WHO Regional Committee for South-East Asia

Report of the Fifty-second Session
Dhaka, 6-9 September 1999
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Part I

INTRODUCTION

THE 52ND SESSION of the WHO Regional Committee for South-East Asia was held in Dhaka, Bangladesh, from 6 to 9 September 1999. It was attended by representatives of all the ten Member States of the Region, UN Agencies, nongovernmental organizations having official relations with WHO, as well as observers.

The session was inaugurated by Her Excellency Sheikh Hasina, Hon’ble Prime Minister of Bangladesh.

The Committee elected Mr M.M. Reza (Bangladesh) as Chairman and Dr Azrul Azwar (Indonesia) as Vice-Chairman of the session.

The Committee reviewed the report of the Regional Director for the period 1 July 1997 to 30 June 1999, and considered the recommendations arising out of the Technical Discussions on (1) Tobacco or health: Actions for the 21st century, and (2) Intensification of HIV/AIDS surveillance, held during the 36th meeting of the Consultative Committee on Programme Development and Management.

The Director-General of WHO, Dr Gro Harlem Brundtland, addressed the session.
The Committee accepted the confirmation by the Government of India to host its 53rd session in early September 2000.

A drafting group, consisting of representatives from Bangladesh, Bhutan, India, Maldives, Nepal and Thailand, was formed to draft resolutions for consideration by the Regional Committee. Ms Sujatha Rao was elected Chairperson of the group. During the session, the Committee adopted eight resolutions.
Part II

INAUGURAL SESSION

Welcome Address by the Secretary, Ministry of Health and Family Welfare, Government of Bangladesh

MR M.M. REZA, Secretary, Ministry of Health and Family Welfare, welcomed the Chief Guest, Her Excellency Sheikh Hasina, Prime Minister of Bangladesh, and other dignitaries. He said that the Regional Committee was being held in Bangladesh after a gap of 17 years during which considerable improvements had taken place in the field of public health. WHO had provided technical and financial assistance for health development, particularly in the battle against polio and communicable diseases, such as malaria, tuberculosis and HIV. The country had recently adopted a sector-wide approach for strengthening health system structures and functions to help reduce expenditure and improve the health of the people, particularly the poor. He underscored the importance of ensuring access to drugs and vaccines as well as the development of new ones to counter major killer diseases. He looked forward to new directions from the Regional Committee for effectively dealing with health problems in the country.
Address by the Regional Director

DR UTON MUCHTAR RAFEI, Regional Director, highlighted the collaborative activities in Bangladesh and referred to WHO’s support for improving the health of the people, particularly mothers, children and the poor. WHO had closely worked with the Government in tackling the problem of arsenic contamination of drinking water in the country and ensuring the safety of blood and blood products, which assumed greater significance in the context of the emerging problem of HIV/AIDS.

WHO’s partnership with other UN Agencies and nongovernmental organizations had resulted in significant gains in the fight against vaccine-preventable diseases, including polio, through synchronized National Immunization Days by several countries of the Region. Multidrug therapy (MDT) for leprosy control, the DOTS strategy against TB and the use of impregnated bednets in malaria control were some of the key approaches in WHO collaborative activities. However, the challenges posed by the growing population, high maternal mortality and HIV/AIDS, TB, malaria as well as noncommunicable diseases, avoidable blindness and malnutrition still needed attention. Considering the global economic scenario, WHO needed to be increasingly effective and efficient, and to prioritize and focus its support to countries.

Reiterating that health should be treated as central to development, Dr Uton called for continued collaboration from the Member Countries to enable WHO to strengthen its partnership with development partners to ensure that the benefits of cooperation with WHO reached people who had been neglected for long (for full text, see Annex 4).
Address by the Director-General, WHO

DR GRO HARLEM BRUNDTLAND, Director-General, WHO, said that the Organization’s decentralized structure was one of its strengths. WHO drew upon the experiences of all regions and Member Countries. WHO was committed to fight poverty and to promote equity and access to health benefits for all. Though the South-East Asia Region faced many challenges, she believed that it had the resources and the ability to overcome them.

Referring to the important role played by WHO in health development in the Region, Dr Brundtland visualized its continued role as adviser, supporter, catalyst and partner for ensuring the health of those in greatest need. She sought the cooperation of the Member Countries in fulfilling WHO’s noble task. She said that, as a future member of the United Nations Development Group, WHO would actively promote coordination and cooperation with other UN Agencies.

Address by the State Minister for Health and Family Welfare, Bangladesh

PROFESSOR DR M. AMANULLAH, Minister of State for Health and Family Welfare, expressed the hope that the outcome of the Regional Committee meeting would help to develop future health programmes in Bangladesh with intensified WHO collaboration.

Briefly outlining the health programme activities in the country, he said that many of the benefits from advances in medical technology were yet to reach the third world countries. Though there had been improvements in health infrastructure
development, problems of poverty, illiteracy, malnutrition and communicable and noncommunicable diseases had yet to be fully dealt with. Simultaneously, there was the danger posed by emerging killer diseases such as HIV/AIDS. He referred to arsenic contamination of drinking water in Bangladesh and sought WHO’s support in dealing with this problem. He cautioned against the arms race, particularly the disastrous effects of the use of nuclear weapons. Bangladesh had embarked on a Health and Population Sector Programme using a comprehensive sector-wide approach for the provision of health care services. There had been increased participation of women in social development activities and local government bodies.

Address by the Minister of Health and Family Welfare, Bangladesh

MR ALHAJ SALAH UDDIN YUSUF, Minister of Health and Family Welfare, thanked WHO for holding the meeting in Bangladesh and said that he looked forward to benefiting from the experiences of other Member Countries regarding health development activities. Though there had been overall improvement in the health situation in the country, continuing challenges posed by communicable diseases, malnutrition and emerging and re-emerging diseases needed to be met. At the same time, there had been underutilization of the health infrastructure, particularly at the thana level. Provision of basic health services to the entire population, particularly the underserved, had been a national goal. The Health and Population Sector Programme, launched in July 1998, was a positive step in this direction. He identified investment in health and human resources development as critical and sought the support of development partners in this regard. The global
Inaugural Session

initiatives of the WHO Director-General, such as Roll Back Malaria, Tobacco Free Initiative and Tuberculosis Control, were in line with the priorities of Bangladesh. He also referred to the additional difficulties caused by natural calamities and disasters and underlined the need to strengthen the country’s capacity and capability to effectively deal with these.

Inaugural Address by the Prime Minister of Bangladesh

HER EXCELLENCY SHEIKH HASINA, Prime Minister of Bangladesh, welcomed the dignitaries and thanked WHO for holding the Regional Committee session in Bangladesh. WHO’s assistance in meeting the needs of the developing countries, especially in enhancing the national capacity-building process, was much appreciated. She considered health sector reforms as an inevitable process of change leading to wide-ranging improvements in policy and strategic issues. Countries needed to adjust their policies and strategies according to the changing needs brought about by the advances in science and technology.

Tracing the history of Bangladesh, she said that the various pragmatic programmes initiated by the Father of the Nation, Bangabandhu Sheikh Mujibur Rahman, had helped the country achieve notable successes. She specifically referred to enhanced food production, a reduction in population growth rate and high couple protection rate, increased life expectancy, and development of the health infrastructure. Of particular importance was the introduction of the Health and Population Sector Programme (HPSP), a package encompassing reproductive health, child health, communicable disease control, family planning, and minimum
curative care at all levels. However, there were formidable health problems owing to population explosion, poverty, low literacy rate, high maternal mortality and malnutrition, coupled with a high prevalence of communicable diseases. Re-emerging communicable diseases, including sexually transmitted diseases and HIV/AIDS, also posed a grave threat. These issues were being addressed through decentralized administration and a democratic system.

The Prime Minister highlighted the achievements of her government in reducing the infant mortality rate through oral rehydration therapy and high immunization coverage. The recently-launched programme of “Education For All by 2006 AD” would go a long way in increasing literacy, including adult literacy. Concerned with environmental pollution, legislation had been enacted regarding rapid deforestation and inappropriate disposal of industrial waste (for full text, see Annex 5).

Vote of Thanks

PROFESSOR A.K.M. NURUL ANWAR, Director-General of Health Services, Bangladesh, proposed a vote of thanks.
Part III

BUSINESS SESSION

OPENING OF THE SESSION
(Agenda item 1)

IN THE ABSENCE of the Chairman of the 51st session, the Vice-Chairman, Dr U Kyi Soe, opened the 52nd session of the Regional Committee, which was attended by the Director-General of WHO, representatives of Member Countries and other participants and observers.

SUB-COMMITTEE ON CREDENTIALS
(Agenda item 2)

A SUB-COMMITTEE on Credentials, consisting of representatives from Bhutan, DPR Korea and Nepal, was appointed. The Subcommittee met under the chairmanship of Dr Kim Myong Dok (DPR Korea) and examined the credentials submitted by Bangladesh, Bhutan, DPR Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand. The credentials were all found to be in order, thus entitling all representatives to take part fully in the work of the Regional Committee. The report of the Sub-committee (SEA/RC52/15) was approved by the Regional Committee.
ELECTION OF CHAIRMAN AND VICE-CHAIRMAN
(Agenda item 3)

MR M.M. REZA (Bangladesh) was elected Chairman of the 52nd session of the Regional Committee. Dr Azrul Azwar (Indonesia) was elected Vice-Chairman.

ADOPTION OF AGENDA (Agenda item 4)
(document SEA/RC52/1)

The Committee adopted the Agenda, as contained in document SEA/RC52/1.

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

DR GRO HARLEM BRUNDTLAND said that the Region was capable of meeting the many challenges it faced. However, the health gains of the past needed to be shared equitably by all. WHO’s commitment to ensuring better health care for all, particularly the poor, was relevant to the Region, which comprised one-fourth of the world’s population but had about 40 per cent of the global burden of disease. Improving the effectiveness of WHO was high on her agenda. The focus on the most important health issues needed to be maintained in a spirit of partnership. An area of concern was the disproportionately high mortality and the burden of diseases in the Member Countries of the Region.

The Director General assessed WHO’s work in the South-East Asia Region based on four global strategic directions. First,
mortality and disability suffered by the poor and marginalized populations needed to be reduced with the focus on the control of communicable diseases and conditions that led to increased child and maternal mortality.

Attributing the global progress in polio eradication to the efforts of SEAR countries, Dr Brundtland said that NIDs were the largest public health campaigns covering millions of children, made possible through partnerships and with the commitment of health workers and volunteers. However, improved surveillance and additional rounds of NIDs were required.

Reiterating WHO’s commitment to fight HIV/AIDS, and its resolve to eventually develop a vaccine against HIV, Dr Brundtland lauded Thailand’s leadership in spearheading HIV prevention education campaigns and participation in AIDS vaccine trials. The Stop TB Initiative was aimed at generating more resources and partnerships for TB control. Urging Member Countries to achieve 100 per cent coverage with DOTS by the year 2005, she emphasized the need for increased surveillance for anti-TB drug resistance.

The second strategic direction related to countering potential threats to health resulting from economic crises, unhealthy environments and risky behaviour. Referring to the arsenic contamination of drinking water in Bangladesh, she underscored the importance of finding technical solutions to purify contaminated water as well as to find uncontaminated sources of water. She called for concerted regional action to support WHO’s global tobacco control efforts and looked forward to the participation of representatives from the Region in the working
Reforms of health systems, health care financing and ensuring health care coverage for all formed the third strategic direction. The pre-paid system for health care services placed less burden on the poor. Member Countries looked to WHO for guidance in handling the issue of rapid growth of private medical care and channelizing it for achieving public health goals.

The fourth strategic direction concerned the development agenda and recognizing health as a key to human development and progress. She said that illness was not only a result of poverty, but could also be a cause of it. Marked improvements in the health status and increased life expectancy, in turn, could lead to strong economic growth in the Region.

In view of the budgetary constraints, there was a need to shift resources from low to high priority areas. A series of efficiency measures had been initiated at the global level to meet this challenge. Savings were also needed to cover the absence of funding for cost increases. As a result, the South-East Asia Region should also identify budgetary efficiency savings for the next biennium in order to focus more sharply on priorities and cover cost increases. Terming conflict and strife as the worst enemies of health, she said that these should not negate the benefits of progress achieved through decades of hard work (for full text, see Annex 5).

* * *
The meeting expressed concern at the proposed budgetary measures, and felt that savings should be effected by allowing countries and the Regional Office to decide the specific areas for their achievements within a general target representing a required amount. Furthermore, the determination of priority areas to which funds would be channelled from efficiency savings should be left to the countries to decide in consultation with the WHO Regional Office.

Responding, the Director-General clarified that WHO was a technical agency and not a funding agency. She was responsible to the World Health Assembly, and while the views of the Regional Committees provided valuable perspective, Constitutional provisions and the overriding roles of the Executive Board and the World Health Assembly were to be acknowledged. Efficiency shifts would not reduce spending at the country level; however, shifts to priorities were needed. Two-thirds of WHO funds were at country and regional levels. Waste existed not just at WHO headquarters. The Director-General hoped for country support in responding to what had been asked of her by the World Health Assembly.

**DRAFTING GROUP ON RESOLUTIONS**

A DRAFTING GROUP on resolutions, comprising representatives from Bangladesh, Bhutan, India, Maldives, Nepal and Thailand, was constituted. Ms Sujatha Rao (India) was elected Chairperson of the group.
THE WORK OF WHO IN THE SOUTH-EAST ASIA REGION - REPORT OF THE REGIONAL DIRECTOR FOR THE PERIOD 1 JULY 1997 - 30 JUNE 1999 (Agenda item 5) (documents SEA/RC52/2, SEA/RC52/Inf. 1 and Inf. 2)

INTRODUCING his report for the period 1 July 1997 to 30 June 1999, the Regional Director referred to the change from input-oriented to a product-oriented approach in programme budgeting and implementation, which had been introduced in 1996. This approach would ensure that WHO moved steadily towards a result-oriented managerial process.

Recalling the Regional Committee’s decision on pooling of resources for a supplementary intercountry programme in 1996-1997 and in 1998-1999, the Regional Director said that problems common to more than one country could be addressed through enhanced intercountry activities. In this context, he urged Member Countries to focus on result-oriented intercountry collaborative programmes in response to national technical needs in support of their health development programmes.

The regional allocation for the biennium 2000-2001 had been reduced by over $ 3 million compared with 1998-1999 as a result of implementation of resolution, WHA51.31. The Region now needed to focus its resources in a concentrated manner in order to respond to the challenges of World Health Assembly resolution WHA52.20, which called for, among other things, shifting resources out of ineffective areas to higher priorities.
The Regional Director informed the meeting that, in keeping with the Director-General’s call to make the concept of “one WHO” a reality, the structure of the Regional Office was being reorganized in line with the clusters in WHO headquarters. The new structure was expected to strengthen opportunities for both intra and interdepartmental teams to jointly address emerging challenges.

Highlighting WHO’s achievements during the reporting period, Dr Uton said that the Organization had contributed meaningfully to overall health development in the Member Countries. Intensified WHO collaborative activities with countries of the Region as well as WHO initiatives, such as intercountry cooperation for health development, joint planning initiative, synchronization of National Immunization Days, and coordination of border meetings had made positive contributions to health development.

WHO had continued to support high-level meetings, such as the Health Ministers Meeting, the meeting of Health Secretaries and the meeting of Medical Parliamentarians, which had helped to place existing and emerging health development issues high on the political and development agendas of the countries.

Efforts had been intensified to promote approaches that addressed specific women’s health issues in the context of women’s lives and their vital role in development. A working group, constituted in response to the decision of the Forty-ninth session of the Regional Committee, had identified a number of obstacles in the recruitment and retention of women in professional posts. Specific action on the recommendations of this group was being formulated. The employment and recruitment of
women at the professional level in the Regional Office had risen from 8-9% in 1993 to 23% at present. A mechanism had been established to monitor and improve the induction of women to achieve WHO’s long-term target of gender parity.

* * *

The Committee lauded WHO’s significant contribution in providing critical support for eradicating guinea-worm disease, reducing the prevalence of leprosy, combating tuberculosis and HIV/AIDS, and near eradication of poliomyelitis. WHO had provided catalytic support to countries in mobilizing international funding thereby enabling them to address the health problems and to develop proposals for such funding more effectively. As the South-East Asia Region comprised a vast geographical area and housed almost a quarter of the world’s population, it also faced the double burden of disease and burgeoning populations. The Committee therefore hoped that WHO, at all levels, would recognize these factors while allocating resources for future collaborative programmes.

In order to enable both WHO and Member Countries to assess the impact of WHO collaborative programmes and their linkage to the overall health and economic development in Member Countries, the Committee expressed the need for more effective and transparent monitoring and evaluation systems.

The Committee acknowledged WHO’s significant role in the areas of research and development of human resources for health, especially through training and fellowships. It further noted the possibility of awarding in-country fellowships as well as training
health personnel at national centres of excellence, which would not only be cost-effective but would also be mutually beneficial for institutions and countries.

Noting that large investments in clinical aspects alone would not be effective in controlling diseases, the Committee called for further strengthening of public health administration in Member Countries through enhanced technical support and increased allocation of budgetary resources.

The Committee appreciated WHO's assistance in the control of communicable and noncommunicable diseases. In particular, the support extended to Member Countries had helped them to overcome the adverse health impacts of the economic crisis and in strengthening the health system. The need for WHO assistance to sustain health development programmes and in accessing good quality drugs was stressed.

The Committee noted that considerable gains had been made in the past few years in developing strategies for controlling diseases in the border areas, particularly malaria, through regular border meetings and enhanced cooperation. Increased cross-collaboration in the border areas, for action at the local level, was recommended.

The Committee noted that conducting rapid assessment among populations with high-risk behaviour, such as injecting drug use, was useful in assessing the problem of HIV/AIDS. Such information could help in instituting control measures. At the same time, HIV/AIDS surveillance, including risk behaviour, was important for planning as well as evaluating the impact of
interventions. In this context, the need for intercountry and interagency collaboration and exchange of experiences in HIV/AIDS surveillance was stressed. Remarkable progress had been made in tuberculosis control using the DOTS strategy. Further rapid expansion of DOTS was expected in the near future so that the goal of nation-wide DOTS coverage with good quality of programme implementation could be achieved in all countries before 2005.

The Committee called for high priority to Integrated Management of Childhood Illnesses to accelerate reductions in infant and child mortality rates. WHO should provide enhanced technical expertise and in-service manpower training for achieving this. In countries where infant mortality rates have declined substantially, WHO should support programmes to reduce mortality in the neonatal period.

The Committee noted that WHO continued to promote an integrated preventive approach to address the increasing incidence of cardiovascular and cerebrovascular diseases, malignancies, metabolic and degenerative disorders and mental illness. Efforts had been made to increase public awareness and to strengthen programme management capabilities for PHC personnel.

Technical support was provided to countries in developing basic eye care and ear care services. Plans were being made to launch Regional Vision 2020 on the lines of Global Vision 2020, launched by the Director-General early this year.

Member Countries had been supported in operationalizing the regional strategy for reproductive health, with special focus on
reducing maternal mortality. Significant technical support had been provided to the countries in the areas of mental health, substance abuse control, nutrition, environmental health, essential drugs and traditional medicine through innovative approaches.

In its fight against tobacco, WHO’s focus had been on reducing consumption levels and preventing initiation of tobacco use. A Regional Policy Framework and Plan of Action, which would be a blueprint for the control of tobacco use, had been developed. The Tobacco Free Initiative had been included as a priority project in the intercountry programme in 2000-2001.

The Committee was concerned that the shift from component-based approach to product-oriented approach had caused some difficulty for country programme managers in the preparation of plans of action. It, however, noted that the Regional Office had organized workshops on programme development and management to orient staff and nationals on the planning process.

The Committee noted that intensified WHO collaborative activities with countries of the Region as well as WHO initiatives, such as intercountry cooperation for health development, joint planning initiative, synchronization of National Immunization Days, and coordination of border meetings, had made positive contributions to health development.

The Committee’s attention was drawn to new and emerging health problems and challenges resulting from global warming and climatic changes. The need was expressed for the Member Countries and WHO to formulate effective strategies to address these.
The Committee also urged Member Countries to consider implementing the international plan of action, as endorsed by the 51st World Health Assembly, for the prevention of violence and injury, which caused a major drain on national resources by way of medical treatment and rehabilitation of the victims.

The Committee expressed the need to support cost-containment measures in the countries, particularly in respect of drugs and vaccines, to make them affordable to the vast majority of the population. It underscored the need for the procurement of diagnostic material such as test kits, drugs and insecticides to deal with malaria and kala azar. Preparation of training materials, particularly their translation into local languages, was no less important.

Considering that the countries lacked expertise in health legislation, the Committee emphasized the need to evolve health legislation and regulatory framework. The implications of agreements relating to WTO/GATT and TRIPS on health should be kept in mind. Herbal drugs and traditional medicines were acknowledged to have an important role in treatment. A multisectoral approach involving the pharmaceutical industry and other relevant nongovernmental organizations was called for in this regard. Clinical research in this area also needed to be supported.

In the area of food safety, the Committee recognized the need to develop closer cooperation with other UN, bilateral and multilateral agencies. Protection of the consumer was equally important.
The Committee underscored the importance of rational use of insecticides for the control of communicable diseases as well as in agriculture. The broad area of surveillance should cover assessment of the problem as well as the study of behavioural aspects. There was a need to analyse surveillance data and provide feedback to help implement specific activities. It felt that the Member Countries should develop disaster preparedness and early warning systems in order to effectively deal with epidemics, as well as natural calamities. The support provided by WHO to field epidemiology training programmes in Thailand, Indonesia and India was acknowledged. This would help raise standards in public health through disease reporting, surveillance analysis and response.

The Committee recognized the need for increased focus on health promotion. WHO had provided assistance in developing health promoting schools, in line with the recommendations made by the Meeting of Health Ministers. At the same time, significant steps had been taken by the relevant countries in the area of mega country initiatives. There was, however, a need to speed up activities since health promotion formed an integral and critical part of control of communicable and noncommunicable diseases. The Committee felt that a strong national network was necessary to develop an even stronger regional network in health promotion activities as a whole. Realizing the importance of healthy cities, Member Countries had initiated action for strengthening this programme. The focus on healthy settings was achieved through the plans of action for the next biennia.

The Committee was informed that the Advisory Committee on Health Research had deliberated on the important areas of
development of clinical research, promotion of herbal and traditional systems of medicine, participatory development process in strategic planning, and research on regulatory system development. It noted that appropriate guidelines in these areas were being developed by the Scientific Working Groups set up by SEA-ACHR.

The Committee noted the serious problem of arsenic contamination of drinking water in shallow tubewells in some countries of the Region, leading to skin cancer and kidney failure. It recognized the need to train health workers in the treatment of arsenic-affected patients. The need to develop a comprehensive workplan enlisting a high level of political commitment was emphasized. The Committee urged that alternative approaches, such as chemical treatment of contaminated water, be explored.

The Committee noted that a working group had been established to study the effectiveness of WHO collaborative programmes in the countries and the Regional Office, which was expected to make its recommendations. It stressed the need to reflect, in the Regional Director’s biennial report, important policy issues regarding the improvement of efficiency in WHO as well as problems and constraints faced by WHO in collaborating with the Member States.

A resolution on the Regional Director’s biennial report was adopted (SEA/RC52/R2).
Address by the Chairman, 24th SEA-ACHR

DR M.P. SHRESTHA, Chairman of the 24th session of the South-East Asia Advisory Committee on Health Research, presented the conclusions and recommendations of its twenty-fourth session, held in April 1999. The SEA-ACHR had recommended, among other things, continued interaction between the regional ACHR and directors of medical research councils for defining the scope and content of national and regional health research agendas, strengthening of health research capacity and information management and enhancement of the roles of WHO collaborating centres and national centres of expertise. It had also stressed the need for monitoring and evaluation of health research. Noting that there were relatively few research activities on health policy development, it had called for the development of good linkages between researchers and policy-makers and greater intersectoral collaboration.

While reviewing the progress in the implementation of the recommendations of the first joint session of SEA-ACHR and MRCs, held in 1998, the SEA-ACHR had recommended that national health or medical research councils be closely involved in monitoring and evaluation.

In its review of important global research programmes, the Committee endorsed the proposal to broaden the mandate of the Special Programme for Research and Training in Tropical Diseases (TDR) to cover tuberculosis and dengue/dengue haemorrhagic fever and directed that a comprehensive regional plan on research for the prevention and control of malaria in border areas be developed. It recommended the formation of a task force and
development of a regional framework to review national ethics under the Special Programme of Research, Development and Research Training in Human Reproduction (HRP). It also requested the WHO Regional Office to convene a task force for reviewing research needs in the prevention and control of HIV/AIDS in the Region.

The 36th session of the WHO Global Advisory Committee on Health Research had called for adequate reflection of the needs and priorities of the Region in its global agenda and felt that the regional and global ACHR systems, including annual meetings of the Committee, should be maintained. The need to enhance partnerships in health research with appropriate organizations and institutions, including NGOs, was stressed. The mission statement and strategic plan for global and regional health programmes on evidence and information for policy should clearly define and delineate the role of WHO in health research at all levels. In view of the importance of vaccine research in disease control, it felt that the Regional Office should explore strategic ways of enhancing intercountry cooperation in the areas of vaccine research, production and delivery.

**Statements by Representatives of Nongovernmental Organizations**

PROF. QUAZI SALAMATULLAH (International Council for Control of Iodine Deficiency Disorders - ICCIDD) said that iodine deficiency was the most common preventable cause of brain damage and his organization was engaged in the sustainable elimination of these disorders. He congratulated the Director-General of WHO on her
excellent report on iodine deficiency and its control, which described the spectacular progress achieved in this area.

DR SANJEEB SAPKOTA (International Federation of Medical Students Associations - IFMSA) said that IFMSA was the biggest and oldest students’ organization, with representation in 75 countries. Apart from encouraging the exchange of students, the Association supported projects on public health, health education, tobacco control and environmental awareness. It offered assistance to refugees and orphans, besides assisting in the provision of books and organizing workshops on medical education. Seminars, workshops and training programmes were also conducted at national and international levels, to raise awareness among medical students and to sensitize them in public and reproductive health.

PROF. DR M. JALISI (International Federation of Oto-rhino-laryngological Societies - IFOS) said that deafness in children was a major preventable problem in South-East Asia affecting 0.5 per cent of all children. This problem could be addressed using a three-pronged approach of compulsory registration of all high-risk neonates, mass campaigns aimed at early detection of the problem, and efficient management. He sought WHO support in this context.

DR S.P. AWASTHY (International Association of Medical Laboratory Technologists - IAMLT) stressed the importance of improving the quality of diagnosis and treatment of diseases. He felt that the quality of education in medical laboratory science was of utmost importance to the national health care system. He sought WHO support in the standardization of diagnosis and
requested the establishment of an Expert Committee on Laboratory Diagnosis Standardization and Quality Assurance to achieve harmonization within the field of laboratory diagnostics.

DR PRABHAKAR SAMSON (International Federation of Anti-Leprosy Associations – IFAL) expressed the need for sustained interest and commitment for leprosy elimination.

DR TULSI BASU (Medical Women’s International Association – MWIA) stated that MWIA, consisting of representation in 74 countries, aimed at affording medical women the opportunity to consider common problems together, particularly in international health. Its activities encompassed the provision of total health care to underprivileged women and children, organizing rural health camps, hygiene literacy programmes, family planning, child welfare and training of junior doctors and paramedicals.

**PROGRAMME BUDGET** (Agenda item 7)
(document SEA/RC52/11 Rev 1 and Add.1)

INTRODUCING the item, the Regional Director referred to documents SEA/RC52/11 Rev.1 and Add.1 and reminded the Committee that the Consultative Committee for Programme Development and Management (CCPDM) had taken over the work of the Sub-committee on Programme Budget. After the Chairman of CCPDM had presented the highlights of the CCPDM discussions, the Regional Director commented on some key Programme Budget issues. Noting that there had been some improvement in the timeliness and quality of implementation in the 1998-1999 programme budget, the Regional Director reiterated that much
remained to be done. Many areas had been identified by WHO’s auditors for improvement. An external study on identifying factors to improve the implementation processes would, along with the recommendations of CCPDM, form the basis for further action to be taken by the Regional Office.

Explaining the rationale and process behind the identification of US$8.6 million regional savings for the 2000-2001 biennium, the Regional Director confirmed that savings would be retained within each country budget. He also confirmed that the CCPDM recommendations in this area would be considered as far as possible when finalizing the details of savings targets for each country budget. The recommendations of CCPDM in regard to the detailed plans of action for 2000-2001, including those relating to the planning and implementation of activities under ICP I, would also be carefully considered. He also indicated that the Director-General had decided on an overall contingency hold-back of 1% from the 2000-2001 biennial funds to cope with the anticipated reduction in assessed contributions.

The Regional Director also commented that even though the Director-General planned to take a fresh look at how individual country figures would be determined for 2002-2003, there was nevertheless a need to begin the planning process now, as indicated in document SEA/RC52/11 Rev.1.

The Committee was informed by the Chairman of CCPDM about the salient points arising from the detailed discussions and recommendations emanating from CCPDM in regard to Programme Budget (document SEA/RC52/11 Add.1).
Concerning efficiency savings, the Committee strongly reiterated its desire for the countries to decide the identification of areas for savings as well as the priorities to which savings would be channelled. As the need for procurement and fellowships varied according to individual country health situation, the Committee felt that the appropriateness of identifying savings from these areas should in certain cases be reconsidered. It was also suggested by the representative of DPR Korea that the savings be allocated on a pro rata country-by-country basis. There was also a proposal to base identification of savings on 2000-2001 planned activities instead of actual expenditures from earlier biennia. In considering areas for savings, efforts should also be made to include other non-activity areas, such as overhead, administrative costs and staffing. In this connection, the Committee noted that identification of areas for savings could form part of the report from the ongoing efficiency review, which would be completed by early 2000.

The Committee also emphasized the need for Executive Board members, who would be meeting with the Director-General at the October 1999 retreat, to be fully briefed in order to adequately represent the views of the Committee.

Regarding the 1% contingency holdback for 2000-2001, the Committee felt that it was unfair to impose this on countries which had been paying their assessed contributions regularly. The Regional Director was asked to pursue the matter with WHO headquarters. The representatives could also raise the issue at the Executive Board or the World Health Assembly.

* * *
Background was provided to the Committee to form a perspective within which to discuss the current issues concerning savings. The background dealt with all the circumstances relating to resolution WHA51.31 which had resulted in budget cuts. In contrast, resolution WHA52.20 dealt with the identification of savings arising out of a need to maintain the purchasing power of the 2000-2001 budget at par with that of 1998-1999, and to shift funds to areas of higher priority. It was not possible to identify the required savings on a pro rata country basis as these savings would accrue from the activity component areas decided by the Director-General in proportions reflected by country patterns of expenditure. The 1996-1997 data were used, since information for the current and future bienniums was incomplete.

Unique country situations would, however, be taken into consideration to the extent possible while finalizing details and at the implementation stage. The active participation of Executive Board members in the Director-General’s forthcoming retreat would be the best means for the Committee’s views to be communicated to the Director-General. The key point for negotiations was the need for regions to be able to decide the priorities for which funds were to be reallocated within the Member Countries.

Reduction in staffing would be complex. Programme needs, performance, staff entitlements under UN system-wide terms of employment, and budgetary constraints, were all important factors. General Service staff reductions in the Region were not considered to be productive for generating savings because of the low salaries as compared with staff in the Professional category. Nevertheless, if programme activities were reduced, there would be
a definite impact on staffing requirement from the point of view of efficiency. Savings were planned in this area in the Regional Office and it was hoped that the target could be achieved through natural attrition.

It was also clarified that detailed plans of action from the countries which could not be discussed at CCPDM due to their late receipt, could be submitted to the WHO representatives and would be reviewed by the Regional Office for further discussion.

The Regional Director confirmed the seriousness with which he accepted the views of the Committee concerning the overall need for greater efficiency, including in the area of administrative overheads. He looked forward to receiving, also, the “efficiencies report” by the group formed, as proposed by the 34th meeting of CCPDM.

CONSIDERATION OF THE RECOMMENDATIONS ARISING OUT OF THE TECHNICAL DISCUSSIONS ON (1) TOBACCO OR HEALTH: ACTIONS FOR THE 21ST CENTURY, AND (2) INTENSIFICATION OF HIV/AIDS SURVEILLANCE (Agenda item 8.1)

THE COMMITTEE was informed that Technical Discussions on the two subjects had been held in conjunction with the 36th meeting of CCPDM, in accordance with the decision of the Regional Committee (SEA/RC51/R4). Reports of the Technical Discussions on both subjects had been placed before the Committee for deliberation.
Technical Discussions on Tobacco or Health: 
Actions for the 21st Century

IN THE ABSENCE of Dr Suwit Wibulpolprasert (Thailand), Chairman of the Technical Discussions, Ms Sujatha Rao (India) presented the highlights of the discussions and the recommendations contained in document SEA/RC52/14. She emphasized the seriousness of the tobacco problem in the Member Countries and the urgent need for action. It was stressed that tobacco consumption had reached epidemic proportions and needed to be monitored like any other disease. A national surveillance and response system as well as treatment centres needed to be set up.

Member States were encouraged to develop their respective action plans for tobacco control. There was an urgent need to frame legal regulations, forge partnerships and effect social mobilization in order to counter the menace of tobacco use. Countries should set up national councils comprising representatives both from the government and non-governmental sectors as well as the private sector to formulate broad-based strategies. Economic and financial implications of tobacco use should be given due attention while launching anti-tobacco drives. Taxation was considered to be one of the most effective measures to contain tobacco use. The examples of Thailand and Nepal, where a proportion of the total tax revenue from tobacco products was used to counter the tobacco menace, could be emulated by other countries.

Many countries had strict regulations on the monitoring of food items, but the use of substances like nicotine was completely unregulated. Mechanisms to introduce licensing for the sale of
nicotine as a controlled drug, other than its use for therapeutic purposes, were required. Mechanisms also needed to be established by Member Countries for monitoring the levels of tar and nicotine in tobacco products in the Region. WHO was planning to hold a meeting in early 2000 to examine and review these issues. The question of regulating international trade in view of its adverse effects on health needed to be resolved with WTO. The Committee solicited WHO’s intervention in this regard.

In order to generate a positive influence, health professionals could themselves set examples by refraining from tobacco use. Public awareness and education, peer pressures, influence of religious groups/institutions and behavioural changes also had important roles to play in tobacco control. The message: “tobacco use is injurious to health” needed to be disseminated and displayed prominently. Alternative messages such as “tobacco revenue or health” should be considered to gain the commitment of policy-makers. Political will and commitment were essential to make tobacco control successful. In some countries, legislation concerning tobacco use already existed. Its effectiveness needed to be monitored while mechanisms for new regulations were instituted.

* * *

The Committee, in reviewing the recommendations emanating from the Technical Discussions, felt that emphasis should be given to education and efforts at inducing the desired behaviour. Several members felt that the recommendation relating to preferred recruitment of non-smokers in government jobs would not be feasible at this stage. The Committee indicated that in licensing
nicotine as a controlled drug, care should be taken to avoid criminalization of its use. The Committee also felt that registration of tobacco retailers as well as the establishment of cessation clinics would be useful.

A resolution on the subject was adopted (SEA/RC52/R7).

**Technical Discussions on Intensification of HIV/AIDS Surveillance**

DR SANGAY THINLEY (Bhutan), Chairman of the Technical Discussions, presented the recommendations as contained in document SEA/RC52/13. Realizing the seriousness of the subject of HIV as a whole, the Committee noted that, in addition to an intensified comprehensive surveillance programme, advocacy, safe blood transfusions establishing voluntary counselling and testing facilities, HIV/AIDS research, multisectoral involvement and response and, most importantly, the allocation of appropriate resources were considered to be of critical importance for HIV prevention and control. High-risk behaviours, including injecting drug use, needed to be tackled with utmost urgency. The Committee called for further WHO support to Member Countries in specific technical areas where WHO had a comparative advantage. These included STD management, blood transfusion safety, HIV/AIDS care, surveillance and research.

A resolution on the subject was adopted (SEA/RC52/R8).

**SELECTION OF A SUBJECT FOR THE TECHNICAL DISCUSSIONS TO BE HELD DURING THE 38th MEETING**
OF THE CONSULTATIVE COMMITTEE ON PROGRAMME DEVELOPMENT AND MANAGEMENT (CCPDM)
(Agenda item 8.2)

THE COMMITTEE selected the following two topics for the Technical Discussions to be held during a meeting of CCPDM in 2000: (1) Equity in access to public health, and (2) Healthy settings. The Committee urged the Regional Director to initiate necessary action to collect technical and scientific data on the subjects chosen for the Technical Discussions in 2000.

A resolution on the subject was adopted (SEA/RC52/R3).

(documents SEA/RC52/10 and Corr 1, and Add.1 and Add.2)

Part 1

THE COMMITTEE was informed that, in accordance with the decision of the Forty-eighth session of the Regional Committee, a combined document had been prepared on the subject in order to achieve a better understanding of the regional implications of
various resolutions passed by the previous sessions of the Executive Board and the World Health Assembly. There were 12 resolutions of regional relevance adopted by the 52nd World Health Assembly and 3 resolutions of the 103rd session of the Executive Board, held in 1999. The Committee took into consideration the deliberations and recommendations of the 36th meeting of CCPDM which had already reviewed these resolutions. The discussions of CCPDM focused on two specific resolutions: (1) Scale of assessment for the financial period 2000-2001 (WHA52.17), and (2) Towards a WHO Framework Convention on Tobacco Control (WHA52.18).

Regarding resolution WHA52.17, the Committee noted the need to review the basis of determining assessed contributions. Even though the scale of assessment was determined by the UN General Assembly, it would be useful to have relevant information on the base year on which assessments were determined. The Regional Office was requested to provide this information later.

As regards resolution WHA52.18 relating to Framework Convention on Tobacco Control, the solidarity among Member Countries of the Region should be used in protecting regional interests. Since the Framework Convention would take a few years to be approved, Member Countries should proceed with the development of their strategies and programmes for tobacco control for early implementation of the Convention. It should, however, be ensured that countries were not adversely affected for not implementing this international Convention.
THE COMMITTEE was informed that in view of the correlation of the work of the Regional Committees with that of the Executive Board and the World Health Assembly, it was customary for it to review the agendas of the forthcoming sessions of these two bodies. This year, however, only a list of subjects likely to be discussed during the 105th session of the Executive Board was available. That list had been examined by CCPDM. The Committee noted the recommendations made by CCPDM on the need for the Executive Board members from the Region to be briefed adequately by WHO Representatives on the process of proposing agenda items of interest to the Region as well as on the need to brief relevant country-level counterparts following the meetings of the Board and the World Health Assembly. This would allow national counterparts to be fully aware of the country-level implications of Executive Board/World Health Assembly resolutions. The Committee also felt that since World Health Assembly resolution WHA51.31 clearly indicated that the interest of the least developed countries would be protected to the extent possible, it should be ensured that that would be the case through the year 2005. The Committee also felt that it would be useful to include persons who are technically sound in health-related areas as part of country delegations to the meetings of WHO governing bodies.

In view of the problem of arsenicosis in Bangladesh and some parts of West Bengal in India, the Committee felt that this issue should be taken up at the highest forum; therefore, efforts should be made to get this item included in the agenda.
Statement by the Representative of the International Federation of Pharmaceutical Manufacturers

DR ALAIN AUMONIER (International Federation of Pharmaceutical Manufacturers - IFPM) said that resolutions WHA52.19 and WHA52.23 relating to the revised drug strategy and strengthening health systems in developing countries, provided encouragement to both national decision-makers and international institutions to give more priority to health in their agendas as well as for more substantive resource allocation. He conveyed the pharmaceutical industry’s appreciation for the WHO Director-General’s initiative in creating a collaborative climate for dialogue with the research-based industries and hoped for productive common initiatives in improving access to drugs for patients in developing countries.

Statement by the Representative of the World Organization of Family Doctors

DR MD. NURUL ISLAM, (World Organization of Family Doctors - WONCA), expressed his organization’s commitment to implement WHA resolution WHA48.8 on the reorientation of medical education and medical practice for Health for All. WONCA was undertaking a number of collaborative activities in various parts of the Region.

ROLL BACK MALARIA (RBM) AND MAINSTREAMING OF ANTI-MALARIA ACTIVITIES IN HEALTH SECTOR DEVELOPMENT (Agenda item 10) (document SEA/RC52/7 and Corr 1)
THE REGIONAL DIRECTOR introduced the subject and referred to the importance of partnership among agencies concerning “Roll Back Malaria”, as endorsed by the World Health Assembly. He said that it was important to link it with other disease control programmes. Sustainable broad-based partnerships and intersectoral coordination were essential for achieving the objectives. In some countries, the malaria menace had re-emerged after having been under control for many years; lack of resources hampered progress in containing its resurgence.

RBM initiative had provided an impetus to intensified country efforts. Due emphasis was being laid on various important aspects, such as political commitment at the highest level, involvement of nongovernmental organizations and the private sector, intersectoral collaboration, epidemic control, vector control, substantial reduction in malaria cases, control of drug resistance, environmental management, adoption of integrated approach and capacity building, etc. The existing malaria control programmes in the Member Countries needed to be reviewed and the possibility of additional resource mobilization by adopting a partnership approach explored. A plan of action for malaria control programmes needed to be developed and a review of capacity-building undertaken at various levels. WHO had an important role to play in assisting countries to mobilize funds from voluntary/external donors. There was a need to establish technical resource networks among countries of the Region with technical guidance and support from WHO. The Organization’s assistance was also sought in tackling cross-border malaria problems.

The Committee took note of certain points for consideration by the Member Countries: (1) enlist national commitment to
support the RBM and the policies needed to sustain it; (2) propose changes and mechanisms required to mainstream RBM in health sector development; (3) identify human and other resources to be mobilized for capacity-building in prevention, early diagnosis and prompt treatment; (4) explore ways of initiating and sustaining partnerships in strategic investment, and (5) identify mechanisms to foster regional support. The Committee emphasized that since 2000-2001 was a pivotal period, countries should select interventions with locally acceptable guidelines and implement the preparatory phase of the Roll Back Malaria initiative. Recognizing that malaria was a complex problem, it called for finding effective solutions within the available resources and expertise. There was a need to strengthen the regional technical support networks to directly address priority issues. The Committee stressed that the development of manpower at all levels should be given priority for achieving the objectives of RBM.

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The Committee urged WHO to assist in (1) assessing the technical expertise available in the countries; (2) identifying gaps for training and human resource development, and (3) capacity-building to strengthen the knowledge base of health personnel engaged by public utilities and of the large number of private medical practitioners in the countries in the prevention, early diagnosis and prompt treatment of malaria cases.

A resolution on the subject was adopted (SEA/RC52/R5).
INTERCOUNTRY COOPERATION IN THE SUPPLY OF ESSENTIAL DRUGS (Agenda item 11) (document SEA/RC52/6)

THE COMMITTEE noted that WHO had been assisting Member Countries in the formulation and implementation of rational drug policies in order to save lives and to reduce morbidity and mortality from common illnesses. Towards this goal, emphasis had been placed on advocating the essential drugs concept, drug supply management, quality assurance and rational use of drugs. Other aspects of a national drug policy, such as drug legislation and regulatory control, essential drugs production, dissemination of drug information, drug financing, training of human resources and technical cooperation among countries of the Region, were being promoted. Even though the Member Countries of the Region had developed national drug or pharmaceutical policies, accessibility to essential drugs differed from country to country and within the same country. These differences became prominent during times of economic crisis and emergency situations due to disruption in drug supply. In the circumstances, intercountry cooperation in sustaining the supply of essential drugs became a critical issue.

The Committee appreciated the increasing regional need for intercountry cooperation in the areas of exchange of available information on drugs and pharmaceuticals; strengthening of national drug regulatory bodies; supporting WHO’s role in encouraging national drug standards; sharing of technological skills for the production of vaccines and high-tech drugs as well as human resource development; supporting rational use of essential
drugs; harmonization of drug regulations; better drug procurement at national and sub-national levels of bulk raw materials, adequate supply, feasible access to the marginalized population; and the rights of large and small countries in getting appropriate essential drugs.

The Committee emphasized that if the idea of bulk purchasing was to be undertaken, Member Countries should decide on the list of basic essential drugs and the quantities to be procured so as to collectively indent for the aggregated quantity in the global market, in order to obtain drugs at competitive prices. It was felt that the validity of WHO acknowledgement of national GMP (Good Manufacturing Practices) should be upheld for this process. In this connection, the Committee noted the successful example of bi-regional cooperation between WHO and ASEAN in the area of pharmaceuticals.

**STRENGTHENING POISON CONTROL CENTRES IN THE REGION** (Agenda item 12)
(document SEA/RC52/8)

THE COMMITTEE noted that, with the rapid economic and industrial growth in the Region, the demand for and use of chemicals in agriculture, health and industrial sectors had increased enormously, leading to indiscriminate and unsafe use of chemicals, particularly pesticides. This had resulted in an increasing incidence of accidental and intentional poisoning with consequent morbidity and mortality. A significant proportion of the population was unaware of the toxic risks of chemicals, which were often poorly
labeled and improperly stored. Pesticide was a major health concern in all SEAR countries.

Occupational exposure to industrial chemicals, ground water and environmental contamination with arsenic, fluorides, lead and pesticides and adulteration of food also posed serious health problems. There had also been industrial accidents involving toxic chemicals. Though toxic chemicals posed a serious health risk in all SEAR countries, the exact magnitude of the problem was not known because of inadequate data. It was therefore essential for the countries to identify the existing capabilities and facilities for poison control and take steps towards resource mobilization, capacity building and institutional strengthening. This called for appropriate policy decisions by the Ministry of Health in active partnership with various NGOs and the private sector. The Regional Office proposed to organize, with the help of the International Programme on Chemical Safety of WHO headquarters and other centres of excellence, a comprehensive poison control programme in the Region to provide necessary technical support to the countries.

A resolution on the subject was adopted (SEA/ RC52/ R6).

**UNDP/ WORLD BANK/ WHO SPECIAL PROGRAMME FOR RESEARCH AND TRAINING IN TROPICAL DISEASES: JOINT COORDINATING BOARD (JCB) - ATTENDANCE AT 1999 JCB**

(Agenda item 13.1) (document SEA/ RC52/ 4 and Add.1)

THE COMMITTEE was informed that, on behalf of India, Sri Lanka and Thailand, the representative from Sri Lanka had reported on
the deliberations of the 22nd session of JCB, held in Geneva in June 1999, to the 36th CCPDM.

JCB had emphasized the important role of the TDR Programme in improving the quality of life of populations exposed to tropical diseases and had noted that the WHO contribution to the Programme’s budget had been increased by 25% for the next biennium. The need for providing adequate administrative support to the TDR Programme had been stressed. The participants discussed the Roll Back Malaria initiative, its principles and key elements, such as early detection, prompt treatment, multiple prevention methods, well-coordinated action, dynamic global movement and focused research.

In view of the re-emergence of tuberculosis and its close association with HIV infections, JCB had agreed to include tuberculosis control in the TDR Programme. A proposal to include research pertaining to dengue control in the TDR Programme had also been endorsed. The need for, and the importance of institutional strengthening, particularly in the least developed countries, had also been underlined.

In response to a query, it was clarified that in 1998, out of the estimated US $ 73 million spent under the Programme, the SEA Region’s share was $ 989,259, which was distributed among India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand. The Committee was informed that research proposals were funded through a competitive process. If the Member Countries proposed high priority and good quality research proposals, the chances of the Region getting a better share were good. In particular, the addition of research on TB and dengue as part of TDR would
enlarge the scope of participation of the Region. The Committee urged that technical assistance be provided to Member Countries to develop good proposals.

**WHO SPECIAL PROGRAMME FOR RESEARCH, DEVELOPMENT AND RESEARCH TRAINING IN HUMAN REPRODUCTION - POLICY AND COORDINATION COMMITTEE (PCC) - ATTENDANCE AT 1999 PCC AND NOMINATION OF A MEMBER IN PLACE OF THAILAND WHOSE TERM EXPIRES ON 31 DECEMBER 1999** (Agenda item 13.2) (document SEA/RC52/5 and Add.1)

THE COMMITTEE was informed that, on behalf of India, Indonesia and Thailand, the representative from Thailand had reported on the deliberations of the 12th meeting of the Policy and Coordination Committee, held in June 1999, to the 36th meeting of CCPDM.

PCC had noted that WHO headquarters had decided to establish a small working group to study the interaction between the work of clusters with those of TDR and HRP.

PCC had also discussed matters relating to the Meeting of the Scientific and Ethical Review Group. It had endorsed the mechanisms adopted by the Programme to ensure that the views of the developing countries contributed to priority setting in the Programme’s activities and had recommended that WHO address ethical responsibilities of researchers at the country level. The reports of the STAG and Gender Advisory Panel had been noted.
PCC had also discussed the 1998-1999 interim financial report and the current funding situation and had noted with some concern the financial constraints that existed.

The Committee nominated Bangladesh as a member of PCC for three years from 1 January 2000 in place of Thailand.

**Statement by the Representative of the International Planned Parenthood Federation**

DR AHMAD NEAZ (International Planned Parenthood Federation - IPPF) offered his organization’s full cooperation to WHO in undertaking further research in the field of human reproduction. Highlighting the activities already undertaken by IPPF, Dr Neaz called for further research to cope with emerging needs. He urged WHO to continue its search for scientific innovations, particularly in the areas of safe motherhood and the HIV/AIDS pandemic as well as in regard to the socioeconomic, cultural and behavioural aspects of human reproduction. A mechanism for the delivery of client-friendly quality service to the underserved groups needed to be developed. He urged further strengthening of the WHO-IPPF partnership in this area.

**WHO ACTION PROGRAMME ON ESSENTIAL DRUGS - MANAGEMENT ADVISORY COMMITTEE (MAC) - ATTENDANCE AT 1999 MAC** (Agenda item 13.3)  
(document SEA/ RC52/Inf.3 and Add 1)
THE COMMITTEE was informed that, on behalf of Bangladesh and Myanmar, the representative from Bangladesh had reported on the deliberations of the 11th meeting of the Management Advisory Committee (MAC), held in March 1999, to the 36th meeting of the CCPDM.

MAC had noted that there was a need to develop capacity in drug regulation in some countries. Surveillance for the safety and efficacy of drugs was necessary. Effective enforcement of the law on drugs was important in order to achieve effective drug regulation. The establishment of a national quality control laboratory would facilitate quality assessment of the drug before and after procurement. Apart from the WHO Regular budget, enhanced extrabudgetary funds and increased financial contributions from the government would go a long way in implementing activities under the Essential Drugs and other Medicines (EDM) Programme within the countries. Additionally, alternative health care financing mechanisms, such as user fees, fees for drugs, community donations and health insurance schemes, could also mobilize additional funds.

Statement by the Representative of the International Organization for Cooperation in Health

DR THELMA NARAYAN (International Organization for Cooperation in Health - IOCH) said that her organization provided technical and financial support to NGOs to promote the PHC approach in strengthening district health systems to improve the health status of poor people. She emphasized the significance of collaboration between government and nongovernmental organizations in the
implementation of national programmes, particularly the control of malaria, tobacco, TB, etc.

TIME AND PLACE OF FORTHCOMING SESSIONS OF THE REGIONAL COMMITTEE
(Agenda item 14)

THE COMMITTEE accepted the confirmation by the Government of India (SEA/RC51/R5) to host its 53rd session in early September 2000.

The Committee accepted the invitation of the Government of the Union of Myanmar to host the fifty-fourth session in 2001, and noted with appreciation the invitation of the Government of Indonesia to host its fifty-fifth session in Indonesia in 2002.

A resolution on the subject was adopted (SEA/RC52/R4).

CONSIDERATION OF DRAFT RESOLUTIONS

THE COMMITTEE adopted eight resolutions. In respect of the resolution on tobacco, the Chairman said that operative paragraph (a), proposing the constitution of a multisectoral national council under the chairpersonship of the Head of State/Government, might not be practicable. However, no change in the text of the resolution was proposed since it had already been adopted.
ADOPTION OF THE REPORT OF THE FIFTY-SECOND SESSION OF THE REGIONAL COMMITTEE
(Agenda item 15)

The Committee adopted the final report of its fifty-second session, as contained in document SEA/RC52/16.

CLOSURE OF THE SESSION
(Agenda item 16)

The representatives congratulated the Chairman and the Vice-Chairman for the efficient manner in which they had conducted the session. They expressed their gratitude to Her Excellency Sheikh Hasina, Prime Minister of Bangladesh, for her graciousness in inaugurating the session despite her busy schedule. They also thanked the Director-General, WHO, Dr Gro Harlem Brundtland, for attending the session and for delivering a thought-provoking address during the business session, which reflected her deep commitment to addressing vital global and regional health issues. They expressed their sense of appreciation to the Government of Bangladesh, especially the Ministry of Health and Family Welfare, for hosting the session, and for the kind hospitality extended to them during their stay in Dhaka. They thanked the Regional Director and the WHO secretariat for facilitating their participation in the meeting and for providing excellent documentation.

The representatives said that the decisions and recommendations of this session of the Regional Committee, the last to be held this century, would have a far-reaching influence in
the new millennium, in bringing about equity in access to health care and in eradicating poverty and ill-health.

In regard to budgetary cuts, the representatives expressed the hope that WHO would take cognizance of the geographical situation, population and the specific needs of the Region and ensure equitable allocation of the WHO Regular budget.

The Regional Director congratulated the Chairman and the Vice-chairman for the most efficient manner in which they had conducted the session, and for their trend-setting effort in effecting overall economy by completing the session ahead of time. He expressed his happiness at the high quality of discussions and the useful suggestions made by representatives and NGOs, all of which had been accomplished in a spirit of cooperation and understanding. He thanked the Honourable Prime Minister of Bangladesh, the Minister of Health and Family Welfare, as well as the Minister of State for Health and Family Welfare, for their deep commitment to the cause of health of the people in the Region, as also for hosting the 52nd session of the Regional Committee. He congratulated the National Organizing Committee for their hard work in making the session a success. In conclusion, he wished the representatives a safe journey back home.

The Chairman acknowledged that he was greatly honoured to be elected to the office, and thanked the representatives for their cooperation in the smooth conduct of the deliberations. He was particularly thankful to the Vice-chairman for conducting the session most efficiently in his absence. He expressed his gratitude to the Honourable Prime Minister of Bangladesh, the Minister for Health and Family Welfare, as well as the Minister of State for
Health and Family Welfare for their presence, guidance and encouragement in organizing the Regional Committee session in Dhaka, which showed their deep commitment to the cause of health. He thanked the Director-General, WHO, for her presence and her thought-provoking address, and the Regional Director and WHO staff, both from the Regional Office and the country offices, for their excellent cooperation and smooth arrangements, which had made the session a success.

He then declared the meeting closed.
Part IV

RESOLUTIONS

The following eight resolutions were adopted by the Regional Committee (the references to the Handbook are to the Handbook of Resolutions and Decisions of the Regional Committee for South-East Asia, Volume 2 (1976 - 1998):

SEA/RC52/R1 RESOLUTION OF THANKS

The Regional Committee,

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

1. CONVEYS its gratitude to the Government of the People’s Republic of Bangladesh for hosting the session, and thanks the members of the National Organizing Committee, the staff of the Ministries of Health and Family Welfare and Foreign Affairs, and other national authorities for making the session a success;

2. THANKS the Hon’ble Prime Minister of Bangladesh, Her Excellency Sheikh Hasina, for inaugurating the session and for her inspiring address to the Regional Committee;
3. THANKS the WHO Director General, Dr Gro Harlem Brundtland, for her timely and far-sighted speech, and

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

Handbook 1.2.3(2) Sixth Meeting, 8 September 1999

SEA/RC52/R2  BIENNIAL REPORT OF THE REGIONAL DIRECTOR

The Regional Committee,

Having reviewed and discussed the biennial report of the Regional Director containing highlights of the work of WHO in the South-East Asia Region for the period 1 July 1997 to 30 June 1999 (SEA/RC52/2 and SEA/RC52/Inf. 1 and Inf.2),

1. NOTES with satisfaction the progress made during this period in the implementation of WHO’s collaborative programmes and activities in the Region;

2. CONGRATULATES the Regional Director and his staff for bringing out a clear and comprehensive report on WHO’s programmes and activities in the Region, and

3. REQUESTS the Regional Director:

(a) to develop appropriate indicators for measuring, preferably in quantifiable terms, the outcomes of the WHO collaborative programmes and activities;
(b) to identify, for taking corrective actions, the problems/constraints faced by WHO in supporting the Member States, and

(c) to provide information and disaggregated data on the country-wise activities implemented with WHO Regular budget and extrabudgetary funds, in order to facilitate better planning and optimum utilization of resources.

Handbook 9
Sixth Meeting, 8 September 1999

**SEA/RC52/R3  SELECTION OF TOPICS FOR TECHNICAL DISCUSSIONS**

The Regional Committee,

  Recognizing the urgent need to bridge the gap in the provision of health services, particularly for the poor and vulnerable groups, and

  Noting the importance of reaching these groups by using the healthy settings approach,

1. **DECIDES** to hold Technical Discussions on the subjects of (1) Equity in Access to Public Health, and (2) Healthy Settings, during a meeting of the Consultative Committee for Programme Development and Management in 2000;

2. **URGES** Member States to participate fully in these technical discussions, and

3. **REQUESTS** the Regional Director:
(a) to take steps for the preparation and conduct of these technical discussions during a meeting of the Consultative Committee for Programme Development and Management in 2000;

(b) to submit its report to the Regional Committee, and

(c) to initiate appropriate follow-up action on the recommendations.

Handbook 1.2.2 Sixth Meeting, 8 September 1999

SEA/RC52/R4 TIME AND PLACE OF FIFTY-THIRD, FIFTY-FOURTH AND FIFTY-FIFTH SESSIONS

The Regional Committee,

1. ACCEPTS the confirmation by the Government of India (SEA/RC51/R5) to host the fifty-third session of the Regional Committee in early September 2000;

2. THANKS the Government of the Union of Myanmar for its invitation to hold the fifty-fourth session of the Regional Committee in Myanmar in 2001, and

3. NOTES with appreciation the invitation of the Government of the Republic of Indonesia to hold the fifty-fifth session of the Regional Committee in September 2002, subject to confirmation.

Handbook 1.2.1 Sixth Meeting, 8 September 1999

SEA/RC52/R5 ROLL BACK MALARIA
The Regional Committee,

Recalling World Health Assembly resolution WHA52.11 relating to Roll Back Malaria,

Considering that malaria causes high morbidity and loss of productivity, particularly among the poor and vulnerable groups, such as pregnant women, children and migrant populations,

Recognizing the urgent need to accord high priority to malaria control,

Realizing the significant contribution of malaria to the burden of disease in the Region and its adverse economic consequences for the poor, and

Noting that Roll Back Malaria represents a new approach to improving equity in health,

1. URGES Member States:

(a) to demonstrate national commitment towards the RBM initiative;

(b) to promote and support the RBM initiative by integrating malaria control activities with the prevention and control programmes of other communicable diseases within existing PHC settings and district health systems;

(c) to mobilize resources for sustaining evidence-based strategies to ensure concerted and sustainable efforts for RBM;
(d) to collaborate with neighbouring countries regarding activities related to, among others, the monitoring of multi-drug resistance, vector resistance to insecticides, and enhancing epidemic preparedness and response, and

(e) to promote multiple preventive measures to reduce malaria transmission by locally acceptable means and to ensure rational use of insecticides, both in public health and in agriculture, and strengthen policy frameworks and guidelines to meet the emerging requirements, and

2. REQUESTS the Regional Director:

(a) to enhance the capacity of the programme for securing and mobilizing community participation, intersectoral collaboration and cooperation to roll back malaria;

(b) to develop the technical capacity of the public health delivery system, including that of the private sector in the Member States, for the prevention of malaria, early diagnosis and prompt treatment, and

(c) to identify the available resources in the Member States and extend the required technical and financial support to help develop a network of experts and research institutions to substantially improve the quality of the programme.

Handbook 5.1.2  
Sixth Meeting, 8 September 1999

SEA/RC52/R6  STRENGTHENING POISON CONTROL MEASURES

The Regional Committee,
Recalling World Health Assembly resolutions WHA30.47, WHA39.2 and WHA50.13, and its own resolution SEA/RC38/R11 relating to chemical safety,

Recognizing the growing incidence of, and morbidity and mortality from chemical poisoning in the countries of the South-East Asia Region,

Being aware that high arsenic, fluoride and other chemical contents in drinking water supply pose a serious threat to the health of large populations in many countries of the Region,

Bearing in mind the various institutional, managerial and technical constraints in the management of poisoning cases from potentially toxic chemicals in agriculture, industry and vector control activities in countries of the Region, and

Having discussed the subject of strengthening poison control centres in the Region,

1. **URGES** Member States:

   (a) to consider establishing/strengthening poison control initiatives as an important part of the chemical safety and control of environmental health hazards, with emphasis on risk assessment and risk management due to poisoning from chemicals and various contaminants, such as arsenic and fluoride in ground water;

   (b) to formulate, develop and implement plans of action for the establishment of poison information and treatment centres, which inter alia would include manpower development, epidemiological studies, and dissemination
of information to the public on the safe use of chemicals in agriculture, industry and health;

(c) to develop analytical toxicological facilities for early diagnosis and to improve patient management;

(d) to undertake epidemiological studies and activities related to prevention and management of arsenic toxicity, which is a public health problem of serious magnitude in Bangladesh and affected districts of West Bengal in India;

(e) to formulate strategies and policies to undertake well-designed health education/promotion campaigns for developing capacity among the affected communities to recognize the dangers of arsenic and fluoride-contaminated water, and

(f) to strengthen cooperation between health and other development sectors to prevent the misuse of chemicals and accidental poisoning, and

2. REQUESTS the Regional Director:

(a) to collaborate and support Member States in strengthening national poison control capability;

(b) to provide guidance on the methodology and epidemiological principles of data collection, analysis, diagnosis and treatment of pesticide poisoning due to consumption of water with a high content of arsenic, fluoride or other chemical contaminants;
(c) to support the development of national plans of action for establishing poison control facilities and capacity building;

(d) to support information dissemination and education to prevent cases of poisoning in the Member States; and

(e) to support multi-centre studies related to poisoning with organo-phosphorus and other chemicals in the Region.

 SEA/RC52/ R7 TOBACCO OR HEALTH: ACTIONS FOR THE 21ST CENTURY

The Regional Committee,

Recalling World Health Assembly resolutions WHA31.56, WHA37.14, WHA39.14, WHA43.16, and WHA44.26 and its own resolutions SEA/RC13/R4 and SEA/RC38/R8 relating to tobacco control,

Noting with concern the increasing use of tobacco across all sections of society, its grave negative impact on the health, economy and social development of countries as well as the steady influx of multinational tobacco companies in the Region,

Recognizing the efforts made so far by Member States and the urgent need to further strengthen national tobacco control strategies, particularly to protect the health of the most vulnerable,

Having considered the recommendations emanating from the Technical Discussions on Tobacco or Health: Actions for the 21st Century, held during the 36th Meeting of the Consultative
Committee for Programme Development and Management (CCPDM), and

Being mindful of the Member States’ responsibilities towards the global initiative on tobacco control,

1. ADOPTS the Regional Policy Framework on Tobacco Control and the Plan of Action 2000-2004 to guide country actions for tobacco control in the Region;

2. URGES Members States:

   (a) to constitute a multisectoral national council, including the Ministries of Health, Education, Labour, Commerce, Foreign Trade, Agriculture, Information and Broadcasting, External Affairs, Law and Finance, under the chairpersonship of the Head of State/Government to facilitate nationwide tobacco control activities;

   (b) to adopt and strengthen policies which will reduce tobacco consumption, particularly among children, women and the poor, including inter alia: restricting and prohibiting advertisements and promotion of all forms of tobacco products; enforcing regulations governing the packaging, visibility and effectiveness of health warnings; increasing taxes on tobacco products; intensifying consumer education on health hazards of tobacco; undertaking cessation programmes; expanding and enforcing smoking-free areas, and conducting focused research;
(c) to dedicate a portion of taxes earned on tobacco products for tobacco control activities;

(d) to regulate nicotine not used for therapeutic purposes as a controlled drug;

(e) to actively participate in the development and negotiation of the WHO Framework Convention on Tobacco Control and related protocols in accordance with resolution WHA52.18, and

(f) to promote regional advocacy for policy change through intercountry activities, such as the South-East Asia Anti-Tobacco (SEAAT) Flame, and

3. REQUESTS the Regional Director:

(a) to facilitate the strengthening of WHO collaborating centres and other centres of excellence, as identified by the Member States, to provide the necessary technical support in research, surveillance, and training on tobacco cessation;

(b) to continue to support Member States in their national tobacco control programmes, particularly in the areas of multisectoral policies, intercountry and interregional collaborative activities;

(c) to provide technical assistance to facilitate the participation of Member States in the development and the negotiation process on the WHO Framework Convention on Tobacco Control and possible related protocols, and
(d) to urge the WHO Director-General to advocate with WTO on the issue of tobacco trade in view of its negative implications to the Region.

SEA/RC52/ R8  INTENSIFICATION OF HIV/AIDS SURVEILLANCE

The Regional Committee,

Recalling World Health Assembly resolutions WHA40.26 and WHA42.33, and its own resolutions SEA/RC40/R1, SEA/RC44/R8 and SEA/RC47/R4 relating to the prevention and control of HIV/AIDS,

Realizing the importance of HIV/AIDS surveillance data in monitoring the trends of the epidemic and for planning prevention and care,

Appreciating the continuing support of WHO and its role in establishing HIV/AIDS surveillance in the Region, and

Noting with concern the inadequacy of information on the status and progress of the HIV/AIDS epidemic in the Region,

1. REITERATES the need for Member States to strengthen strategies for the intensification of HIV/AIDS surveillance and to involve, where relevant, all related sectors, including research institutions and nongovernmental agencies;

2. URGES Member States:
(a) to accord high priority to HIV/AIDS surveillance by providing the required human and financial resources, and

(b) to further strengthen national capacity for comprehensive surveillance of HIV/AIDS/STI and risk behaviour among various population groups, and

3. REQUESTS the Regional Director:

(a) to enhance support to Member States in their efforts to intensify HIV/AIDS surveillance through provision of technical and material assistance;

(b) to promote intercountry collaboration in surveillance activities, monitor the progress and report to the Regional Committee, and

(c) to assist Member States in developing national capacity in HIV/AIDS surveillance through training and strengthening of laboratory diagnostic facilities.

Handbook 5.1.7 Sixth Meeting, 8 September 1999
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
   SEA/RC52/1
   SEA/RC52/2
   and
   SEA/RC52/Inf.1 & Inf.2
6. Address by the Director-General, WHO
7. Programme Budget
8. Technical Discussions:
   8.1 Consideration of the recommendations arising out of the Technical Discussions on:

¹ Originally issued as document SEA/RC52/1 dated 20 July 1999.
(1) Tobacco or Health: Actions for the 21st Century, and
(2) Intensification of HIV/AIDS Surveillance

8.2 Selection of a subject for the Technical Discussions to be held during the 38th meeting of the Consultative Committee on Programme Development and Management (CCPDM)

9. Regional implications of the decisions and resolutions of the Fifty-second World Health Assembly and the 103rd and 104th sessions of the Executive Board

and

Review of the draft provisional agendas of the 105th session of the Executive Board and the Fifty-third World Health Assembly

10 Roll Back Malaria (RBM) and mainstreaming of anti-malaria activities in health sector development

11 Intercountry cooperation in the supply of essential drugs

12 Strengthening poison control centres in the Region

13 Special Programmes:
   13.1 UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases: Joint Coordination Board (JCB) – Attendance at 1999 JCB
13.2 WHO Special Programme for Research, Development and Research Training in Human Reproduction: Policy and Coordination Committee (PCC) – Attendance at 1999 PCC, and nomination of a member in place of Thailand whose term expires on 31 December 1999

13.3 WHO Action Programme on Essential Drugs: Management Advisory Committee (MAC) – Attendance at 1999 MAC

14 Time and place of forthcoming sessions of the Regional Committee

15 Adoption of the final report of the fifty-second session of the Regional Committee

16 Closure of the Session
Annex 2

LIST OF PARTICIPANTS¹

1. Representatives, Alternates and Advisers

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Permanent Mission of Bangladesh in Geneva
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Dhaka University
Dhaka

Prof M.A. Quadri
Vice-Chancellor
Bangabandhu Sheikh Mujib Medical

¹ Originally issued as document SEA/RC52/12 Rev.1 dated 7 September 1999
Annexes

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and
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Ministry of Health and Education
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Science and Technology
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Alternate  Ms K. Sujatha Rao
Joint Secretary (International Health)
Ministry of Health and Family Welfare
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Ministry of Health  
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Technical Disease Control Officer  
Technical Coordinator Centre
Chairman, 24th Session of South-East Asia Advisory Committee on Health Research (SEA-ACHR)  
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### 3. Representatives from Nongovernmental Organizations in Official Relations with WHO

<table>
<thead>
<tr>
<th>International Association for Maternal and Neonatal Health</th>
<th>Prof (Dr) Syeda Firoza Begum President</th>
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<tbody>
<tr>
<td></td>
<td>Bangladesh Association for Maternal and Neo-Natal Health</td>
</tr>
<tr>
<td></td>
<td>11 Shyamoli, Street No.2</td>
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<td></td>
<td>Dhaka 1207, Bangladesh</td>
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<tr>
<td>International Association of Agricultural Medicine and Rural Health</td>
<td>Dr Ashok Patil President-elect, Pravara Medical Trust</td>
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<td></td>
<td>Loni 413736, Dist Ahmednagar</td>
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<td></td>
<td>Maharashtra, India</td>
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<tr>
<td>International Association of Medical Laboratory Technologists</td>
<td>Mr S.P. Awasthy President</td>
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<td></td>
<td>L1/249- B, DDA Flats, Kalkaji</td>
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<td>New Delhi, India</td>
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<tr>
<td>International Council for Control of Iodine Deficiency Disorders</td>
<td>Dr Quazi Salamatullah ICCIDD Country Representative in Bangladesh</td>
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<td></td>
<td>Institute of Nutrition and Food Science University of Dhaka</td>
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<td>Dhaka, Bangladesh</td>
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<tr>
<td>International Council on Social Welfare</td>
<td>Mr M.A. Rashid Deputy Director</td>
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<td>Bangladesh National Social Welfare Council</td>
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<td>Ministry of Social Welfare, 131/2 New</td>
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<td>Organization</td>
<td>Contact Person</td>
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<tr>
<td>International Federation of Anti-Leprosy Associations</td>
<td>Dr Prabhakar Samson</td>
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<td>Director for SE Asia, The Leprosy Mission</td>
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<td>International Federation of Gynaecology and Obstetrics</td>
<td>Dr Shahla Khatun</td>
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<td>Prof, Dept of Obs &amp; Gynae</td>
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<td>International Federation of Medical Students Association</td>
<td>Dr Sanjeeb Sapkota</td>
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<td>Director of SCOPH Standing Committee on Public Health</td>
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<td>International Federation of Oto-rhino-laryngological Societies</td>
<td>Prof M. Jalisi</td>
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<td>6A/5 West Street</td>
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<td></td>
<td>Defense Society, Phase I</td>
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<td>Karachi, Pakistan</td>
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</table>
International Federation of Pharmaceutical Manufacturers Associations  
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| Programme Manager  
| (British High Commission)  
| Dhaka |
Annex 3

**LIST OF OFFICIAL DOCUMENTS**

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### Information

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### Resolutions

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<td>Intensification of HIV/AIDS Surveillance</td>
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TEXT OF ADDRESS BY THE REGIONAL DIRECTOR

On behalf of the World Health Organization and on my own behalf, I welcome you all to this inauguration of the Regional Committee for South-East Asia.

Your Excellency, we are deeply honoured that you have found time in the midst of your busy and demanding schedule to be with us today. Please accept our sincere thanks. Our best wishes are with you and your country, as you address the challenging tasks ahead and guide Bangladesh into the new millennium.

WHO’s collaborative activities in Bangladesh cover a wide spectrum. I will cite but a few examples. WHO has strengthened its support to the country’s efforts in improving the health of the people, especially mothers, children, and the poor.

The Organization is closely involved with the Government in tackling the problem of arsenic contamination of drinking water in some areas. It has also provided technical support to improve the safety of blood and blood products. This assumes added significance in the context of the threatening problem of HIV/AIDS.

Since 1948, WHO has been supporting the Member States in their efforts to improve the health of the people.
The universal application of the “cold chain” has resulted in significant gains in the fight against vaccine preventable diseases. Today, polio is on the verge of eradication from our Region. In this regard, I must acknowledge our strong partnership with UNICEF, other UN agencies, and NGOs, including Rotary International.

Our united approach helped to mobilize and coordinate the efforts of countries in the Region and in neighbouring countries in other regions, in synchronizing National Immunization Days.

WHO’s blueprint for multi-drug therapy in Leprosy control, the DOTS strategy to fight against tuberculosis, and impregnated bednets as one of the key approaches in malaria control, are but a few examples of WHO’s collaborative activities.

Standard setting and advocacy for health has been and will continue to be, WHO’s comparative advantage. I am happy to recall WHO’s initiative in developing and institutionalizing the Health Ministers Forum and the Health Secretaries Meeting. The political commitment and policy guidance arising from these meetings have contributed greatly to channelizing WHO’s technical support to the Member Countries.

Much has been done. However, a lot more remains to be done. The rate of population growth is still far too high. Maternal mortality must be reduced. HIV/AIDS, tuberculosis, and Malaria continue to hamper social and economic progress and need our urgent attention.

Noncommunicable diseases, avoidable blindness, and malnutrition are also on the increase. We have to make concerted efforts to address this “double burden.”
In the competitive global economic scenario of the 21st century, our Member Countries are demanding that WHO “does more with less”. WHO must always strive for efficiency and effectiveness.

Making the Organization more efficient and effective is just one facet of the ongoing reorganization process. Our support to countries must also be prioritized and focused. WHO can no longer afford the luxury of supporting large numbers of diverse activities in the countries.

The Director-General, Dr Brundtland, has already indicated the directions WHO must take to make it more effective.

In consultation with the Member States, I will make the required changes in WHO in the Region to follow those directions. These changes will ensure that this Region plays its appropriate role as an integral part of one WHO.

No one, and certainly no organization, can move forward confidently without building on the past. This is so with WHO too. Over the past 50 years, this noble organization has made a tremendous impact on health development.

Change is needed in WHO, not for change’s sake, but to enable WHO to work more productively. To enable WHO to strengthen its partnerships with development partners, and, above all, to ensure that the ultimate beneficiaries are the people, particularly those who have for so long been neglected.

I foresee that in the future there will be more players in the arena of national health development. This is because health is indeed central to development. This brings to mind the popular
saying that “health is not everything, but without health there is nothing”. Let us recall the historic resolution adopted by the 30th World Health Assembly in 1977 calling for “Health for All”. Let us move resolutely towards this goal.

Thank you very much for gracing this occasion. I am sure the distinguished delegates will have a pleasant stay in this most hospitable and beautiful city of Dhaka. I wish the 52nd session of the Regional Committee for South-East Asia all success in its deliberations.
It gives me great pleasure to be in Dhaka and to attend the Regional Committee meeting for a Region which faces so many health challenges, but also a Region where there is so much we can do to give people the opportunity to live healthy lives.

Year 2000 is now only a few months away and the world is taking stock. We who devote our work to health can celebrate many remarkable achievements. But there is also a legacy. More than a billion people – hundreds of millions of whom live in this Region – will enter the next century without having shared in the gains of the health revolution of the 20th century.

That we have to change. With a combination of vision, commitment, successful leadership, effective organization, and working together, we can achieve notable accomplishments in the years ahead. The knowledge which produced the revolution of past decades can still bring the excluded billion into our midst.

Today I wish to take the opportunity to share with you how I see the role of the World Health Organization in this major transition. You know our mandate and I can assure you of our commitment: We are after a better deal for world health. A better
deal with the prime purpose of delivering a better, healthier future to all, but especially to the poor.

Such a better deal will matter immensely in this region, which is home to a quarter of the world’s population.

As Director-General of WHO, I have seen it as one of my prime tasks to improve the effectiveness of our Organization’s work. Working together more effectively, as one WHO, is key. We – WHO – cannot do everything, but what we decide to do, we must do well. It goes for all of us: In times of many conflicting challenges we must all learn to focus on the health issues that matter most – and we must reach out and convince our partners to do likewise. Reaching out to civil society, NGOs, our UN partners and to the private sector – as we do it in this region – increases the impact we can make.

Let me share with you today our assessment of our work with the South-East Asia Region, based on four global strategic directions.

First, we have to reduce the burden of excess mortality and disability, especially that suffered by poor and marginalized populations.

The South-East Asia Region, while containing a quarter of the world’s population, bears 40% of the world’s total burden of disease. Communicable diseases are responsible for nearly every second death. The five traditional child killers bear responsibility for a large part of this mortality, and maternal and perinatal problems also take a serious toll on women and infants.
Six countries in the Region have already adopted the Integrated Management of Childhood Illness, a highly effective strategy to attack the traditional childhood killers by breaking down the limitations of single-disease treatment, and to educate health workers and parents to see their child’s health and nutrition as a whole.

Roll Back Malaria is another example of such a cross-cutting health initiative. Roll Back Malaria is also a critical element of the better deal for world health as it engages our partners and mobilizes across societies.

Every year the world’s poor face an increasing burden as a result of malaria. Yet it would be possible to cut malaria-related mortality by half by the year 2010 if existing interventions are used according to available evidence. This goal can be achieved as health services become more focused on helping communities tackle priority diseases.

The long-term success of Roll Back Malaria will require better interventions, new preventive measures and treatments. We need to be innovative. New alliances for more effective research and product development, such as the Multilateral Initiative on Malaria, and the Medicines for Malaria Venture, are essential to this success.

Countries in the South-East Asia Region are showing the way in identifying actions to Roll Back Malaria. They are breaking new ground. Thailand and Myanmar are working with China, Vietnam, Cambodia and Laos from the Western Pacific Region to establish the Mekong Region initiative which will harmonize responses to
malaria across borders and ensure that all adopt consistent strategies and action.

India, after hosting the South Asia inception meeting, has initiated pilot studies to assess institutional and political requirements for rolling back malaria. Bangladesh, Sri Lanka and Nepal have all indicated their intentions. In all countries, the Roll Back Malaria movement will be supported by a range of development partners, and will contribute to measurable reductions in malaria morbidity and mortality.

For those of us who work in public health, the horizon can often seem so far away. The journey to real progress may seem so long and arduous. We work for decades against diseases which seem to have a nearly endless ability to escape our efforts to contain them. This makes me all the more delighted to tell you that we can be just months away from eradication of one of the greatest disabling diseases of humankind.

We are making great progress towards eliminating poliomyelitis - and the progress is mainly made in this region where, last year, 60% of all polio cases were reported. Already, Thailand, Indonesia, Bhutan and Sri Lanka are moving towards being polio free. Myanmar has also made great progress.

Over the past year, India and Nepal have taken some impressive steps towards vaccinating all children against polio. The ongoing series of National Immunization Days is the largest public health campaign ever undertaken. More than 130 million children are reached on each of these days. In India alone, an unprecedented 1 billion doses will be given during the
immunization days over the next six months. These are truly impressive feats of logistics and commitment by tens of thousands of health workers and volunteers.

Yet, success must not lead to complacency. We need to spend every day until the end of next year to accomplish the task we have set ourselves. We are anxiously awaiting detailed plans from Bangladesh, Myanmar and the Democratic People’s Republic of Korea on their efforts to improve surveillance and introduce additional rounds of National Immunization Days. The importance of surveillance cannot be stressed enough. It is part and parcel of the eradication campaign.

A world free of polio – what a gift to the generations of the next century! But it will take an extraordinary effort. We need to go from house to house, from marketplace to marketplace, again and again, until every single child has felt the drop of the vaccine on his or her tongue. We may never again have the opportunity to rid the world of polio forever.

As an example of the kind of synergy we always try to achieve, the polio vaccinations have been combined with doses of vitamin A. Globally, 3 million children suffer clinical vitamin A deficiency. However, an estimated 140-250 million children under five years of age are at risk of sub-clinical deficiency. These children suffer a dramatically increased risk of death and illness, particularly from measles and diarrhoea, as a consequence. By including vitamin A doses in the polio vaccines, we use resources better and achieve great health gains.
Contrasting these positive developments is the formidable global battle against HIV/AIDS. WHO’s commitment to this battle is unshakeable. We are fighting it on every front, from issues of blood safety and mother-to-child transmission, to the use of anti-retroviral treatments and the care of people living with HIV, and of course, the dual epidemics of HIV and tuberculosis. We will push for new drugs and eventually the vaccine against HIV. And we will push for every deal that can make these innovations available for all – not least on this continent.

I would like to say some words of praise to Thailand, in particular, for its comprehensive and courageous approach to the HIV/AIDS prevention issue. Thailand has been a leader in policy development for prevention of HIV/AIDS, and it is carrying out a broad educational campaign. It is also taking a leadership role in the development of an AIDS vaccine, with its third-stage trials, which could for the first time show us whether a vaccine will be able to prevent infection.

Through its open and decisive approach to its HIV/AIDS problem, Thailand stands as an example for the Region and, indeed, the world.

Unfortunately, other countries, including in this region, continue to avoid some of the hard decisions of facing up to the HIV/AIDS pandemic. I want to be frank. By hoping that silence and traditional values will be sufficient to protect their populations, these leaders are exposing them to serious risk of mass infection with the devastating suffering and economic consequences this entails. I have made this clear to political leaders in my direct communications with them.
Even without HIV as its deadly ally, tuberculosis is a major global threat to health, and demands an urgent and massive response. Last month I moved all of WHO’s TB control efforts under the single umbrella of the Stop TB Initiative. It will redouble its efforts to bring new partners into the coalition working to control TB, and aims to double the worldwide expenditure on TB control within three years.

We must all commit ourselves to achieving 100% coverage with the DOTS TB control strategy by the year 2005. Again, countries in this Region hold some of the highest numbers of TB patients in the world, and success here will go a long way to achieving success world-wide. But DOTS is not enough. Several countries in the Region need to increase their surveillance for anti-tuberculosis drug resistance. We are confident we will see more reliable data on this issue in the year to come.

In the years ahead, we will intensify our work on reducing maternal mortality. In many countries in the Region, maternal mortality remains unacceptably high. In part this results from the long-standing division of responsibilities between “health” and “family welfare”. We need to sort out such administrative ‘turf’ issues. The health of women must not continue to fall between the cracks.

To push the agenda on reproductive health forward, WHO has developed a strategy to make pregnancy safer, and a draft has been circulated among our Regional colleagues for comments. The Making Pregnancy Safer Initiative will encourage governments and our international partners to ensure that safe motherhood is placed
high on the political agenda. It is a matter of social responsibility and economic good sense.

Then there is the area of immunization. Over the last year, the issue of vaccines and immunization has been reviewed by WHO with the major partners - UNICEF, the World Bank, bilateral donors, and the private sector.

We have agreed to establish a Global Alliance for Vaccines and Immunization to push for a renewed effort to develop new vaccines and to help increase immunization rates all over the world. WHO will be chairing this Alliance in its first two years.

Let me end by also stressing the critical rising tide of noncommunicable diseases – exposing all countries in this region to new challenges. At WHO we are building capacity to better advise and support countries, especially as health sectors have to go through profound change.

One of the most critical areas that needs our attention is mental health. The Global Burden of Disease tells us that mental health conditions are emerging as one of tomorrow’s major public health concerns, in rich and poor countries alike. We have to rise to properly face this challenge.

Let me briefly move to the second strategic direction. Focusing on the things that matter does not just mean diseases. There is also the need to counter potential threats to health that result from economic crises, unhealthy environments and risky behaviour.
The issue of unhealthy environments is urgent here in Bangladesh. Here, a 30-year long successful campaign to ensure clean drinking water has unwittingly led to what has been called “perhaps the largest case of mass poisoning in the history of mankind”.

I am talking, of course, about arsenic contamination in the drinking water. A major obstacle to solving this problem is a lack of knowledge. We need to find technical solutions to clean contaminated water, and to find uncontaminated water sources. We need to know more about the health effects, the size of the population affected and the severity of the problem, and we need to spread the knowledge we have to local health officials so they can better detect and eventually prevent poisoning.

We need to strengthen the focus on how sectors outside the health sector have a major impact on health. In the environmental field, the arsenic issue is evident. But so is the dramatic burden of indoor air pollution, especially exposing millions of women to dangerous substances. And let me also include the smog seen in too many cities in this region.

Talking about air pollution – there is another threat that is already with us in a big way – an emerging epidemic about to hit the developing world. I am referring to tobacco.

South-East Asian countries already have too many disease burdens without the threat of a tobacco epidemic. Industry is now focusing its attention and advertising power on the developing world and on Asia - and especially on Asian women and children.
We have a real window of opportunity to avoid bading yet another burden on Asia’s shoulders. I have called for concerted Regional action to support our global tobacco control efforts. In October, we will welcome South-East Asian representatives at the meeting in Geneva of the working group on the WHO Framework Convention on Tobacco Control.

Still, some continue to say that after all tobacco may be good for the economy because of employment opportunities and tax incomes to the government. They are making a big mistake. Health is WHO’s business, so we let the World Bank answer – and in their latest report – Curbing the Epidemic – their message is clear: Tobacco is not only bad for health - it is also bad for the economy.

The third strategic focus concerns health systems. WHO must focus on helping countries to develop health systems which will contribute to the reduction of health inequalities in each society, which are responsive to people's legitimate needs, and which are financially fair.

The challenge is to ensure health care coverage for all.

There will be tough choices: not just in deciding which services governments should cover, but in determining how health care should be financed. Health care has to be paid for - but solidarity through a pre-payment system places less of a burden on the poor than systems which rely on out-of-pocket payment. Increasingly, evidence suggests that pre-payment is an efficient as well as equitable financial policy.

As I speak to Ministers and health professionals on my visits to countries and at the Assembly, I hear their many concerns about
health systems reform, looking to WHO for guidance. They want to engage us in how to handle the rapid growth of private medical care and to harness the energies of the private sector for public goals. We will respond to that call.

We need to be able to understand why one country’s health system performs better than another’s. We must point to our successes in areas such as immunization as pathfinders in addressing more system-wide problems. This understanding – of success, failure and best practice – needs to underpin the new agenda for health systems reform. To indicate the importance of this subject, the whole of the forthcoming World Health Report 2000 is being dedicated to it.

The fourth direction concerns the development agenda itself. I have pledged to do what I can to place health at the core of that agenda – where it belongs. Health is key to human development and progress.

Research, some of it carried out here in Bangladesh, illustrates clearly how illness is not only a result of poverty – but can also cause it. What we are increasingly seeing is that improved health conditions can turn this vicious circle around. Healthier, better fed people are more productive and can focus their resources on improving their livelihood. It is no coincidence that marked improvements in health status and life expectancy preceded the 20-year period of strong economic growth in East and South-East Asia. One of this region’s own leading economists, Nobel Laureate Amartya Sen, has eminently shown how closely linked health is to progress and development.
The challenge for those of us who are gathered here today is to turn this knowledge into concrete policies and to execute them. Our responsibility is to see that enough resources are spent on health - and spent in an equitable fashion - so that the poor are given their chance to join the rest of us in enjoying the health achievements of the 20th century.

You have to face many players in development - and we all are facing many players in international health. As the lead agency in health with a broad mandate, WHO needs to refine its role and see how we can best be of use to our Member States. Let me share with you some of the issues. They will indeed be brought to your attention as we start planning for the 2002-2003 budget.

In each area - be it HIV/AIDS, or making pregnancy safer - we need to ask ourselves where WHO's comparative advantage really lies. Which functions are we best equipped to perform? Which are better left to other organizations? Or where can we call on our collaborating centres?

WHO is a technical agency, not a major donor. We also need to think of ourselves as a catalyst - forging alliances and building consensus in many different contexts - at national and international level. This catalytic role lies at the heart of all our core functions, and will be a dominant theme as we prepare our coming budget.

Focusing means having clearer priorities so that we can have a greater impact where the needs are greatest. There is the famous example of how in one country US$ 4.9 million from WHO’s regular budget was allocated to cover the cost of 428 priority activities in...
44 different national health programmes. That is not the best way to make a difference and should now be a history lesson.

In too many countries our resources are divided between too many disparate activities, and there is little coordination between our activities. We are in the process of changing that, and I hope you will support this process.

I would like to conclude with some comments on the World Health Assembly budget resolution, and the work that is now underway in response to it. The Assembly decided not to compensate us for cost increases. And in addition we were asked to shift resources from so-called low priority areas to high priority areas.

It has been a tough task. But I believe we have found a realistic way forward, one which avoids cutting our key activities.

You know where I stand: WHO’s most important tasks lie in countries, and our budgets and joint efforts will reflect this. The efficiency shifts we have to make in the 2000-2001 budget will not lead to a reduction in spending at the country level. But throughout WHO, we can become more efficient.

In reviewing the options for efficiencies, I have looked first at measures that are applicable across the whole of WHO. We are concentrating on cutting our travel bill, for example, and taking a critical look at what we publish and what we procure. I know that procurement is important for many countries. But even here, there should be scope for switching from low to high priority areas.
Globally, I have decided on a figure for efficiency measures of around $50 to $60 million at this stage, in line with what the World Health Assembly called for. I would ask for your cooperation as Ministers when it comes to focusing the funding that this will free up for priority health areas within your country.

This is a Region of rapid change. In every country, we are facing new challenges, political, cultural and economic. The answer to fundamental questions such as the durability of popular democracy and the peaceful solution of disputes in a nuclear age are highly relevant to the people and nations of the South-East Asian Region.

Conflict and strife are the worst enemies of health. Apart from the casualties, armed conflict can ruin decades of progress in health in a matter of days. This is as true in the high mountains as it is in the lush archipelagos of this region. We must not let conflict ruin the progress your people have achieved through decades of hard work. Respecting fundamental human rights means securing people’s right to health.

We should also remember that essential lesson of Dr Amartya Sen: Democracy and a free press help prevent famine. These two basic institutions also are crucial in improving health and reducing poverty. Only when there is a commitment among the leaders to respect the will and the basic rights of its people can real development take place.

This region holds the key to answering the question of eradicating poverty and creating a world where all its citizens enjoy the basic human rights of health and nourishment. The world’s
eyes are on you. I am confident that you will succeed, and WHO stands ready to support you.

Thank you.
1. REVIEW OF ACTIONS ON THE RECOMMENDATIONS OF THE THIRTY-FIFTH MEETING OF THE CONSULTATIVE COMMITTEE FOR PROGRAMME DEVELOPMENT AND MANAGEMENT (Agenda item 3)

Discussion Points:

© In the context of budgetary constraints, the WHO Governing Bodies had emphasized the most cost-effective utilization of the budget.

© The quality of the proposals continues to cause concern. The large number of activities undertaken diluted the focus and realization of quantifiable results. Incomplete information and absence of defined outcomes make it difficult to justify release of funds. This aspect has also been pointed out by WHO’s auditors on several occasions.
The quality of the Plans of Action had deteriorated over the last 2-3 biennia leading to difficulties in the formulation of detailed proposals. This was one of the important reasons for delays in implementation.

Provision of data and an analysis of the specific outcomes of the activities implemented by the Member Countries and SEARO would improve the quality of WHO reports.

Evaluation of the quality of proposals was essential in order to improve the technical aspects of programme implementation. SEARO had recently engaged a management consultancy firm to improve the process-related aspects of proposal review, implementation and evaluation.

To improve the reporting on the progress of activities, clear and objective indicators were needed to reflect transparency, quality, participation, efficiency and other characteristics of the processes at the country and regional levels.

Some essential elements necessary to ensure technical quality of the implementation process were: (1) complete information in the proposal, and (2) relevance of the proposal to the country’s needs and WHO’s policies and strategies.

The PDM workshops conducted in SEARO provided an opportunity to WHO staff in the Country Offices and concerned national officials to review the Programme Budget and Plans of Action. Considering the collaborative nature of the WHO programmes, the national authorities and WHO staff in Country Offices should work closely to ensure quality.
Concern had been expressed by the external auditors regarding the possible effect of the delegation of authority to WRs on programme implementation. This, therefore, required careful examination. The report on the progress of adequate delegation of authority to the WRs and the concerns of the auditors should be made available to the members of the CCPDM.

The proposal for a review of the regional health situation by senior public health specialists for formulating strategies for health development in the Region, to be incorporated in the 2002-2003 Programme Budget, was an excellent initiative. However, in order to ensure high quality outcomes, two suggestions were made: (a) SEARO should undertake a preparatory technical exercise to provide adequate data and information to the public health specialists, and (b) WHO collaborating centres or other centres of excellence may be utilized for analysing such data as they have the advantage of using a multidisciplinary approach. Such an approach would also help in institutional strengthening and building of national/regional capacity.

It was necessary to ascertain whether the Activity Management System (AMS) was relevant to SEAR; if not, it should be modified or replaced with another system.

Since the AMS was a tool for technical monitoring of the WHO programme budget, there was need to improve the quality of Action Plans for optimal utilization of this system.

A new simplified sub-system of AMS called ‘Regional Activity Monitoring System’ (RAMS) had been tried out at the WHO
Eastern Mediterranean Regional Office with considerable success. It was observed that the quality of the Plans of Action was also an important determinant for the success of RAMS in EMRO. Efforts were now on in SEARO to modify the system to suit the Region’s needs. A country version of the AMS was also being tried out in Indonesia.

The sharp increase in the number of meetings organized by WHO was a matter of concern. There was an urgent need to critically examine the real utility and outcome of these meetings.

As a result of the Joint Programming Initiative workshop held earlier this year, the quality of the Action Plans had improved to a certain extent. A joint policy and programme review mission is planned to be conducted in countries beginning October 1999 to review the situation and identify priority areas for the formulation of the Programme Budget for 2002-2003.

Progress in the implementation of the Regional Health Declaration should be systematically monitored.

**Recommendations**

(1) Clear and objective indicators should be developed to measure progress, transparency, quality, participation and efficiency in the implementation of proposals at the country and regional levels and enforced from the 2000-2001 biennium.

(2) SEARO should undertake a preparatory exercise to review the situation and assess the trends of health policy and strategy development with a view to prioritizing health programmes in the Region, prior to the convening of a meeting of regional
public health specialists and/or allocating analytical work to collaborating centres and other centres of excellence.

(3) A critical review of the use of the AMS should be undertaken to study its efficiency and feasibility. If necessary, appropriate alternative plans for early installation and operationalization before the end of 2000 should be formulated.

(4) For more cost-effective utilization of WHO resources, the use of national centres of excellence/expertise and WHO collaborating centres in the planning and implementation of the WHO collaborative programmes at country and regional levels should be encouraged as this was less expensive than hiring consultants.

(5) Further detailed and systematic analysis of delegation of authority to the WRs should be considered to facilitate implementation of the Plans of Action.

(6) In view of a number of recurring shortfalls at the country level regarding the preparation of Plans of Action, proposals and execution of fellowships and study tours, the following steps should be taken both by Member Countries and WHO:

- Emphasis be laid on capacity building of health staff in the planning of the biennial programme budget.
- Clear criteria and Terms of Reference for fellowships and study tours be developed, agreed to and strictly followed.
- Monitoring of programme implementation be carried out more frequently to make the best use of scarce resources.
2. STUDY OF THE EFFICIENCY OF WHO/SEARO AND WHO COUNTRY OFFICES (Agenda item 4)

Discussion Points:

- It was difficult for some members to spend 4-5 days each in three countries, as it entailed an absence of almost 2-3 weeks (including travel time), from their countries. It was, therefore, necessary that the group restricted its visit to five days each in two countries only, so that in-depth study of the situation in those countries could be undertaken. Additional members could be co-opted from Bhutan, DPR Korea, Myanmar and Nepal, as these countries were not represented in the working group.

- In trying to expedite the completion of the efficiency study, there should not be any compromise on the quality of the study.

- The Member Countries to be visited by the team should prepare good documentation through the judicious use of questionnaires, developed by the Working Group, well in advance, in order to facilitate an objective assessment during their short visit.

- There was concern at the inadequate coordination and gaps in communication between the working group members and the Regional Office.

Recommendations

(1) Some members of the working group may restrict their visit to two countries only, in order to ensure an in-depth study of the
situation as per the terms of reference and protocol. Additional members from other countries may be included to undertake the studies in the remaining countries. The study should be taken up in more than one spell although this may require additional funds.

(2) The questionnaires, developed by the working group, should be sent by the Regional Office to the WHO Country Offices well in advance for completion. One copy of the completed questionnaire should be sent to the working group members concerned. The second copy should be sent to the Regional Office for analysis and forwarding to the working group members concerned before the country visit.

(3) The countries to be visited by the members of the working group should prepare good documentation based on an analysis of the questionnaires well in advance, to facilitate the study.

(4) The Regional Officer responsible for Liaison with WHO Country Offices (LCO), who has been assigned as the Coordinator of this study in the Regional Office, should facilitate coordination and communication with working group members.

(5) Members of the working group should reconfirm the time frame and the dates of their country visits to the Coordinator at the Regional Office.

3. **REVIEW OF THE IMPLEMENTATION OF WHO COLLABORATIVE PROGRAMMES IN THE MEMBER STATES, INCLUDING REGIONAL AND INTERCOUNTRY PROGRAMMES,**
DURING THE PERIOD 1 JANUARY 1998 TO 30 JUNE 1999
(Agenda item 5)

Discussion Points:

捽 It would be useful if the conclusions of the final report of the management consulting firm could be shared with the countries.

捽 There was a need to evolve a mechanism to ensure that the desired results were achieved at the end of the activities and to measure the objective impact of the outcome of such activities on health development in the countries.

滘 Compared to previous years, the performance of SEAR was better but slow. The slow take-off of the implementation process tended to accelerate towards the end of the biennium. To counter such a situation, it would be useful to start early and fix appropriate targets for implementation, such as 50% of obligation of funds within the first six months and 100% by the end of the first year. This would ensure earlier benefits to people in the Member Countries. It would also facilitate close monitoring of implementation and liquidation of funds during the second year, and ensure that there would be no backlog of unfinished activities spilling over to the ensuing biennium from a current biennium.

捽 It was often difficult for some countries to reach the target of 75% implementation by the end of the first year owing to certain country-specific situations. It was also noted that quality tended to suffer if there was pressure to formulate proposals only to meet the deadlines.
In order to overcome the problem of ‘late implementation’ of the programme budget, preparations of DPoA for the 2000-2001 biennium had started with the Joint Programming Initiative in March 1999.

Timely obligation of funds was important to avoid bunching of activities at the end of the biennium and the danger of funds being diverted out of the Region.

Information on programme implementation, disaggregated by country, should also be provided to facilitate comparison of country performance. This might stimulate action for faster and better implementation by individual countries.

The progress of activity implementation, for which funds have already been obligated, needs to be monitored until liquidation of funds is completed. It is also essential to develop indicators to measure not only the progress but also the quality of implementation.

Planned activities should be reviewed periodically in order to ensure adherence to targets for initiation and completion. Such reviews would also be helpful to avoid duplication and the tendency for submission of proposals for activities which had already been successfully completed in previous bienniums.

WHO programmes cover a wide range of health and health-related areas, diluting their focus and impact as compared to programmes of other agencies. The need, therefore, was for fewer programmes having a clear focus to enable better outcomes.
In-depth analysis of activities implemented during previous bienniums should be undertaken to help countries prioritize their programme activities for technical support from WHO.

There was a need to progressively decentralize the implementation of intercountry activities to the country level.

**Recommendations**

(1) Expected result(s) and activities should be clearly and specifically spelt out in the Plans of Action at the time of their preparation to facilitate effective review upon completion of activities.

(2) An appropriate mechanism for technical monitoring of activities and their completion should be developed and implemented.

(3) The Plans of Action for the ensuing biennium should be finalized at least three months before the beginning of the biennium to ensure timely commencement of the activities. Accordingly, this also implies that the WHO offices at country and regional levels should convey their approvals before the biennium begins.

(4) The target of 75% obligation by December of the first year, and 100% by September of the second year of the biennium, should be maintained. This would provide adequate time for liquidation of funds and avoid carry over of unfinished activities to the ensuing biennium.

(5) There should be careful coordination of proposals by WHO country offices, for ensuring quality, adherence to WHO
policies and strategies, and feasibility of implementation within the specified time frame.

(6) SEARO should explore the feasibility of implementing the ICP II activities through facilities/institutions available in the countries.

(7) There should be periodic review of expenditure and activity patterns for previous bienniums with a view to avoiding unnecessary duplication of efforts.

4. REPORTS BY COUNTRY REPRESENTATIVES ON THEIR ATTENDANCE AT THE MEETINGS OF THE COORDINATING BODIES OF WHO’S GLOBAL PROGRAMMES (Agenda item 6)

4.1 Action Programme on Essential Drugs - Management Advisory Committee (MAC) (Agenda item 6.3)

Discussion Points:

© Improving assistance to Member countries for the Essential Drugs Management programme, as stated on page 9 of the working paper, should be considered for support under the ICP II mechanism. However, the emphasis should be on the National Drug Policy/National Essential Drugs List and the rational use of drugs.

© It is important to ensure continuous availability of essential drugs to developing countries.
5. PROGRAMME BUDGET (Agenda item 7)

5.1 Budget Issues (Agenda item 7.1)

Discussion Points:

- Efficiency savings had emanated from the concern of many developed countries at the very high administrative overhead costs. Such costs should be contained at global, regional and country levels without penalizing country programmes.

- From the point of view of developing countries, WHO assistance for fellowships and supplies and equipment were valuable inputs for capacity building and development of health manpower, as they contributed to long-term sustainability in health development.

- Concern was expressed about the suggestions to scale down procurement, fellowships and study tours. Such measures would adversely affect the progress being made by the countries towards attaining self-sufficiency in the development of human resources. The utility of these components should be properly analysed and measures identified to improve implementation. Planning and management of fellowships should be improved to ensure transparency and efficiency. Accordingly, a critical evaluation of fellowships and study tours should be undertaken expeditiously.

- Analysis of other components, particularly the staff and administrative costs being incurred in the Regional and Country Offices, should also be undertaken. In view of the budgetary cuts, it is important that SEARO seeks to achieve
internal efficiencies. A strict evaluation of long-term staff should be made.

Areas for achieving efficiency savings should be decided by consensus involving Member States. The identification of priority areas for utilization of efficiency savings should be left to the Member Countries, as they have a better knowledge of their needs and priorities.

Concern was expressed about the tendency to centralize decision-making while the trend in other international organizations was towards decentralization of this process.

During 1998-1999, 3% of the working allocation was withheld to cover the shortfall in assessed contributions. It is anticipated that for 2000-2001, 1% of such allocation would be retained for the same reason.

The zero nominal growth budget for 2000-2001 did not provide for increase in costs due to inflation. Therefore, Member Countries were required to identify adequate savings to offset the cost increases on account of inflation. Under resolution WHA51.31, the least developed countries (LDCs) were protected from the budget cuts through 2000-2001. However, these countries would have to absorb the cost increases and identify efficiency savings within the ceiling of their country planning figures.

Under the spirit of resolution WHA51.31, protection of LDCs’ budget should be sustained through 2005.
Countries could plan for only 90% of their budget in the first instance, so that the remaining 10% could be used for meeting efficiency savings without upsetting planned activities.

WHA52.20 encourages the Director-General to continue to identify additional efficiency savings to the tune of 2-3% for reallocation to priority programmes, in particular, at country level. The savings so identified at HQ and regional levels should be redistributed for use at the country level, especially in LDCs. The resultant savings should be used in accordance with HQ, regional and country priorities to be decided through regional mechanisms such as the CCPDM and RC.

**Recommendations**

(1) In the process of generating efficiency savings and reducing administrative costs in WHO, utmost care should be taken to protect the budgetary allocations for WHO collaborative programmes at the country level.

(2) The EB members from this region should be thoroughly briefed on all aspects of the efficiency savings, so that they could raise this issue with the Director-General and suggest reallocation of such savings to priority programmes identified by the countries.

(3) Countries should critically examine their plans of action and identify areas for savings from different components.

**5.2 Country Plans of Action (PoAs), 2000-2001** (Agenda item 7.2)

**5.3 ICP II Plans of Action (PoAs), 2000-2001** (Agenda item 7.3)
**Discussion Points:**

- The countries welcomed the opportunity to examine the ICP-II and flagship projects as this helped them to ensure that there was no duplication of activities between ICP II and country plans of action.

- The allocation of funds under ICP-II reflected a good distribution between the five thematic priority programmes and five flagship projects. There was no allocation for long-term staff and supplies and equipment as per the guidance of the Advisory Group.

- Funds for ICP-II should be used for innovative intercountry activities and not for holding intercountry consultations and workshops, as these were not cost-effective or useful. Activities having specific outcomes for individual countries should be undertaken using the country budget.

- There should be some mechanism in SEARO to ensure interdepartmental teamwork. It may be advisable to have someone from another department as the team leader.

- The number of activities and expected results was still high and should be scaled down by one-third.

- The Advisory Group had recommended that the five flagship projects should have clear medium-term regional targets. All projects should uniformly indicate their medium-term targets.

- A clear explanation of the background outlining the process and mechanism for development of the ICP-II plans of action should be included at the beginning of the document, to provide a historical perspective to this regional initiative.
There was concern at the quality of activities identified in some areas. It was felt that members of the CCPDM should scrutinize the DPoAs in detail and send their comments to SEARO in writing. This was suggested in view of the non-availability of technical experts from the countries and SEARO and to facilitate a meaningful discussion at the CCPDM. The Regional Committee may be requested to approve the allocations to priority areas and to authorize the Regional Office to finalize the detailed Plans of Action before the end of October 1999 in consultation with Member Countries.

Recommendations

(1) The CCPDM members should undertake a broad review of the ICP-ll plans of action to further improve their quality; reduce the number of expected results and activities by one-third, and ensure that there will be no duplication of activities with the country plans of action. The CCPDM members should provide their observations prior to or during the PDM Workshop in order to modify, revise and improve the Plans of Action.

(2) The format for ICP-II should be improved to include WHO targets for 2000-2001 and the short-term/long-term objectives. The activities should be presented in a tabular form under all 8 components to enable an easier appreciation of activity-wise allocations. Care should also be taken to ensure that supplies and equipment and long-term staff are not included in ICP II Plans.

(3) A brief explanation on the evolution of the ICP-II mechanism should be included at the beginning of the DPoA document to provide a historical perspective.
(4) A monitoring mechanism should be evolved from the cross-programme approach and steps developed for ensuring effective inter-departmental cooperation. These mechanisms should be communicated to Member Countries for their information.

(5) The DPoA of RO and ICP-I projects should also be presented to facilitate a proper review of all WHO collaborative activities in a holistic manner.

(6) The Member Countries should further rationalize the detailed Plans of Action for the 2000-2001 biennium before the next PDM Workshop in conformity with the decisions taken at the CCPDM meeting.


6.1 Review of the Regional Implications of the Decisions and Resolutions of the 52nd World Health Assembly and the 103rd and 104th Sessions of the Executive Board

**Discussion Points:**

© The solidarity prevailing among Member Countries in the Region for health development could be utilized to ensure that
regional interests were protected on the issues of Programme Budget, as also on technical issues. For example, there was need to be proactive, such as taking action to nominate experts at least from one Member Country of the Region as a member on the expert group on the eradication of variola virus.

It might not be realistic to base the assessed contributions for an ensuing biennium, on the GDP of a country calculated on the information gathered several years ago. However, the scale of assessment was determined by the UN General Assembly. Relevant information on the base year on which these are determined would be provided later by the Regional Office.

As regards the resolution on the WHO Framework Convention on Tobacco Control, it was felt that the long-drawn process of preparation and adoption of the Convention by the WHA in 2003 and approval thereafter by individual countries, in accordance with their procedures, may perhaps soften the expected impact of the Convention. It was clarified that the Framework Convention would have to be adopted by the WHA by a two-thirds majority, and then ratified by the countries through their constitutional process. It was important, therefore, while supporting the Convention, that Member Countries go ahead towards formulating strategies and programmes for immediate implementation.

It was necessary to ensure that there were no adverse implications of not implementing international conventions on the Member Countries.
Developing countries need to strengthen national capacities on matters of international health to safeguard the regional interests at international fora, particularly WHO Governing Body meetings.

**Recommendations**

(1) SEARO should follow up with WHO headquarters and keep itself abreast of developments relating to the Framework Convention for Tobacco Control and keep Member Countries informed of the action being taken.

(2) Member Countries should formulate activities and plans of action for the implementation of tobacco cessation programmes.

(3) Member Countries should initiate follow-up action on the decisions and resolutions of the WHA/EB at the country level and provide regular feedback to the Regional Office on the actions taken.

(4) There should be concerted efforts on the part of the Member Countries and WHO, in a spirit of solidarity, for safeguarding the regional interests in the decisions and resolutions of the WHO Governing Bodies.

(5) Member Countries should carefully assess and monitor any adverse implications arising out of the adoption or non-adoption of International Conventions and resolutions adopted by WHA/EB with appropriate assistance from the Regional Office.
(6) The Regional Director should explore with the Director-General the possibility of including at least one expert from the South-East Asia Region in the expert group to be established by her on the destruction of variola virus stock.

6.2 Review of the Indicative List of Items for Discussion by the 105th Session of the Executive Board

Discussion Points:

- The Executive Board Members from the Region could be briefed appropriately by WHO Representatives on the process of proposing additional agenda items such as arsenic problems, protection of the budget of the least developed countries, priorities for 2000-2001, implementation of WHA resolution WHA52.20, etc.

- With WHO support, the problem of contamination of water supply with arsenic, which was of grave public health concern in some countries, had been studied. More attention was needed with regard to management of arsenicosis.

- It was also necessary to ensure that there would be no more than 3% reduction each year of the Regional Budget over the period of 2000-2005. It was, however, noted that resolution WHA51.31 had urged the Director-General to protect the interests of the least developed countries.

- According to WHA51.31, the current formula based on HDI and immunization coverage, adopted by WHA, could be reviewed and the Executive Board members from SEAR could suggest an agenda item in this regard.
Efforts of Member Countries in dealing with polio eradication through synchronized NIDs with neighbouring countries as also border meetings for prevention and control of communicable and other diseases through border meetings were noted. WHO could provide a useful forum for dialogue and coordination of these bilateral efforts and facilitate such endeavours.

The need to have experts with technical background in specific health-related areas as part of country delegations to the Governing Body meetings was highlighted.

Recommendations

1. The Executive Board members from SEAR should be advised appropriately on the process of inclusion of any additional agenda item for the EB session.

2. Support for the bilateral efforts of the countries, with assistance from WHO, to deal with cross-border health problems such as poliomyelitis, malaria and HIV/AIDS should be assessed by Member Countries with support from SEARO.

3. The possibility of including technical experts in country delegations to the Governing Body meetings should be explored.

4. WHO should continue to provide support to countries in combating the problem of arsenicosis.
Annex 7

RECOMMENDATIONS ARISING OUT OF THE TECHNICAL DISCUSSIONS ON TOBACCO OR HEALTH: ACTIONS FOR THE 21ST CENTURY

1. INTRODUCTION

The Technical Discussions on Tobacco or Health: Actions for the 21st Century were held on 2 September 1999 under the Chairmanship of Dr Suwit Wibulpolprasert, Assistant Permanent Secretary for Public Health, Ministry of Public Health, Thailand. Dr H.A.P. Kahandaliyanage, Senior Assistant Secretary, Ministry of Health and Indigenous Medicine, Sri Lanka, was elected Rapporteur. During the absence of Dr Suwit, Ms Sujatha Rao, Joint Secretary, Ministry of Health and Family Welfare, Government of India, chaired the discussions. The agenda and annotated agenda (SEA/PDM/Meet.36/9.1.1 and SEA/PDM/Meet.36/9.1.1 Add.1) and the working paper for the Technical Discussions (SEA/PDM/Meet.36/9.1.2) formed the basis for the discussions.

1.1 Opening Remarks by the Director, Department of General Management, WHO/SEARO

Mr R. Spina Helmholz said that the global increase in tobacco consumption, particularly in the developing world, presented a
major public health concern, considering the heavy disease and economic burden in the Region. Taking cognizance of the serious health implications of the use of tobacco, the 51st session of the Regional Committee selected this subject for Technical Discussions with a view to define a focussed and collective direction for tobacco control in the Region. Mr Helmholz expressed the hope that the recommendations of the Technical Discussions, duly endorsed by the Regional Committee, would guide the Member States in employing a multi-pronged strategy for tobacco control in the Region.

1.2 Introductory Remarks by the Chairman

In his opening remarks, Dr Suwit Wibulpolprasert said that tobacco use posed one of the greatest public health challenges globally. However, it was heartening to note that some countries in the Region had addressed the tobacco-related issues facing them effectively and made significant progress in containing this 20th-century scourge. He stressed that strong political will, legislation, a complete ban on tobacco advertising and social mobilization among the tobacco users could be important ways in which the increase in tobacco consumption could be arrested.

1.3 Presentation by Dr (Ms) Martha Osei, Regional Adviser on Health Promotion and Education, WHO/SEARO

Ms Martha Osei, Regional Adviser on Health Promotion and Education, presented the working paper and introduced the subject. She said that the objectives of the discussions were to review the global and regional situation and to develop strategies for action in the 21st century. She recalled the various resolutions
adopted by the World Health Assembly towards comprehensive strategies for tobacco control. Between 1970 and 1988, a total of 17 resolutions were adopted, all stressing effective control measures. But tobacco consumption had been on the increase, particularly in developing countries. Against this background, the World Health Assembly requested the Director-General to develop a Framework Convention in Tobacco Control, which would be a global, legally binding instrument.

The WHO cabinet project on Tobacco Free Initiative, launched in July 1998, had adopted a fast-track approach towards the development of this framework. The recently adopted World Health Assembly resolution WHA52.18 provided clear guidance on the process of the development and negotiation of the Framework Convention and related protocols.

**Tobacco Use: Implications for Global Public Health**

On tobacco production and trade, she noted the steady increase since the 1900s, particularly in developing countries. Eighty percent of the tobacco consumed globally was produced in developing countries. Currently several million metric tonnes of tobacco was produced globally. Over the past decade, the share of global production by high income countries had decreased from 30% to 15% while that by countries in the Middle East and Asia had risen from 40% to 60% World wide tobacco consumption was increasing by about 2% annually with the biggest rise occurring in the developing countries and Eastern Europe. Of the 1.2 billion smokers globally, 800 million lived in developing countries. Tobacco killed 3.5 million people every year. By 2030, this number would rise to 10 million, with 7 million deaths occurring in
developing countries. The shift of the tobacco epidemic to the developing countries was obvious.

Tobacco use among women was also known to cause stillbirths, low birth weight and perinatal deaths. The linkages between tuberculosis and smoking had also been documented, with smokers infected with tuberculosis facing a greater risk of death from tobacco-related diseases than tuberculosis-infected non-smokers. Tobacco also caused considerable economic loss for all countries. Currently, the world loses US$200 billion a year with one-third of the loss being borne by developing countries. The impact of tobacco on the environmental sustainability was also significant.

**Tobacco-related morbidity and mortality**

In the South-East Asia Region, there had been a steady increase in the production and consumption of tobacco in both its smoking and smokeless forms across all sections of population groups, particularly among women, children and the poor. Tobacco products in the Region contained higher levels of nicotine and tar compared with the levels in developed countries.

Cancers, cardiovascular diseases and emphysema were increasing, as major killers in some countries of the Region. Low literacy, high poverty levels and lack of adequate public awareness of the hazards of tobacco, presented a favourable environment for a possible tobacco epidemic in the Region. Effective action to control tobacco was therefore urgently needed.

**Controlling Tobacco Use in the Region**
It was noted that an effective balance was needed between opportunities and challenges in the Member Countries, to achieve comprehensive tobacco control. Opportunities such as existing components of national control strategies, documented, effective and proven strategies and the current global movement for tobacco control would need to be maximized to achieve the desired level of reduction in tobacco consumption in the Region. But the challenges of the perceived economic value of tobacco, the huge pool of potential smokers being targetted by the tobacco industry advertisements, the lowering of the age of initiation, lack of awareness of tobacco hazards and the steady shift of the tobacco industry into the Region, should be recognized.

Significant action had been taken in most countries of the Region to tackle the menace of tobacco. A partial ban on advertisements, establishment of non-smoking islands and districts in some countries, non-smoking flights, and a ban on smoking in public places were some of them. However, additional efforts and resources were urgently needed in a concerted manner and on multiple fronts.

Several legislative measures, such as a comprehensive ban on advertisements of tobacco products, restriction of access to tobacco products by minors in schools, restriction on smoking at workplaces and public areas to protect people from the effects of environmental tobacco smoke, compulsory disclosure of ingredients including nicotine levels in cigarettes and highly visible warnings on cigarette packets and cartons could be undertaken. Increase in the real price of tobacco products to reduce consumption and make it unaffordable for poor consumers and, at
the same time, increase government revenue, was an effective weapon for tobacco control.

**Making Tobacco Control a reality**

Tobacco should be a priority item on the political and development agenda of countries. The leadership role of ministries of health cannot be overemphasized for advocacy and intensified political commitment for the participation of other sectors. A network of NGOs, institutes of excellence, training colleges, the primary health care infrastructure and poverty alleviation programmes could work in partnership with each other. Research and surveillance tended to be weak and data was hard to come by. These needed to be strengthened to support tobacco control measures and to provide basic information and evidence for advocacy and policy-making. Mobilization of communities and civil society was critical for effective tobacco control measures.

2. **DISCUSSIONS**

© The Regional Policy Framework for Tobacco Control and the Action Plan 2000-2004 developed at a Regional consultation to provide collective direction for tobacco control should be proposed for adoption by the Regional Committee for implementation by Member Countries. These documents were endorsed by the group.

© Political commitment and conviction were essential for the success of the tobacco control initiatives in the countries. It had been demonstrated that public concern motivated strong
political will resulting in significant progress in tobacco control measures, as in Sri Lanka and Thailand.

- The necessity for countries to have focal points for tobacco control activities was emphasized. It was, however, preferable to have a network of several institutions or focal points, as individuals could always become vulnerable to the manipulations of multinational cigarette companies.

- The most important strategies for tobacco control were: taxation, legislation, regulation and education with the emphasis on social mobilization.

- Some of the myths and beliefs associated with smoking in the rural, hilly areas of Nepal were that it helped to keep users warm and provided energy in the cold weather. In the urban areas, cigarettes were associated with better self-image, stress relief and a sense of belonging to peer groups.

- The possibilities of involving different sections of society in tobacco control such as teachers, community leaders, religious leaders, NGOs, and role models such as sports personalities, film stars and models should be explored. The involvement of NGOs in imparting suitable training to opinion leaders in the community should be encouraged.

- Insufficient information and data on the ill-effects of smoking was one of the reasons for the low effectiveness of advocacy programmes. Meanwhile, information and documents on the strategies adopted by the multinational tobacco companies to promote sales of tobacco were becoming available; these should be used to strengthen advocacy and education for tobacco control.
Tobacco companies marketed their products aggressively with huge budgets for sophisticated advertising campaigns. On the other hand, health ministries had scarce resources and were therefore unable to counter these campaigns.

Some countries had achieved a breakthrough in tobacco control through a complete ban on advertising of tobacco products and alcohol on national television. These efforts were, however, getting diluted by advertisements of tobacco products on some foreign channels, cable television networks and the foreign print media. It was extremely difficult to regulate such advertising for want of international protocols. This was an area that WHO needed to focus on, as it was beyond the control of any single country.

Since there were substantial numbers of potential smokers in the school-going and adolescent age groups, it was necessary to include strong messages against smoking and tobacco use in the school health education curriculum.

Media involvement and support in countering tobacco advertisements by highlighting the adverse cosmetic effects of smoking on the health and personality of the smoker could be explored.

Youth and adolescents could be reached through mass rallies, campaigns, etc. They could be motivated to advocate on behalf of tobacco control with senior government leaders.

The countries of the Region faced a heavy disease burden and had very scarce resources to combat a wide spectrum of communicable and noncommunicable diseases. As such, it was difficult to allocate adequate funds for tobacco control to make
a difference. However, the use of mass media, pamphlets, booklets, handbills, etc. should be encouraged to convey the message that tobacco kills, to the large populations in the countries of the Region.

While several countries earned substantial revenues from tobacco taxation and excise duties, there was no policy to earmark any proportion of these revenues for tobacco control activities. However, it was seen that in some countries such as Thailand and Nepal, a percentage of the revenue earned was utilized to sustain the tobacco control programme. WHO should strongly urge all Member States to allocate a portion of the revenue earned from tobacco advertising and taxation for tobacco control programmes.

It had been established that tobacco caused impotence and sub-fertility. This message could be used as an effective counter-measure to combat tobacco advertising.

WHO could encourage the medical community and health professionals to eschew the use of tobacco to set an example as role models for the community.

Different approaches for reaching illiterate populations could be attempted. Especially in the rural areas, where there is no electronic media, puppet shows, radio talks, folk theatre and pop songs could be effective tools to be considered.

Mere control of tobacco consumption might not yield the desired results. The most important and sustainable measure was the ‘social vaccine’ injection through intensive education to women and children. Through partnership among various
sections of society, some measure of success could be achieved.

- Focused research on the prevalence, causes and effects of tobacco consumption and research related to effective strategies to reduce prevalence among adolescents, women and the poor should be undertaken.

- There was a need for solidarity among Member Countries for exchange of information and experiences on tobacco-related issues.

- While strict rules were in force for food additives and flavours, there was no regulation for the manufacture of cigarettes. It was now recognized that product regulation could be a key approach for the control of tobacco.

- Governments faced difficulty in enforcing tobacco regulations due to cross-border smuggling of tobacco products.

- Due to a fall in tobacco consumption in the developed countries, there was increasing pressure from western countries to dump tobacco products in the developing world.

- Teachings in various religions were a powerful tool to advocate rejection of tobacco consumption. Religious bodies and leaders could be mobilized for educating the people in the community regarding the ill-effects of tobacco use.

- Fires caused by smouldering cigarette butts had resulted in heavy economic losses in Bangladesh.

- WHO/HQ should take up the issues and regulations on advertising and media coverage with the international media,
with WTO regarding dumping and the right of countries to impose non-tariff barriers on tobacco trading and the development of media materials for wide dissemination.

WHO should focus more on support to country efforts to establish cessation services and less on holding consultations or meetings.

WHO/HQ should also allocate adequate resources for tobacco control. Currently, the budget is hardly US$2 million as compared to US$1000 million allocated to Roll-Back Malaria.

3. RECOMMENDATIONS

(1) The members of the Technical Discussions group should adopt the document on ‘Policy Framework for Tobacco Control and Action Plan for 2000-2004’ and forward it to the Regional Director for adoption by the Regional Committee.

(2) Each Member Country should constitute a national council for tobacco control with representation from government, nongovernmental organizations, tobacco control experts, etc. and also take steps to develop the capacity of a network of institutions on different aspects of tobacco control.

(3) Member Countries should initiate action to develop more comprehensive country-specific strategies for tobacco control.

(4) Member Countries should initiate action to enact strong legislation, increase taxation on tobacco products, institute regulations and impart education on the ill-effects of tobacco use.
(5) Focused research on the prevalence, causes and effects of tobacco consumption and research related to effective strategies to reduce prevalence among adolescents, women and the poor should be undertaken.

(6) Nicotine should be regulated as a drug and governments should establish a mechanism to monitor its use.

(7) Strong messages about the ill-effects of smoking and tobacco use should be included in the school curriculum for adolescents.

(8) WHO should adopt a strongly worded resolution urging all Member States to set apart a portion of the money earned from tobacco advertising and taxation for tobacco control programmes.

(9) WHO should provide all available information and data on the adverse effects of tobacco on health and the long-term economic implications of tobacco use to the political leadership in the Region for policy formulation.

(10) WHO should advocate tobacco control measures in collaboration with WTO for the regulation of tobacco trade.

(11) WHO should encourage medical associations and health professionals to lead, by example, by eschewing tobacco use themselves. National governments should give preference on recruitment to non-smokers for positions in government service.

(12) WHO/HQ should allocate adequate resources for tobacco control activities.
Annex 8

RECOMMENDATIONS ARISING OUT OF THE TECHNICAL DISCUSSIONS ON INTENSIFICATION OF HIV/AIDS SURVEILLANCE

1. INTRODUCTION

Technical Discussions on “Intensification of HIV/AIDS Surveillance” were held on 2 September 1999 under the Chairmanship of Dr Sangay Thinley, Director of Health Division, Ministry of Health and Education, Bhutan. Dr Saw Myint, Director (Planning), Department of Health, Ministry of Health, Myanmar, was elected Rapporteur. The agenda and annotated agenda (SEA/PDM/Meet.36.9.2.1 and Add. 1) and the working paper for the Technical Discussions (SEA/PDM/Meet.36/9.2.2) formed the basis for the discussions.

1.1 Opening Remarks by the Deputy Regional Director, WHO/SEARO

Dr Samlee Plianbangchang, Deputy Regional Director, said that it was appropriate for the CCPDM to take cognizance of this issue and discuss strategies for further intensification of HIV/AIDS surveillance in SEAR, considering that the HIV/AIDS problem was acute in the developing world, particularly in the Region. Almost every country in the world had reported HIV infection and the
number of people infected with HIV continued to increase steadily. The number of infected persons, however, varied according to different age groups and by gender. Highlighting the importance of surveillance programmes, he pointed out that public health interventions based on effective and appropriate planning and policy could alter the course of the epidemic in the Region based on accurate information obtained through surveillance programmes. Surveillance also ensured efficient, effective and evidence-based decisions. It was gratifying to note that the importance of initiating surveillance of Sexually Transmitted Infections (STI) and assessment of risk behaviour on a regular basis to complement HIV/AIDS surveillance was being recognized. Dr Samlee expressed the hope that the recommendations of the Technical Discussions, duly endorsed by the Regional Committee would guide the Member States in strengthening their efforts in HIV/AIDS surveillance and in planning public health interventions.

1.2 Introductory Remarks by the Chairman

In his opening remarks, Dr Sangay Thinley highlighted the importance of HIV/AIDS surveillance and the need for its intensification, given the alarming situation that existed in the Region with regard to HIV/AIDS. He hoped that the focused discussions by the participants would generate important recommendations on the intensification of HIV/AIDS surveillance in the countries of the Region.

1.3 Presentation by Dr Jai P. Narain, Regional Adviser, HIV/AIDS and TB, WHO/SEARO
While reviewing the status of HIV/AIDS surveillance, Dr Narain stated that though such surveillance programmes were well established in the Region, their scope and reach needed to be strengthened to respond better to the epidemic. Epidemiological surveillance data were useful to plan interventions targeted at various population groups as well as for advocacy among decision makers. The data on reported AIDS cases did not reflect the actual magnitude of the problem, due to under-diagnosis and under-reporting, coupled with the latency period of 7-10 years between infection and development of AIDS. On the other hand, HIV sentinel surveillance based on unlinked anonymous testing among various population groups when repeated at regular intervals provided more accurate and unbiased information on the HIV trends in a country or area. The focus now should be on improving quality of surveillance data by strict adherence to methodology between surveys and on prompt dissemination and use of data for programme purposes.

Dr Narain noted that surveillance of HIV-related risk behaviours was not yet well established in most countries of the Region. The behavioural surveillance data are needed to assess the types and intensity of risk behaviours in various areas. The use of such data for planning and evaluating more quickly the impact of intervention strategies aimed at bringing about behavioural change could not be underestimated. While countries in the early stages of epidemic should focus on surveillance particularly among populations with high risk behaviour, those with a more advanced epidemic should cover both the higher as well as lower risk populations. Surveillance for sexually transmitted infections also needed to be standardized and established, together with
behaviour surveillance, as a part of comprehensive HIV/AIDS surveillance programmes in the countries.

2. DISCUSSIONS

During the discussions, the participants voiced their concern at the seriousness of the HIV/AIDS situation in the Region. They recognized the need to intensify HIV/AIDS surveillance to enable countries to plan and implement various interventions to combat the epidemic.

It was noted that all the countries in the Region were involved in HIV/AIDS surveillance, including AIDS case reporting and HIV sentinel surveillance. Promoting and implementing intervention-linked behavioural surveillance, particularly in view of the need to bring about behaviour change in various population groups, would greatly benefit HIV/AIDS surveillance. Information obtained through surveillance of risk behaviours and STI could be also be used for advocacy and resource mobilization. The importance of collating and analyzing risk behaviour data quickly for planning interventions was stressed. This included mapping, estimation of size, risk ranking and prioritizing of populations for targeting interventions.

Development of a simple and standardized set of indicators for behaviour surveillance was extremely valuable. This could be developed at the national level with assistance from WHO/SEARO.

Reporting of STI syndromes was considered appropriate among men. However, in view of the asymptomatic nature of STI in
women, it would be useful to focus on the etiological diagnosis in women, particularly data on gonococcal culture and VDRL obtained at certain sites where such laboratory facilities were available. Also, a prevalence survey should be undertaken to establish the overall burden, at least once in three years.

© Multisectoral involvement in HIV/AIDS surveillance was highlighted. Even though the surveillance activities which provided information for public health action could be undertaken by nongovernmental organizations, the academia and research institutions, the overall coordination of these activities remained the responsibility of the government.

© The participants noted that HIV/AIDS could not be considered only as a health problem. It was also a social problem. At the same time, the danger of HIV/AIDS losing priority attention due to its being designated as a social problem rather than a health problem should be kept in mind.

© The networking of surveillance activities at the national, subnational and intercountry levels was also discussed. Collaboration between countries to share their experiences through the use of established mechanisms was essential to further develop HIV/AIDS surveillance in all Member Countries of the Region.

© The participants briefly discussed the problem of HIV testing among expatriate workers as well as the ethical and public health dimensions relating to mandatory testing of various population groups. The participation bias associated with voluntary confidential testing was highlighted. It was
suggested that for surveillance purposes, unlinked anonymous testing was the preferred methodology.

- The need for the Member countries to have a technical sub-committee for exchange of information on HIV/AIDS surveillance and the role of WHO/SEARO in setting up and supporting such an activity was highlighted.

- Recognizing the importance of epidemiological research in prevention and control of HIV/AIDS, the participants urged enhanced support in this area. In addition, it was stressed that each country should develop and share databases on HIV/AIDS among interested parties both within and outside the country. WHO support to strengthen surveillance data management was also highlighted during the discussions.

- WHO/SEARO was urged to promote, document and disseminate experiences on “social vaccines” such as the 100% condom programme, HIV/AIDS education in schools as a part of lifeskills approach, and education and prevention interventions among various population groups, particularly those with high risk behaviour. Such initiatives should be supported and funded through ICP II mechanism.

3. RECOMMENDATIONS

3.1 Advocacy

In view of the crucial role surveillance plays in planning, implementing and evaluating national AIDS control programme activities, the Governments in the Member Countries should give a high priority to strengthening comprehensive HIV/AIDS
surveillance by allocating adequate resources, both human and financial.

3.2 Enhancing Quality of HIV/AIDS Surveillance Data

While HIV/AIDS surveillance is well established in all countries, there is a need to improve the quality of surveillance data. To improve AIDS case reporting, it is important to train health care workers in diagnosing and reporting AIDS cases and to widely disseminate AIDS case definition to all health care facilities. HIV sentinel surveillance should be based on unlinked anonymous methodology which should be adhered to strictly in various rounds of survey. The problem of not having adequate sample size can be minimized by expanding the survey period and by carrying out surveillance only once a year instead of every six months. Moreover, countries with low HIV prevalence should carry out surveillance only among population groups with high risk behaviour.

3.3 Establishing National Working Groups on HIV Estimates

In order to develop a consensus on current estimates of HIV in the country, a Working Group on HIV estimates should be established in all Member Countries. This multidisciplinary Working Group consisting of national experts with experience and expertise in HIV/AIDS including epidemiologists, behavioural scientists, etc. could meet once a year to review all relevant data to prepare an estimate of HIV prevalence in the country.

3.4 Expanding Surveillance of Risk Behaviours and STI
In addition to AIDS case reporting and HIV sentinel surveillance, the data on risk behaviour and STI should form an integral part of comprehensive HIV/AIDS surveillance. This should include geographical mapping of risk behaviour and estimation of population size. Such data should be used quickly for planning and evaluating the impact of prevention interventions. Simple and practical guidelines including indicators to measure the risk behaviour in various population groups should also be developed by countries in collaboration with WHO/SEARO.

3.5 Building Partnerships for Strengthening HIV/AIDS Surveillance

While the national AIDS control programme has overall responsibility of coordinating the national response to HIV/AIDS in the country including establishment and strengthening of HIV/AIDS surveillance, multisectoral involvement is essential to implement surveillance activities. NGOs, the private sector, the academia and research institutions, where relevant, should be involved in planning and implementing surveillance activities. This is particularly relevant in the area of behavioural and STI surveillance.

3.6 Intercountry Collaboration

Many countries have, over the years, attained considerable experience in establishing HIV/AIDS surveillance. These experiences should be shared through established intercountry mechanisms. Development of uniform methodology and networking among surveillance focal points should be considered. SEARO should provide a forum for information exchange among countries.
3.7 Data Dissemination and Use

Surveillance data should be more quickly analysed and made available to national programmes so that these are used for action. Ideally, surveillance data should be collected, analysed and used for action at local level.

WHO/SEARO should assist countries in coordinating surveillance activities and assisting in data management. All national AIDS control programmes should develop HIV/AIDS databases to be shared with various stakeholders, including health workers, various governmental sectors, nongovernmental organizations, the private sector, donor agencies and, most importantly, with the surveillance personnel. These databases should be updated regularly.

3.8 Epidemiological Research to fine tune HIV/AIDS Surveillance

Epidemiological research should be carried out periodically to evaluate HIV/AIDS surveillance programmes and to assess ways to improve the quality (completeness, accuracy and timeliness) of surveillance data in the Member Countries.