REGIONAL COMMITTEE

Sixty-fifth Session
Yogyakarta, Indonesia
5–7 September 2012

SEA/RC5/24 Rev.1
5 September 2012

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DRAFT REPORT
OF THE SIXTY-FIFTH SESSION
OF THE WHO REGIONAL COMMITTEE
FOR SOUTH-EAST ASIA
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Part I

Introduction

1. The Sixty-fifth Session of the WHO Regional Committee for South-East Asia was held in Yogyakarta, Indonesia from 5 to 7 September 2012. It was attended by representatives of all 11 Member States of the Region, UN and other agencies, nongovernmental organizations having official relations with WHO, as well as Observers.

2. The joint inauguration of the Sixty-fifth Session of the Regional Committee and the Thirtieth Meeting of Ministers of Health of Countries of the South-East Asia Region was held on 4 September 2012. Her Excellency Dr Nafsiah Mboi, M.Ped., MPH, Honourable Minister of Health of the Republic of Indonesia, delivered the inaugural address.

3. The Committee elected H.E. Dr (Ms) Nafsiah Mboi, Honourable Minister of Health, Ministry of Health, Republic of Indonesia, as Chair, and H.E. Dr Ahmed Jamsheed Mohamed, Honourable Minister of Health, Ministry of Health, Republic of Maldives, as Vice-Chair of the session.

4. The Committee reviewed the Report of the Regional Director covering the period 1 January 2010 to 31 December 2011.

5. The Committee decided to hold its Sixty-sixth session in 2013 in the WHO Regional Office for South-East Asia, New Delhi.

6. A Drafting Group on Resolutions comprising a representative from each of the Member States was constituted with Dr Thaksaphon Thamarangsi, Medical Officer, International Health Policy Programme, Ministry of Public Health, Kingdom of Thailand, as Convener. During the session, the Regional Committee adopted nine resolutions.
Part II

Inaugural session

7. The joint inauguration of the Thirtieth Meeting of Ministers of Health of Countries of the WHO South-East Asia Region and the Sixty-fifth Session of the WHO Regional Committee for South-East Asia was held in Yogyakarta, Indonesia, on 4 September 2012.

8. In his welcome address, His Excellency Sri Sultan Hamengkubuwono X, Governor of Yogyakarta Special Region Province, warmly welcomed representatives of the WHO South-East Asia Region Member States to Yogyakarta. He wished delegates to have fruitful discussions that would produce beneficial results and commitments in health development, not only at the national or regional level, but also those that would effectively affect all the WHO South-East Asia Region. He felt that the agenda to be discussed in the meeting had topics well-selected that would play an important role in the health development of the people in the Region.

9. Dr Nafsiah Mboi, Honourable Minister of Health, Republic of Indonesia, welcomed the distinguished delegates and conveyed gratitude to His Excellency Prof. Dr Boediono, Vice-President of the Republic of Indonesia, on behalf of all participants for gracing the joint inaugural session with his presence.

10. She also extended a warm welcome to Dr Margaret Chan, Director-General of the World Health Organization, D Samlee Plianbangchang, Regional Director, WHO South-East Asia Region and H.E. Sri Sultan Hamengkubuwono X, Governor of Yogyakarta Special Province.

11. The Health Minister termed this year's World Health Day theme “Ageing and Health” significant in view of the increasing population of elderly persons in the Member countries of the Region that necessitated a revamp of health care and social support systems. She encouraged the Ministers of Health to adopt the Yogyakarta Declaration on Ageing and Health which calls upon governments to commit to building partnerships among various stakeholders at the national, regional and global levels.

12. In conclusion, Her Excellency expressed an earnest hope that selecting Yogyakarta as the venue of these meetings would contribute to the successful outcome of the deliberations.

13. Dr Samlee Plianbangchang, WHO Regional Director for South-East Asia, welcomed the Ministers of Health and representatives of Member States. The Regional Director commended the achievements of the Government of Indonesia for making impressive progress in increasing access to health care for its population despite major challenges being faced by the countries of South-East Asia Region. He attributed it to the various health insurance schemes which covered 58% of the country’s population.
14. The Regional Director noted with appreciation that routine immunization in Member countries had been successfully intensified to achieve the desired coverage of 90% or more. It is expected that the WHO South-East Asia Region would attain polio-free status early in the year 2014.

15. The Regional Director stressed the need to build a strong health system based on the primary health care approach with a balance between preventive and curative care. He also called for mobilization of multisectoral partnerships.

16. Thanking the organizers of the host country for the excellent arrangements, he conveyed his greetings and best wishes to the distinguished participants for successful and fruitful meetings. (for full text of the address, see Annex--) (to be added from RD’S address once it is finalized)

17. His Excellency Professor Dr Boediono, Vice-President of the Republic of Indonesia, jointly inaugurated the Thirtieth Meeting of Ministers of Health and the Sixty-fifth Session of the WHO Regional Committee for South-East Asia and extended a warm welcome to the Ministers of Health, the Director-General, the Regional Director, Governor of Yogyakarta and distinguished delegates.

18. His Excellency congratulated Dr Margaret Chan, Director-General of the World Health Organization, for her re-election to a second term in office. Recalling the statement of the President of Indonesia that global development collaboration should be based on the foundation of common but differentiated responsibilities and open participation of all stakeholders, he said that this cooperation must be aimed at empowering the poor in developing countries, and upholding the principles of proportionally shared responsibility and mutual benefits.

19. Noting that the World Health Day theme of 2012 of “Ageing and Health” was very relevant in view of the increasing number of elderly in the South-East Region, he stressed the need to strengthen national and regional policies on ageing and health and to ensure sufficient resources for the programme.

20. The Vice-President reiterated the strong commitment of Indonesia to achieve universal health coverage by 2019, considering its importance in ensuring the social and economic wellbeing of the population.

21. He reiterated Indonesia’s strong commitment to fully implement International Health Regulations (IHR) 2005 and urged the need for strong commitment from all the WHO SEA Region Member States ‘for its implementation.

22. The Vice-President mentioned that his country was facing the double burden of communicable diseases coupled with rising trends in morbidities and mortalities in noncommunicable diseases (NCDs). He called upon all Member countries of the Region to work together to cope with the alarming situation.

23. In conclusion, His Excellency conveyed his greetings and best wishes for the successful deliberations and fruitful outcomes of these meetings.
Part III
Business Session
Opening of the Session

24. The Sixty-fifth Session of the WHO Regional Committee for South-East Asia was opened by the Vice-Chair of the Sixty-fourth session, H.E. Professor Dr Pe Thet Khin, Union Minister of Health, Ministry of Health, Government of Myanmar, in the absence of the Chair of the Sixty-fourth session of the Regional Committee. His Excellency acknowledged the role of the Regional Committee in assisting Member countries to address the formidable challenges facing the health sector in the Region through enhanced collaboration among Member countries. He commended WHO’s immense contribution to fight the spread of communicable and noncommunicable diseases in the Region.

Appointment of the Subcommittee on Credentials (Agenda item 1.1)

25. A Subcommittee on Credentials, comprising representatives from Bhutan, DPR Korea and Maldives, was appointed.

Approval of the report of the Subcommittee on Credentials (Agenda item 1.2)

26. The Subcommittee met under the chairpersonship of Mr Nima Wangdi, Secretary, Ministry of Health, Bhutan, and examined the credentials submitted by all Member States. The credentials submitted by all 11 Member States, viz., Bangladesh, Bhutan, DPR Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste, were found to be in order, thus entitling the representatives to take part in the work of the Regional Committee.

Election of Office-bearers (Agenda item 1.3)

27. H.E. Dr (Ms) Nafsiah Mboi, Honourable Minister of Health, Ministry of Health, Indonesia, was elected Chair of the Regional Committee, and H.E. Dr Ahmed Jamsheed Mohamed, Honourable Minister of Health, Ministry of Health, Maldives, was elected Vice-Chair. Dr Nafsiah Mboi thanked the representatives for the honour of electing her as the Chair of the Regional Committee. Recalling that it was the eighth Regional Committee hosted by Indonesia, she noted that this Regional Committee session would be taking up several key regional and global issues and hoped that with the support and cooperation of all, the Committee would be able to transact its business and accomplish the agenda in a meaningful manner. She was hopeful that the meeting would provide a platform for the sharing of perspectives, ideas and initiatives to give a clear direction to the health agenda in meeting the hopes and aspirations of the people of the Region. She acknowledged the support of the Director-General, the Regional Director and the WHO Secretariat in strengthening such efforts.

Adoption of the Agenda (Agenda item 1.4)

28. The Committee proposed that Agenda item 6.3 (Process for Nomination of the Regional Director) be brought forward to immediately following Agenda item 2.2 (Address by the Director-General of the World Health Organization). The Agenda as contained in Document SEA/RC65/1 (Rev-2) was adopted with the proposed revision.

Drafting Group on Resolutions

29. A Drafting Group on Resolutions comprising a representative from each of the Member
States was constituted with Dr Thaksaphon Thamarangsi, Medical Officer, International Health Policy Programme, Ministry of Public Health, Kingdom of Thailand, as Convener. During the session, the Committee adopted nine resolutions.

Key Addresses and Report on the Work of WHO
(Agenda Item 2)
Introduction to the Regional Director's Biennial Report on the Work of WHO in the South-East Asia Region covering the period 1 January 2010—31 December 2011
(Agenda item 2.1: Document number SEAIRC65I2 and Inf.Doc)

30. Introducing his report for the period 1 January 2010 to 31 December 2011 the Regional Director, Dr Samlee Plianbangchang, said that with WHO’s supportive contributions Member States of the South-East Asia (SEA) Region had intensified their efforts to reduce the burden of communicable diseases. The Year 2012 has been declared by Health Ministers as the ‘Year of Intensification of Routine Immunization in the South-East Asia Region”. WHO worked closely with Member States in reviewing and further strengthening national immunization programmes.

31. Significant progress has been made in improving the coverage of DPT3 to reach 77%, with 90% or more in seven countries. Considerable progress has been made in improving the coverage of measles immunization, especially in India and Indonesia. Some countries were expected to reach the measles elimination target of 95% soon.

32. There have been no new cases of wild poliovirus infection in India since January 2011. If AFP surveillance remains strong and there are no further new cases of wild poliovirus, the South-East Asia Region is expected to be declared polio-free in early 2014.

33. With regard to neglected tropical diseases (NTDs), all countries had achieved the leprosy elimination target with prevalence rate of less than one per 10 000 population. As the endemicity of leprosy still prevails, especially in remote areas, efforts to reduce the disease burden need to be maintained.

34. Lymphatic filariasis continued to affect populations of many countries of the South-East Asia Region. With the intensification of mass drug administration (MDA) in recent years, the Region is expected to reach the elimination target of reducing the microfilaria rate to less than 1% of the population at risk by 2020. In disease control, surveillance systems have been further strengthened and WHO’s technical support enhanced through training staff and developing standard surveillance procedures.

35. As no country in the South-East Asia Region had achieved all core capacities required for effective implementation of the International Health Regulations (IHR) 2005, WHO had redoubled its efforts during this period to strengthen and support Member States to ensure such capacities are in place by the extended deadline of June 2014.

36. All Member States have national plans in place for influenza pandemic preparedness and response, and WHO has been providing support in strengthening alert and response capacities for possible outbreaks of emerging infectious diseases.

37. Over the past two decades, overall tuberculosis prevalence in the Region reduced by almost 40%, though multidrug-resistant (MDR) TB remains a serious concern due to inadequate management of control programmes. More sophisticated laboratories and more expensive drugs are needed for the treatment of the 100 000 MDR-TB patients. TB coinfection with HIV remains another concern with 1.1 million such patients in the Region.
38. The Region has 3.5 million people living with HIV/AIDS and 220,000 new cases of HIV infection occurring each year. While there has been an overall decline in new HIV infections in all Member States — especially among female sex workers — high transmission continued to be recorded among injecting drug-users, men having sex with men (MSM) and transgenders. Antiretroviral treatment (ART) of advanced HIV infections had increased from 5% in 2003 to 34% in 2010. Member States have also been supported in efforts to prevent mother-to-child transmission of HIV. With two of every three pregnant women living with HIV not having access to ART, a large number of children are born with HIV.

39. Considerable progress has also been made in malaria control. Malaria in high-risk populations was reduced from 30 per 1,000 population in 2005 to 22 per 1,000 in 2010 largely due to insecticide-treated bednets, rapid diagnostic tests and artemisinin-based treatment.

40. Noncommunicable diseases (NCDs) now account for more than half of all annual deaths in the Region. A Ministry of Health-based NCD coordination mechanism has been established and seven Member States have developed a multisectoral strategy for NCD prevention and control. The Regional Meeting on Health and Development Challenges of Noncommunicable Diseases in Jakarta, Indonesia, in 2011 issued a comprehensive Call for Action.

41. All Member States are increasingly paying more attention to control of use of tobacco products through designating smoke-free areas, promoting cessation programmes, and promoting awareness. Several countries have also initiated actions to reduce harm from use of alcohol, drugs and other psychotropic substances.

42. Considerable achievements have been made with regard to Millennium Development Goals 4 and 5 on infant mortality and maternal mortality, with the United Nations Secretary-General honouring Nepal and Bangladesh in September 2010 with a special award for significantly reducing their maternal mortality rate (MMR) and under-five mortality rate, respectively.

43. Of the Member States where the MMR was greater than 100 in 1990, three had achieved the target of 75% reduction; and the Region is on track to reduce the under-five mortality rate by two thirds by 2015.

44. WHO is also assisting countries in training skilled birth attendants, preventing unplanned pregnancies and improving family planning services. Increasing life expectancy is the focus of attention with the emphasis on promoting “active and healthy ageing”, with Member States in the process of developing multisectoral strategies for promoting healthy ageing.

45. In addition to technical support from WHO, financial support was provided from the SEA Region Health Emergency Fund (SEARHEF) for immediate relief in a number of humanitarian emergencies in Member States. WHO is also collaborating with Member States to build capacity for effective preparedness and response, including safe health facilities during emergencies, and a framework to build up community resilience through the primary health care approach.

46. All Member States are in the process of reviewing their health strategies to improve universal health coverage as well as tackle health inequity, especially between the genders. Healthy environments were promoted through healthy workplaces.

47. The Regional Director observed that though the Region had achieved 90% coverage of safe drinking water, much remains to be done in the area of sanitation, where the coverage is only 44%.
48. Undernutrition and micronutrient deficiencies, diet-related diseases and infant and child nutrition demand continued attention. A framework for promoting safe street food was developed at a regional consultation in 2011 and the Region showed increased participation in Codex Alimentarius and the International Food Safety Authorities Network (INFOSAN).

49. WHO’s support with partners in strengthening country capacities with national health systems has resulted in increasing the availability and accessibility of quality and essential medicines.

50. The Regional Director lauded the significant progress made by Member States in improving their health infrastructures and health systems performance. He also reiterated that WHO is committed to collaborating with Member States in developing and implementing their programmes to overcome the evolving health challenges. WHO in the South-East Asia Region remained fully committed to taking ahead the initiatives of the Reform Agenda of the Director-General, Dr Margaret Chan (For full text of the Regional Director’s Introductory Remarks see Annex).

Address by the Director-General of the World Health Organization (Agenda item 2.2)

51. The Director-General of the World Health Organization, Dr Margaret Chan, began her address by congratulating India for “providing definitive proof that polio eradication is technically feasible”. She stated that India’s success had proved that the poliovirus was not permanently entrenched, it was not destined to remain a perpetual threat to each new generation of children. It could, indeed, be driven out of existence. "The Indian government succeeded because of its passionate engagement in a mission to protect its people from a vicious disease,” Dr Chan said.

52. The most critical factor for success is ownership of the programme, from the local to the national level. The Government of India owned this programme, operating as the principal source of staff and funds. The other lessons learnt included the importance of tight-knit partnerships, constant innovation, and a relentless drive to improve quality and accountability.

53. Public health faces some heavy challenges. In that sense, any long-standing problem that can be resolved and solved, once and for all, will free much-needed capacity and resources.

54. The Director-General also congratulated the Region on the Draft Strategy for Universal Health Coverage.

55. The SEA Region has millions of low-income households living on the margins of survival. Just paying for medicines can push them deeper into the abyss of abject poverty. As is well known, the costs of care can cause patients to delay seeking treatment until the disease or condition has become much more difficult and costly to treat, if treatment is still possible and available. This is an extreme example of waste and inefficiency.

56. Universal coverage upholds the core values of solidarity, social cohesion and human security. Above all, universal coverage is a powerful social equalizer that helps correct gaps in health outcomes that have been growing, almost unchecked, for decades. But market forces will never solve social problems all by themselves. This happens only when equity is an explicit policy objective, as set out in the draft strategy.

57. Universal coverage stresses equity in entitlement to services and gives a prominent role to compulsory or public funding to ensure social protection. Based on their disease profile and epidemiology, countries must take leadership and ownership to decide what is important.
58. The target date for reaching the Millennium Development Goals (MDGs) is fast approaching. The debates about the next generation of internationally-agreed development goals are already under way. As with the MDGs, international goals shape the political agenda and attract resources.

59. Dr Chan added that health was a precondition for development. It was a powerful driver of socioeconomic progress. The process for sustainable development goals had started. She exhorted the countries to ensure that their inputs were accommodated in the goals, in order to ensure that their health priorities were appropriately reflected.

60. The Millennium Development Goals have been a powerful force in focusing implementation efforts and maintaining political support for development. They have been good for public health. Pursuit of the MDGs has left a legacy of innovations, including the GAVI Alliance, the Global Fund, UNITAID, the International Health Partnership Plus, and numerous other global health initiatives focused on individual diseases. The need for accountability is just one of the many lessons that are part of the MDG legacy.

61. Most donors now appreciate the need to channel aid for health development in ways that build capacities in countries and move countries towards self-reliance. This is the best exit strategy for aid. Developing countries do not want charity, they want capacity. Given the success of the MDGs, most agree that the post-2015 agenda should likewise focus on a limited number of measurable goals.

62. Some of today’s threats include a changing climate, more emergencies at the global level, disasters, soaring health care costs, soaring food prices, demographic ageing, rapid and unplanned urbanization and the globalization of unhealthy lifestyles. “In my view, one of the best ways to respond to these challenges is to make universal health coverage a part of the post-2015 development agenda,” Dr Chan emphasized.

63. In her closing remarks, the Director-General said, “Let me mention one case: Australia’s High Court upheld legislation mandating plain packaging, with no branding, for tobacco products. The legislation had been aggressively challenged by several large tobacco companies. The court ruling was not only a huge victory for the Australian government, but also for public health, opening a brave new world for tobacco control. As Australia’s Attorney-General Nicola Roxon said, ‘The message to the rest of the world is that big tobacco can be taken on and beaten.’ I think we can all take heart from a game-changing story, where the good guys win,” Dr Chan concluded.

64. Commending the Regional Director for his comprehensive report, the Committee noted that the report provided a comprehensive and excellent update on some of the notable and remarkable achievements made by the Member States of the Region, especially the momentous success achieved by India in polio eradication. The Committee also congratulated the Director-General for her thought-provoking and inspiring address. Success achieved in areas of core capacity building for IHR 2005, early and rapid treatment of malaria, child and maternal mortality, disease preparedness, and drinking water and sanitation, etc. was noted by the Committee. It also acknowledged the challenges and hindrances faced by countries in areas such as vaccine production, climate and health interface, short absorptive capacity for utilization of aid from the Global Fund to Fight AIDS, Tuberculosis and Malaria, nutritional deficiency, lack of access to quality drugs, absence of a mechanism for bulk purchase of essential drugs and medicines for countries with small populations such as Bhutan, Maldives and Timor-Leste, and inefficient birth and death registration systems leading to weak and unreliable health information systems.
65. India’s polio eradication efforts received special mention from all Member States. It was attributed as a notable achievement for the whole Region. At the same time, countries of the South-East Asia Region emphasized the need to not be self-complacent in order to sustain the progress recorded by the Region in many areas of health.

66. While commending the efforts of WHO to bring the issue of universal health coverage (UHC) to the forefront and to highlight its importance in the context of the current global economic downturn, the Committee underscored the fact that UHC could well be achieved even in low-income settings. What is important is to remember that UHC does not only imply “health” per se but also “poverty reduction”. Thus, it is essential for all countries, irrespective of their economic status, to optimally use their resources, especially financial and human, for it is possible to achieve “good health at low cost”. Therefore, a concerted effort from not only the ministry of health of the Member States but all other ministries, especially the ministries of foreign affairs, would be needed for UHC to be a sustainable success. In this context, the Committee was apprised of the notable success achieved by countries such as Sri Lanka, India (in Kerala state) and Thailand in implementation of UHC.

67. The Committee acknowledged WHO’s commitment for continued support to all Member States in the Region for UHC. It also noted that the Regional Office accorded considerable importance to the issue of bulk purchase of essential drugs and medicines for Bhutan, Maldives and Timor-Leste and that it was making all-out efforts to explore the possibility of creating a suitable mechanism to address this particular issue.

68. It is important to look at UHC not only as a “financial investment” but also as a health tool that impacts on the design and capacity of good health systems and in the formulation of a good health policy. Thus, while designing a good health system, it is important to ensure a proper balance between the preventive and curative aspects of health care, aspects that are adequately addressed by WHO’s Regional Strategy for UHC. The Committee also noted the need for WHO to utilize the WHO collaborating centres more productively; to review/update the information, education and communication (IEC) materials in order to adapt them to contemporary realities; and to develop sound and reliable health information systems, especially through updated health statistics.

Programme of Reform for WHO
(Agenda item 3)

WHO reform
(Agenda Item 3.1: Document number SEA/RC6513 Rev. 1 and Inf. Doc.)

69. The Committee was informed that although WHO Reform initially focused on financing and better aligning the Organization’s objectives and resources, it had since evolved into a Member States-driven process to address more fundamental questions about WHO’s priorities, its governance and management, so that the Organization can be more effective, efficient and accountable.

70. A consolidated paper on WHO Reform was submitted to the Sixty-fifth World Health Assembly for discussion in May 2012, which the Committee noted with appreciation.

71. Under each of the three main areas of reform, namely, programme and priority setting (wherein were contained the six categories for Programme Budget (PB) 2014—2015 and the 12th Global Programme of Work), governance, and managerial reforms, the paper summarized progress of implementation and identified in each of the main sections where further guidance or decisions by the World Health Assembly were needed.
72. The Committee urged the Secretariat to develop a strategy to assure funding for categories 2 and 3, i.e. noncommunicable diseases and promoting health throughout the life-course. The Deputy Regional Director, Dr Poonam Khetrapal Singh, informed the Committee that the Director-General has set up a task force on financing of WHO programmes. This task force, with representation from all the six regions, would look into the issue of adequate resource allocation for all categories. The Committee noted that polio had been placed in Category 5 and questioned whether it would not be better placed under Category 1. Similarly it was questioned whether nutrition would not be better located under Category 3.

73. On the issue of managerial reform for organizational effectiveness, the Director-General stressed that reforms did not only concern the Secretariat but also involved changes in Member States. In some cases, the capacity of Member States to adhere to their commitments needs to be strengthened for the success of the Reform process. Other reforms required changes to staff rules. This issue would be taken up at the next session of the Executive Board.

74. In this connection, the Committee urged the Secretariat to support Member States in strengthening their human resources for health in order to address effectively managerial reforms. The Committee also requested WHO to help build and deploy communications capacity in country offices through improved coordination across the Organization, emphasizing efficiencies in the way communication functions are delivered. It was observed that there was need for more technical expertise to be made available in country offices in the form of additional staff. The Committee urged that the Reform process give priority to the critical health workforce shortage in countries.

75. The Committee underscored the importance of increasing delegation of authority to WHO country offices for better project management and effective implementation of Reform. The Regional Director informed that the South-East Asia Region has the highest degree of delegation of authority among the regions. He observed that this delegation of authority has been accompanied by strong accountability and internal oversight measures including review mechanisms in countries.

76. The Committee recalled that at the Sixty-fifth World Health Assembly Member States had urged for better working relationships with non-health partners and stakeholders. While observing that social determinants of health will be mainstreamed into all programmes in the next biennium as per recommendations of Member States, proposals for transparency, predictability and feasibility of WHO finances would be accorded the highest priority.

77. The Director-General said the speed of their implementation is constrained by inadequate resource mobilization. She underscored the need for more balance in the Budget with 40% of current contributions coming from non-State actors.

78. Since the Organization is currently facing financial constraints, in order to implement reforms in a timely manner the Director-General urged Member countries to make a strong political statement in favour of WHO Reform by making an increase, even if small, in their assessed contributions (ACs).

79. While lauding the commitment of WHO in moving ahead with Reform, the Committee expressed its desire that the Reforms result in tangible improvements. The importance that all key decisions be consulted with Regional Committees was also stressed.

Programme Budget Matters
(Agenda item 4)
Programme Budget Performance Assessment: 2010-2011
80. The Committee was informed that the Organization-wide report on the 2010-2011 Programme Budget Performance Assessment (PBPA) (SEA/RC6514 Inf. Doc. 1) was submitted to the Sixty-fifth World Health Assembly in May 2012 after being initially reviewed at the Sixteenth Meeting of the Programme Budget and Administration Committee (PBAC) of the Executive Board. The PBAC, in its report to the World Health Assembly (SENR65/4 Inf. Doc. 2 — Document A65144) welcomed the 2010—2011 PBPA report and recognized the important results achieved by WHO in priority areas, in particular those related to the health-related Millennium Development Goals, noncommunicable diseases and immunization. At the same time, the PBAC raised some concerns, especially in relation to the methodology of the assessment, querying whether the means of judging performance had not been too self-critical. The PBAC also raised concerns about variation in funding across regions and across Strategic Objectives.

81. The Committee's attention was drawn to document SENR65/4 that provided a summary of the findings of the 2010—2011 PBPA exercise as conducted in WHO South-East Asia Region. The summary document included an overview of key achievements recorded during the biennium, WHO’s contributions to these achievements, an assessment of the degree of achievement of expected results in the SEA Region, and an overview of financial implementation for each of the 13 Strategic Objectives (SOs) that comprise the 2010—2011 Programme Budget.

82. The Fifth Meeting of the Subcommittee on Policy and Programme Development and Management (SPPDM), on 6 July 2012, had reviewed the working paper and recommended that WHO-SEARO should validate the statistics presented therein concerning malaria rapid diagnostics tests and the availability of long-lasting and insecticide treated mosquito nets (LLINs/ITNs); revise the paper before presenting it to the Sixty-fifth Session of the Regional Committee, by clarifying that the figures showing unutilized voluntary contribution (VC) funds, included VC funds to be carried forward to future bienniums; and add an annexure to the paper showing the breakdown of SO13 budget implementation by country. This had been complied with—the statistics had been validated and the papers revised.

83. The Committee commended the Programme Budget Assessment Report, which it noted was excellent and in alignment with the SPPDM meeting recommendations. Countries felt that the Assessment Report was a vital tool for national health planning. The results of the assessment will provide lessons learnt, which can be used as inputs for future programme planning and budgeting. WHO’s resources are expected to optimize collaboration between WHO and the ministries of health. Therefore there needs to be synergy, harmonization and better coordination between Member States' budget funding and WHO’s Programme Budget support in order to fill the gaps and avoid duplication of activities. Such an approach will help achieve the desired outputs and outcomes of health sector development. Countries expect WHO’s activities to support the priority programmes of ministries of health of countries in the Region, and for WHO to support strategic rather than logistical activities.

84. It was noted that out of the total of 1235 OSERs for the 2010-2011 biennium, 1138 (93%) were systematically assessed as part of the PBPA exercise. Out of the total 1138 OSERs assessed, 886 were deemed to be “fully achieved” and 53 were “not achieved”. This was a small number compared to the total.

85. Member States expressed the need for regular sharing of information on the financial situation of WHO, as well as on monitoring of results.
86. The Committee was assured that quality aspect of programme implementation will continue to be given its due importance.

87. The Director-General stressed the need for WHO and all Member States to "change the way we do business" by living within the means available in view of the serious financial and economic constraints being faced by the Organization as well as by countries in the present scenario of economic downturn and pledged to improve WHO's assessment process.

88. The Committee noted the Programme Budget Performance Assessment (2010-2011) Report as well as the revised working paper, and endorsed the recommendations made on this Agenda item by the 15th SPPDM.

Implementation of Programme Budget 2012—2013
(Agenda item 4.2: Document number SEA/RC65/5)

89. The Committee was informed that the approved Programme Budget for the South-East Asia Region for 2012—2013 was US$ 384.2 million, which was made up of US$ 102.3 million assessed contributions (AC) and US$ 281.9 million voluntary contributions (VC) to be mobilized. As of May 2012, the operational budget as per approved workplans stood at US$ 375.4 million. This was supported by AC resources of US$ 99.2 million and VC resources of US$ 156.8 million (including carry-overs from 2010—2011). The overall implementation rate against budget was 19.4% in the first five months of the biennium. By extrapolation, this would give a performance level of 93% for the biennium, indicating that extra efforts are required to speed up the current pace of implementation.

90. The Committee also took note of the uneven distribution of resources across countries as well as across technical areas, i.e. Strategic Objectives (SOs) as pointed out by India. While countries such as Bhutan, India, Indonesia, Nepal and Thailand had received resources up to more than 55% of the budgeted amounts, DPR Korea, Maldives and Sri Lanka had less than 30% of their budgets financed at the end of May 2012. Similarly a review of technical areas had revealed that SQ1 and 504 were comfortably placed with resources to budget ceiling proportions of 121% and 74%, respectively. At the same time S05, S08 and S09 were struggling with levels of resources lower than 30% of the budgeted figures.

91. The Committee noted with concern that in some areas budget ceilings were insufficient to accommodate voluntary contributions flowing into the countries. It was clarified that to overcome this issue during the course of biennium, budget analysis was undertaken three times during each biennium. The objective of these analyses is to enable budget ceilings to be enhanced in areas of high implementation where new VCs are being mobilized. The Region has a small amount of flexible voluntary contributions (CVC funds) which are allocated to priority areas which have not been successful in raising sufficient voluntary funds to finance important priorities.

92. It was reiterated that countries, donors, and the Regional Office as well as headquarters must work closely together to ensure better alignment of resources with the priorities agreed to by the World Health Assembly and as specified in the Programme Budget.

93. The Committee noted the revised working paper including tables on AC implementation and the SPPDM recommendations submitted for its consideration.

94. The Committee noted the request of the4member States for additional information on the technical and quality aspects of implementation. In this regard, the Committee noted that the Programme Budget Performance Assessment process was undertaken to evaluate the quality of implementation of the
WHO collaborative programme. A request was also made to provide updated financial utilization data as of 31 August as an additional annex to the working paper. In response to a request for provision of six-monthly implementation data to facilitate programme managers to monitor programme implementation, the Committee was informed that monthly and quarterly data on implementation was already being shared with WHO Representatives in countries. The Committee noted that WHO will provide more details on the implementation of activities.

95. The Committee also noted with concern the increasing proportion of voluntary contributions in the WHO Budget which could result in skewing WHO priorities, potentially leading to WHO programme delivery becoming increasingly donor driven. This could adversely affect capacity development of countries. The Committee was informed that this problem is being addressed through the results-based 12th General Programme of Work and the Programme Budget 2014—2015 development process, which are currently ongoing.

12th General Programme of Work (GPW) and Proposed Programme Budget 2014-2015 (Agenda Item 4.3: Document number SEA/RC65/6 Rev. 1 and Inf.Docs. 1 and 2

96. The Committee noted that the 12th General Programme of Work (GPW) 2014—2019 and Programme Budget 2014—2015 are an essential means of taking forward the WHO Reform process. Some of the key objectives of the 12th GPW and the Programme Budget 2014-2015 are systematic and transparent priority setting; simplified results chain with clear outputs; realistic budget based on reliable projections of income and expenditure; and increased accountability of outcomes achieved against agreed outputs. The 12th GPW provides the vision and mission for WHO. It is a framework for priority-setting and accountability. It is based on a six-year vision for WHO that takes into account new political, economic, social and environmental realities; a changing agenda for global health and the institutional landscape for global health.

97. It was further noted that the Programme Budget 2014—2015 is the key instrument for strengthening financing, resource mobilization and strategic communication. It is also the basis for detailed operational planning that will be initiated in late 2013. As such, it is the primary instrument for expressing the full scope of work of the Organization along with the roles and responsibilities at all levels of the Organization (country offices, regional offices and headquarters).

98. The Committee was apprised of the background developments especially the recent global financial crisis that had brought the issue of results-based budgeting into sharper focus, spurring the Organization to change the way “we do business” by setting realistic and measurable outputs and sound performance indicators. This new approach of budget development implies that both Member States and WHO need to work together.

99. The Committee appreciated the need for country-specific and cost-effective innovative financing and cooperation focusing on technical, rather than financial assistance, from WHO in order for countries to do more with less money. This would involve WHO resources being used strategically. It was also emphasized that the Regional Office should continue to critically review, and analyse objectively all resolutions, declarations and recommendations in the context of the regional situation. It is also important for the Organization to select the right kind of performance indicators so that a proper assessment could be made of countries’ achievements/deficiencies in programme implementation. It was suggested that priorities identified under the six categories be further sub-prioritized and fine-
tuned before presenting the Programme Budget document to the Executive Board Session to be held in
January 2013.

100. The Committee appreciated the new categories identified under the 12th GPW and the results
chain focusing on the Secretariat’s outputs. Concern was expressed regarding voluntary contributions by
donors often forcing WHO to divert its core attention from country health priorities to donor priorities.
The importance of alignment of the Budget with national health challenges, global health priorities,
global and regional resolutions, regional declarations and decisions taken at its high-level meetings was
stressed.

101. The Committee emphasized the need for all Member States to have a sense of ownership of the
12th GPW and PB 2014—2015. This requires that WHO adequately consults and engages Member States
in the GPW and Programme Budget development process.

102. The need for WHO to review all global norms and standards in the field of public health and to
make the updated information on these norms and standards easily available to all Member States
through easily navigable and user-friendly web-based applications was stressed.

103. The Committee stressed the importance that Member States of the Region be adequately
consulted in budget allocation matters. Implications of country priorities vis-à-vis regional priorities in
respect of allocation of budgets to individual countries should also be articulated. This would help in
delineating common but differentiated priorities. Country priorities as identified by WHO through the
review of country cooperation strategies (CCS) should be complemented by the consideration of
national priorities identified by the respective governments.

104. The Committee acknowledged the need for Member States to leverage WHO’s expertise in resource
mobilization at country level. Ministries of health in countries also need to work in close collaboration
with other partners engaged in the area of health in countries through intersectoral/multisectoral
mechanisms.

105. The Director-General emphasized that the WHO country offices should facilitate dialogue with all
partners—governments, United Nations, international government organizations; nongovernmental
organizations, and the private sector—in support of the country programme. She noted, however, that
both Member States and WHO need to have the courage to say “no” to money that does not support
their programme of work.

106. The Committee’s attention was drawn to the working paper that discussed the sequence of
events that took place in developing the 12th GPW and the Proposed Programme Budget for the
2014—2015 biennium. The Committee noted the working paper and endorsed the SPPDM’s
recommendations on this agenda item.
Technical Matters
(Agenda item 5)
Consideration of the recommendations arising out of the Technical Discussions on “Non-communicable diseases, including mental health and neurological disorders”
(Agenda item 5.1: Document number SEA/RC65/7 and ml. Doc.)

107. The Committee was informed that the Regional Director had convened a regional meeting to hold technical discussions on "noncommunicable diseases (NCDs) including mental health and neurological disorders" from 24 to 26 April 2012 in Yangon, Myanmar, as per the decision of its Sixty-fourth session in September 2011. The Committee noted the recommendations of the Yangon meeting to strengthen multisectoral actions to tackle NCDs, develop a monitoring framework and voluntary global targets to prevent and control NCDs, reduce harm from alcohol and promote mental health and well-being.

108. The Committee noted with concern that while communicable diseases were still highly prevalent in the Region, the rising trend in noncommunicable diseases due to changing lifestyle patterns was posing a double disease burden in countries of the SEA Region.

109. Noncommunicable diseases were the top killers in the Region accounting for more than half of all deaths. The four most common NCDs — cardiovascular diseases, cancers, chronic respiratory diseases and diabetes — cause 80% all deaths in the Region. The problem of NCDs is compounded by ageing populations, globalization, unplanned urbanization and other social determinants leading to unhealthy lifestyles characterized by tobacco use, unhealthy diet, harmful use of alcohol and physical inactivity. In addition to the four major NCDs, thalassaemia is a major public health problem in some countries which requires effective prevention and care interventions. In the SEA Region, a significant number of premature deaths among the young population was caused by NCDs, linked to social determinants of health. Such premature deaths also have a catastrophic economic impact on poorer sections of the population.

110. Further, the prevailing weak health systems, limited human resources, inadequate health information systems and NCD mortality data in the countries of the Region were major impediments to tackling the challenge of NCDs.

111. The Committee noted that lifestyles in countries were greatly influenced by cross-border marketing of unhealthy food, beverages and tobacco use, particularly among children and adolescents; this calls for greater intercountry collaboration for its regulation.

112. The Committee noted that “what gets measured gets done”. Accepting the “4 x 4 model” (4 risks and 4 diseases), it observed there should be at least one target for each of the four risk factors and four diseases. Adding one target on mortality and one on health systems would result in a total of 10 targets, which was felt to be reasonable, given the huge magnitude of the problem of NCDs. Support was expressed for additional targets on reducing harm from alcohol, obesity, diabetes and cholesterol. As tobacco is a major problem in several Member States of the Region, it was suggested that the proposed target on “tobacco smoking” be replaced by “tobacco use” to cover all forms of tobacco usage.

113. The Committee acknowledged that high-level political commitment and multisectoral actions from multiple stakeholders beyond the health sector were needed to tackle NCDs. It called for a “Health in all
Policies” approach to address NCDs. An integrated approach should be used to tackle NCDs, rather than a separate approach for each condition.

114. Concerns were expressed with regard to achieving global targets proposed in the monitoring and evaluation framework to prevent and control NCDs as well as on the lack of availability of baseline data to measure some targets. The Committee was informed that the proposed targets were voluntary in nature and countries were encouraged to set their own targets based on national situations.

115. It was emphasized that there should be consistency between global and regional mental health action plans under development.

116. The Committee urged Member countries to strengthen capacity for surveillance, including measurement of baseline data to monitor and evaluate NCDs. Further, it requested Member counties to participate actively in the ongoing global consultation process, including WHO Governing Bodies and other forums, to advocate for inclusion of NCDs in the post-2015 UN development agenda.

117. The Committee also requested WHO to: disseminate normative guidelines and best practices including achievements in the Member countries for prevention and control of NCDs; build capacity of Member countries for strengthening health systems and developing national multisectoral policies and plans; and provide technical assistance to Member States in developing a national monitoring framework, including targets for prevention and control of NCDs.

118. The Committee observed that all Member States agreed with the emerging importance of mental health and neurological disorders. Member States agreed with the concept of including “mental health and neurological disorders” as being distinct from the overall spectrum of NCDs as these were rapidly emerging as important causes of morbidity and mortality. It was suggested that, although at this time mental health and neurological disorders were part of the NCD resolution, in future, mental and neurological disorders should be considered separately because of their distinct epidemiology and magnitude.

119. The current scenario of mental and neurological disorders manifests with a huge treatment gap associated with social stigma. This has been documented in pilot studies in the Region. Also, the cost of care for these conditions is already high and rapidly increasing.

120. The Committee proposed that autism be given specific attention in documents dealing with mental and neurological disorders. Member States generally agreed that autism spectrum disorders were an important cause of morbidity among children and cause substantial social stigma to the affected child and the family. They were also of the opinion that autism should not be singled out in a resolution addressing mental health and neurological disorders. The proposed resolution on NCDs including mental health and neurological disorders, is based on the discussion held at the Yangon meeting which autism was not discussed. Therefore it was finally decided that a separate resolution would be developed for autism spectrum disorders for consideration by the Regional Committee.

Selection of a subject for the Technical Discussions to be held prior to the Sixty-sixth session of the Regional Committee
(Agenda item 5.2: Document number SEA/RC65/8)

121. The Committee endorsed the recommendation of the HLP meeting and decided to hold the technical discussions on the subject of “Universal Health Coverage” prior to its Sixty-sixth session in 2013.

Role of WHO in managing emergencies
122. The Committee noted that this Agenda item had been discussed at the HIP meeting in two parts. The first part related to World Health Assembly resolution WHA65.20 on WHO’s response and role as the health cluster lead in meeting the growing demands of health in humanitarian emergencies, while the second part dealt with the utilization of the South-East Asia Regional Health Emergency Fund (SEARHEF) as a follow-up to the Regional Committee resolution (SENRC6OIR7) adopted at its Sixtieth session.

123. The new World Health Assembly resolution on emergencies confirms the commitments of Member States to: (i) strengthen and integrate risk management capacities into the health sector; (ii) build capacities in this area of work across various phases of risk reduction, preparedness, response and recovery; and (iii) coordinate with other sectors. It also describes WHO’s work as the health cluster lead and its commitments for better response through a new emergency response framework.

124. The Committee was informed that the SEARHEF was established through Regional Committee resolution SEA/RC6O/R7. As per the Fund’s policies and guidelines, a working group was established to oversee the management of the Fund. The working group comprised representatives nominated by all 11 Member States of the South-East Asia Region. The Fund’s resources had been successfully managed and utilized in respect of 13 emergencies since it was made operational in January 2008. These included emergencies that were either small in magnitude or chronic or insidious at onset. The Committee noted the recommendations made by the HLP meeting on this Agenda item.

125. The Committee noted with concern that the Region is vulnerable to disasters and appreciated WHO for its support to preparedness and prompt response to disasters and emergencies in the Region. It was stressed, however, that there was a continued need to build national capacities in collaboration with WHO.

126. The Committee also recognized the role of WHO as health cluster lead in humanitarian response mechanisms. It also acknowledged the Emergency Response Framework as the overarching guide for emergency response for WHO.

127. The Committee noted with appreciation the progress made by Member States in improving capacities in disaster risk management in the health sector, highlighting new initiatives, increased focus in community resilience, the need for fostering partnerships and activities leading to better emergency risk management systems.

128. The following needs were mentioned as important to improve emergency risk management capacities in countries: comprehensive health systems strengthening for emergency risk management; human resource development; mobilizing resources according to country needs; strengthening capacities for mitigation/risk reduction; risk communication and early warning systems; especially for hard-to-reach areas; and efficient logistic systems.

129. It was noted that the Centre for Health Crisis in the Ministry of Health of the Government of Indonesia, had been recently designated as a WHO Collaborating Centre for Disaster Risk Reduction.

130. Delegates recognized the usefulness of a comprehensive capacity assessment through the SEAR Benchmarks, which has been completed in some countries and is ongoing in some, to identify priorities and gaps.

131. The Committee acknowledged the efficient support provided by SEARHEF in many emergencies that occurred in countries of the Region in the past few years. It was appreciated that the financial
support from SEARHEF was released within 24 hours upon request. Flexibility, transparency and quick response have remained and should continue to be the guiding principles for the Fund.

132. Representatives of Member States emphasized the need to continue to contribute to, mobilize resources for, and advocate for more support to the Fund.

133. The Committee noted the conclusions reached at the SEARHEF Working Group meeting held in WHO-SEARO, New Delhi from 23 to 24 August 2012. In summary, the SEARI-IEF Working Group:
- affirmed the oversight role of the SEARHEF Working Group;
- affirmed that the Fund should continue to focus on support for emergency response; and
- provided various suggestions for additional resource mobilization, replenishment mechanisms and advocacy to partners for additional support.

134. The Committee endorsed the recommendations made by the HIP meeting on this Agenda item.

Statements by representatives of nongovernmental organizations and international nongovernmental organizations

135. Dr Jacob Roy Kuriakose, Chairman of Alzheimer Disease International (ADI), stated that his organization is the global umbrella organization of Alzheimer disease associations worldwide. He said that an estimated 38 million people are living with dementia worldwide, which is roughly the same number as those living with HIV/AIDS. Dementia, including Alzheimer disease, creates memory loss, confusion, disorientation to time and place, and which, when it progresses, leaves those affected unable to work or care for themselves. Left unsolved, this number is estimated to grow to 65 million by 2010.

136. The UN high-level political declaration emerging from the meeting on noncommunicable diseases held last year, called for recognition of Alzheimer disease and dementia as a major NCD. However, for some reason, dementia has not yet been included in the global monitoring framework for NCDs that WHO is drafting. Dr Kuriakose conveyed his organization’s support for the draft monitoring framework, especially because of the growing consensus that dementia shares most of the risk factors of other NCDs.

137. The WHO NCD plan should adopt a multisectoral approach to rapidly identify evidence-informed dementia surveillance tools that could be integrated into country-level surveillance systems. Dr Kuriakose promised ADI’s support to WHO in this effort.

138. Dr Pustika Amalia Wahidiyat, speaking on behalf of the Thalassaemia International Federation (TIF) said that her organization is a non-profit organization dedicated to improving the quality of life and life expectancy of patients with inherited haemoglobin disorders that fall within the scope of noncommunicable diseases. The Federation comprises 108 member associations from 55 countries, cooperating in official relations with WHO since 1996. The global burden of haemoglobin disorders including thalassaemia and sickle-cell disease continues to increase. The current epidemiological data are a gross underestimation of the magnitude of the problem, taking into account the increasing migration of populations worldwide.

139. Dr Wahidiyat commended WHO for adopting resolutions on sickle-cell anaemia (WHA59.R20) and thalassaemia (EB1 18.R1), which requested Member States to develop and implement comprehensive national programmes for the prevention and management of these diseases. She stated that TIE had taken steps to raise awareness across the South-East Asia Region for haemoglobin disorders by organizing national workshops and conferences in various countries.
140. TIE, with its motto “Equal access for quality health care for all patients with thalassaemia” actively advocates for universal health care coverage for these patients, whose treatment regimes put an unbearable burden on their families, Dr Wahidiyat concluded.

141. Dr Vinod S. Saxena of the International Bureau for Epilepsy stated that epilepsy is one of the world's most common chronic neurological disorders with approximately 50 million people diagnosed worldwide. With a population of 1.8 billion in the Region, there are about 9—18 million people affected with epilepsy, with about 0.5—1 million new cases occurring each year. Furthermore, the stigma attached to people with epilepsy is a barrier to the exercise of their human rights and social integration. Scientific advances have improved the understanding and management of epilepsy and up to 70% of people with epilepsy can be seizure-free with appropriate treatment. In addition, 40% of children with epilepsy face difficulties at school. Epilepsy also disrupts every aspect of life and can impose physical, psychological and social burdens on individuals and families.

142. Dr Saxena called for WHO to prepare a strategic plan, as part of an integrated response to develop lifelong programmes for people with epilepsy, which will include prevention, treatment and rehabilitation.

143. Some of the key areas that such a plan could address, for persons with epilepsy, would be: prioritizing epilepsy as a major disease that imposes a significant burden and reducing existing treatment gaps; ensuring equal quality of life in education, employment, transport and public healthcare; encouraging research and innovation in the area of prevention and early diagnosis and treatment; strengthening legal frameworks to protect the human rights; strengthening human resources to improve national epilepsy programmes and training; and combating stigma and discrimination.

144. Mr Andi Putra Kevinsyah from the International Federation of Medical Students' Associations (IFMSA) stated that the WHO South-East Asia Region is prone to many emergencies and disasters, because of its geography and socioeconomic conditions. The World Disasters Report 2010 had even stated that the populations of the countries of the SEA Region continued to account for the most number of deaths due to disasters. Scientific evidence also suggests that increase in global warming may raise the incidence of natural disasters.

145. Mr Kevinsyah stated that the IFMSA was committed to assist the health sector in reducing the ill-effects of emergencies and disasters. The federation is a unique network of 107 medical students' associations from 100 countries, representing over 1.3 million medical students worldwide and has the capability to spread knowledge, and also mobilize medical students in every stage of disaster management — risk reduction, preparedness, response and rehabilitation.

146. Mr Kevinsyah expressed his Association’s desire to involve medical students in emergencies and disasters. Medical students can be mobilized to engage in community-based initiatives that raise awareness, and enhance the capacity of communities for disaster preparedness and emergency management. They can also be mobilized as medical volunteers, especially to provide psychosocial support and to engage in fund-raising activities, and community rehabilitation, he said. “Medical
students are ready to work with WHO and its Member States towards a healthier and safer South-East Asia Region,” Mr Kevinsyah concluded.

149. Mr Manindra Chaudhuri of the International Federation of Biomedical Laboratory Scientists (IFBLS) stated that many issues highlighted in the World Health Report 2006, titled "Working Together for Health", are relevant even today. The education and development of health-care professionals and health systems in general, and the global employment opportunities for health professionals continue to be discussed. However, information on the biomedical science profession and specifically, biomedical laboratory scientists, is found to be lacking in such reports. As a result, the ageing of the biomedical science workforce along with reduced government budgets to support health services, education and training, continue to impact the biomedical laboratory profession.

150. IFBLS is dedicated to the global promotion of the biomedical laboratory science profession. Globally, IFBLS’s focus is on the absolute numbers of biomedical laboratory scientists in every country. WHO compiles data on health workforce populations from several sources; including population censuses, labour and employment-based surveys, health facility assessments, and administrative information systems, however, data summarizing the total numbers of biomedical laboratory scientists are often missing or, at best, incomplete. Mr Chaudhuri expressed the wish of IFBLS to partner with WHO in the promotion of quality patient care through the efforts of biomedical laboratory scientists and the biomedical laboratory science profession.

Health workforce training and education (Agenda item 5.4: Document number SEA!RC65/22)

151. The Committee noted that countries are confronted with numerous health challenges, such as those related to health systems, sociodemographic changes, changing disease patterns and changing vulnerabilities and risks. These challenges require a multidisciplinary approach and multisectoral collaboration, which have an impact on the work of health-care providers and thus on how they are educated and trained. It is a common observation that health workforce (HWF) education and training has not been well adapted to address these challenges.

152. The Committee was informed that The World Health Report 2006 had revealed that 6 out of 11 countries of the South-East Asia (SEA) Region faced a human resources for health (HRH) crisis, with fewer than 23 health workers (doctors, nurses and midwives) per 10 000 population. However, the Member States of the SEA Region are committed to achieving effective and well-motivated health workforces as witnessed in the 2006 Dhaka Declaration on Strengthening Health Workforce in the Countries of South-East Asia Region and the Regional Committee resolution on Strengthening the Health Workforce in South-East Asia adopted at its Fifty-ninth Session.

153. The challenges associated with a rational distribution of the workforce within a country and its integration into community health clinics need to be addressed. Migration of health workforces exists in most countries. The Committee expressed concern for the fact that funding support for HRH development was not sufficient to bring about the desired improvement in most countries. The Committee strongly supported the recommendation of the HLP Meeting that, with regard to the changing patterns of the health workforce in the Region, there was a need for WHO and Member States to work together to achieve the objective of developing a committed and effective health workforce.
Concern was also expressed on the existence of a critical shortage of health workforce, especially in rural and remote areas. The numerous health challenges exacerbated the situation. Hence, greater collaboration and networking among countries was called for. There is also a need to strengthen inter-professional education and community-based health workforce training and education with a focus on both health promotion and disease prevention. Further, an effective community-based health workforce is one of the ways to ensure that essential health interventions reach even “unreached” populations in order to achieve universal health coverage.

There is thus a need to renew the commitment and investment to strengthening HWF training and education; and to have clear national health policies, strategies and plans on the focus of health systems, and on HWF requirements and education. Countries also need to find new and better ways to educate their health-care providers to meet the needs of health systems and communities. The importance of strengthening institutional capacity building was also highlighted.

The Committee noted that the Regional Office had produced many guidelines on the Subject of health workforce. It urged WHO to now strive for a greater focus on implementation.

The Committee noted the revised working paper and endorsed the recommendations made by the HLP Meeting on this Agenda item, incorporating them in a Regional Committee resolution.

Reports of WHO global working/advisory groups:

(Agenda item 5.5)
Substandard/spurious/falsely-labelled/falsified counterfeit medical products and strengthening drug regulatory authorities

(Agenda item 5.5.1: Document number SEA/RC65/10)

The Committee was informed that the issue of substandard/spurious/falsely-labelled/falsified/counterfeit medical products (SSFFC) had been discussed at the World Health Assembly since 2010 following the seizure in 2008 of a consignment of generic medicines in transit through the Netherlands for infringement of intellectual property. Since then the lack of a uniform definition of "counterfeit" medical products and the International Medical Products Anti-Counterfeiting Task Force (IMPACT) set up in 2006 to combat counterfeit medical products had engaged the attention of Member States.

IMPACT and WHO’s involvement was discussed at the Sixty-third World Health Assembly in 2010. The World Health Assembly decided “to establish a time-limited and results-oriented working group on substandard/spurious/falsely-labelled/falsified/counterfeit medical products comprising and open to all Member States” to examine inter alia WHO’s role in ensuring the availability of quality, safe, efficacious and affordable medical products.

The Inter-Governmental Working Group (IGWG) presented its report to the Sixty-fifth World Health Assembly in 2012 and its recommendations were incorporated in Resolution WHA65.19. Indonesia was Vice-Chair of the IGWG meeting held in October 2011, at which there was unanimous support for WHO’s role to ensure the availability of good quality, safe, efficacious and affordable medical products. The Committee agreed with the recommendations including additional funds for WHO’s work in this area.

The Committee noted the comprehensive report and commended the regional solidarity in countering the issue of substandard/spurious/falsely-labelled/falsified/counterfeit medical products at global forums.
162. The Committee appreciated the role of WHO in combating substandard/spurious/falseylabelled/counterfeit medical products, strengthening drug regulatory authorities, improving access to safe, efficacious and affordable quality medicines, developing international norms and guidelines and providing technical assistance. The Committee welcomed the new Member State Mechanism and called for further deliberations on the new mechanism and addressing the challenges in its implementation through wholehearted participation of Member States of the Region. The Committee’s attention was drawn to Annex 2 of the working paper where the structure was explained.

163. The Committee raised concerns on the use of terminology such as substandard or counterfeit medicines and urged a need to revisit these definitions and their use. This issue had not been discussed in the October meeting of the IGWG. It felt that the TradeRelated Aspects of Intellectual Property Rights (TRIPS) and patents may hinder the availability and affordability of medicines to countries in need. In this regard, in-depth baseline assessment of the capacities of national drug regulatory authorities, development of regional medium and long-term plans for bulk procurement of life-saving drugs, medicines and vaccines of assured quality for humans, poultry and livestock should be prioritized, the Committee observed.

164. The Committee called for sharing of information, experiences and best practices among Member States and the development of information sharing mechanisms at all levels. The Committee stressed that regional solidarity was the most effective tool in counteracting networks of crime and was assured full commitment and support from Member States.

165. The Committee noted the working paper and endorsed the HIP Meeting’s recommendations made on this Agenda item.

Pandemic influenza preparedness (PIP)
(Agenda item 5.5.2: Document number SEA/RC65/1 1)

166. The Committee noted that since 1957 influenza viruses have been shared by Member States through the WHO Global Influenza Surveillance and Response System (GISRS), but that in 2007 issues were raised about how this might be linked to access to vaccines and other benefits.

167. To address these issues, the World Health Assembly resolution WHA60.28 recommended the Director-General to:
• develop a framework and mechanism for benefit sharing;
• establish an international stockpile of influenza A (H5N1) vaccine; and
• prepare guidance on vaccine distribution.

168. The resulting Pandemic Influenza Preparedness Framework (PIP Framework) is expected to enhance the capacity for surveillance, risk assessment and early warning.

169. The Committee was informed that the PIP Framework also aimed to prioritize financial and “in kind” benefits to developing (H5N1-affected) countries that lacked the capacity to
advisory mechanisms — a network of research institutions and funders that may include specialized sections according to the subject of research.

176. The Committee noted that CEWC had considered a number of innovative sources of financing for increased commitment for meeting the needs of developing countries. The Committee supports the commencement of negotiations for a proposed R&D convention, in principle, as suggested by CEWG.

177. The Committee emphasized the importance of capacity building and technology transfer to developing countries. The Committee also suggested further improving commitment to improve R&D to better address the public health needs of developing countries. The need to include traditional medicine in the R&D agenda was also emphasized.

Progress reports on selected Regional Committee resolutions:

(Agenda item 5.6)

Progress towards achievement of the immunization targets adopted in the Framework for Increasing and Sustaining Immunization Coverage (SEA/RC64/R3) (Agenda item 5.6.1: Document number SEA/RC65/13)

178. The Committee noted that the Year 2012 had been declared as the “Year of Intensification of Routine Immunization” in the South-east Asia Region. This was supported by the High-Level Ministerial Meeting on Increasing and Sustaining Immunization Coverage in South-East Asia, held in August 2011 in New Delhi, and the Sixty-fourth session of the Regional Committee held in Jaipur, India in September 2011.

179. At its Sixty-fourth session, the Regional Committee passed a resolution (SEAJRC64/R3) to report the progress towards achievements of the immunization targets adopted in the Regional Framework for Increasing and Sustaining Immunization Coverage. Since then all countries have developed plans for intensification of routine immunization and begun implementing them.

180. While according the highest priority to the polio certification in early 2014, the Committee requested the Secretariat for its continued assistance to implement the action plan for intensification of Routine Immunization. In this regard, the Secretariat reiterated its commitment to the implementation of the Global Vaccine Action Plan (GVAP).

181. The Committee requested the Secretariat for technical support to further strengthen the measles elimination efforts by drawing lessons from the success of the polio eradication programme. It, therefore, recommended including an Agenda item on “Establishing a measles elimination goal in the SEA Region” in the Sixty-sixth session of the Regional Committee in 2013.

Challenges in polio eradication (SEA/RC6O/R8) (Agenda item 5.6.2: Document number SEA/RC65/14)

182. The Committee was presented with an update on the progress and challenges to polio eradication in the SEA Region.

183. Commending India for the tremendous progress made towards polio eradication, the Committee noted that it was the only country in the SEA Region that had endemic transmission of wild poliovirus (WPV) in 2011. As a result of concerted effort over the previous 12—24 months, the number of polio cases in India decreased by over 99% as compared with 2009. In 2011, only one wild poliovirus case was detected — the lowest number since surveillance was initiated in 1997. Success and lessons learnt in building a highly sensitive surveillance network for polio had been replicated to strengthen surveillance for other vaccine-preventable diseases and monitor routine immunization activities.
185. Strategies adopted to stop polio transmission in India represented a multipronged approach. Eradication challenges had been approached systematically with specific strategies: the 107 high-risk block initiative in historically polio-endemic areas of western Uttar Pradesh and central Bihar had focused on rapid improvement in sanitation, availability of clean water, hygiene and prevention/control of diarrhoea; migrant populations that played an important role in sustaining and spreading polio were targeted for surveillance and immunization activities; and, the introduction of bivalent oral polio vaccine (bOPV) provided an additional tool for epidemiological-based supplemental immunization activities.

186. With continued, sustained effort in 2012—2013, the Region can look forward to certification as polio-free in early 2014, and the Committee agreed to intensify efforts to fill the gap towards this end. The Secretariat reaffirmed its commitment to support fully the activities of the National Certification Committee for Polio Eradication (NCC) and the South-East Asia Regional Commission for the Certification of Poliomyelitis Eradication (SEA-RCCPE).

187. The Committee requested WHO to look beyond polio certification and provide guidance on the polio end-game strategy and the role of oral polio vaccine and inactivated polio vaccine in implementing the OPV cessation strategy. The Committee was advised that the integration of polio immunization into routine immunization, and integration of routine immunization into health systems may be considered by the Member States.

Regional Strategy for Universal Health Coverage (SEA/RC63/R5)
(Agenda item 5.6.3: Document number SEA/RC65/15 and Inf.Doc.)

188. The Committee was informed that countries in the SEA Region were prioritizing universal health coverage (UHC) in their health and development policies with an urgent emphasis on improving equity. A key driver of inequities in health and a major challenge to UHC in the SEA Region is out-of-pocket payments, particularly for the purchase of medicines. Further inequities as well as inefficiencies were evident in service delivery in the context of an increasing burden of noncommunicable diseases and largely unregulated private provision of curative care.

189. Based on an in-depth analysis and discussion of the South-East Asia Region’s and international experiences, four strategic directions recommended to accelerate UHC in the Region were:

- Strategic Direction 1: Placing primary health care at the centre of UHC.
- Strategic Direction 2: Improving equity through social protection.
- Strategic Direction 3: Improving efficiency in service delivery.
- Strategic Direction 4: Strengthening capacities for UHC in the SEA Region.

190. Countries supported the strengthening of the public health system with the government being its primary provider supplemented by private health-care providers.

191. The Committee highlighted the need to have good primary health care services with proper referral mechanisms, technology assessment, comprehensive information systems and involvement of the private sector to achieve universal health coverage. The implementation of policy with inbuilt mechanisms for monitoring and evaluation was also considered important. Capacity building was strongly advocated, including through South—South cooperation.

192. The Committee requested that the Regional Office secure funds to assist UHC action at country level including documentation and exchange of experiences. It also requested WHO to provide technical
193. The Secretariat informed that as per the recommendation of the Sixty-fourth session of the Regional Committee, the Regional Strategy on Universal Health Coverage has now been developed with a consultative and inclusive process with the Member States. As requested by the Member States, the Strategy has been developed as a practical document and is based on the recommended Strategic Directions on international experience Capacity building of Member States in global health (SEA/RC63/1R6) (Agenda item 5.6.4: Document number SEA/RC65/1 6)
194. The Committee noted that the term "global health" had emerged as part of the larger political and historical process, and that it had replaced the term "international health". The term is associated with the growing importance of actors beyond governments, intergovernmental organizations and agencies, and international nongovernmental agencies, etc.
195. Recognizing the need to provide support to Member States to organize national, regional and global seminars and training workshops on global health that could act as effective tools for strengthening national capacity, and enable them to participate and play active roles in international/global health forums with improved negotiation skills, many international training programmes on global health were conducted in 2010, 2011 and 2012 through multidisciplinary, didactic and experiential learning in collaboration with the Ministry of Public Health, Thailand, WHO-SEARO, Thai Health Global Link Initiative Project (TGLIP) and the Rockefeller Foundation.
196. The Committee noted that this had resulted in vast improvement in the quality of interventions by representatives of the Member States at the Governing Body meetings.
197. The Committee requested WHO to develop standard models for the national and international training courses on Global Health and to conduct comprehensive evaluation with a view to further improving the quality of the training course.
198. The Committee felt the need to institutionalize the training on global health by including it as a subject in the curriculum of Masters of Public Health (MPH) or related courses conducted in schools of public health and encouraged Member States to take advantage of these courses.

Key issues arising out of the Sixty-fifth World Health Assembly and the 130th and 131st sessions of the WHO Executive Board
(Agenda item 6: Document number SEA/RC65/1 7)
199. The Committee took note of the most significant and relevant resolutions from the perspective of the SEA Region, emanating from the Sixty-fifth World Health Assembly (held from 21 to 26 May 2012) as well as the 130th and 131st sessions of the Executive Board (held from 16 to 23 January 2012 and on 28-29 May 2012, respectively). These resolutions are deemed to have important implications and merit follow-up action by both Member States and WHO at its Regional Office and country office levels.
September 2013, she urged the Committee to strongly consider implementation with immediate effect to fall in line with the procedures followed by other regions.
206. The Committee discussed establishment of a subcommittee under Rule 51 of the Rules of Procedure of the Regional Committee for the purpose of revision of Rule 49 “Nomination of the
Regional Director" and whether to consider the Consultative Meeting held in March 2012 as a subcommittee of the Regional Committee.

207. The Regional Committee decided not to consider the Consultative Meeting to be a “subcommittee” for purpose of amendment to the Rules of Procedure, but rather to suspend the proceedings of the Regional Committee and immediately establish a subcommittee of all Member States to further discuss the matter.

208. The Regional Committee was adjourned to permit the Subcommittee to meet in private to review the draft resolution of the March 2012 Consultative Meeting with a view to preparing a recommendation thereon for consideration by the Regional Committee.

209. Under the Chairpersonship of Dr Nafsiah Mboi, Health Minister, Republic of Indonesia, the Subcommittee decided to recommend to the Regional Committee that Annexes A, B and C of the draft resolution of the March 2012 Consultative Meeting be approved as recommended by the Consultative Meeting.

210. The Subcommittee further decided to recommend to the Regional Committee that the presentation process included in the draft resolution presented by the Consultative Meeting of March 2012 be made applicable with immediate effect instead of 1 January 2014 as originally proposed.

211. The Regional Committee reconvened to take up the recommendations of the Subcommittee. After deliberation, the Regional Committee accepted the recommendations of the Subcommittee. The Regional Committee adopted the resolution including its Annexes, A, B and C and approved the amendments proposed by the Subcommittee regarding the immediate effectiveness of the presentation process.

Special Programmes (Agenda item 7)


212. The Committee noted that the report of the Thirty-fifth Meeting of the Joint Coordinating Board (JCB) of the UNICEF/UNDP/World Bank Special Programme for Research and Training in Tropical Diseases held in Geneva, Switzerland, from 18 to 20 June 2012 was presented to the HLP meeting held in the Regional Office, New Delhi, from 2 to 5 July 2012.

213. The Committee also noted that the membership of Member States from the Region nominated in the JCB is valid up to 2013.


214. The Committee noted that the report of the Twenty-fifth Meeting of the Policy and Coordination Committee (PCC) of the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, held on 21-22 June 2012 in Geneva, Switzerland, was presented to the HLP meeting held in the Regional Office,
New Delhi from 2 to 5 July 2012.

215. The Committee nominated Maldives as a member of the PCC for a three-year term starting 1 January 2013, and requested the Regional Director to inform WHO headquarters accordingly.

Closure of the Session (Agenda item 8)

Time and place of future sessions of the Regional Committee
(Agenda item 8.1: Document number SEA/RC65123)

216. The Committee decided to hold its Sixty-sixth Session in September 2013 at the WHO Regional Office for South-East Asia, New Delhi.

217. The Committee noted with appreciation the confirmation by the Government of the Republic of Bangladesh of its invitation to host the Committee’s Sixty-seventh Session in September 2014.

Adoption of resolutions (Agenda item 8.2)

Adoption of the Report of the Sixty-fifth Session of the Regional Committee
(Agenda item 8.3)
Draft Resolutions

REGIONAL COMMITTEE

Sixty-fifth Session
Yogyakarta, Indonesia
5–7 September 2012

7 September 2012
10 a.m.

DRAFT RESOLUTIONS OF THE SIXTY-FIFTH SESSION OF THE WHO REGIONAL COMMITTEE FOR SOUTH-EAST ASIA
Draft Resolutions for consideration by the
Sixty-Fifth Session of the Regional Committee

A. Consultative Expert Working Group on Research and Development: Financing and Coordination

B. Report of the Regional Director

C. Noncommunicable Diseases, Mental Health and Neurological Disorders

D. Regional Strategy for Universal Health Coverage

E. Process for the Nomination of the Regional Director

F. Strengthening Health Workforce Education and Training in the Region:

G. Comprehensive and Coordinated Efforts for the Management of Autism Spectrum Disorders (ASD) and Developmental Disabilities

H. Proposed Programme Budget 2014-2015

I. Resolution of Thanks
CONSULTATIVE EXPERT WORKING GROUP ON RESEARCH AND DEVELOPMENT: FINANCING AND COORDINATION

The Regional Committee,


Further recalling resolution WHA63.28 on the establishment of a Consultative Expert Working Group (CEWG) on Research and Development: Financing and Coordination; requesting the Director-General, inter alia, to establish the CEWG to take forward the work of the Expert Working Group earlier established under resolution WHA61.21;

Noting the resolution WHA65.22 which requests Regional Committees to discuss at their 2012 meetings the report of the CEWG in the context of the implementation of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property in order to contribute to concrete proposals and actions;

Recognising the need for enhancing investments in health research and development (R&D) related to Type II and Type III diseases and the specific R&D needs of developing countries in relation to Type I diseases;

Recognising that improved access to medical products such as medicines, vaccines and diagnostics in relation to Type II and Type III diseases and specific R&D needs of diseases of Type I in developing countries are the paramount goals;

Acknowledging the importance of innovation, technology transfer and access to medical products for essential health R&D relevant to diseases which disproportionately affect developing countries, proposing clear objectives and priorities for R&D, estimating funding needs in this area, and coordinating, facilitating and promoting health R&D;
Recognising the importance of securing sustainable financing mechanisms for R&D to develop and deliver health products to address the health needs of developing countries and develop mechanisms to monitor and evaluate the implementation of the Global Strategy and Plan of Action, including reporting systems;

Realizing the need for improving priority-setting and transparent decision-making processes based on the public health needs of developing countries;

Appreciating the Regional Director for convening a regional technical discussion on the report of the CEWG where Member States take an active role in the discussions; and

• Welcoming the recommendations made by the CEWG and the need of Member States of the Region to implement the same in phases starting with coordination mechanisms, including the setting up of a global health R&D observatory, inter alia, to determine the existing capacities, requirements and the absorptive capacities of developing countries in essential health R&D relevant to diseases which disproportionately affect developing countries which would enable the individual countries to decide the level of commitment of resources;

URGES Member States:

(1) To strengthen health R&D capacities on diseases of Type II, Ill and specific R&D needs of developing countries on diseases of Type I, through increased financial
• resources from the existing government budgets and private sources through different
• incentive schemes, and explore potential new or innovative sources specifically for health R&D;

(2) To build, strengthen and sustain human resources and infrastructure for health research and development;

(3) To promote coordination of health R&D among public and private partners in the country, and support regional and global coordination for health R&D in order to maximize synergies and avoid duplications;

(4) To establish or strengthen national health R&D observatories for tracking and monitoring human and financial resources spent on health R&D and contribute to the work of a global health R&D observatory;

(5) To promote the establishment of Advisory Mechanisms and the Global Health R&D Observatory as suggested by the CEWG to enable WHO to play a central and stronger role in improving coordination of R&D directed at the health needs of developing countries;

(6) To support the formation of a working group with equal representation from each Region to undertake future preparatory work for the convention as suggested by the CEWG;
To explore the potential role of pooled funding at the global level, from different sources of finance, in supporting health R&D, and that the promising medical products, technologies and innovations generated from the pooled fund are global public goods and made available free of R&D cost; and

To engage actively in the negotiations in an open-ended meeting of Member States in November 2012, inter alia, by supporting the development of the Global Health R&D Observatory, effective global R&D coordination, adequate and sustainable funding for R&D on diseases of Type II and III and specific R&D needs of diseases of Type I in developing countries; and REQUESTS the Regional Director:

(1) To support Member States in their endeavour to establish or strengthen health R&D capacities and national health R&D observatories, which inter alia also contribute to the Regional and Global Health R&D observatory;

(2) To facilitate the establishment of Regional and Global Health R&D Observatories and related Advisory Mechanisms as suggested by the CEWG through technical and financial support;

(3) To strengthen the capacity of Member States to access and benefit from mechanisms as suggested by the CEWG, including the Global Health R&D Observatory and the pooled fund mechanism;

(4) To promote partnerships and coordination at the country, regional and global levels in order to maximize synergies in health R&D;

(5) To convey to the Director-General the wish of the Member States for consideration that the Chair of the open-ended meeting of Member States be-from the SEA Region; and

(6) To report to the Sixty-seventh Session of the WHO Regional Committee for SouthEast Asia in 2014 on the progress made in implementing this resolution.
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 January 2010 to 31 December 2011 (SEAJRC65/1), and

Recalling its own resolution SENRC52/R2, relating to the preparation of biennial reports on the Work of WHO,

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

(2) CONGRATULATES the Regional Director and his staff for bringing out a clear and comprehensive report.
Draft Resolution C

NONCOMMUNICABLE DISEASES, MENTAL HEALTH AND NEUROLOGICAL DISORDERS

The Regional Committee,

Recalling World Health Assembly resolutions WHA53.17, WHA56.1, WHA57.17, WHA60.23, WHA 64.11 and WHA 65.4, and its own resolutions SEA/RC52/1R7, SEA/RC53/R10 and SENRC60/R4, relating to the prevention and control of noncommunicable diseases including mental and neurological disorders;

Acknowledging the Political Declaration of the High-Level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases, the Moscow Declaration adopted at the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Diseases Control, and the Rio Political Declaration on Social Determinants of Health;

Reaffirming the World Health Assembly Decision WHA 65.8(7) on follow-up to the High-Level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases and the adoption of the global target of a 25% reduction in premature mortality from noncommunicable diseases by 2025;

Recognizing that noncommunicable diseases such as cardiovascular diseases, cancers, chronic respiratory diseases and diabetes are the leading cause of premature death and disability, and that the burden is likely to increase in the South-East Asia Region due to population ageing, globalization, changes in dietary patterns, unplanned urbanization and other social determinants;

Recognizing that mental and neurological disorders are common causes of disability, suffering and premature death;

Noting with concern that the rapidly increasing health-care costs associated with the treatment of NCDs, mental and neurological disorders disproportionately affect the poor, impoverish families, and overburden the public health-care systems;

Recognizing the substantial stigma against mental and neurological disorders;
Further recognizing the substantial harm from alcohol use that goes beyond health risks and includes social, psychological and economic risks;

Realizing that effective and affordable interventions are available to modify the common risk factors of NCDs such as unhealthy diet, physical inactivity, tobacco use and harmful use of alcohol;

Recognizing the role of the "life course" approach that emphasizes the critical importance of health promotion and disease prevention strategies to minimize the risk of NCDs, and mental and neurological disorders at each stage of life;

Appreciating that policies in sectors other than health have a major bearing on risk factors and environmental and social determinants of NCDs, and reiterating that there is a pressing need to strengthen multisectoral collaboration at all levels; and

Acknowledging the need for development of standard indicators and targets to monitor the progress towards prevention and control of NCDs and their risk factors at global, regional and national levels;

URGES Member States:

(1) To integrate NCD policies and programmes into national health planning processes and the global and national development agenda, and, by 2013, to strengthen national multisectoral policies and plans for the prevention and control of NCDs, including mental health and neurological disorders;

(2) To address NCD risk factors using the "life course" and an evidence-based approach beginning in the pre-pregnancy period and continuing through childhood and adulthood, including the elderly, with the emphasis on public health interventions;

(3) To accelerate implementation of the WHO Framework Convention on Tobacco Control, the Global Strategy on Diet, Physical Activity and Health, and the Global Strategy to Reduce the Harmful Use of Alcohol with the emphasis on implementation of "best buys";

(4) To develop and strengthen national strategies and plans to address NCDs with clear indicators and targets, taking into account results of the global consultations on the NCD Action Plan and Global Monitoring Framework and voluntary targets, as well as national priority and context;

(5) To strengthen national surveillance systems and information systems, and encourage research on NCD prevention and control;

(6) To develop comprehensive policies and strategies that address the promotion of mental health, and prevention of mental and neurological disorders taking into account the results of the global consultations for development of the Global Mental Health Action Plan;
(7) To ensure adequate financial, technical and human resources for health promotion and primary prevention, and strengthen health systems for early identification, diagnoses and management of acute and chronic NCDs and mental and neurological disorders, particularly at the primary care level;

(8) To enhance participation in all steps of the noncommunicable diseases follow-up processes, including consultations and meetings of WHO Governing Bodies on the Global Monitoring Framework and the setting up of global targets, the Global Action Plan for Prevention and Control of Noncommunicable Diseases, and the comprehensive Mental Health Action Plan;

(9) To collectively advocate for the consideration of global targets for the prevention and control of noncommunicable diseases to cover all major risks, namely, tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol, as well as targets relating to health outcomes and health systems response; and

(10) To collectively advocate for NCDs to be included in discussions at the highest international forums, including in the post-2015 UN Development Agenda, and

REQUESTS the Regional Director:

(1) To work closely with Member States and partner agencies to address the regional and national burden of NCDs, including mental and neurological disorders, and to ensure optimum communication and advocacy messages in support of multisectoral actions for NCD prevention and control through existing forums such as WHO Governing Bodies, the UN General Assembly, the WHO Regional Committees, and other UN regional bodies;

(2) To provide technical guidance and support to Member States for building capacity, and for developing and strengthening national health systems and multisectoral plans and policies for the prevention and control of NCDs, including mental and neurological disorders; and

(3) To support Member States to develop and strengthen national strategies and plans with clear indicators and targets to address noncommunicable diseases, including mental and neurological disorders;
Draft Resolution D

REGIONAL STRATEGY FOR UNIVERSAL HEALTH COVERAGE

The Regional Committee,

Having considered SEAIRC65/15 Information Document on Regional Strategy for Universal Health Coverage;

Concerned that 1 billion people worldwide do not have access to health care, 150 million people face catastrophic health-care costs each year because of direct payments for health care, while 100 million are driven below the poverty line thereby contributing to avoidable morbidity and premature mortality, aggravating inequity and impeding sustainable social and economic development;

Recognizing the contribution of universal health coverage (UHC) towards achieving Millennium Development Goal 1, to eradicate extreme poverty and hunger; Goal 4, to reduce child mortality; Goal 5, to improve maternal health; Goal 6, to combat HIV/AIDS, malaria, TB and other diseases; and Goal 8, to develop a global partnership for development; and the achievement of wider social policy objectives as set out by the Joint UN Social Protection Floor Initiative;

Acknowledging the crucial importance and contributions of all health systems building blocks including human resources for health, medicines, and a resilient and responsive health services delivery with extensive geographical coverage of functioning primary health care with an effective referral system is a key foundation for UHC;

Noting that each country can start providing financial risk and social protection to targeted populations, taking into account harmonization across different schemes, and gradually accelerate progress towards UHC, which is possible and affordable even at a low level of economic development provided that there are strong and sustained political and financial commitments by governments; and

Appreciating the Director-General of the World Health Organization and the Regional Director of the WHO South-East Asia Region for their leadership and support to Member States
in moving towards UHC and formulating the Regional Strategy for Universal Health Coverage, based on evidence and participatory processes;

ENDORSES the Regional Strategy for Universal Health Coverage;

URGES Member States:

(1) To develop and/or strengthen country-specific strategies for UHC including health development and investment plans, as appropriate, applying the four Strategic Directions of the Regional Strategy for Universal Health Coverage.

(2) To strengthen national capacity for monitoring and evaluation and regularly monitor progress towards UHC; and

(3) To actively contribute to the work of the regional UHC platform for exchange of UHC experiences across countries, which could also accelerate the implementation of national UHC agendas; and

REQUESTS the Regional Director:

(1) To provide technical support to Member States in developing, implementing and monitoring country-specific strategies for UHC, applying the four Strategic Directions of the Regional Strategy for Universal Health Coverage;

(2) To strengthen capacity in the Region and the existing platform initiated by WHOSEARO for sharing of UHC experiences, supporting collaborative research, monitoring progress and linking with other UHC networks;

(3) To support countries to produce evidence on impact of UHC, including on reduction of out-of-pocket expenditure, prevention of household catastrophic health expenditure and impoverishment; and using this for discussions on universal health coverage at the highest regional and global development forums;

(4) To convene regular workshops for Member States in the SEA Region to share experiences, identify challenges and their potential solutions, and monitor progress towards UHC; and

(5) To support mechanisms at regional and international levels for specific needs of Member States for health system strengthening for UHC, including bulk procurement of medicines.
Resolution E

PROCESS FOR THE NOMINATION OF THE REGIONAL DIRECTOR

The Regional Committee,

Having considered the Report on the Process for Nomination of the Regional Director by the WHO Regional Committee for South-East Asia submitted by the sub-committee constituted under Rule 51 of the Rules of Procedure of the WHO Regional Committee for South-East Asia at its Sixty-fifth Session;

Desiring to improve the degree of transparency in the process for Nomination of the Regional Director;

Having considered the practice followed by the World Health Organization for the nomination of the Director—General and Regional Directors,

(1) DECIDES to amend Rule 49 of the Rules of Procedure of the WHO Regional Committee for South-East Asia, by adding a new paragraph (f)(bis) to Rule 49, regarding presentations by candidates for the post of Regional Director, as contained in Annex A to this Resolution. This amendment will become effective immediately;

(2) DECIDES, with regard to such presentations, that the modalities set forth in Annex B to this Resolution shall also become effective immediately; and

(3) DECIDES that the criteria set forth in Annex C to this Resolution, should be used for assessing candidates for the post of Regional Director with immediate effect.
Draft Resolution F

STRENGTHENING HEALTH WORKFORCE EDUCATION AND TRAINING

IN THE REGION

The Regional Committee,

Recalling WHA63.1 6 WHO Global Code of Practice on the International Recruitment of Health Personnel, and its own resolution SEA/RC59/R7 on Strengthening the Health Workforce in SEA Asia,

Reaffirming the Dhaka Declaration on Strengthening the Health Workforce in Countries of : the South-East Asia Region;

Noting with serious concern on the critical shortage and imbalance of the health workforce, particularly in rural remote areas in the Region, and that the situation has not been improved;

Aware that current education and training of the health workforce need an urgent attention for improvement in order to produce competent health professionals to match the health needs of the population; and

Aware that an adequate, competent and equitably distribufed health workforce is the backbone of Universal Health Coverage;

URGES Member States:

(1) To review national health workforce policies, strategies and plans to maximize their contributions to the health of the population and the achievement of universal health coverage;

(2) To conduct comprehensive assessments of the current situation of health workforce education and training, based on an agreed regional common protocol, as a foundation for evidence-based policy formulation and implementation;

(3) To develop or strengthen policies for education and training of the health workforce as an integral part of national health and education and training policies;

(4) To increase resources and support for the strengthening of education and training of the health workforce, including community-based health workforces, while ensuring appropriate accreditation, in support of universal health coverage, for which the training curriculum is relevant to country health and health systems needs.
REQUESTS the Director-General of the World Health Organization through the Regional Director for South-East Asia to propose the inclusion of an Agenda item entitled “Health Workforce Education and Training” in the Provisional Agenda of the 132nd Session of the Executive Board in January 2013; and

REQUESTS the Regional Director:

(1) To support Member States in conducting a comprehensive assessment of the current situation of health workforce education and training based on an agreed regional common protocol;

(2) To convene regional technical consultations to review the result of the country assessments and to formulate regional strategy on strengthening health workforce education and training in the Region;

(3) To support Member States in their efforts to further strengthen health workforce education and training, including community-based health workforces; and

(4) To submit the Regional Strategy on Strengthening Health Workforce Education and Training, as well as progress of the implementation of this resolution, to the Sixtyseventh session of the Regional Committee;
Draft Resolution G

COMPREHENSIVE AND COORDINATED EFFORTS FOR THE
MANAGEMENT OF AUTISM SPECTRUM DISORDERS (ASD) AND
DEVELOPMENTAL DISABILITIES

The Regional Committee,

Recalling the Universal Declaration of Human Rights 1948 and the Convention on the
Rights of the Child 1989 by the United Nations General Assembly; and the Convention on the
Rights of Persons with Disabilities 2007; and the Declaration of 2nd April as World Autism
Awareness Day by the United Nations General Assembly in 2007; and the Dhaka Declaration on
Autism Spectrum Disorders and Developmental Disabilities of July 2011;

Reiterating commitments of safeguarding citizens from discrimination and social exclusion on the
grounds of disability or other condition, and ensuring citizens' basic necessities of life, education,
medical care and social security, and attention to vulnerable groups of the population;

Noting that more and more children are being detected to have autism spectrum disorders (ASD) and
other developmental disabilities worldwide, and that the likelihood that still more remain unidentified in
society due to lack of awareness;

Understanding that ASD and developmental disabilities are life-long and affect the functioning of the
brain, and are characterized by impairments in social interaction, problems with verbal and non-verbal
communication, and restricted, repetitive behaviour, interests and activities;

Further noting that such disabilities seriously influence everyday functioning of affected children,
severely interfere with their developmental, educational and social attainments, and bring significant
economic costs to their families and societies;

Concerned that, despite increasing evidence documenting the effectiveness of early interventions in
improving the overall functioning of the child and long-term outcomes, children and families in need
often have poor access to services and do not receive adequate treatment and care;
Deeply concerned about the dramatic rise in the numbers of children with autism and developmental disabilities and the growing costs involved in managing such disabilities;

Recognizing that children with ASD and developmental disabilities and their families often face major challenges associated with stigma, isolation and discrimination; and

Acknowledging that the Mental Health Gap Action Programme (mhGAP 2008) of the WHO Secretariat can be particularly instrumental for developing countries if it gives increasing focus on ASD and developmental disabilities;

URGES Member States:

(1) To give appropriate recognition to ASD and developmental disabilities in all policies and programmes related to early childhood development;

(2) To develop and implement policies and legislation, as appropriate, and multisectoral plans including public awareness, stigma removal campaigns, supported with adequate human, financial and technical resources to address issues related to ASD and developmental disabilities;

(3) To develop strategies for early detection and community-based interventions for children with ASD and developmental disabilities;

(4) To develop appropriate infrastructure for comprehensive management, including care, support, intervention, services and rehabilitation, of ASD and developmental disabilities;

(5) To provide social and psychological support and care to families affected by ASD and developmental disabilities;

(6) To promote research on the public health aspects of ASD and developmental disabilities; and

(7) To implement the Dhaka Declaration on Autism Spectrum Disorders and Developmental Disabilities of 2011; and

REQUESTS The Regional Director:

(1) To collaborate with Member States and partner agencies for support to strengthen national capacities and implement national efforts to address ASD and developmental disabilities, including early identification, management and care, at all levels of facilities and monitoring progress;
(2) To support Member States in the implementation of the Dhaka Declaration on Autism Spectrum Disorders and Developmental Disabilities of 2011;
(3) To support the activities of autism-related networks, including the South-east Asia Autism Network (SAAN); and
(4) To mobilize resources to address ASD and developmental disabilities in the SouthEast Asia Region.
Draft Resolution H

PROPOSED PROGRAMME BUDGET 2014-2015

The Regional Committee,

Having considered the Proposed Programme Budget 2014—2015, which follows a significantly different approach from previous bienniums, and keeping in mind the recommendations of the Fifth Meeting of the Subcommittee on Policy and Programme Development and Management calling on WHO-SEARO to ensure country-level engagement in the 2014—2015 Programme Budget development process;

Recognizing that unlike in previous bienniums, the Proposed Programme Budget 2014—2015 is being developed in parallel with the 12th General Programme of Work;

Appreciating that the Proposed Programme Budget 2014—2015 is structured around the six Categories described in the 12th General Programme of Work, and noting that under each Category there is a description of priorities and rationale, challenges, strategic approaches, linkages and a series of outcomes and outputs;

Recognizing the need for adequate country-level consultation and engagement in the Proposed Programme Budget 2014—2015 development process in order to engender a sense of ownership among Member States;

Noting that the Proposed Programme Budget 2014—2015 does not as yet include initial Budget figures or performance indicators, and that work is still ongoing to standardize the outcome statements and improve their linkages to the priorities and outputs;

Recognizing the need for innovative funding mechanisms to help Member States fund national health programmes, and to ensure funding of the Proposed Programme Budget 2014—2015;

ENDORSES the recommendations of the Fifth Meeting of the Subcommittee on Policy and Programme Development and Management;

URGES Member States:

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(5) To engage proactively with WHO in the 2014-2015 Programme Budget development process and the finalization of the 12th General Programme of Work; and

REQUESTS the Regional Director to take up with the WHO Director-General for her consideration, when finalizing the Proposed Programme Budget 2014-2015:

(1) Inclusion of realistic, measurable indicators to track performance during implementation of Programme Budget 2014-2015.

(2) Consideration of the recommendations emanating from WHO-SEARO consultations with countries on country-level priorities and budgetary requirements when determining 2014-2015 budget allocations; and

FURTHER REQUESTS the Regional Director:

(1) To help ensure country-level ownership and engagement in the next phase of the Programme Budget 2014-2015 development process and during 2014-2015 operational planning.
Draft Resolution I

RESOLUTION OF THANKS

The Regional Committee,

Having brought its Sixty-fifth Session to a successful conclusion,

(1) THANKS His Excellency, Prof. Dr Budiono, M.Ec, Vice-President of Indonesia, for graciously inauguring the session and for his thought-provoking address;

(2) CONVEYS further its gratitude to His Excellency, Sri Sultan Hamengkubuwono X, Governor of Yogyakarta, Special Region for his participation in the joint inaugural session and for his hospitality,

(3) THANKS the Director-General of WHO for her inspiring address and participation;

(4) CONVEYS its gratitude to the Government of the Republic of Indonesia and the members of the National Organizing Committee, the staff of the Ministries of Health and Foreign Affairs, and other national authorities for organizing and hosting the session;

(5) FURTHER expresses its appreciation to the Honourable Health Ministers, other distinguished representatives and participants from United Nations agencies and other organizations; and

(6) CONGRATULATES the Regional Director and his staff for their dedicated efforts towards the successful and smooth conduct of the session.
Decisions

SEA/RC65(1) Technical Discussions: selection of a subject for the Technical Discussions to be held prior to the Sixty-sixth Session of the Regional Committee

The Committee decided on the subject of “Universal Health Coverage” as the subject for Technical Discussions to be held prior to the Sixty-sixth Session of the Regional Committee in 2013.

SEA/RC65(2) Nomination of a Member State to the Policy and Coordination Committee (PCC) of the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction

The Committee nominated Maldives as member of the PCC for a three-year term starting 1 January 2013, and requested the Regional Director to inform WHO headquarters accordingly.

SEA/RC65(3) Time and place of future sessions of the Regional Committee

The Committee decided to hold its Sixty-sixth Session in the WHO Regional Office for South-East Asia, New Delhi, in September 2013.