was informed of the need for Member Countries to become actively involved in reviewing and finalizing the revision of IHR. It was emphasized that the involvement must extend beyond technical experts in health ministries to include policy-makers within the health arena and in other key sectors that will be affected by the regulations such as tourism, trade, transport, legislation and food safety. The regional consensus meetings, to be held in 2004, were expected to provide Member Countries with an opportunity to ensure that the revised regulations provided the world with the legal framework needed to support global health security through an epidemic alert and response mechanism. It was stressed that the delegations to these meetings must have wide consultations and prepare carefully in order to make meaningful contributions.

Recognizing the need for development and training of core capacities, the Committee urged WHO to carefully assess the training needs of the Member Countries. It urged WHO to provide the draft guidelines much in advance for wider distribution. Due consideration should be given so that there is no dilution of the legal status on measures taken.

The Committee also stressed that the revision should ensure minimal impact on international travel and trade.

The Committee fully supported the timely initiative of WHO and noted the progress and process of revising the International Health Regulations.

20. Declaration on Health Development in the South-East Asia Region in the 21st Century: Review of Progress

(Agenda item 13, documents SEA/RC56/10 and SEA/RC56/Inf.3)

THE COMMITTEE recalled that in the "Declaration on Health Development in the South-East Asia Region in the 21st Century" (Regional Health Declaration) adopted by the Ministers of

Health of the countries of the Region, at their 15th meeting at Bangkok in August 1997, the Ministers had noted the progress of health development in the Region since the adoption of the universal social goal of "Health for all" two decades earlier. The Committee noted that since then the principles and policy actions stipulated in the Declaration had been adopted and integrated into medium-term and long-term national health development plans and activities in the countries through concrete steps leading to the achievement of notable success in several areas.

The Committee commended the comprehensive progress report brought out on the "Declaration on Health Development in the South-East Asia Region in the 21st Century: Review of Progress". It noted that health was recognized as one of the key factors for economic development. National policies on health, population and AIDS control had been formulated. The impact of changes in the legislative framework in the Food and Drug Administration was clearly visible. The emphasis was to close the gaps through equitable distribution of funds for health care among primary, secondary and tertiary health levels. New initiatives had been taken in tertiary health care by opening super specialty hospitals with medical colleges attached to them in some of the underserved parts of the country.

The Committee noted that considering that 46 countries of the world accounted for 90 per cent of the global maternal and child health mortality, there was a need for a global alliance on maternal and child health to offer technical, financial and managerial support to meet the Millennium Development Goals. Several countries had made rapid strides in the area of immunization with a coverage as high as 95 per cent and it was expected that the target of universal immunization would be achieved by 2005. The Region would be in a position to meet the demand of all countries of the Region for hepatitis B vaccine.

The major disease control programmes where significant progress was evident included malaria, tuberculosis and leprosy. It was expected that by 2005, leprosy would be nearly eliminated. It was recognized that HIV/AIDS continued to be a major challenge in a few countries with a large number of cases due to migrant population, both within and from outside the country. There was a strong need for regional cooperation in this area.

The focus of health sector reform strategies was on reducing inequities between the urban and rural populations, rich and poor and between sexes and ensuring universal access to basic health care. Universal access to basic health care was sought to be provided according to the needs rather than the socioeconomic capacity, gender, equity or location of the people.

The Committee noted that women's health was very crucial for overall health development and should be accorded national priority. It was suggested that more importance be given to deliberating on this issue and additional resources allocated for it to bring down the maternal mortality rate and improve the health of women.

The Committee observed that the subject of emerging and re-emerging diseases, regionally as well as globally, was also very important. SARS, influenza and other epidemics were major global concerns. There was a need to intensify efforts for global as well as regional cooperation to control such diseases. Social development being the cornerstone of overall development, due emphasis was placed on strengthening health systems and promoting health care, intersectoral collaboration, participation of communities and NGOs to forge a stronger partnership for health in Member Countries of the Region. An environment needed to be created for sustainable health development by dedicating more resources and commitment. Food safety and nutrition were other priority areas to be included in the Regional Health Declaration.

Although much progress had been made in achieving primary health care coverage, concerted and focused efforts, strong commitment and additional resources were required in

order to reach the unreached population. The Committee urged WHO to sustain the momentum of implementing the Regional Health Declaration.

The Committee noted that in order to close the gap in the health care needs of the poor and vulnerable, health development should focus on the rural areas. The focus had to be process-oriented rather than measurement-oriented. Rural health care development programmes had been introduced in some countries. Many more midwives and public health workers at the rural level were introduced in order to reduce child and maternal mortality rates.

Maternal and infant mortality rates could be reduced by developing a nutrition programme for pregnant as well as lactating mothers. Distribution of folic acid and iron supplements to pregnant and lactating mothers was being undertaken through donor-supported programmes in some countries.

The Committee was informed that many countries of the Region depended on NGOs and donor countries for polio vaccine. Regional cooperation was very essential for making the immunization programme affordable. Hepatitis B vaccine was being developed with the help of friendly countries apart from vaccines donated by GAVI. It was necessary to develop a community trust health fund in the Region for people who could not afford social health insurance.

Traditional systems of medicine was another area where regional cooperation was required in sharing the experience and human resources, training of traditional medicine practitioners and production of traditional medicine.

The Committee noted that health care services were a major casualty in situations of long-drawn conflicts. After political reconciliation there were several challenges to expand health care coverage, rehabilitation and resettlement of populations.

The Committee expressed satisfaction at the implementation of the Regional Health Declaration. It was heartening to note the progress reported by the Member Countries despite constraints and challenges. A lot remained to be done, not only by ministries of health but by other sectors as well. The Committee noted that the Regional Health Declaration could be used as an assessment tool and as a process of measurement of the targets achieved. It was suggested that the Declaration be reviewed and revised at suitable period, e.g. every 2-3 years. The programme budget for 2004-2005 was in the process of finalization and funds could be allocated to some of the priority areas.

The Committee was informed that this item had been extensively discussed at the 21st Meeting of Ministers of Health. It fully endorsed the recommendations of that meeting.

The Committee, having considered the report on reviewing progress of the Declaration on Health Development in the South-East Asia Region in the 21st Century, **noted** the progress achieved and the future course of action.

21. Water, Sanitation and Hygiene Determinants of Health in the South-East Asia Region – Situation Analysis and Role of Health Ministries *(Agenda item 14.1, document SEA/RC56/8)*

THE COMMITTEE acknowledged that unsafe drinking water, inadequate sanitation and poor hygiene were important risk factors in the South-East Asia Region for many infectious diseases, especially diarrhoea. Globally, 88 per cent of diarrhoeal diseases were considered to

correspond to these risk factors. In the SEA Region, diarrhoeal diseases caused greater morbidity and mortality than any other communicable disease except respiratory infections. Despite important improvements in case management in recent decades, the burden of disease due to diarrhoea and other water-related diseases remained unacceptably high. Children under five had to bear the greatest share of this burden which was largely due to gaps in water supply and sanitation coverage, poor quality of services and poor hygiene practices, especially among rural populations and the urban poor.

The Committee observed that health ministries could support the attainment of the Millennium Development Goals and targets on safe drinking water and sanitation, and the consequent health gains, by enhancing their role as evidence-based advocates for increased investment, increased efficiency and increased equity in that sector. Health ministries could also accelerate health gains by promoting low-cost interventions such as household-level treatment of water, rainwater harvesting, low-cost sanitation, and others.

With regard to hygiene, it was noted that all countries in the Region had active hygiene promotion programmes but all could benefit from initiatives to strengthen them.

The Committee noted the impact of morbidity and mortality, particularly among the rural population and the urban poor due to inadequate water supply, poor hygiene and lack of sanitation facilities, and underlined the importance of bringing about behavioural changes in the community for practising healthy life styles.

The Committee acknowledged that WHO had been working together with other UN agencies on integrated water and sanitation programmes, emphasizing a community participation approach. WHO had developed guidelines for improving the quality of drinking water which had been adopted by most countries.

Recognizing the need to mobilize resources and forge partnerships aimed at bringing about behavioural changes in the population, particularly with regard to sanitation, the Committee called for strengthening the role of health ministries. It urged WHO to convene a regional intersectoral meeting at the ministerial level to launch an action plan in order to reduce infections resulting from unsafe water, poor hygiene and sanitation.

Emphasizing the significance of water quality surveillance and hygiene promotion, the Committee urged WHO to assist Member Countries in developing trained public health engineering personnel for managing water and sanitation facilities. It was important also to focus on other environmental factors such as air pollution which had an adverse impact on health.

The Committee stressed the need to re-examine the role of health ministries in the areas of water, sanitation and hygiene in the countries.

A resolution on the subject was adopted (SEA/RC56/R8).

22. Health of the Newborn *(Agenda item 14.2, document SEA/RC56/9)*

THE COMMITTEE noted that though significant advances had been made in reducing childhood mortality over the past decades, the pace of progress in reducing infant and under-five mortality had slowed down in recent years. Failure to address neonatal mortality was identified as an important reason for this trend. The South-East Asia Region accounted for 40 per cent of the global neonatal mortality and there was wide variation in mortality rates among the countries.

The Committee reiterated the need for commitment of Member Countries and national and international partners to further reduce infant and child mortality. It was agreed that promotion of appropriate care practices, combined with identification and management of maternal and newborn complications, was necessary to ensure optimal health outcomes. The need for evidence-based interventions in existing safe motherhood and child health programmes for promoting the survival and health of neonates was emphasized.

The Committee was informed that WHO was in the process of evolving a regional strategy for neonatal health as part of its efforts to strengthen neonatal health initiatives. WHO would work with countries and partners for advocacy, technical support for capacity building, forging partnerships, research for enhancing the evidence base for effective interventions and measurement of progress of initiatives related to neonatal health.

The Committee observed that issues such as provision of adequate maternity leave for mothers and imparting training aimed at behavioural change for family members, as also educating new mothers themselves on various aspects of handling newborns, was essential. It was pointed out that while WHO would support the training requirements of skilled birth attendants, including midwives, the issue of quantum of maternity leave was better left to the countries themselves to determine. The Committee emphasized the need for increased focus on advocacy for maternal and neonatal health for addressing specific issues such as involvement of family members during pregnancy and neonatal care, wherever relevant.

The Committee noted that training for health personnel involved in the provision of emergency obstetric and neonatal care would help reduce infant mortality. At the same time, it was important to build up referral back-up services at secondary and tertiary levels aimed at capacity strengthening. The Committee underlined the need to impart training to community health workers from geographically inaccessible areas and for their deployment at the local level. The Committee also recognized the important role played by nongovernmental organizations in reducing infant mortality through advocacy efforts.

The Committee was informed that in view of the significance of neonatal health in the regional context, the Regional Office had recently established a technical unit dedicated to newborn health. WHO continued to collaborate with various international and nongovernmental organizations and other partners to support neonatal health in the Region.

The Committee agreed that countries needed to focus attention on issues like creating a supportive environment for neonatal care; health system strengthening for providing quality neonatal care; improving access to skilled birth attendance; and ensuring essential neonatal care, including care and referral of sick neonates. In addition, attention needed to be given to narrowing the gaps in knowledge and instituting mechanisms to measure progress.

The Committee urged Member Countries to accord high priority to neonatal health in national policies and develop appropriate strategies; to provide essential care for the mother during pregnancy and childbirth; to promote cost-effective, evidence-based care for the newborn, and to strengthen essential neonatal care services as an integral part of national maternal and child health (MCH) programmes.

The Committee urged WHO to formulate and finalize a regional strategy for neonatal health; to provide technical support in building national capacity for policy formulation, programme planning, implementation, monitoring and evaluation for improving newborn health; to carry out research to generate evidence and support for countries in changing policies and practices on neonatal care, and to support countries in the dissemination, adaptation and utilization of cost-effective, evidence-based practices for newborn health.

A resolution on the subject was adopted (SEA/RC56/R9).

23. Regional Implications of the Decisions and Resolutions of the Fifty-sixth World Health Assembly and the 111th and 112th Sessions of the Executive Board, *and* Review of the Draft Provisional Agendas of the 113th Session of the Executive Board and the Fifty-seventh World Health Assembly *(Agenda item 15, documents SEA/RC56/12 and Add.1)*

THE COMMITTEE took note of the regional implications of the decisions and resolutions and urged the countries and WHO to take appropriate follow-up actions as proposed by CCPDM.

The Committee had no comments on the draft provisional agenda of the 113th session of the Executive Board which was **noted.** The Committee also **noted** that the agenda of the Fifty-seventh World Health Assembly would be discussed and finalized at the 113th session of the Executive Board.

24. UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases : Joint Coordinating Board (JCB) – Report on Attendance at 2003 JCB and Nomination of a Member in Place of Bangladesh Whose Term Expires on 31 December 2003 *(Agenda item 16.1, document SEA/RC56/5)*

THE COMMITTEE was informed that the representatives from Bangladesh, India and Thailand had attended the 26th session of JCB, held in New Delhi from 23 to 25 June 2003 and the report of the session had been presented to the 40th meeting of CCPDM. The Committee noted the observations and recommendations of CCPDM on this subject.

The Committee was also informed that the 26th session of JCB unanimously elected India along with Japan, Luxembourg and Norway as a JCB member for a further period of three years from 1 January 2004.

The Committee **nominated** Myanmar to replace Bangladesh for a three-year term commencing 1 January 2004 and requested the Regional Director to inform WHO headquarters accordingly.

25. WHO Special Programme for Research, Development and Research Training in Human Reproduction: Policy and Coordination Committee (PCC) – Report on Attendance at 2003 PCC and Nomination of a Member in Place of Indonesia Whose Term Expires on 31 December 2003 *(Agenda Item 16.2, document SEA/RC56/7)*

THE COMMITTEE was informed that the representatives of India, Indonesia and Thailand, had reported on the deliberations of PCC, held in Geneva in June 2002 to the 40th meeting of CCPDM. The Committee noted the report of CCPDM on this item.

The Committee **nominated** Sri Lanka to replace Indonesia for a three-year term commencing 1 January 2004 and requested the Regional Director to inform WHO headquarters accordingly.

26. Time and Place of Forthcoming Sessions of the Regional Committee
(Agenda item 17, document SEA/RC56/3)

THE COMMITTEE reconfirmed its earlier decision to hold its fifty-seventh session in Maldives in the second week of September 2004 in conjunction with the meeting of Ministers of Health. The exact venue and dates will be decided in consultation with the Ministry of Health and communicated to Member Countries in due course. A proposal was made to reconsider the linkages between the Health Ministers' Meeting and the Regional Committee with a view to avoiding duplication and possibly reducing the overall time required for both the meetings. The Committee further noted that four countries of the Region, viz., Bangladesh, Bhutan, Nepal and Sri Lanka, had offered to host the session in 2005. The Committee therefore proposed that the four countries consult among themselves with a view to arriving at an agreement regarding the venue of the sessions in 2005, 2006, 2007 and 2009 (the session in 2008, being an election year for the Regional Director, would need to be held in the Regional Office) and inform the Regional Office accordingly in due course. The Regional Office would then inform the Committee of the outcome at the fifty-seventh session in Maldives.

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27. Other Matters

THE COMMITTEE **decided** that elective posts of office-bearers of the World Health Assembly and membership of the Executive Board from the countries of the SEA Region would be rotated among the Member Countries.

For the forthcoming Fifty-seventh World Health Assembly, Timor-Leste was nominated to the office of Vice-President. The following nominations were made to various other Committees: Bhutan (Chairman, Committee B), Bangladesh (Rapporteur, Committee A), India and Myanmar (Committee on Credentials), Bangladesh and Sri Lanka (Committee on Nominations) and Thailand (Member, Executive Board) in place of Myanmar whose term expires in May 2004.

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28. Closure of the Session *(Agenda item 19)*

The Representatives from Member Countries congratulated the Chairperson and the Vice-Chairperson for the smooth conduct of the session. They thanked the Regional Director and his staff for the excellent arrangements and the Government of India for its warm hospitality. They also expressed their appreciation to the new WHO Director-General, Dr LEE Jong-wook, for his thought-provoking address which provided a clear direction and guidance to strengthen WHO's role in the countries. They said that the 56th session was a landmark where they had the opportunity to meet the new Director-General, nominate a new Regional Director and welcome Timor-Leste. It afforded an excellent opportunity to renew friendship, share experience and further strengthen collaboration. The meeting discussed some issues of vital concern to the people of the Region and passed important resolutions which would be translated into action.

The representatives expressed their appreciation to Dr Uton Muchtar Rafei on his outstanding contribution and dedicated efforts to improve the health of the people of the South-East Asia Region and wished him a happy, healthy and peaceful retired life. They

congratulated Dr Samlee Plianbangchang on his nomination as Regional Director and hoped that under his dynamic and able leadership, the Region would make greater strides. The representatives pledged their support to him.

The Regional Director thanked the Ministers of Health and representatives for their active participation in a spirit of cooperation and solidarity. He also thanked the Director-General for providing a clear direction and guidance to strengthen the role of WHO in Member Countries. Congratulating Dr Samlee on his nomination as Regional Director, he expressed the hope that the collective dream of making the Region a leader in health development globally would be realized. He was confident that the common purpose and shared values would further strengthen the ties between the countries of Region.

The Chairperson, in her closing remarks thanked the representatives for their active participation; support and consideration during the deliberations which enabled the meeting to discuss many important issues and adopt important resolutions. She expressed her appreciation to the Director-General, Dr LEE Jong-wook, for his address and hoped that under his able guidance, Member Countries would be able to improve the health status of their people. She also expressed her appreciation of the hard and untiring work of Dr Uton Muchtar Rafei, who would be relinquishing his office in March 2004, and wished him a happy retired life.

The Chairperson then declared the session closed.