WHO Regional Committee for South-East Asia

Report of the Fifty-fourth Session
Yangon, Myanmar, 3-6 September 2001
World Health Organization
Regional Office for South-East Asia
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# CONTENTS

<table>
<thead>
<tr>
<th>Part I - INTRODUCTION</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Part II - INAGUGRAL SESSION</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address by the Minister for Health, Government of the Union of Myanmar</td>
<td>3</td>
</tr>
<tr>
<td>Address by the Regional Director, WHO</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Part III - BUSINESS SESSION</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening of the Session</td>
<td>8</td>
</tr>
<tr>
<td>Sub-Committee on Credentials</td>
<td>8</td>
</tr>
<tr>
<td>Election of Chairman and Vice-Chairman</td>
<td>9</td>
</tr>
<tr>
<td>Adoption of Agenda</td>
<td>9</td>
</tr>
<tr>
<td>List of Participants</td>
<td>9</td>
</tr>
<tr>
<td>List of Official Documents</td>
<td>9</td>
</tr>
<tr>
<td>Address by the Director-General, WHO</td>
<td>9</td>
</tr>
<tr>
<td>Statements by Representatives of UN and Specialized Agencies</td>
<td>12</td>
</tr>
<tr>
<td>Address by the Chairman, SEA-ACHR</td>
<td>22</td>
</tr>
</tbody>
</table>
Statements by Representatives of intergovernmental and Nongovernmental Organizations ................................................................. 23

Evaluation of Implementation of the two Intercountry Priority Programmes During 2000-2001: (a) Improving the Health of the Marginalized and Vulnerable Groups, and (b) Tobacco Free Initiative .... 27

Detailed Work Plans for Programme Budget 2002-2003................................. 28
### Page

Consideration of the Recommendations Arising out of the Technical Discussions on Mental Health and Substance Abuse, including Alcohol .......................................................... 30

Selection of a Subject for the Technical Discussions to be held prior to the Fifty-fifth Session of the Regional Committee ......................................................... 30

Arsenic Contamination of Groundwater Affecting Some Countries of the South-East Asia Region ................................................................. 31

Health and Environment in National Development: Regional Progress and Preparations for Rio+10 Conference ................................................................. 31

Multi-disease Surveillance: Cross-Border Collaboration ........................................ 32

Polio Eradication in the South-East Asia Region .................................................. 32

Regional Implications of the Decisions and Resolutions of the Fifty-fourth World Health Assembly and the 107th and 108th sessions of the WHO Executive Board, and Review of the Draft Provisional Agendas of the 109th session of the WHO Executive Board and the Fifty-fifth World Health Assembly ................................................................. 33

UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases: Joint Coordinating Board (JCB) – Report on attendance at 2001 JCB, and nomination of a member in place of Sri Lanka whose term expires on 31 December 2001 ..................................... 36

WHO Special Programme for Research, Development and Research Training in Human Reproduction – Report on the Policy and Coordination Committee (PCC) session and nomination of a member to PCC in place of India whose term expires on 31 December 2001 .......... 36

Time and Place of Forthcoming Sessions of the Regional Committee ........ 37

Adoption of Resolutions ................................................................................ 38
Report of the Fifty-fourth Session

Adoption of the Report of the Fifty-fourth Session of the WHO Regional Committee for South-East Asia .......................................................... 38
Closure of the Session ........................................................................................................ 38

Part IV - RESOLUTIONS ........................................................................................................ 41

SEA/RC54/R1 Programme Budget 2002-2003 ................................................................. 41
SEA/RC54/R2 Mental Health and Substance Abuse, Including Alcohol .................. 42
SEA/RC54/R3 Arsenic Contamination of Ground Water Affecting Countries of the South-East Asia Region ......................................................... 44
SEA/RC54/R4 Resolution of Thanks ................................................................................ 45
Annexes

1. Agenda ............................................................................................................ 35

2. List of Participants ........................................................................................... 38

3. List of Official Documents ............................................................................... 50

4. Text of Address By H.E. Major General Ket Sein, Minister for Health, Government of the Union of Myanmar .......................................................... 53

5. Text of Address by the Regional Director ....................................................... 62

6. Text of Address by the Director-General, WHO ............................................. 70

7. Report of the 38th Meeting of the Consultative Committee for Programme Development and Management to the Regional Director ........ 81

8. Recommendations Arising out of the Technical Discussions on Mental Health and Substance Abuse, Including Alcohol ........................................... 96

9. Presentation on Health Systems Reform .......................................................... 104

10. The New Global Fund for AIDS and Health: A WHO Perspective ............. 105

11. Release of Publication ................................................................................... 109
Report of the Regional

1 Originally issued as Draft Report of the fifty-fourth session of the Regional Committee for South-East Asia (document SEA/RC54/17, dated...
Part I

INTRODUCTION

The FIFTY-FOURTH session of the WHO Regional Committee for South-East Asia was held in Traders Hotel, Yangon, Myanmar, from 3 to 6 September 2001. It was attended by representatives of all the ten Members States of the Region, UN and other agencies, nongovernmental organizations in official relations with WHO and observers.

The session was inaugurated by His Excellency Major General Ket Sein, Minister for Health, Government of the Union of Myanmar.

The Committee elected Dr U Kyi Soe (Myanmar) as Chairman and Professor Dr Azrul Azwar (Indonesia) as Vice-Chairman of the session.

The Committee reviewed the biennial report of the Regional Director for the period 1 July 1999 to 30 June 2001 and considered the recommendations arising out of the Technical Discussions on Mental Health and Substance Abuse, including Alcohol, held during the 38th meeting of the Consultative Committee for Programme Development and Management.
The Committee decided to hold its fifty-fifth session in Indonesia in the second week of September 2002.

The Committee adopted four resolutions as contained in Part IV.
Part II

INAUGURAL SESSION

ADDRESS BY THE MINISTER FOR HEALTH, GOVERNMENT OF THE UNION OF MYANMAR

MAJOR GENERAL KET SEIN, Minister for Health, in his inaugural address, expressed his pleasure that the Regional Committee was meeting again in Myanmar after almost thirty years.

He commended WHO’s new corporate strategy which would help the Organization to be more effective and responsive to the needs of the Member Countries. Myanmar had incorporated the country cooperation strategy in its national health plan to reflect the country’s needs and priorities.

The inadequate level of resources available for health vis-à-vis the high burden of disease in the Region warranted an increased allocation of resources. Despite achieving some success in improving the health status of people, many major health challenges such as malaria, tuberculosis, HIV/AIDS and cross-border transmission of diseases still existed. WHO was supporting cross-border joint action programmes that would definitely strengthen rapid response mechanisms and surveillance networks to contain outbreaks of diseases in border areas.
Recognizing the importance of health for all citizens and their role in the sustainable development of the country, his government had given priority to enhancing the capacity of human resources for health. Health infrastructure development, rural health development and improving the quality of health care were also receiving attention. The country was now heading towards increasing health coverage of the rural population and their access to quality health care.

Like other countries of the Region, Myanmar was also facing the double burden of disease including HIV/AIDS. His government was addressing these problems by utilizing all available resources. In addition to the high-level multisectoral National AIDS Committee set up in 1989, the National Health Committee, which was the highest policy-making body, was providing policy guidelines and support in the prevention and control of HIV/AIDS.

The Ministry of Health had formed a Central Committee with representation from all health-related sectors and NGOs for the prevention and control of multidrug-resistant malaria, which was emerging due to the rapid population migration and ecological imbalances. Myanmar had also adopted Roll Back Malaria under the Mekong Initiative.

The World Health Day theme this year provided a fresh perspective for mental health. Myanmar had implemented a community-based mental health project which aimed at early detection of mental disorders. The mental health programme had been integrated into the primary health care delivery system.
While Myanmar was participating in the negotiation process for the Framework Convention on Tobacco Control, it had banned tobacco advertisements on the TV and prohibited smoking in all public transport, hospitals and schools.

The Minister said that the country’s health systems were developing and flourishing within the context of the traditions and policies of the countries of the Region. It was necessary to seize the opportunity for collaboration and cooperation in responding to the health problems of the Region (for full text of the address, see Annex 4).

ADDRESS BY THE REGIONAL DIRECTOR, WHO

DR UTON MUCHTAR RAFEI, Regional Director, said that WHO was glad to be associated with the health development efforts in Myanmar. He commended the country’s tradition of tolerance and kindness which had adapted well to socioeconomic changes.

In early 2000, the Region was certified as free of guinea worm disease. Exemplary progress had also been achieved in efforts to eliminate leprosy. Seven countries of the Region had achieved national leprosy elimination targets; the remaining three were expected to achieve their targets by 2005. Cross-border collaboration between Bangladesh, India and Nepal was being strengthened to eliminate kala-azar in the next decade. A regional strategy for eliminating lymphatic filariasis by 2020 had been developed for all countries where the disease was a problem. Five countries had eliminated neonatal tetanus in 2001. Preparations had begun for the final assault to achieve polio eradication in the Region.
In TB control, the Region had achieved nearly 45 per cent coverage with DOTS in 2000. It was expected that all countries would be able to achieve nationwide coverage by 2005. A few countries had been successful in reversing the trend in HIV incidence, which was spreading rapidly in the Region. In order to firmly place the control of HIV/AIDS within national agendas and to establish an enabling policy environment and appropriate resources for preventive efforts, it was necessary to strengthen political commitment and leadership at the highest levels.

Mental health, cardiovascular diseases, cancer and diabetes had emerged as major public health problems. Efforts had been made to support countries to strengthen surveillance risk factors and to integrate the control of these diseases through health promotion. In the field of traditional medicine, WHO continued to work closely with Member Countries, especially in strengthening research capacity, building human resources and improving traditional practices.

Every year, countries of the Region were affected by natural disasters, such as landslides, floods, drought and earthquakes. In this context, WHO would assist Member Countries to jointly draw up plans for future preparedness.

The issue of arsenic contamination of drinking water sources, which was causing serious concern in a few countries of the Region, was now being addressed as a global health problem.

Referring to the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), which had the potential to affect the affordability and accessibility of essential medicines, the
Regional Director urged the ministries concerned to work closely with consumers as well as commerce and industry to avail of the safeguards stipulated in the Agreement.

WHO, in close consultation with experts and representatives from Member Countries, was finalizing a regional vaccine policy which highlighted the importance of establishing national regulatory authorities and ensuring good manufacturing practices.

WHO had continued its reform process to bring about greater efficiency and effectiveness. A series of initiatives had been undertaken to ensure full participation of Member Countries in the planning, programming and evaluation of the Organization’s work resulting in 100 per cent implementation (for full text of the address, see Annex 5).
Part III

BUSINESS SESSION

OPENING OF THE SESSION (Agenda item 1)

IN THE absence of the Chairman of the fifty- third session, Dr U Kyi Soe (Myanmar), Vice- Chairman, opened the fifty- fourth session of the Regional Committee. Representatives of Member Countries, UN and other agencies as well as nongovernmental organizations in official relations with WHO and other observers attended the session.

SUB-COMMITTEE ON CREDENTIALS (Agenda item 2, document SEA/ RC54/ 15)

A SUB-COMMITTEE on Credentials, consisting of representatives from Bangladesh, DPR Korea and Maldives was appointed. The Sub- committee met under the chairmanship of the representative of Bangladesh and examined the credentials submitted by Bangladesh, Bhutan, DPR Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand. The credentials were found to be in order, thus entitling all representatives to take part in the work of the Regional Committee.
ELECTION OF CHAIRMAN AND VICE-CHAIRMAN (Agenda item 3)

DR U KYI SOE (Myanmar) was elected Chairman and Professor Dr Azrul Azwar (Indonesia) as Vice-Chairman.

Dr U Kyi Soe thanked the representatives for electing him Chairman, which he considered an honour for himself and his country. He was confident that with the cooperation and support of all concerned, the Committee would successfully cover the agenda within the next few days.

ADOPTION OF AGENDA AND SUPPLEMENTARY AGENDA
(Agenda item 4, document SEA/RC54/1)

THE COMMITTEE adopted the Agenda as contained in document SEA/RC54/1 (Annex 1).

LIST OF PARTICIPANTS

THE LIST of Participants is at Annex 2.

LIST OF OFFICIAL DOCUMENTS

THE LIST of Official Documents is at Annex 3.

ADDRESS BY THE DIRECTOR-GENERAL, WHO (Agenda item 6)

IN THE absence of the Director-General, the Regional Director delivered the address of Dr Gro Harlem Brundtland. In her speech, Dr Brundtland stated that the current session of the Regional Committee was taking place at a time when total eradication of polio was about to be achieved. The global success achieved so far
was a great inspiration to the Organization in its march towards addressing other health challenges such as epidemics of noncommunicable diseases, illnesses related to environmental issues and improving people’s access to health systems. The availability of increased resources as well as their appropriate utilization were essential prerequisites in this context. The commitment of the international community to the Global AIDS and Health Fund, and the Global Alliance for Vaccines and Immunization reflected the joint efforts of Member States and WHO to attain better health globally.

There was a critical need to respond to the unprecedented health crisis caused by HIV/AIDS with systematic and coordinated implementation of effective strategies. WHO’s goal was to help identify more effective responses and implement them effectively, taking into account people’s cultural traditions and social realities. Together with other co-sponsors, WHO was working to adapt evidence-based practices to the needs of the people. The Organization was committed to offer prompt and effective support to countries.

Most countries faced the challenge of mental health and brain disorders within their limited resources. But new and more effective means were now available to treat and prevent such disorders and illness. The focus was on prevention, early detection and treatment using effective and inexpensive medicines.

WHO was also involved in many national, intercountry and inter-regional disease surveillance initiatives.
Besides assisting Member Countries in coping with disease outbreaks, the regional offices were willing to help countries to undertake surveys for regular assessment of the status of people’s health and functioning of health systems.

The increasing threat to people’s health posed by tobacco necessitated the participation of governments in the negotiations on WHO’s Framework Convention on Tobacco Control. It was anticipated that, with the agreement of the Member States, the Convention would be finalized in 2003. WHO was also helping countries in handling ethical issues like code of conduct for research involving human subjects. A WHO-wide initiative on health ethics with a focus on ethics in public health, health research ethics and biotechnology ethics was also proposed. WHO was enhancing its cooperation with FAO to help countries in the area of food safety.

WHO was determined to contribute to better and more equitable health outcomes. Based on the deliberations at the regional committees, global priorities for the subsequent biennium would be submitted to the Executive Board in January 2002.

It was hoped that appropriate joint actions of the Member States would make it possible to respond to the legitimate expectations of the people that promote equity of health outcomes and contribute to reductions in the poverty levels (for full text of the address, see Annex 6).
STATEMENTS BY REPRESENTATIVES OF UN AND SPECIALIZED AGENCIES

DR WAHEED HASSAN (Deputy Regional Director, UNICEF Regional Office for South Asia) appreciated the collaboration with WHO, especially in eradicating polio. He said that while undertaking polio eradication efforts, UNICEF would continue to support strengthening of routine immunization services. He commended the contribution of Rotary International whose support made it possible for UNICEF to provide adequate supply of vaccines, assist with the cold chain and train health workers. Emphasizing the need to support community health initiatives across the Region, he assured that UNICEF would give high priority to good quality care to prevent and control childhood diseases. He also stressed the importance of mental and physical health of children and the need to provide basic health education to girls. He said that UNICEF considered the reduction of maternal mortality in South Asia a health priority. He stressed that it was time to strengthen partnerships and seek new alliances. He hoped that the forthcoming SAARC summit would provide an opportunity to review its goals for children.


INTRODUCING his report for the period 1 July 1999 to 30 June 2001, the Regional Director referred to the significant improvement in responses to prevention and control of major communicable...
diseases. WHO had responded promptly to tackle 20 episodes of epidemics/outbreaks in the Region. A landmark in public health had been reached in February 2000 when the Region was certified to be free of guinea worm disease. A regional strategy to eliminate lymphatic filariasis in eight endemic countries had been formulated.

National and intercountry malaria control programmes had been strengthened as part of the Roll Back Malaria initiative. Dengue and dengue haemorrhagic fever continued to be a significant public health problem in the Region.

Member Countries were implementing national strategic plans to combat HIV/AIDS by involving all government sectors, NGOs and the community. The close association between tuberculosis and HIV was well established and at least 60-70 per cent of AIDS patients developed tuberculosis. Member Countries had adopted the global TB control strategy using DOTS as the main intervention. By 2000, the coverage with DOTS in the Region had expanded to nearly 45 per cent of the population, with a treatment success rate of 80 per cent.

The Region accounted for 80 per cent of the global caseload of leprosy, concentrated mainly in three endemic countries. Control activities had been accelerated in these countries with a view to achieving national leprosy elimination targets by 2005.

In the field of noncommunicable diseases, WHO had taken many initiatives to reduce common lifestyle-related risk factors. The South-East Asia Anti-tobacco Flame was launched in January 2000 with a view to mobilizing public participation in tobacco
control activities. WHO also supported the development and negotiation process of the International Framework Convention on Tobacco Control.

In the area of health systems and community health, adolescent health had been given high priority. The Integrated Management of Childhood Illness strategy was being implemented in countries with high infant and under-five mortality. Programmes for making pregnancy safer were receiving high priority. Member Countries had also developed strategies for gender mainstreaming.

WHO assisted Member Countries in reviewing progress and exchanging experiences in developing and implementing national nutrition promotion plans. With regard to food safety, new concerns had arisen with the increasing use of chemicals in agriculture and food processing, in addition to a lack of appropriate food safety measures. Efforts had also continued to support hospital waste management and to strengthen poison control and management capacity. Technical support was also provided to national drinking water and sanitation programmes and the problem of arsenic contamination of drinking water.

During the reporting period, WHO mobilized large extrabudgetary resources to tackle the natural disasters and complex emergencies that occurred in the Region. WHO had intensified its efforts to place injury prevention and control on the development agenda. Following the regional launch of the Vision 2020 initiative in September 2000, prevention of blindness programmes had received an added thrust.

In the area of mental health, the focus was on the development of community-based mental health care
programmes. A regional strategy on substance abuse was developed to create awareness and to define the goals for controlling substance abuse.

WHO continued its efforts to strengthen national drug policies to ensure the provision of essential drugs of acceptable quality and their rational use. WHO also worked closely with Member Countries to protect the intellectual property rights of traditional medicine.

The polio eradication initiative continued to receive priority support. Till end August 2001, only 56 cases of wild polio had been reported in India. Bhutan, Maldives and Sri Lanka had not had any wild polio virus isolates for more than six years while Thailand and Indonesia had not reported any case for more than three years. However, other vaccine-preventable diseases, including measles, tetanus and hepatitis B, continued to be major causes of morbidity and mortality.

WHO worked closely with the Member Countries in the collection, validation, analysis and dissemination of information on health situation and trends. Support was also provided to strengthen the quality of morbidity and mortality statistics and to improve the health information systems.

The Research Policy and Cooperation programme supported the strengthening of national health research capability, including ethics in health research, and promoted country-oriented research.

WHO continued to strengthen its partnership with UN agencies and other intergovernmental organizations to bring health into the centre of the development agenda. New initiatives had been launched to ensure full participation of Member Countries in
programme planning, development and evaluation. The Regional Office closely monitored programme implementation which resulted in efficiency savings and accelerated implementation during the biennium. The Regional Director’s Development Programme continued to support emergency situations in Member Countries and also to enhance innovative health development initiatives.

In conclusion, the Regional Director stated that while remarkable gains had been made in health development, there were still many formidable challenges to be faced. He was confident that with collective experience and in a spirit of solidarity, the goal of health for all could be achieved.

* * *

The Committee reviewed and discussed the report chapter by chapter.

The Committee felt that there was a need to identify research issues relating to various diseases, especially those that were close to elimination. However, more basic information about the impact of the diseases on health as well as the community’s knowledge regarding the nature of certain diseases, complications and risk factors needed to be highlighted. People’s awareness about common diseases in general should be increased through various measures and a conducive environment created to highlight the importance of healthy lifestyles to improve the health of the people.

The Committee noted with concern that bovine insulin for the treatment of diabetes might become scarce in the near future. At
the same time, unless appropriate efforts were made, human-origin insulin might not be accessible to the developing countries. It felt that cardiovascular disease, diabetes and hypertension were diseases that might begin in childhood and should be tackled through preventive means, in addition to adopting better lifestyles at the early stages. There was a need to reorient health services in managing noncommunicable diseases.

The Committee noted with satisfaction that the Region was promoting Integrated Management of Childhood Illness. Several initiatives had been undertaken, but there was a need to further develop and strengthen the programme. It stressed that priority be given to adolescent and reproductive health.

WHO’s role in human resources development was highlighted. The Committee appreciated the efforts made in this regard but called for further strengthening of this important area in Member Countries.

The need to strengthen health care financing to improve health system performance was recognized. Emphasizing that no programme could be carried out effectively without appropriate human and financial resources, the Committee called for special training programmes for non-medical and medical personnel to provide efficient managerial input for undertaking various health-related activities. This would help to streamline the health financing system.

The Committee called for more efforts in the area of water supply and sanitation and urged WHO to provide up-to-date
guidelines to the Member Countries for better management of water supply.

In response to a query, it was clarified that the various initiatives, such as healthy cities, healthy districts, health promoting schools, and health promoting hospitals formed part of the healthy environment initiative.

The Committee called for enhanced allocation for health promotion which was a vital area of concern.

Highlighting the need to improve mental health services in rural as well as urban areas, the Committee called for greater emphasis on services in rural areas.

Noting with concern the insufficient efforts made in regard to the ‘ageing’ population, the Committee requested WHO to stimulate constructive action in this area.

Affirming that accessibility and affordability of essential drugs were important issues, the Committee sought WHO’s increased collaboration, particularly with regard to the implications of the TRIPS Agreement. These had been discussed at the meeting of Health Ministers in Maldives in August 2000 which recommended appropriate policy actions to be undertaken by the Member Countries as well as WHO.

Appreciating the importance given by WHO to traditional medicine, it was noted that a large part of the population in the Region was dependent on medicines derived from natural herbs or medicinal plants. This was particularly so because diagnostic and curative services were expensive and inaccessible. Some countries were undertaking clinical trials and studies on the efficacy of
indigenous medicines for use in their primary health care systems. While preserving the existing knowledge, modernization of the old practices and processes and integration of traditional medicine into the national health care systems was needed. The efforts of WHO in this area should continue to be further enhanced.

The Committee appreciated the efforts being undertaken by Member Countries in the indigenous production of vaccines. It was felt that the existing national capacities of the Member Countries for vaccine production should be augmented with support from WHO and other international organizations. This would help achieve self-sufficiency and enable resources to be diverted to other important areas. It noted that sustainability in vaccine production could be achieved, especially in the smaller countries, through enhanced intercountry cooperation.

It was recalled that although five companies in India produced hepatitis B vaccine, the vaccine could not be introduced to cover risk groups in India. Similarly, some of the enteric vaccines (vaccines against rota virus, salmonella and cholera) produced in Asian countries very cheaply, could not be made available widely or afforded by their own populations.

The Committee commended the success of NIDs in the Member Countries that had contributed to major achievements in the polio eradication programme. It also noted the achievements of some countries in reaching the neonatal tetanus elimination targets and noted their efforts to upgrade the cold chain with external assistance. The Committee was informed that DPR Korea was sending weekly reports on AFP surveillance to the Regional Office. There was evidence that there was no polio transmission in the country.
The Committee noted that in Indonesia, a new institute of Food and Drugs Control had been constituted directly under the President. A new directorate within the Ministry of Health had been established to deal with pharmaceutical services. It was hoped that these mechanisms would ensure the quality of drugs and food products being imported as well as their regulated distribution.

Regarding extrabudgetary resources, the Committee was informed that these resources currently exceeded the level of the Regular budget in the SEA Region. Globally, these resources represented over 60 per cent of the funds available to WHO. The Committee agreed that extrabudgetary funding should be mobilized for priorities identified by WHO and the countries. Efforts must be intensified to ensure maximum flexibility in the use of voluntary funds.

The Committee appreciated WHO’s efforts in mobilizing extrabudgetary resources for various health-related activities in the countries as well as the continued positive trend in this direction. The Committee recognized the difficulty in ascertaining 2-3 years in advance the quantum of funds that would be available. This hampered the proper planning and management of such resources. The Committee also noted that most of the extrabudgetary resources are either earmarked for specific geographical areas or programmes, usually in the field of communicable diseases.

While recognizing that communicable diseases were a high priority, the Committee was informed that globally there would be an appreciable shift in Regular budgetary resources for noncommunicable diseases and mental health in the 2002-2003 biennium.
The Committee noted the increasing role of WHO in coordinating health development at the country level and ensuring that clear health priorities at the country level were identified and conveyed to donors. WHO also needed to work with other UN agencies in the UN Development Action Framework (UNDAF). In this regard, appropriate operational guidelines for country offices would be needed.

The importance of Information Technology in relation to health development was stressed. The Committee recognized the scope for increasing information flows through greater use of the Internet. WHO’s role in building informatics infrastructure for health telematics pilot projects in Bhutan, which was targeted to improve health care delivery, was appreciated. The need for training programmes and training material and inputs in the field of telemedicine was also highlighted.

Noting that snakebite was a major cause of morbidity and mortality in Myanmar and India, the Committee felt that the two countries should work together in this area to effectively address the problem.

It was suggested that the report in future should also include a section on lessons learnt. In response to a query, it was clarified that the report mainly contained details of WHO’s work in Member Countries and could not possibly cover various health interventions financed by other partners or national budgets. There were several other WHO publications and documents which provided evidence-based information, including quantitative data and qualitative analysis. The Committee noted that the biennial report highlighted the results achieved and provided detailed financial information for the first time.
The Committee noted with satisfaction the progress made during the period under review in implementing WHO’s collaborative programmes in the Region and congratulated the Regional Director and his staff on producing a clear and comprehensive report.

ADDRESS BY THE CHAIRMAN, SEA-ACHR

PROF N.K. GANGULY (Chairman, SEA-ACHR) presented the conclusions and recommendations of the 26th session of the South-East Asia Advisory Committee on Health Research, held in Thimphu, Bhutan, in April 2001. He said that research capacity strengthening and effective management of health research were critical for improving the functioning of national health research systems. The following criteria for health research activities to be supported by WHO were identified: WHO-supported research must contribute to knowledge gains in health and health development, address priority health problems of the Region, and result in capacity strengthening. Scientific and ethical clearance at appropriate levels was needed.

The management aspect of WHO collaborating centres was also reviewed. Networking of the collaborating centres would enable them to exchange information and share their strengths.

Reviewing the regional perspective in human genetics, SEA-ACHR emphasized that developments in this area should be health-driven rather than technology-driven. A situation analysis on the availability of clinical genetics and other related data was also recommended.
The SEA-ACHR recommended updating of the profile of national health research systems using a common framework. It also recommended undertaking a regional analysis and updating the information booklet on the criteria for supporting health research activities.

The Committee noted the paper prepared by SEA-ACHR on strategies for health research systems development in the South-East Asia Region and urged that ways and means be found to transform the strategic framework into action.

**STATEMENTS BY REPRESENTATIVES OF INTERGOVERNMENTAL AND NONGOVERNMENTAL ORGANIZATIONS**

DR Y. OZAWA (Office International Des Epizooties – OIE) stated that his organization was recognized as the intergovernmental organization for animal health and zoonoses by WTO and, together with the Codex Alimentarius, was one of the standard-setting organizations. It established international standards, guidelines, and recommendations aimed at preventing animal diseases and zoonoses through trade in animals and animal products. OIE thus contributed to overall global animal and human health as well as food safety.

DR SUCHITRA PRASANSUK (International Federation of Otolaryngological Societies – IFOS) stated that hearing impairment and deafness were global problems, particularly among the deprived community, in developing countries. Fifty per cent of cases of deafness were preventable at various levels through early detection and management. Successful implementation of the programme called for better management, a multidisciplinary
approach, better understanding of the problems and long-term follow-up.

DR CHANDRAKANT S. PANDAV (International Council for Control of Iodine Deficiency Disorders – ICCIDD) stated that his organization was dedicated to the elimination of iodine deficiency disorders. Goiter was only the tip of the iceberg as iodine deficiency affected all stages of human growth and development. The high-risk population groups were the unborn children, infants and young children. He, therefore, advocated the communication of a simple message “daily consumption of iodized salt – a healthy habit”. Efforts should be made to reach the unreached, the marginalized and vulnerable sections of the population.

MR J.B. MUNRO (Inclusion International Asia Pacific – IIAP) stated that intellectual disability should not be confused with mental health. He suggested that future reports of the Regional Director make a mention of this subject. Three out of a population of 1 000 were intellectually disabled or in medical terms known as ‘mentally retarded’. ESCAP had estimated that there were more than 240 million people with disability in the Asia Pacific Region. There was a need for more efforts in the rural areas to tackle this issue.

DATUK DR RAJ KARIM (Regional Director, East and South-East Asia Office, International Planned Parenthood Federation – IPPF) stated that IPPF was the largest international NGO working in the field of reproductive and sexual health with a presence in more than 150 countries. Its objective was to support hard-to-reach and marginalized groups, especially those not generally covered by government programmes or the health sector. Promotion of
women’s health and prevention of maternal mortality and morbidity continued to be its priorities. IPPF continued to advocate the need for sexuality education for adolescents and youth. It had also integrated HIV/AIDS prevention and management in its work programme.

PROF M. PARAMESHVARA DEVA (Zonal Representative, World Psychiatric Association – WPA) stated that the World Psychiatric Association represented psychiatrists in over 115 member societies in more than 100 countries. WPA assisted Member Countries by contributing to changes in knowledge, skills and attitudes towards the betterment of mental health of the people. It endeavoured to spread the highest quality of care for the mentally ill all over the world.

MR SUDHARSHAN AGARWAL (Rotary International – RI) stated that Rotary International fully supported the initiative of WHO, CDC and UNICEF to certify the world polio-free by 2005, by helping to bridge the resources gap through public and private sector advocacy and mobilization of funds. Since 1995, RI’s polio eradication advocacy task force had been playing a significant role in influencing the donor governments to contribute over US $ one billion. In addition, the joint appeal by RI and the United Nations Foundation had generated nearly US$ 80 million. Over 1.2 million Rotarians and their family members worked in close collaboration with WHO and other agencies in polio-endemic countries for social mobilization, vaccination, surveillance and other activities. However, there was no room for complacency and all needed to strive hard to accomplish the common goal of polio eradication.
MS EILEEN BARBARO (International Council of Nurses – ICN) stated that ICN, a federation of national nursing associations in 124 countries, had the mandate to improve standards of nursing practice, education and research and strengthen their contribution to health systems. She stated that the ICN leadership training programme was being offered in Bangladesh, with plans to extend it to Myanmar and Nepal. ICN firmly believed that effective performance of health systems, including disease surveillance, monitoring and control measures, required strong team effort. ICN assured its continued commitment with full participation as equal partners.

MR ALAIN AUMONIER (International Federation of Pharmaceutical Manufacturers Associations – IFPMA) highlighted the discussions at the Fifty-fourth World Health Assembly relating to HIV/AIDS and the WHO medicines strategy. The Assembly resolutions called for access to medicine as a matter of shared responsibility between the pharmaceutical industry, Member Countries, international organizations and nongovernmental organizations. Though medicines and vaccines were manufactured in large quantities, the responsibility to ensure that they reached the people usually depended on the health infrastructure, distribution systems and regulatory framework. Another significant issue was the affordability of medicines. Eighty per cent of the retail price consisted of taxes, duties and distribution costs. The Association continued to collaborate with WHO through a regular round-table process, which was very valuable in undertaking concrete work on R&D for neglected diseases, new mechanisms to improve access to medicines, promote drug quality and combat counterfeit drugs.
DR NWE OO (Myanmar Maternal and Child Welfare Association - MMCWA) stated that MMCWA actively participated in the formulation of the National Health Plan. The MMCWA was a partner with the Ministry of Health in providing comprehensive health services to the people. It firmly believed in the principles of self-reliance, community participation, intersectoral cooperation and coordination. Some of its notable activities included organization of national immunization days, national sanitation weeks, leprosy elimination campaigns, and participation in TB control and HIV/AIDS prevention programmes.

PROF (DR) SHATENDRA K. GUPTA (World Organization of National Colleges and Academies of General Practitioners/Family Physicians - WONCA) stated that the objectives of WONCA included improvement of the health of individuals, families, communities and nations. These objectives could be achieved through training of patient-centred family doctors. He highlighted the need to strengthen training programmes for family doctors in the developing world. WONCA would be glad to assist in strengthening training programmes for family doctors in the medical colleges of the countries.

EVALUATION OF IMPLEMENTATION OF THE FOLLOWING TWO INTERCOUNTRY PRIORITY PROGRAMMES DURING 2000-2001:
(A) IMPROVING THE HEALTH OF THE MARGINALIZED AND VULNERABLE GROUPS, AND (B) TOBACCO FREE INITIATIVE
(Agenda item 7.1, document SEA/RC54/6)

THE COMMITTEE noted that, in accordance with the recommendations of the 53rd session of Regional Committee, two
ICP-II programmes (Improving the health of the marginalized and vulnerable groups, and Tobacco-free Initiative) were selected for joint evaluation. The evaluation was undertaken in India, Indonesia, Myanmar, Nepal and Sri Lanka. The report of the evaluation was reviewed by the 38th meeting of CCPDM. The CCPDM recommended that: (1) the joint evaluation exercise should be continued within the overall context of WHO’s evaluation framework; (2) the areas chosen for support through intercountry programmes should continue over at least two biennia; and (3) the joint evaluation team should include an expert from outside the Region.

Noting the observations and recommendations of the 38th meeting of CCPDM, the Committee suggested that the intercountry programme would also benefit the indigenous population in the countries of the Region which hitherto had been neglected. It noted that the indigenous population in the Region was slowly dwindling owing to infertility and vulnerability to specific infections, such as malaria, thalassaemia and sickle-cell anaemia. Intercountry exchange of data and information would help to develop suitable interventions to address their problems.

**DETAILED WORK PLANS FOR PROGRAMME BUDGET 2002-2003**
(Agenda item 7.2, document SEA/RC54/R16)

As recommended by the 38th meeting of CCPDM (Annex 7, items 5 and 7), the draft work plans were presented to the Regional Committee for noting. The Committee reviewed the detailed work plans (country, Regional Office/ICP and supplementary intercountry programme) for the 2002-2003 biennium, prepared within the context of a strategic “One WHO” programme budget. Extensive
consultations among the national counterparts, WHO country offices, the Regional Office and WHO headquarters ensured that the work plans were complementary and mutually supportive. The Committee noted with satisfaction that country-level activities could contribute to regional and global expected results.

The CCPDM considered that while finalizing the work plans, summary tables for ICP-I work plan, identifying categories of expenditure, should be provided. For further enhancing the implementation level during 2002-2003, the Committee agreed that the implementation targets for the Regular budget during the biennium should be set at 85 per cent by 31 December of the first year and 100 per cent by June of the second year. It also suggested that the implementation of the revised targets at country and regional levels should continue to be closely monitored. Countries could still reprogramme the planned activities during the biennium for emerging priorities.

The Committee appreciated the efforts of the Regional Office in accelerating the implementation of the programme budget for the current biennium (2000-2001) compared with the previous three biennia, when huge reserves were surrendered. It was suggested that fellowships and supplies and equipment could be implemented in the first year of the biennium.

The Committee recognized that there were other managerial mechanisms at country and regional levels which could enhance the level of implementation.

The challenge of achieving the 85 per cent target called for concerted efforts by both national and WHO staff at all levels (country and regional). The Committee suggested that WHO
mobilize extrabudgetary funds that could be utilized for implementation during the second year of the biennium.

A resolution on the subject was adopted (SEA/RC54/R1).

CONSIDERATION OF THE RECOMMENDATIONS ARISING OUT OF THE TECHNICAL DISCUSSIONS ON MENTAL HEALTH AND SUBSTANCE ABUSE, INCLUDING ALCOHOL
(Agenda item 8.1, document SEA/RC54/14)

THE COMMITTEE was informed that Technical Discussions on mental health and substance abuse, including alcohol, had been held in conjunction with the 38th meeting of the Consultative Committee for Programme Development and Management. The report and recommendations arising out of the Technical Discussions (Annex 8) were placed before the Committee for deliberation. The Committee reviewed the report and endorsed the recommendations.

A resolution on the subject was adopted (SEA/RC54/R2).

SELECTION OF A SUBJECT FOR THE TECHNICAL DISCUSSIONS TO BE HELD PRIOR TO THE FIFTY-FIFTH SESSION OF THE REGIONAL COMMITTEE
(Agenda item 8.2, document SEA/RC54/10)

THE COMMITTEE decided to hold Technical Discussions on the subject of Management of Decentralization of Health Care in 2002 during the 39th meeting of CCPDM prior to the fifty-fifth session of the Regional Committee.

The Committee urged the Member States to participate fully in these Technical Discussions.
ARSENIC CONTAMINATION OF GROUNDWATER AFFECTING SOME COUNTRIES OF THE SOUTH-EAST ASIA REGION
(Agenda item 9, document SEA/RC54/8)

THE COMMITTEE was concerned that high arsenic content in drinking water supply posed a serious threat to the health of the people in the Member Countries. Epidemiological studies had shown that arsenic contamination, though widespread in Bangladesh and India, was confined to certain geographical areas. It was estimated that approximately 30 million people in the Region were potentially at risk from arsenic-related diseases. Nearly a quarter of a million showed signs of arsenicosis.

The Committee noted that the strategic plan developed by the Regional Office focused on three main areas: (1) responding to arsenic hazards through exposure assessment, risk determination and risk management; (2) strengthening infrastructure for arsenic mitigation, and (3) capacity building through human resource development. The Committee emphasized the need for the countries to intensify their efforts, particularly with regard to resource mobilization and sharing of country experiences.

A resolution on the subject was adopted (SEA/RC54/R3).

HEALTH AND ENVIRONMENT IN NATIONAL DEVELOPMENT:
REGIONAL PROGRESS AND PREPARATIONS FOR RIO+10 CONFERENCE
(Agenda item 10.1, document SEA/RC54/11 and Corr.1)

THE COMMITTEE recognized that the preparations for Rio+10 provided an excellent opportunity to ministries of health to proactively involve themselves in national review processes. This
opportunity should be utilized since the determinants of health and diseases mostly lay in sectors other than health.

The Committee noted that a Regional Strategic Plan and national plans of action for Health and Environment had been prepared. Considering the significant role of factors such as population explosion, rapid urbanization and poverty, intersectoral action was urgently required.

**MULTI-DISEASE SURVEILLANCE: CROSS-BORDER COLLABORATION**

(Agenda item 10.2, document SEA/RC54/9)

THE COMMITTEE was informed that increased cross-border travel and trade in the Region had highlighted the risk of the spread of diseases. Thus, it was important that health security was given priority attention. The Committee recommended development of multi-disease surveillance for effective control of disease and risk factors, especially at district and sub-district levels.

The Committee noted that effective intersectoral action was needed to address common cross-border health problems, as highlighted by the Ministers of Health at their meeting in August 2001 in Maldives. It emphasized the need to carefully review the use of insecticides for effective cross-border prevention and control of vector-borne diseases.

**POLIO ERADICATION IN THE SOUTH-EAST ASIA REGION**

(Agenda item 10.3, document SEA/RC54/7)

THE COMMITTEE noted that polio eradication efforts in the Region had recently made tremendous strides. Laboratory confirmed cases had decreased by nearly 80 per cent in 2000. Though this decrease
indicated the effectiveness of the strategies, current efforts needed
to be maintained and even intensified. In 2001, extensive reviews
of the AFP surveillance system had been carried out in Nepal, India,
DPR Korea and Bangladesh. In addition to maintaining adequate
surveillance, all countries of the Region would be continuing
intensified National Immunization Days or Sub-national
Immunization Days as a cornerstone of the eradication strategy.

The Committee noted with appreciation the progress made by
the Region towards the goal of certification of polio-free status.
Interruption of wild polio-virus transmission in the Region by late
2001 or early in 2002 was possible. Synchronized observance of
NIDs and SNIDs in the countries of the Region since 1996 was an
excellent example of intercountry collaborative actions. The
infrastructure that had been built for polio eradication could be
used for other disease control and public health interventions.

The Committee reiterated the need for continued advocacy
and political commitment, sustaining the current surveillance and
immunization strategies, planning for “laboratory containment”
and preparing the documentation needed for certification.

REGIONAL IMPLICATIONS OF THE DECISIONS AND RESOLUTIONS
OF THE FIFTY-FOURTH WORLD HEALTH ASSEMBLY AND THE
107TH AND 108TH SESSIONS OF THE WHO EXECUTIVE BOARD,
AND REVIEW OF THE DRAFT PROVISIONAL AGENDAS OF THE
109TH SESSION OF THE WHO EXECUTIVE BOARD AND THE
FIFTY-FIFTH WORLD HEALTH ASSEMBLY
(Agenda item 11, document SEA/RC54/12 and Add.1)

Part I
THE COMMITTEE was informed that this agenda item had been presented along with the report of the 38th meeting of CCPDM, which had already reviewed this item. As per the recommendation of the 37th meeting of CCPDM, all resolutions and decisions of the WHO Executive Board and the World Health Assembly were included in the working paper for review and comments. The purpose of presenting the document to the Committee was to seek its response on those resolutions which had regional implications.

On resolution WHA54.1, relating to the General Programme of Work, the Committee noted that the Health Ministers, at their recent meeting in Maldives, had identified areas to be included as regional input to the Organization-wide priorities for 2004-2005 and requested the Regional Director to transmit these to the WHO Director-General.

The Committee called upon the Member Countries to realign their policy in keeping with resolution WHA54.2 on Infant and Young Child Nutrition, to emphasize exclusive breast-feeding for six months.

With regard to resolution WHA54.10 on Scaling up the Response to HIV/AIDS, noting the developments relating to the new Global AIDS and Health Fund, the Committee endorsed the recommendation of the meeting of Health Ministers to establish a Task Force to deal with this important issue. The Committee also called for the highest level of political commitment for effective prevention and control of HIV/AIDS.

While reviewing resolution WHA54.12 on Strengthening Nursing and Midwifery, the Committee expressed the need to train nurses and midwives to equip them to attend to emergency
situations in rural health centres. The Committee acknowledged the shortage of nursing and midwifery personnel in some countries.

With regard to resolutions WHA54.17 and WHA54.22, relating to assessments for the financial period 2002-2003 and Reform of the Executive Board respectively, the Committee requested the members of the Executive Board from the SEA Region to effectively participate and articulate regional perspectives in the sessions of the Executive Board. The Committee felt that these issues should also be effectively deliberated at the ensuing meeting of Health Secretaries of the Region.

The Committee, while appreciating resolution WHA54.19 on Schistosomiasis and Soil-transmitted Helminth Infections, recognized that there would be problems in ensuring access to essential drugs to control the infections.

The Committee noted the observations and recommendations of the 38th meeting of CCPDM and requested the Regional Director to transmit its observations and comments as above to WHO headquarters.

**Part II**

THE DRAFT provisional agenda of the 109th session of the Executive Board was submitted for review by the Committee. The agenda of the Fifty-fifth World Health Assembly would be available after review by the Executive Board in January 2002.

The Committee noted, without comment, the provisional agenda of the 109th session of the Executive Board and requested the Regional Director to communicate this to the Director-General.
UNDP/ WORLD BANK/ WHO SPECIAL PROGRAMME FOR RESEARCH AND TRAINING IN TROPICAL DISEASES: JOINT COORDINATING BOARD (JCB) - REPORT ON ATTENDANCE AT 2001 JCB, AND NOMINATION OF A MEMBER IN PLACE OF SRI LANKA WHOSE TERM EXPIRES ON 31 DECEMBER 2001
(Agenda item 12.1, document SEA/RC54/5)

THE COMMITTEE was informed that on behalf of Bangladesh, India and Sri Lanka, the representative from Sri Lanka had reported to the 38th meeting of CCPDM on the deliberations of the 24th session of JCB, held on 25-26 June 2001. Among other issues, JCB called upon the TDR programme to maintain close collaboration with other special programmes of WHO, particularly regarding vaccine development and other related activities. It also emphasized the use of geographical mapping in forecasting and control of epidemics, the use of traditional medicine for the treatment of malaria and the need to support vector control research, including transgenic vector control.

The Committee noted the report of the 38th meeting of CCPDM on this subject.

The Committee nominated Thailand as a member of JCB for three years from 1 January 2002 and requested the Regional Director to inform WHO headquarters accordingly.

WHO SPECIAL PROGRAMME FOR RESEARCH, DEVELOPMENT AND RESEARCH TRAINING IN HUMAN REPRODUCTION - REPORT ON THE POLICY AND COORDINATION COMMITTEE (PCC) SESSION AND NOMINATION OF A MEMBER TO PCC IN PLACE OF INDIA
WHOSE TERM EXPIRES ON 31 DECEMBER 2001
(Agenda item 12.2, document SEA/RC54/4 and Corr.1)

THE COMMITTEE was informed that on behalf of Bangladesh, India and Indonesia, the representative from Indonesia had reported to the 38th meeting of CCPDM on the proceedings of the 14th meeting of PCC, held on 20-21 June 2001. The PCC deliberated on a wide range of activities, including the report of the eighteenth meeting of the Scientific and Technical Advisory Group. The PCC noted that in the context of development, family planning was critical and needed to remain at the forefront of the reproductive health and development agenda.

The Committee noted the report of the 38th meeting of CCPDM on this item.

The Committee renominated India to PCC for a further period of three years with effect from 1 January 2002 and requested the Regional Director to inform WHO headquarters accordingly.

TIME AND PLACE OF FORTHCOMING SESSIONS OF THE REGIONAL COMMITTEE
(Agenda item 13, document SEA/RC54/3)

THE COMMITTEE accepted the confirmation by the Government of Indonesia to host the fifty-fifth session of the Regional Committee in the second week of September 2002 in conjunction with the Meeting of Ministers of Health. The exact venue and dates of the session would be decided in consultation with the Ministry of Health.
The Committee reiterated its earlier decision to hold the fifty-sixth session of the Regional Committee in 2003 at the WHO Regional Office for South-East Asia in New Delhi, India.

The Committee also accepted the invitation of the Government of the Republic of Maldives to host the fifty-seventh session in Maldives in 2004. The exact venue and dates of the session would be decided in consultation with the Ministry of Health.

ADOPTION OF RESOLUTIONS

THE COMMITTEE adopted the following four resolutions:

(1) Programme Budget 2002-2003
(2) Mental Health and Substance Abuse, including Alcohol
(3) Arsenic Contamination of Groundwater Affecting Countries of the South-East Asia Region
(4) Resolution of Thanks

ADOPTION OF THE REPORT OF THE FIFTY-FOURTH SESSION OF THE WHO REGIONAL COMMITTEE FOR SOUTH-EAST ASIA
(Agenda item 14, document SEA/RC54/17)

The Committee adopted the draft report of the fifty-fourth session, as contained in document SEA/RC54/17, with certain modifications.

CLOSURE OF THE SESSION (Agenda item 15)

The representatives of the Member Countries congratulated the Government of Myanmar for hosting the session and for the
excellent arrangements made. They thanked His Excellency Major General Ket Sein, Minister for Health, Government of Myanmar, for inaugurating the session and for his inspiring address. They also congratulated the Chairman, the Vice-chairman, the Regional Director, the Deputy Regional Director and the WHO Secretariat for their efforts in bringing the session to a successful conclusion. The representatives expressed their appreciation and gratitude to the Government of Myanmar for their generous hospitality. They hoped that the decisions taken by the Regional Committee would help promote and strengthen health development activities in the countries of the Region. They also thanked the Government of Indonesia for their offer to hold the fifty-fifth session of the Regional Committee in 2002 in their country.

The Regional Director, in his closing remarks, said that the important resolutions on mental health, arsenic and programme budget 2002-2003, adopted by the Committee, would strengthen collaborative activities and help the countries in facing the many challenges of health development in the Region. He thanked H.E. Major General Ket Sein for his encouraging and inspiring address and congratulated him for his valuable guidance in the health development of his country. He also thanked H.E. Senior General Than Shwe, Chairman, H.E. Lt. General Khin Nyunt, Secretary I, State Peace and Development Council, and other officials of the Ministry of Health, the Organizing Committee and the Traders Hotel for the excellent arrangements which contributed to the successful conduct of the session.

The Chairman thanked the representatives for their words of appreciation and said that the proceedings of the Regional Committee had been very useful and stimulating. He appreciated
the cooperation and support extended by the representatives during the session, and also thanked the Vice-Chairman, Dr Azrul Azwar, for sharing the responsibility of chairing the meeting. He hoped that the important decisions taken by the Committee would be a driving force for the Member States in their endeavour to achieve the best possible level of health for their people. He also thanked the representatives of nongovernmental organizations for their contributions. Finally, the Chairman expressed his sincere gratitude to the Regional Director, the Deputy Regional Director and the WHO Secretariat for their untiring work in making the event a success, and to the Government of Indonesia for offering to hold the fifty-fifth session in their country.

The Chairman then declared the session closed.
Part IV

RESOLUTIONS

SEA/RC54/R1  PROGRAMME BUDGET 2002-2003

The Regional Committee,

Recalling its own resolution SEA/RC53/R2,

Having considered the report of the 38th meeting of the Consultative Committee for Programme Development and Management (document SEA/PDM/Meet.38/8),

Noting the efforts undertaken by the Regional Director to achieve full implementation of the programme budget for the 2000-2001 biennium, and the evaluation of two intercountry priority programmes on (1) Improving the Health of the Marginalized and Vulnerable Groups, and (2) Tobacco Free Initiative,

Appreciating the collaborative efforts in preparing and finalizing the Work Plans for countries, intercountry and Regional Office for the biennium 2002-2003 within the "One WHO" managerial framework, and
Recognizing the need to further enhance the implementation level during 2002-2003,

1. APPROVES the report of the Consultative Committee for Programme Development and Management;
2. ENDORSES the increased use of the intercountry mechanism in the implementation of priority health programmes, and
3. CALLS for a strong commitment and joint endeavours by the Member States and WHO to meet the implementation target of 85 per cent of the funds by 31 December 2002 and 100 per cent by 30 June 2003.

Sixth Meeting, 5 September 2001

SEA/RC54/R2 MENTAL HEALTH AND SUBSTANCE ABUSE, INCLUDING ALCOHOL

The Regional Committee,

Recalling World Health Assembly resolutions WHA29.21, WHA30.38, WHA32.40, WHA33.27 and WHA39.25, and its own resolutions SEA/RC30/R4 and SEA/RC41/R5 relating to mental health and drug and alcohol-related problems,

Recognizing that neuropsychiatric conditions account for 10 per cent of the burden from noncommunicable diseases in developing countries and that globally, depression is a leading cause of disability-adjusted life years lost in young adults,

Concerned at the increasing number of persons becoming dependent on narcotics and alcohol in both rural and urban areas in the Member Countries of the Region, and
Having considered the recommendations of the Technical Discussions held during the 38th meeting of the Consultative Committee for Programme Development and Management,

1. ENDORSES the recommendations arising out of the Technical Discussions on Mental Health and Substance Abuse, including Alcohol (document SEA/RC54/14);

2. URGES Member States:
   (a) to further strengthen the development of national policies and programmes on mental health, drug and alcohol-related problems through assessment of the burden and major determinants of such disorders;
   (b) to enhance human resource development in mental health for appropriate levels of health workers;
   (c) to strengthen community-based prevention and control programmes on mental health and substance abuse, including alcohol, and
   (d) to integrate essential interventions pertaining to promotion of mental health and prevention and control of mental disorders into public health and social welfare programmes at the policy and implementation levels, and

3. REQUESTS the Regional Director:
   (a) to support Member States in strengthening national programmes on mental health and substance abuse, including alcohol;
(b) to promote intercountry cooperation and exchange of information in the area of mental health and substance abuse, including alcohol, and

(c) to facilitate mobilization of resources for programmes on mental health and control of substance abuse, including alcohol.

Sixth Meeting, 5 September 2001

SEA/RC54/R3 ARSENIC CONTAMINATION OF GROUND WATER AFFECTING COUNTRIES OF THE SOUTH-EAST ASIA REGION

The Regional Committee,

Recalling its resolution SEA/RC52/R6 relating to arsenic poisoning,

Concerned that high arsenic contents in drinking water supply pose a serious threat to the health of large populations in the affected countries of the South-East Asia Region,

Recognizing the importance of proper case detection and management for mitigating the effects of arsenic poisoning in many countries of the Region, and

Appreciating the measures undertaken by Member States to tackle the situation of arsenic in ground water by involving all the relevant sectors, including nongovernmental organizations,

1. URGES Member States to accord high priority to arsenic mitigation activities, including strengthening of national capacity for laboratory confirmation of arsenic poisoning,
2. REQUESTS the Regional Director:

   (a) to enhance support to Member States in their efforts to intensify arsenic mitigation activities, including provision of guidelines, norms and standards for the surveillance, diagnosis and treatment of poisoning;

   (b) to promote intercountry collaboration, exchange of information and networking in the management of arsenic poisoning, and

   (c) to facilitate resource mobilization for the provision of safe water supply in affected countries.

Sixth Meeting, 5 September 2001
3. CONGRATULATES the Regional Director and his staff on their dedicated efforts towards the successful and smooth conduct of the session.

Sixth Meeting, 5 September 2001
Annexes
Annex 1

AGENDA¹

1. Opening of the Session

2. Sub-committee on Credentials
   2.1 Appointment of the Sub-committee
   2.2 Approval of the report of the Sub-committee

3. Election of Chairman and Vice-Chairman

4. Adoption of Agenda and Supplementary Agenda, if any


6. Address by the Director-General, WHO

¹ Originally issued as document SEA/RC54/1 dated 18 July 2001.
7. Programme Budget

7.1 Evaluation of implementation of the following two intercountry priority programmes during 2000-2001:

(a) Improving the health of the marginalized and vulnerable groups
(b) Tobacco Free Initiative

7.2 Detailed work plans for Programme Budget 2002-2003

8. Technical Discussions:

8.1 Consideration of the recommendations arising out of the Technical Discussions on Mental Health and Substance Abuse, including Alcohol

8.2 Selection of a subject for the Technical Discussions to be held prior to the fifty-fifth session of the Regional Committee

9. Arsenic contamination of groundwater affecting some countries of the South-East Asia Region

10. Technical Updates:

10.1 Health and environment in national development: Regional progress and preparations for Rio+10 Conference

10.2 Multi-disease surveillance: cross-border collaboration

10.3 Polio eradication in the South-East Asia Region
11. Regional implications of the decisions and resolutions of the Fifty-fourth World Health Assembly and the 107th and 108th sessions of the WHO Executive Board, and Review of the draft provisional agendas of the 109th session of the WHO Executive Board and the Fifty-fifth World Health Assembly

12. Special Programmes

12.1 UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases: Joint Coordinating Board (JCB) – Report on attendance at 2001 JCB and nomination of a member in place of Sri Lanka whose term expires on 31 December 2001

12.2 WHO Special Programme for Research, Development and Research Training in Human Reproduction: Policy and Coordination Committee (PCC) – Report on attendance at 2001 PCC and nomination of a member in place of India whose term expires on 31 December 2001

13. Time and place of forthcoming sessions of the Regional Committee

14. Adoption of the report of the fifty-fourth session of the Regional Committee

15. Closure of the Session
Annex 2

LIST OF PARTICIPANTS

1. Representatives, Alternates and Advisers

**BANGLADESH**

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<th>Role</th>
<th>Name</th>
<th>Title and Organization</th>
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<tr>
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<td>Director-General of Health Services</td>
<td>Dhaka</td>
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<td>Alternate</td>
<td>Mr Md Afzal Hossain</td>
<td>Joint Secretary (WHO and Public Health)</td>
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**BHUTAN**

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<tr>
<td>Representative</td>
<td>Dr Sangay Thinley</td>
<td>Secretary</td>
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  - Pyongyang

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### 4. Representatives from International Nongovernmental Organizations
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<th>Organization</th>
<th>Contact Person</th>
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<td>Organization</td>
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<tr>
<td>International Federation of Gynaecology and Obstetrics</td>
<td>Prof. Mary Krasu</td>
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<tr>
<td>International Federation of Pharmaceutical Manufacturers Associations</td>
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<td>International Planned Parenthood Federation</td>
<td>Datuk Dr Raj Karim</td>
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<td>Medical Women’s International Association</td>
<td>Dr Jyoti H. Trivedi</td>
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<tr>
<td>Save the Children</td>
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<td>Organization</td>
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<td>Rotary International</td>
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<td>World Dental Federation</td>
<td>Prof. Ba Myint</td>
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<td>World Organization of Family Doctors</td>
<td>Prof. Shatendra K. Gupta</td>
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<tr>
<td>World Psychiatric Association</td>
<td>Prof. M. Parameshvara Deva</td>
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5. Representatives from Nongovernmental Organizations in Myanmar

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Myanmar Health Assistant Association
U Pan
President
U Aye Myint
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Myanmar Maternal and Child Welfare Association
Prof. Dr Daw Kyu Kyu Swe
President
Dr Daw Khin Win Shwe
Vice President
Dr Nwe Oo
Joint Secretary

Myanmar Red Cross Society
Dr Kyaw Win
President

Myanmar National Committee for Women’s Affairs
Prof. Dr Mya Mya
Annex 3

LIST OF OFFICIAL DOCUMENTS

SEA/RC54/1 Agenda


SEA/RC54/3 Time and place of forthcoming sessions of the Regional Committee

SEA/RC54/4 and Corr.1 Special Programme of Research, Development and Research Training in Human Reproduction – Report on the Policy and Coordination Committee (PCC) session and nomination of a member to PCC in place of India whose term expires on 31 December 2001

SEA/RC54/5 UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases: Joint Coordinating Board (JCB) – Attendance at 2001 JCB and nomination of a member in place of Sri Lanka whose term expires on 31 December 2001

SEA/RC54/6 Joint Evaluation of two Supplementary Intercountry Programmes (ICPO- II) “Tobacco Free Initiative” and “Improving the health of the marginalized and vulnerable groups”

SEA/RC54/7 Technical Update on Polio Eradication in the South-East Asia Region
<table>
<thead>
<tr>
<th>Annexes</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>SEA/RC54/8</td>
<td>Arsenic contamination of Groundwater affecting some countries in the South-East Asia Region</td>
</tr>
<tr>
<td>SEA/RC54/9</td>
<td>Multidisease Surveillance: Cross-Border Collaboration</td>
</tr>
<tr>
<td>SEA/RC54/10</td>
<td>Selection of a subject for the Technical Discussions to be held during the 39th meeting of the Consultative Committee for Programme Development and Management (CCPDM)</td>
</tr>
<tr>
<td>SEA/RC54/11 and Corr.1</td>
<td>Health and Environment in National Development: Regional Progress and preparation for Rio+10 Conference</td>
</tr>
<tr>
<td>SEA/RC54/12 and Add.1</td>
<td>Regional implications of the decisions and resolutions of the Fifty-fourth World Health Assembly and the 107th and 108th sessions of the WHO Executive Board and Review of the draft provisional agendas of the 109th session of the WHO Executive Board and the Fifty-fifth World Health Assembly</td>
</tr>
<tr>
<td>SEA/RC54/13</td>
<td>List of Participants</td>
</tr>
<tr>
<td>SEA/RC54/14</td>
<td>Consideration of the recommendations arising out of the Technical Discussions on Mental Health and Substance Abuse, including Alcohol</td>
</tr>
<tr>
<td>SEA/RC54/15</td>
<td>Report of the Sub-committee on Credentials</td>
</tr>
<tr>
<td>SEA/RC54/16</td>
<td>Detailed work plans for programme budget 2002-2003</td>
</tr>
<tr>
<td>SEA/RC54/17</td>
<td>Draft report of the fifty-fourth session of the WHO Regional Committee for South-East Asia</td>
</tr>
<tr>
<td>SEA/RC54/18</td>
<td>Report of the fifty-fourth session of the WHO</td>
</tr>
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</table>
Regional Committee for South-East Asia

**Information Documents**

SEA/RC54/Inf.1 List of technical reports issued and meetings and courses organized during 1 July 2000 - 30 June 2001

SEA/RC54/Inf.2 List of plans of action in operation during 2000-2001 (Regular Budget)

SEA/RC54/Inf.3 Strategies for health research systems development in WHO South-East Asia

SEA/RC54/Inf.4 Presentation on Health Systems Reform

**Resolutions**

SEA/RC54/R1 Programme Budget 2002-2003

SEA/RC54/R2 Mental Health and Substance Abuse, Including Alcohol

SEA/RC54/R3 Arsenic Contamination of Ground Water Affecting Countries of the South-East Asia Region

SEA/RC54/R4 Resolution of Thanks
TEXT OF ADDRESS BY H.E. MAJOR GENERAL KET SEIN, MINISTER FOR HEALTH, GOVERNMENT OF THE UNION OF MYANMAR

IT GIVES ME great pleasure to deliver the inaugural address at this 54th Regional Committee Meeting of the WHO South-East Asia Region. This is the fourth time that the Regional Committee meeting is being held in Myanmar. The Regional Committee was last held in 1971 and now it is our pleasure to once again host this important meeting. On behalf of the Government and the people of the Union of Myanmar, may I extend a most cordial welcome to the honourable advisers and distinguished delegates to our country.

It is evident that during the past three years, there has been a change in WHO’s ways of working. A corporate strategy and a strategic programme budget have been adopted. Special efforts have been made to encourage intensive and focused partnerships. These include the government sector, professional associations, the research community, community-based organizations, foundations and bilateral agencies. This has made WHO inputs more effective and responsive to meet the challenges faced by Member Countries. The country cooperation strategy has been incorporated into our national health plan, in ways that reflect the country’s needs and priorities.
The South East-Asia Region is home to 25 per cent of the world’s population and bears a very high burden of diseases. But the level of resources available for health is grossly inadequate. Thus, the declaration from the Non-aligned movement, following the meeting in Africa, calling for a major increase in resources for health is most encouraging. In fact, the resource gap is the underlying cause of the health divide. It is clear that only very few countries have access to the fruits of the technological revolution. To bridge that divide we will have to increase access to resources, commodities, health systems, information and technology.

The South -East Asia Region has experienced a steady gain in the health status of the people, of which we can justifiably be proud. However, we are still faced with major health challenges due to changing social, demographic, epidemiological and environmental changes. Malaria, tuberculosis and HIV/AIDS continue to be major health problems in our Region. In addition we are faced with the burden of increasing noncommunicable diseases as well. It is well known that infectious agents do not respect international boundaries and can spread from one country to another. Thus, close collaboration among the countries is essential to prevent and control the trans-border spread of diseases. The World Health Organization has supported cross-border joint action programmes that will definitely strengthen rapid response mechanisms and surveillance networks to contain outbreak of diseases in the border areas.

The Government of the Union of Myanmar, recognizing the role of health for sustainable development of the country, is committed to strengthen its health systems to meet the needs of the people. Making health central to human development,
equitable access to essential primary health services have been ensured, even in the remote areas. The Head of State, His Excellency Senior General Than Shwe, has stated that the health of all citizens of the country is important to enable everyone to strive towards building a modern developed nation. In planning for health development in the country, priority has been given to:

- enhancing capacity of human resources for health
- health infrastructure development
- rural health development, and
- improving the quality of health care.

The National Health Plan has been drawn up based on these priorities and with the aim of ensuring sustainable development and enhancing the quality of life of future generations. Accordingly, the Government views expenditures on health as a sound investment, especially for achieving national development. It is well known that promotion of health and social development are vital for enhancing the quality of life. The health sector has received priority in the allocation of government budget and is the fourth largest recipient after agriculture, construction and education sectors. This is supplemented to a lesser extent by a social security system, community contributions, private household expenditure and external aid, which are other sources of health care financing in Myanmar. Although the Ministry of Health is the main service provider, Ministries such as Railways, Mines, Transport etc. have their own medical facilities for its employees and dependents. The Social Security System, established in 1956 under the Ministry of Labour, covers medical services for workers under the scheme. Trust funds have also been set up in the
hospitals all over the country to ensure that the indigent have access to adequate medical care.

Let me take this opportunity to inform you of the determined efforts of the State Peace and Development Council to improve the health status of the people of Myanmar. In 1988, government health expenditure was Kyats 436 million. In the year 2000, it has risen to Kyats 43.859 billion (forty three point eight billion). During the 12-year period, a total of 114 hospitals, 67 rural health centres, 20 urban health centers, and 28 dispensaries in rural areas were established. A total of 84 existing hospitals were also upgraded.

Furthermore, necessary modern equipment, drugs and health manpower were provided for these health facilities. Health institutions in Mandalay have also been upgraded so that the facilities are on par with those in Yangon. The main objectives are to increase health coverage of the rural population and to ensure that the community has access to quality health care, meeting the health needs of the people, thereby improving their quality of life. All these would not have been possible without ensuring peace and tranquillity in the country. The Government of the Union of Myanmar has been able to end almost all the armed conflicts in the country, which has contributed to the health and development of the country, including the border areas.

Most of the developing countries of the world are facing the double burden of diseases, communicable and noncommunicable. No country has been immune to the problem of HIV/AIDS. The African and Asian continents have borne the brunt of the epidemic. It is the right and responsibility of the countries to mount
appropriate responses based on its specific health needs, available resources and cultural and societal norms. Contrary to the gloomy picture presented in some reports, especially those of the Western media, HIV/AIDS is not rampant in Myanmar. However, we are fully aware of the tremendous toll it could exact, not only on the victim but also on the society as a whole. Myanmar is committed to fight this disease by using all its available resources.

A high level, multi-sectoral National AIDS Committee, chaired by the Minister of Health, was formed in 1989 to oversee the National AIDS Programme in Myanmar. The National Health Committee, the highest policy making body in Myanmar, chaired by H.E. Lt. General Khin Nyunt, Secretary (1) State Peace and Development Council, with ministers from various government ministries as members, is providing policy guidelines and necessary support to enhance HIV/AIDS prevention and control activities in the country.

Sentinel surveillance has been in place since 1992 and currently covers all states and divisions with 27 sentinel sites. Moreover, behavioural surveillance was introduced in the country in 1997. Most of these sentinel sites are in urban areas and some are in the border areas considered to be high risk. Therefore, the data from these sentinel sites cannot be generalized to represent the whole country. Despite the very limited international assistance, Myanmar has implemented a comprehensive HIV/AIDS prevention and control programme. Early this year, the National AIDS Programme and the UNAIDS drafted a joint plan of action for prevention and control of HIV/AIDS in Myanmar. This plan has incorporated the priorities of the country and contains technologically sound strategies. It is comprehensive in nature,
covering all aspects: preventive, curative and rehabilitative. However, implementation of the plan will require considerable financial resources, which we are mobilizing from local as well as international agencies.

In the fight against HIV/AIDS, the developing countries should have access to anti-retroviral drugs. Reaping enormous profits despite suffering and death of millions of people is unacceptable. Compromise on investments, patents, production and commercialization of these products are urgently required so as to prevent monopoly control. The setting up of a global AIDS and Health fund is most welcome. It would ensure a more intensified health action that will definitely secure lasting results and ultimately limit the spread of HIV.

Malaria is still the leading cause of morbidity and mortality in most of the countries of the South East Asia Region. The situation has been complicated with the emergence of multidrug-resistant malaria. Rapid population migration and environmental degradation upsetting the ecological balance are major contributing factors. The Ministry of Health has formed the Central Committee on Management, Prevention and Control of malaria with representatives from all health-related sectors and NGOs. A multi-sectoral approach and strengthening partnerships among government sectors, NGOs and other agencies and communities have been promoted in order to effectively combat the problem of malaria.

Myanmar has fully adopted the Roll Back Malaria Mekong Initiative and is taking an active part in the prevention and control of this disease, both nationally and regionally. As part of the
programme, training of basic health workers has been provided and diagnostic facilities have been made available right down to the rural health sub-centres. More than 50,000 insecticide impregnated bednets have been distributed in the whole of Kayah state this year. National Malaria Week has been conducted annually in May for the last two years to increase awareness of the community on malaria prevention and control measures, to mobilize the people to carry out environmental measures to control the mosquito vectors and to enhance access to early diagnosis and treatment services. Measures have been taken to ensure that anti-malaria drugs are widely available in the country. In accordance with the guidance from Senior General Than Shwe, efforts have been made to produce both traditional and western drugs on a wider scale for common diseases such as malaria, tuberculosis, diarrhoea, dysentery and diabetes. Local production of raw materials has been promoted. Cultivation of cinchona and artemisia has been extended and research has been conducted to refine the production methods. Research and standardization of potent traditional drugs have been conducted to make available safe, affordable and good quality medicines to meet domestic demands.

The theme of this year’s World Health Day on Mental Health has provided a fresh perspective to the mental health issue. It has increased awareness, created better understanding and encouraged appropriate care for mental disorders. The Myanmar people usually wish to be endowed with both "Good health and peace of mind", which signifies great importance attached to mental health. In our culture, meditation is widely practised so as to achieve a state of peaceful and harmonious mental state. A
A community-based mental health project has been implemented in the country which is aimed at early detection of mental disorders and rendering services which will address the basic minimum needs of the country. The mental health programme has been integrated into the primary health care delivery system.

Today, globalization has profoundly affected the lives of the people. Most significantly, it has strongly influenced the lifestyles, particularly in developing countries. The youth have been bombarded with cigarettes and alcohol commercials. Cigarette multi-nationals are expanding their business in developing countries where regulations are less strict. Thus, it is important for the government to develop socioeconomic, cultural and legal environments that support the adoption of healthy lifestyles. Myanmar has participated in the meetings of the Framework Convention on Tobacco Control and appreciates the comprehensiveness of the Framework concept. As part of the Tobacco Free initiative in Myanmar, advertisements have been banned on Myanmar TV and smoking has been prohibited in all public transport, hospitals and some townships have established tobacco free schools. Recognizing that tobacco is a killer, an all-out effort has been launched to implement tobacco control measures throughout the country.

In conclusion, I would like to emphasize that advances in information technology have made the world a global village. This has created an excellent opportunity for promoting health and creating public awareness aimed at changing people’s behaviour and lifestyles conducive to health. Our health systems are developing and flourishing within the context of the traditions and polices of our respective countries. However, we face common
health challenges and share a common public health agenda. Therefore, we must seize the opportunity for collaboration and cooperation in responding to the health problems of our region. I am confident that our combined efforts carried out in the spirit of caring, sharing, solidarity and friendship will contribute to the success of our deliberations. I would like to wish all the distinguished delegates a pleasant and enjoyable stay in our country.

Thank you.
MIN-GALA-BAR. I warmly welcome you all to the fifty-fourth session of the WHO Regional Committee for South-East Asia, being so graciously hosted by the Government of the Union of Myanmar. We are deeply honoured that His Excellency Major General Ket Sein, Honourable Minister for Health, is with us this morning. I take this opportunity to extend our appreciation and to reiterate to His Excellency the Organization’s commitment of support in the health development efforts of Myanmar in the new millennium.

I have been closely associated with health development in Myanmar since the early 1980s. I have witnessed, with great interest, several community-level health development initiatives. WHO is happy to be associated with these initiatives, some of which have received international recognition. These include the Ayadaw Township Health Development Project, which was awarded the prestigious Sasakawa Health Prize in 1986. Myanmar’s Maternal and Child Welfare Association received WHO recognition in 1998 for its creditable work. The Institute of Nursing in Yangon also received the United Arab Emirates Health Foundation Prize in 1999.

Your Excellencies, distinguished representatives, Myanmar’s tradition of tolerance and kindness has adapted remarkably well to
the rapid changes in all aspects of socioeconomic and health development during the past decades. The Government of Myanmar has made noteworthy efforts to accelerate improvements in the health of the people, especially women and children, and for ensuring equitable access to health care in the rural and border areas.

Distinguished representatives, the Region has witnessed considerable improvement in its health situation in recent years. This is reflected in the decline in mortality and morbidity attributable to major communicable diseases. WHO has been closely involved with respective health and related ministries and with other development partners to support the health development efforts of Member Countries.

Ladies and gentlemen, health, as an integral part of sustainable development, is rightly becoming the major policy thrust of WHO and its Member Countries. This is vital for ensuring that the centrality of health in sustained economic growth and poverty reduction is not only recognized but also acted upon.

I am happy to state that our Region was certified, in early 2000, as a region free from guinea worm disease. Exemplary progress has also been achieved in efforts to eliminate leprosy. The registered prevalence of leprosy in the Region decreased significantly from 85 per 10 000 population in 1988 to 2.87 per 10 000 population in 2000. Seven countries of the Region have achieved national leprosy elimination targets. The remaining three countries are on track to achieve elimination targets by 2005.
A regional strategy has been developed for all countries where lymphatic filariasis is a problem for eliminating the disease by 2020.

Five countries, namely, Bhutan, DPR Korea, Maldives, Sri Lanka and Thailand, are considered as having eliminated neonatal tetanus in 2001.

With massive efforts in effective surveillance and national immunization days, undertaken by Member Countries for eradicating poliomyelitis, it is reassuring that this year, till end August, only 56 cases of wild polio virus were reported in the Region. As we prepare for the final assault to achieve polio eradication from our Region, we must not become complacent. I would like to take this opportunity to thank all external agencies, both bilateral and multilateral, as well as international and national nongovernmental organizations, for their valuable cooperation. WHO will continue to support these efforts, especially in sustaining the high coverage of immunization, and in establishing an appropriate network for effective disease surveillance.

Excellencies, the Region achieved nearly 45 per cent DOTS coverage for TB control in 2000. It is expected that all countries in the Region would achieve nationwide DOTS coverage by 2005.

I am also confident that Myanmar and its neighbouring countries in the Mekong Region, in partnership with international agencies, will be able to successfully control drug-resistant malaria through effective surveillance and rational use of drugs.

Distinguished representatives, ladies and gentlemen, HIV/AIDS is spreading very rapidly in the Region. A few countries have been
successful in reversing the rising trend in HIV incidence. We need to strengthen our efforts to more effectively combat HIV/AIDS and minimize its health and socioeconomic consequences.

Distinguished representatives, it is incumbent upon the health ministries and WHO to secure the involvement of political leadership at the highest level in the fight against HIV/AIDS. The upcoming Summit of ASEAN Heads of State will also discuss HIV/AIDS as part of its agenda. It is a welcome beginning. We must broaden this effort. Most importantly, we must find ways to articulate the concerns of Asia – its vulnerability to HIV/AIDS, the potential for epidemics and the opportunities to prevent the disease provided necessary resources become available. It is crucial for Heads of State from all Member Countries in our Region to individually and collectively address this critical issue.

While Member Countries are continuously fighting against communicable diseases, noncommunicable diseases including mental health, cardio-vascular diseases, cancer and diabetes have emerged as major public health problems. Efforts have been made to support countries to strengthen risk factor surveillance and to integrate the control of these diseases through health promotion. Community-based health promotion and services will be emphasized rather than institutional-based approaches.

Distinguished representatives, traditional medicine is used widely in our Region. WHO will continue to work closely with Member Countries, especially in research capacity strengthening, building human resources and improving traditional practices and care.
Natural disasters and complex emergencies are also common in the Region. It is important to put emergency preparedness higher on the national health agenda. I would like to take this opportunity to offer WHO's support for activities to enhance the capacity of Member Countries on disaster preparedness and response.

Distinguished representatives, arsenic contamination of drinking water sources in a few countries is causing serious concern. The issue is now being addressed as a global health problem. WHO has organized a series of technical and policy meetings in order to mitigate the situation. The subject will be discussed in greater detail at this session.

WHO has been highlighting, through various fora in recent years, the health implications of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). The health ministries need to work closely with consumers and the ministries of trade, commerce and industries in order to avail of the safeguards stipulated in the TRIPS Agreement and to protect their public health needs.

Our Region has the technical capability and manufacturing capacity to provide an adequate quantity and good quality essential medicines and vaccines. We need to find appropriate fora to safeguard our interests within the existing regional intergovernmental bodies.

I am happy to submit that WHO, in close consultation with experts and representatives from Member Countries, is finalizing a regional vaccine policy and strategy. The policy highlights the
importance of establishing national regulatory authorities and ensuring good manufacturing practices.

Excellencies, distinguished representatives, our Region has a long and rich tradition of technical cooperation among Member Countries. A series of intercountry and regional fora have been organized, from the highest-level policy meetings of Health Ministers to the cross-border meetings of district-level health personnel. These have served to further strengthen regional cooperation, leading to coordinated action against a broad range of common health problems. These mechanisms need to be further energized in order to enhance regional solidarity and cooperation.

During the past few years, the World Health Organization has continued its reform process by changing the way it works to ensure greater efficiency and effectiveness.

A series of initiatives have been undertaken to ensure full participation of Member Countries in the programme planning, development and evaluation of WHO collaborative programmes. This includes the formulation of WHO Country Cooperation Strategies which serve as the basis for planning the 2002-2003 and 2004-2005 programme budget. The Regional Office intensely monitored WHO collaborative programmes, which resulted in accelerated implementation.

Excellencies, distinguished representatives, the foremost challenge is to ensure that policy and decision-makers have access to evidence-based information for improving the performance of the health care delivery system. In this regard, steps will be taken to further develop regional and national capacity to critically
analyse, organize and disseminate appropriate health information to support decision-making.

Distinguished representatives, the emerging complex challenges in the field of public health demand a high level of technical expertise and support to Member Countries in improving the health status of their people. WHO would address these challenges by improving its human resource policy recently adopted by the World Health Assembly, by strengthening its collaboration with the network of WHO collaborating centres and national institutions, and by working more closely with other development partners. Through this collaboration, WHO would be able to provide technical solutions suited to the needs of specific countries.

Based upon the recommendations of the Honourable Health Ministers last year, I established a High-level Task Force comprising senior health managers and policy makers representing each Member Country. The Task Force has identified areas to be supported under the supplementary intercountry programmes. The Regional Office, in close consultation with the Task Force and the national health administrations, has developed detailed work plans for the supplementary intercountry programmes for 2002–2003, which will be submitted to this session of the Regional Committee for its consideration.

In conclusion, let me again express my sincere gratitude to His Excellency Lt General Khin Nyunt, Secretary 1 of the State Peace and Development Council and the Chairman of the National Health Committee, and also to His Excellency, Major General Ket Sein,
Minister for Health, and through them to the Government of the Union of Myanmar, for kindly hosting the Regional Committee.

Distinguished representatives, once again, I welcome you to this 54th session of the WHO Regional Committee for South-East Asia and wish you a happy stay in Yangon, the beautiful capital of the Golden Land. I look forward to a fruitful session and wish you all success in your deliberations.

Thank you.
Annex 6

TEXT OF ADDRESS BY THE DIRECTOR-GENERAL, WHO

THIS MEETING is taking place as we mark an impressive health achievement in the South-East Asia Region. We are watching the eradication of polio as it takes place. We are witnessing a public health sensation. Millions of children have been immunized through repeated campaigns. Surveillance has been built up to a level previously thought to be impossible. Hundreds of thousands of volunteers have been mobilized. They have worked hard under difficult conditions, especially in conflict-affected regions.

The efforts now made to ensure the eradication of polio are among the largest and most impressive public health interventions the world has witnessed. Last year alone, 550 million - 85 per cent - of the world’s children were immunized. The Global Polio Eradication Initiative has reduced the number of cases by 99 per cent. Three thousand and five hundred cases were reported worldwide in the year 2000. So far this year, there have been only 266 confirmed cases of polio globally. Only 56 cases have been reported in this Region. This has meant that three million people in the developing world, who would have been paralysed, are walking today.

Through the polio campaign, people are seeing how health action brings results. In years to come, the benefits of this action
will stretch beyond the eradication of polio. Health systems will have been strengthened and made more effective. Public health programmes will have a viable infrastructure. Thousands of health personnel and volunteers will take on new tasks with pride and commitment.

We are inspired by what has been achieved; we move forward to address other health challenges in this Region. The tasks are daunting. How can we enable all people to access health systems that are efficient, equitable, and respond well to their health needs? How can we improve services for people who are the hardest to access – whether because of their poverty, their location or their gender? How can we better address communicable diseases, challenges faced by pregnant women and children, the epidemics of non-communicable illness, and illness related to environmental issues?

My answers are straightforward. First, we need to see a significant increase in available resources for health. Second, we must ensure that these resources are used in ways that bring health benefits to all.

Within the last year we have seen growing global awareness of the need to invest much more in people’s health as a basis for broader social and economic development.

In four months’ time, I will receive the report of the Commission on Macroeconomics and Health. I expect the Commissioners, led by Professor Jeffrey Sachs, to call for a dramatic and rapid increase in action for better health.
The international community is starting to respond, building on efforts already under way in many nations. At the World Health Assembly, at the UN General Assembly Special Session on HIV/AIDS, and at the G8 Summit, we heard commitments to increased resources for global health. Public and voluntary and private sector bodies are already making new commitments.

The Global AIDS and Health Fund will be an important part of this much-needed scaling up. It is planned that the Fund will be operational by the end of the year. As part of the transitional working group designing the Fund, WHO wants to be sure that it stimulates a build-up of national health system capacity. We would like the Fund to help governments and civil society to enhance health systems. This means focusing on priorities, on the coverage and quality of interventions, and on careful monitoring of what is achieved. The result should be an increase in efficiency with which health systems use scarce resources to achieve better health outcomes for all.

WHO sees the need for this Fund to live up to its name and be a global Fund. This means that it should bring benefits to people in need within all regions, including this one.

The Global Alliance for Vaccines and Immunization shows what can be achieved. The Alliance is two years old. It has established a Vaccine Fund, which received a generous initial contribution of $750 million from the Bill and Melinda Gates Foundation. The Vaccine Fund provides resources for countries. The members of the Alliance work with countries to strengthen the performance of their health systems in immunizing children. WHO – as a key member of this Alliance – makes all of its technical
expertise available to help strengthen national vaccine programmes and introduce new vaccines when needed.

GAVI responds to country-level priorities, working with governments and civil society to make the best use of resources available for health system action. Support has already reached several countries in this region because the countries are committed to improving their children’s access to vaccines.

As experience is gained, the GAVI Board reviews lessons learned. Board members adjust the ways in which the Alliance works to ensure flexible and effective responses to countries’ immunization needs. GAVI can act as a pathfinder for other health actions too. In last week’s Regional Committee meeting in Africa, I heard Ministers indicate how the GAVI experience will inform their contributions to the design of the new AIDS and Health Fund.

I would like to focus on other health issues of concern to us all. I start with a focus on those who are at risk from, or are infected with, HIV.

Understandably, much of the attention to HIV/AIDS has been directed towards Africa. But we estimate that more than five million people are living with HIV within the South-East Asia Region. The trends are not good.

The UN General Assembly Special Session on HIV in July this year indicates the strategies and interventions that can halt the spread of HIV infection. All of us are committed to responding better – helping people protect themselves from infection, and increasing the proportions of HIV-affected people who can access care for their illnesses.
But it is not easy to scale up our response to this unprecedented health crisis. It calls for an extraordinary and courageous response. Experience shows how hesitation and delay in the early stages of an HIV epidemic lead to devastating consequences for the whole of society. It is essential that we see the systematic and coordinated implementation of effective strategies within this Region – soon. The alternative – an explosive increase in the incidence of HIV infection and AIDS-related deaths – is unacceptable.

I have directed that WHO scale up its contribution to the struggle. Our goal is to help identify more effective responses and implement them effectively in ways that take account of people’s cultural traditions and social realities. Together with the other co-sponsors of UNAIDS, and both government and nongovernmental development partners, we are working to adapt evidence-based practice to the needs of people. To obtain evidence on what works, we coordinate and take forward extensive research in the fields of diagnostics, spermicides, vaccine development, operational research on care and support, and assessments of programme effectiveness.

To this end we have reorganized and substantially increased WHO’s contribution to HIV/AIDS action. We are now in a better position to respond promptly and effectively to countries’ requests for assistance. We will continue to improve this response in succeeding years.

The burden of mental ill health and brain disorders is a serious global challenge. In most countries, the resources and the manpower available to tackle mental ill health are sparse. But new
and more effective means are now available to treat and prevent brain disorders and mental illness. As a result, modern mental health care is focusing more on supporting the family within the local community. It is geared to prevention, early detection and treatment and uses effective and relatively inexpensive medicines.

Experience from countries within the South-East Asia Region shows how governments can reform mental health care so that it is based within the community and backed by effective and humane mental health legislation.

The forthcoming World Health Report, to be released on 4 October, focuses on mental health. It provides a global overview of the current and future burden of mental ill health and their main contributing factors. It offers strategies for ensuring that effective prevention and treatment are both put in place and adequately funded.

Throughout this Region, countries are working hard to improve the overall effectiveness of their health systems. They recognize the need for reliable information - both on the burden of disease and on health system responses. There are several examples of national, intercountry and inter-regional disease surveillance initiatives. WHO is involved in most of them. During the last two years, disease surveillance within this Region has enabled effective responses to more than 20 outbreaks of cholera, acute diarrhoeal disease, dengue, dengue haemorrhagic fever, malaria, Japanese encephalitis, anthrax, rabies and hand-foot-and-mouth disease.
Regional Offices are a critical element of WHO-wide support to countries as they cope with disease outbreaks. WHO is helping all countries to strengthen their surveillance systems through initiatives handled by the regional offices. This is not visible or high-profile work, but it is vitally important if populations at risk are to have sustainable futures.

Policy-makers and programme staff need to make informed decisions about how best to allocate all resources for health action. They need regular assessments of the status of their people’s health and the working of health systems. To this end, some countries have initiated regular national health surveys. WHO is ready and keen to help countries as they undertake these surveys.

Tobacco is an increasing threat to the health of people throughout the nations of South-east Asia. Countries have initiated responses which help reduce the uptake of smoking by young people, or help those who wish to quit to do so. But there is much more to be done to curtail the efforts of those who encourage tobacco use - and resulting ill-health. That is why governments within the Region are playing their part in the negotiations of WHO’s Framework Convention on Tobacco Control.

During the second round of negotiations in May, the first draft of the Convention document was debated at length. The next round of the negotiation process will take place in November. I am confident that Member States will agree on a Convention that really helps countries to confront the threat of tobacco for their people. I stress the need for countries to continue to be engaged until the Convention has been finalized – hopefully in 2003.
We are now confronted, each day, with controversies about access to health care, and to the results of medical research. We read of even more exciting new advances with real potential to prolong life and improve well-being. Yet, in our daily work, we see the difficulties people face as they try to access inexpensive care for malaria or TB that is already available and known to work. Each day health professionals in this Region make difficult choices about how to allocate their resources. They wonder, for example, when the results of recent advances in genetics will have a positive impact on the health of ordinary people in the Region.

WHO’s regional offices and departments in headquarters are helping countries to start to handle complex ethical issues – such as codes of conduct for research involving human subjects. It is now time to draw together this work, providing Member States with the opportunity to share experiences, establish consensus and be in a better position to handle individual ethical challenges.

I therefore propose to establish a WHO-wide initiative on health ethics which focuses on Ethics in Public Health, Health Research Ethics and Biotechnology Ethics. This will include ethical aspects of genome-related work, stem cell research, cloning and other ethical areas of biomedical science. The initiative would be designed to help increase Member States’ capacities to handle ethical issues and to provide support for inter-governmental action on health and ethics issues.

The issue of genetically-modified food is one area where health, ethics and economics have come together, and there have been some tensions. But genetically-modified food crops are already in widespread use. They have the potential to increase food
production – steeply. They can reduce levels of nutritional deficiency. But are these products safe and beneficial for consumers? Negative effects are possible, especially if such products are too expensive for poorer people or have not been adequately tested. It is thus vital that authorities with responsibility for food standards and safety always focus primarily on the well-being of consumers, and not on the profits of producers or suppliers. WHO is stepping up its cooperation with FAO to help countries answer questions about the safety of all foods – including those that have been genetically modified.

Links between the environment and health are also of increasing concern in this Region. Countries in South East Asia are severely affected by the global problem of arsenic contamination of drinking water. At least 30 million people from the Region are at risk from arsenic related diseases. There are no easy solutions to this problem, and WHO offers technical support to national governments as they establish and implement strategies to deal with arsenic contamination.

All WHO’s work is for countries, but only a part of it is in countries. Country work, though, is critical, and our country representatives are at the centre of all we seek to do.

We are committed to improving the capacity of the WHO teams within countries who need us the most, so that they are better equipped to contribute to better and more equitable health outcomes. WHO country representatives and regional offices will play a central role in making this happen. They will build on our recent experiences with establishing strategies for our cooperation with individual countries.
The work of WHO’s regional offices and departments in headquarters is summarized within the corporate strategy for WHO’s Secretariat that was agreed upon by Member States in 1999. This is the basis of the General Programme of work for 2002 to 2005. During 2000, the Secretariat established a Strategic Programme Budget, identifying 35 areas of work across the Organization. This formed the basis for the expected results, milestones, activities and allocation of regular and extrabudgetary resources for the 2002-2003 biennium.

I will be working with the Regional Directors over the coming months to develop a proposed set of global priorities for the next period, 2004-2005. We will draw on your deliberations at this Regional Committee. My proposals will then be presented to the Executive Board when it meets in Geneva in January 2002.

As health professionals, we all face enormous challenges. People’s expectations are greater than ever. We respond to their legitimate expectations in ways that promote equity of health outcomes and contribute to reductions in levels of poverty.

We must answer the needs of the people we serve. For, their well-being is our responsibility; their suffering and ill health is our failure.

These values underlie all our actions – as WHO Member States and as the Secretariat.

Let us work together for a constructive and successful meeting, and for effective health action throughout the Region in the coming year.
Thank you.
Annex 7

REPORT OF THE 38TH MEETING OF THE CONSULTATIVE COMMITTEE FOR PROGRAMME DEVELOPMENT AND MANAGEMENT TO THE REGIONAL DIRECTOR

1

1. INTRODUCTION

The thirty-eighth meeting of the Consultative Committee for Programme Development and Management (CCPDM) was held at the Traders Hotel, Yangon, Myanmar, from 30 August to 2 September 2001.

2. INAUGURAL SESSION

In the absence of the Regional Director, Ms Poonam Khetrapal Singh, Deputy Regional Director and Director, Programme Management, read the inaugural address. Welcoming the participants, the Regional Director stated that CCPDM would be considering some very important items. The review of the WHO collaborative programmes for the first eighteen months of the biennium 2000–2001 revealed that the overall implementation rate

1 Originally issued as document SEA/PDM/Meet 38/8 dated 2 September 2001.
for the regular budget, including earmarking, as of 15 August 2001 was 98% compared to 87% for the same period in the previous biennium. The 53rd session of the Regional Committee had recommended proactive involvement and participation of Member Countries at all stages of the intercountry programme, including planning and programme evaluation. Accordingly, two intercountry programmes relating to “Tobacco-free initiative” and “Improving the health of the marginalized and vulnerable groups” were evaluated by a joint team composed of representatives from Member Countries and staff from the Regional Office.

The Regional Director urged CCPDM to discuss the issues thoroughly and with a sense of great responsibility. The CCPDM’s report containing its recommendations on crucial areas would be submitted to the 54th session of the Regional Committee for its consideration.

3. ELECTION OF CHAIRMAN AND RAPPORTEUR

Mr G.R. Patwardhan (India) was elected Chairperson, and Mr Ahmed Salih (Maldives) as Rapporteur.

4. ESTABLISHMENT OF A DRAFTING GROUP (Agenda item 2)

A Drafting Group, consisting of Dr Wanchai Sattayawuthipong (Thailand), Dr Hla Pe (Myanmar), and Ms J.A.S.S. Gunawardhene (Sri Lanka) was established to prepare the report of the meeting.
5. REVIEW OF WHO COLLABORATIVE PROGRAMMES IMPLEMENTED DURING THE FIRST EIGHTEEN MONTHS OF THE BIENNium 2000-2001 (Agenda item 3.1)

Introducing the Agenda item, Ms Poonam Khetrapal Singh, Deputy Regional Director, stated that the background document on this important agenda item provided information on the implementation of the WHO collaborative programmes at the country and intercountry/regional levels during the period 1 January 2000 to 30 June 2001. The document had been presented in three parts and under eight major headings in line with the Programme Budget for 2000-2001. The document, prepared on the basis of contributions received from the WHO country offices and technical units in the Regional Office, indicated an improvement in the implementation of technical programmes through WHO’s joint collaborative efforts with the Member Countries.

Discussion Points

- It was pointed out that the activities relating to Accident and Injury Prevention were reported under the broader heading of Social Change and Mental Health. As Accident and Injury Prevention is recognized as a significant problem area in the Region with a substantial budget allocation, it was felt that these activities should be reported under a separate heading.

- The Committee noted that the amount and percentage of surrendered reserves had been declining since the 1994-1995 biennium due in a large measure to: increased efficiency; establishment and monitoring of implementation targets (i.e.
75 per cent at the end of the first year and 100 per cent by the end of June of the second year of the biennium); and the introduction of mechanisms to minimise currency fluctuations. However, surrender of some reserve was inevitable.

- Given the effectiveness of early implementation targets in reducing carry-over of funds into the next biennium and the need to further limit the surrender of reserves, there was a consensus to set enhanced targets for the 2002-2003 biennium. Even with stricter implementation targets, the countries could maintain flexibility to reprogramme funds to address unanticipated programme requirements.

**Recommendations**

1. Implementation targets for the 2002-2003 biennium should be set at 85 per cent by 31 December of the first year, and 100 per cent by 30 June of the second year.

2. The implementation of the revised targets at the country and regional levels should continue to be closely monitored.

6. **EVALUATION OF IMPLEMENTATION OF TWO PRIORITY INTER-COUNTRY PROGRAMMES DURING 2000-2001: (A) TOBACCO FREE INITIATIVE, AND (B) IMPROVING THE HEALTH OF THE MARGINALIZED AND VULNERABLE GROUPS** (Agenda item 3.2)

In her introduction, Ms Poonam Khetrapal Singh, Deputy Regional Director, stated that in accordance with the suggestions of the 53rd session of the Regional Committee and the High-Level Task Force for Intercountry Collaboration, established by the Regional Director, two ICP-II programmes, namely, “Tobacco Free Initiative”
and “Improving the health of marginalized and vulnerable groups” were selected for evaluation. The evaluation was undertaken in five countries and the Regional Office by a joint team comprising country representatives nominated by the Member Countries and the Regional Office staff, based on pre-determined criteria. The report of the joint evaluation team, finalized in May 2001, was now being placed before CCPDM for its review. The CCPDM’s comments and observations would be presented to the Regional Committee.

**Discussion Points**

- The Committee appreciated the work of the evaluation team and endorsed its findings and recommendations.

- The scope of FCTC activities implemented under the ICP-II programme on the Tobacco Free Initiative noted in the evaluation, were further elaborated. It was noted that the evaluation team reviewed the actual achievement of the expected results as well as the implementation process, including how it benefited the Member countries.

- The Committee highlighted the Evaluation Team’s recommendation that the areas chosen for support through the intercountry programme should continue over at least two biennia.

- The Committee noted the importance of evaluation. It appreciated that the majority of the recommendations of the evaluation team had already been taken into account while preparing the RO/ICP and country work plans for the next biennium.
It was clarified that the team members from the countries were selected on the basis of the countries’ involvement in the ICP programmes and the expertise available there.

The Committee, while reviewing the composition of the evaluation team, suggested that it should include an expert in the field from outside the Region. Such experts could be drawn from other parts of the Organization or from centres of excellence, including WHO collaborating centres.

**Recommendations**

1. The joint evaluation exercise should be continued within the overall context of WHO’s evaluation framework.
2. The areas chosen for support through the intercountry programmes should continue over at least two biennia.
3. The joint evaluation team should include an expert from outside the Region.

**7. REVIEW OF DETAILED WORK PLANS FOR PROGRAMME BUDGET 2002-2003 (Agenda item 3.3)**

Ms Poonam Khetrapal Singh, Deputy Regional Director, introducing the subject, stated that the detailed work plans for 2002-2003 for country, Regional Office/ICP, and the supplementary intercountry programme (ICP-II), submitted to CCPDM, were the first to be prepared within the context of an integrated “One WHO” programme budget. In the coming biennium, there would be closer linkages between the work plans of the country offices, Regional Office and WHO headquarters with each level contributing to global
expected results to which WHO, as a single organization, was committed. In order to measure achievements and to ensure transparency and accountability, indicators had been defined. The work plans had been formulated through consultations among national counterparts, the WHO country office and the Regional Office to ensure that they were complementary, mutually supportive and avoided duplication.

The work plans for ICP-II had been developed through an approach unique to SEAR with greater participation by Member Countries, addressing the priority health needs of the Region. A high-level task force was established by the Regional Director to advise him on strengthening intercountry collaboration during 2002-2003. The task force identified 14 content areas for developing ICP-II work plans, reflecting global priorities and regional priorities as noted by the 53rd session of the Regional Committee as well as priorities identified by the individual countries in their WHO Country Cooperation Strategies. Based on a recommendation made by the high-level task force, the Health Secretaries, at their sixth meeting, proposed to the Regional Director that the funding for ICP-II should be at least at the same level as that of the 2000-2001 biennium, that is US$ 3.73 million. Following a process of intensive consultation between the countries, WHO country offices and the Regional Office, the task force reviewed and finalized the detailed work plans for ICP-II for 2002-2003.

Mr Helge Larsen, Director, Budget and Management Reform, WHO headquarters, stated that the structure and contents of the work plans reflected well the collaborative spirit of “One WHO”.

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Discussion Points

- The Committee reviewed and noted the draft work plans for RO/ICP as well as country programmes.

- The Committee noted that, for the first time, work plans for RO/ICP provided a clearer picture of the activities of the Regional Office. The increased transparency was appreciated.

- The Committee appreciated the efforts of the Regional Office in presenting the work plans for supplementary intercountry programme (ICP-II) in accordance with the recommendations of the high-level task force for intercountry cooperation. It was favourably noted that minimum budget was allocated for supplies, fellowships and short-term staff.

- The Committee suggested that a summary table on the same lines as that of ICP-II be included for ICP-I work plans. This should also highlight the category of expenditure e.g. APW, STC, S&E, etc. The cost of long-term staff should also be included in the individual work plans.

- The Committee noted that the work plans reflected clear linkages with global expected results.

- The Committee noted that the SEAR Health Ministers, at their meeting in August 2001, had identified areas for inclusion in the Organization-wide priorities for the 2004-2005 biennium. In accordance with resolution WHA54.1, these inputs would be conveyed to the Director-General for inclusion in the General Programme of Work.
Recommendations

(1) The draft work plans should be presented to the 54th session of the Regional Committee for noting.

(2) While finalizing the work plans, summary tables for ICP-I work plans should also be provided, identifying categories of expenditure.


Introducing the agenda item, Ms Poonam Khetrapal Singh, Deputy Regional Director, said that previously, only those resolutions and decisions adopted by the WHO governing bodies which had significant regional implications were brought to the attention of the Member States. In accordance with the suggestion of the fifty-third session of the Regional Committee in 2000, all the resolutions adopted and decisions taken by the 107th and 108th sessions of the Executive Board and the 54th World Health Assembly were being placed before the CCPDM for its review. The comments and observations of the CCPDM would be placed before the Regional Committee.

Ms Poonam Singh added that the draft provisional agenda of the upcoming 109th session of the Executive Board was reviewed by CCPDM. The comments and observations, apart from providing
guidance to the WHO Secretariat, would also be useful to the members of the Executive Board from the SEA Region who would be attending the meetings of the governing bodies next year.

The CCPDM then considered the resolutions/decisions and made the following observations and recommendations:

**Discussion points**

- The Committee noted the actions taken and proposed as contained in the working paper SEA/PDM/Meet.38/7.

- With regard to the regional implications of resolutions WHA54.10 and WHA54.11, the Committee noted the importance of equity and access to essential medicines, especially drugs related to priority diseases such as HIV/AIDS.

- The Committee stressed the need for and importance of sustainability of traditional medicine in the countries of the Region. It urged the Regional Office to further focus on promotion of traditional medicine and use of plant-based drugs. WHO should assist Member States in evaluating the progress made in promoting the use of traditional medicine.

- With regard to resolution WHA54.17, “Assessment for the financial period 2002-2003”, the Committee noted that four countries would face an increase in the assessed contribution in 2003. This situation would be reviewed at the Executive Board and the World Health Assembly in 2002. It was important that the EB members and the delegates to the Health Assembly from the Region should have a clear and consistent approach to the issue. It was noted that in 2002 the anticipated deficit in the
overall WHO regular budget would be made up from Miscellaneous Income. In 2003, however, it was possible that there would be a shortfall, unless payment of arrears from the major contributors materialized. If this did not happen, the Director-General would have no other option but to implement a budget cut.

Recommendations

(1) WHO should continue to enhance its support for traditional medicine, with special emphasis on the use of plant-based drugs and integration of alternative/traditional medicine with the national health care systems.

(2) The Member Countries of the Region should work towards having a scale of assessment which reflects the ability to pay the assessed contributions.

9. REPORTS BY COUNTRY REPRESENTATIVES ON THEIR ATTENDANCE AT THE MEETING OF THE COORDINATING BODIES OF WHO’S GLOBAL PROGRAMMES (Agenda item 5)

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

Ms Poonam Khetrapal Singh, Deputy Regional Director, in her introductory remarks, said that the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, known as TDR, had been functioning under the aegis of WHO. A Joint Coordinating Board (JCB) had been established to coordinate the interests and responsibilities of the parties cooperating in this
Special Programme. From the SEA Region, representatives from India, Indonesia and Sri Lanka attended the 24th session of JCB, held in Geneva on 25-26 June 2001.

On behalf of the participants, Dr K.C.S. Dalpatadu of Sri Lanka reported on the meeting. Among other issues debated at the meeting, the JCB called upon TDR to maintain close collaboration with other special programmes of WHO, particularly regarding vaccine development and other related activities. They also emphasized the use of geographical mapping in forecasting and control of epidemics, the use of traditional medicine for the treatment of malaria, and the need for TDR to support vector control research, including transgenic vector control.

**Discussion point**

- The CCPDM noted the report.

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

Ms Poonam Khetrapal Singh, Deputy Regional Director, said that the Policy and Coordination Committee (PCC) of the Special Programme of Research, Development and Research Training in Human Reproduction (HRP) acted as a governing body and was responsible for HRP’s overall policy and strategy. To coordinate the interests and responsibilities of the collaborating partners, the PCC reviewed and decided upon the planning and execution of the Special Programme, including the budget. At present Bangladesh, India and Indonesia are members of the PCC from the Region.
Representatives from India and Indonesia participated in the 14th PCC meeting held on 20-21 June 2001 in Geneva.

On behalf of the participants, Dr Setiawan Soeparan of Indonesia reported on the proceedings of the meeting. Highlighting the salient deliberations, he said that a wide range of activities including the report of the eighteenth meeting of the Scientific and Technical Advisory Group was presented and discussed. The PCC noted that in the context of development, family planning was critical and needed to remain at the forefront of the reproductive health and development agenda. The PCC commended the Scientific and Ethical Review Group (SERG) in strengthening institutional capacity in developing countries for ethical review of research in reproductive health and suggested that SERG takes into consideration relevant existing international guidelines on the use of tissue, gametes and pre-embryos in research.

Discussion point

➢ The CCPDM noted the report.

10. TECHNICAL DISCUSSIONS ON MENTAL HEALTH AND SUBSTANCE ABUSE, INCLUDING ALCOHOL (Agenda item 6)

Technical discussions on “Mental Health and Substance Abuse, including Alcohol, were held on 1 September 2001. Dr. K.C.S. Dalpatadu, Deputy Director-General, Department of Health Services, Sri Lanka, was elected Chairperson and Dr Gado Tshering, Director of Health, Ministry of Health and Education, Bhutan as the
Rapporteur. The report and recommendations arising out of the technical discussions will be submitted to the Regional Committee.

11. ADOPTION OF REPORT

The CCPDM reviewed the draft report of its thirty-eighth meeting and adopted it with minor modifications.

12. CLOSURE

Ms Poonam Khetrapal Singh, Deputy Regional Director and Director, Programme Management, congratulated the members of CCPDM for a very productive meeting and lively discussions. The recommendations of the CCPDM would now be submitted to the Regional Committee. She congratulated the Chairman for not only conducting the meeting effectively with his skillful handling of the discussions but also for ensuring a cordial environment that helped fruitful deliberations. She expressed her appreciation for the excellent arrangements and hospitality of the national authorities.

The Regional Director, Dr Uton Muchtar Rafei, expressing his pleasure at being able to attend the closing session of CCPDM, stated that due to the joint efforts of the Member Countries and WHO, it was possible to achieve programme implementation targets. The guidance given by CCPDM would be useful to the countries and the WHO Secretariat in regard to programme development and management.
The Chairman, in his concluding remarks, congratulated the Rapporteur and the drafting group for preparing a report that truly reflected the discussions. He also appreciated the support provided by the WHO Secretariat.

He then declared the meeting closed.
Annex 8

RECOMMENDATIONS ARISING OUT OF THE TECHNICAL DISCUSSIONS ON MENTAL HEALTH AND SUBSTANCE ABUSE, INCLUDING ALCOHOL

1. INTRODUCTION

Technical Discussions on Mental Health and Substance Abuse, including Alcohol, were held on 1 September 2001. Dr K.C.S. Dalpatadu (Sri Lanka) was elected Chairperson and Dr G. Tshering (Bhutan) as Rapporteur. The Agenda and Annotated Agenda (SEA/PDM/Meet.38/TD/1.1 and SEA/PDM/Meet.38/TD/1.2 respectively) and the working paper for the Technical Discussions (SEA/PDM/Meet.38/TD/1.3) formed the basis for the discussions.

1.1 Introductory Remarks by the Chairman

Welcoming the participants and representatives of nongovernmental organizations, the Chairman highlighted the need to broaden public health attention towards noncommunicable diseases, such as neuropsychiatric disorders, which were amongst the leading causes of disability and disease burden in developing countries. He urged the participants to consider innovative community-based programmes for mental health. He added that substance abuse, including alcohol abuse, was emerging as a

1 Originally issued as document SEA/RC54/14 dated 2 September 2001.
problem in most countries. These had a particularly deleterious effect on the poor, as precious household income was wasted on these substances rather than on food, health and education. The public health significance of mental disorders was acknowledged by WHO, as reflected in this year’s theme for World Health Day, World Health Report 2001 and the Technical Discussions at the Fifty-fourth World Health Assembly.

1.2 Introduction to Working Paper on Mental Health and Substance Abuse, including Alcohol

Dr Vijay Chandra, Regional Adviser (Health and Behaviour), WHO-SEARO, presented a summary of the working paper. He highlighted the importance of mental health issues in the Region. He stressed the importance of planning appropriate strategies to address mental health aspects of both communicable and noncommunicable diseases. Dr Chandra explained that mental and neurological disorders had emerged as priority causes of human suffering and disability. In the Region, there were many myths and beliefs that hampered the recognition and treatment of mentally ill patients. Some mental and neurological disorders were considered as a "curse from Gods" or manifestations of evil spirits or punishment for sins in the past life. There was also clear evidence that alcohol-related morbidity and mortality was high in most countries of the Region, which needed due attention. Mental disorders had a wide-ranging, long-lasting and significant economic impact. Measurable causes of economic burden due to mental disorders included health and social service needs, impact on families and care givers (indirect costs), loss of employment and lost productivity, crime and public safety, and premature death.
The resources available and allocated to meet the mental health needs of populations by Member Countries were limited. WHO was supporting the countries in the control of certain priority mental and neurological disorders such as epilepsy and suicides. Programmes on mental health were also being initiated for community-based rehabilitation of those with mental illness, promotion of mental health amongst adolescents and community-based strategies for prevention of harm from alcohol. Dr Chandra pointed out that the Technical Discussions would not include the subject of drug abuse. However, the Regional Office was actively working on numerous programmes and projects related to drug abuse.

2. DISCUSSIONS

The discussions were lively and there was general agreement that mental and neurological disorders were important health problems in the Region. The major issues discussed were:

2.1 Burden of Mental and Neurological Disorders

Participants emphasized the need for reliable population-based information on the burden and major determinants of mental illnesses in the Member Countries. Such information would be valuable for mobilizing political commitment, programme planning and priority allocation. Mental illnesses are usually associated with poverty, low status of women, violence and ageing. Rapid sociological changes during the last few decades have had a significant psychological impact on children and families, for example, through growing competition in schools or sports events
no longer being seen as participatory enjoyment for children and adolescents.

2.2 **Access to Mental Health Services**

Access is hampered by social stigma associated with visiting mental health care facilities. The community holds views about causes of mental disorders that are usually non-medical. For example, many communities in the Region believe that these are caused by supernatural factors. Traditional systems of health care, including care by faith healers, play an important role in many countries. However, some regulation is needed to prevent harmful practices. Essential medicines for the care of mental disorders must be made available at the primary health care level at affordable prices. Coverage for mental illness in general health insurance is needed in those Member Countries where health or social insurance is available.

2.3 **Human Resource Development**

It is important to recognize that there are different types of mental disorders with different degrees of severity. Different types of human resources with different levels of expertise are required. The pyramid model was suggested. Specialists on mental health should be at the top of the pyramid for referral and training, with the base made up of community health workers of different cadres, depending on the country. There is a severe shortage of mental health specialists. However, basic health workers at the village and community levels could provide essential mental health care with appropriate training. Comprehensive pre-service and in-service training about mental health should be included for all health
professionals. Training is also required for mental health programme managers and policy-makers to support the development of mental health services.

Treatment for different types of mental and neurological disorders may vary according to the structure of the health system in each country. Which type of health worker and who should be given the responsibility for the care of patients with mental disorders will depend upon the way health systems are organized. The scope and level of undergraduate, graduate and postgraduate medical training as well as training of paramedical staff to carry out mental health care may need to be defined for each country and for each level of health care provider.

2.4 Integrated, Comprehensive Community-based Approach

In addition to the regional strategy for providing integrated community-based care (five A’s strategy – Availability, Acceptability, Accessibility, Affordable Medication and Assessment), two more A’s were suggested: Advocacy and Acquaintance with other services. Mental health promotion should be considered over the life span of the individual, from infancy to old age. Essential interventions pertaining to promotion of mental health and prevention and control of mental disorders should be integrated into public health and social welfare programmes at policy and implementation levels.

2.5 Intersectoral Collaboration

It was acknowledged that care and promotion of mental health could be provided by several sectors related to health. The sectors identified were education, private NGOs, traditional practitioners
including faith healers, religious leaders and the mass media. There should be active collaboration among these sectors, supported by firm political commitment, appropriate legislation and financial support. Traditional family values prevalent in the Region which promote good mental health should be strengthened. Essential interventions pertaining to promotion of mental health and prevention and control of mental disorders should be integrated into public health and social welfare programmes at policy and implementation levels.

2.6 Prevention

The importance of prevention of mental disorders was highlighted. Measures for poverty reduction, violence reduction, gender discrimination and reducing stress in education were suggested as potential preventive strategies. Others included management of stress by techniques such as meditation and life skills training for adolescents.

2.7 Advocacy

Advocacy was needed for both policy-makers and the community. Policy-makers needed sensitization to encourage the development of appropriate legislation, policy and resource allocation. Incorporating teaching about mental health in the school curriculum to provide scientific facts about causes and treatment was suggested. Campaigns are needed to promote knowledge about mental illness and elimination of stigma. The involvement of NGOs is vital in this task.
2.8 Alcohol Abuse

The scale of the problem of alcohol abuse varied between countries. Both religion and community action could counter alcohol abuse. Harm reduction and legislation, such as limiting hours of operation of drinking establishments, prohibiting under-age drinking, increasing taxation of alcohol and banning advertisement of alcohol, are some legislative measures to counter alcohol abuse.

3. RECOMMENDATIONS

(1) Assessment of the burden and major determinants of mental disorders in each Member Country should be carried out through population-based surveys and other sources of information. Documentation and dissemination of information and research should be strengthened.

(2) Human resource development in mental health should be enhanced for community and primary health workers, district health workers and tertiary care mental health specialists.

(3) Comprehensive teaching on mental health should be included in pre-service and in-service curriculum of medical, nursing and other health personnel.

(4) Essential interventions pertaining to promotion of mental health and prevention and control of mental disorders should be integrated into public health and social welfare programmes at policy and implementation levels.

(5) Intersectoral and inter-agency collaboration to promote mental health and control of substance abuse, including alcohol, and
to improve mental health care should be encouraged. Major sectors for collaboration include education, the private health sector, NGOs, traditional medical practitioners, faith healers, religious leaders and the mass media.

(6) Advocacy to policy-makers should be intensified to facilitate the adoption of healthy public policies and to increase the allocation of resources to mental health. Similarly, efforts should be intensified at the community level to promote life skills and reduce the stigma against the mentally ill.
Annex 9

PRESENTATION ON HEALTH SYSTEMS REFORM

PROFESSOR PRAWASE WASI, Professor of Medicine (Emeritus), Mahidol University, Thailand, and former Chairman, SEA-ACHR, made a presentation on Health Systems Reform (SEA/RC54/Inf 4) on 3 September 2001.
Annex 10

THE NEW GLOBAL FUND FOR AIDS AND HEALTH:
A WHO PERSPECTIVE

DR DAVID NABARRO, Executive Director, Director-General’s Office, WHO/HQ, made a presentation on The New Global Fund for AIDS and Health: A WHO Perspective, on 4 September 2001.

During recent months, there have been intense calls for more resources (around US$ 7-10 billion annually, as estimated by the WHO Commission on Macroeconomics and Health) to tackle the global burden of HIV/AIDS, malaria, tuberculosis and other health priorities. The UN Secretary-General and the governments of G8 proposed that a part of the additional resources could be provided through a global fund. The establishment of the Global Fund for AIDS and Health was endorsed at the Fifty-fourth World Health Assembly in May 2001 and the UNGA Special Session on HIV/AIDS, held in June 2001. So far, pledges from countries and individual contributions amounting to US$ 1.4 billion had been received. The Fund was expected to be operational by the end of 2001. The stakeholders wanted the Fund to address priorities, respond to country needs, provide resources to communities quickly and, above all, to do things differently.

A global Transition Working Group (TWG) had been established to develop the managerial and operational aspects of
the Fund. TWG consists of 35 members including donor countries, developing countries, one representative each from the World Bank, WHO and UNAIDS, and the private sector as well as nongovernmental organizations. TWG would meet three times for consultations and consensus-building till the end of 2001. From the South-East Asia Region, India and Thailand were included as members of TWG. The UN Secretary-General had nominated Dr Chrispus Kiyonga (Uganda) as Chairperson of this Group, backed by a Technical Support Secretariat based in Brussels, headed by Mr Paul Ehmer. Funds are being offered by donor nations to support two persons from developing countries to work in the Secretariat. There were several issues that needed to be addressed by TWG. Discussions among governments and other interested parties during the last few months have led WHO to suggest that the Fund have the following characteristics:

- The stakeholders would ideally not create new mechanisms or processes to manage resources in countries; rather, they could use existing national mechanisms for channelling funds.

- Initially, countries with critical needs in respect of HIV/AIDS, malaria and tuberculosis could be selected to be beneficiaries of the Fund.

- Only applications for feasible proposals could be considered for funding; the screening process should be transparent and quick.

- It is desirable to have a transparent, standardized mechanism to monitor the use of funds.
Board members of the Fund could decide to use the existing institutional framework of WHO, UN and other bilateral agencies for implementation if they consider these processes to function satisfactorily.

The Fund should support the national planning, budgeting and implementation process.

All conditions attached to the release of funds should be made clear in the beginning itself.

Ideally, decisions about the release of funds should be made at the country level, when possible, and all partners should be encouraged to work together on implementation.

The need for involvement of in-country institutions has to be reconciled with the desire for independent technical appraisal of proposals.

Dr Nabarro said that the WHO Secretariat would like to see the Fund support effective initiatives at the country level, drawing on positive experiences such as those of GAVI, Roll Back Malaria, Stop TB and Polio Eradication.

The discussions at the recently concluded Health Ministers’ Meeting had focused on this Global Fund. The Health Ministers had recommended that the Regional Director establish a Task Force, as soon as possible, comprising one representative from each Member Country, to prepare a regional position paper, to strengthen the Region’s case for appropriate allocation of funds. Thailand and India, as members of TWG, would carry forward the views of the Region at TWG. The regional position paper could also
be submitted to ASEAN and SAARC to ensure a higher level of commitment for the allocation of funds. Requests from this Region for additional resources from the Global Fund would be strengthened if Heads of States/Governments endorsed them. Health Ministers should seek the cooperation of foreign ministers and missions to advocate the cause so that it is correctly seen as a national development issue.

WHO will work closely with those responsible for the design and development of the Fund to help them achieve their objectives in a timely and effective manner.
Annex 11

RELEASE OF PUBLICATION

THE REGIONAL DIRECTOR released a publication entitled “Health, Development and Prosperity in the South-East Asia Region: Control of Communicable Diseases” and a special edition of the newsletter “Window on SEAR – Success Stories from the SEA Region” on 4 September 2001.