Sixty-sixth Meeting of the Regional Director with the WHO Representatives

Report of the Meeting
WHO-SEARO, New Delhi
17-19 June 2014

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Annexes

1. Background

The Sixty-sixth Meeting of the Regional Director with WHO Representatives (WRs) was held at the WHO Regional Office for South-East Asia, New Delhi, from 17 to 19 June 2014.

The agenda and list of participants of the meeting are contained in *Annexes 1* and *2* respectively.

This report presents the background and highlights of discussions on each agenda item along with major conclusions and action points for follow-up in country offices and in the Regional Office.

2. Business session

2.1 Regional Director's opening remarks

The Regional Director for WHO South-East Asia, Dr Poonam Khetrapal Singh, welcomed the distinguished participants to the Sixty-sixth Meeting of the Regional Director with WHO Representatives. This annual meeting normally takes place in November but was shifted to June this year, she informed. This meeting provides an opportunity for WRs and Regional Office staff to review and discuss various issues related to the implementation of the current Programme Budget, and discuss the development of the next biennial Programme Budget and several other issues of regional priority, Dr Singh added.

[The full text of the Regional Director's opening remarks is contained in Annex 3.]

2.2 Follow-up actions of Meeting of WHO Representatives held in June 2013 and Sixty-fifth Meeting of the Regional Director with WRs held in the Regional Office in October 2013 *(Agenda item 2.1)*

Background

This agenda item was intended to review the follow-up actions arising from the Meeting of WHO Representatives held in June 2013 and the Sixty-fifth Meeting of the Regional Director with WRs held in the WHO Regional Office for South-East Asia in October 2013.

The actions were summarized according to the major topics discussed at these meetings and were based on detailed inputs received from WRs and department directors.

Discussion point

- The meeting noted the follow-up actions taken on the important conclusions arrived at the Meeting of WHO Representatives held in June 2013 and the Sixty-fifth Meeting of the Regional Director with WRs held in October 2013.

Major conclusions and action points

(1) Develop a regional evaluation plan for the 2014–2015 biennium with a focus on impact evaluation, based on what has been planned by the WHO country offices and the Regional Office ***(Action: DPM/PMO)***.

(2) The vacant position of BFO should be filled. There should be separate positions of Compliance Officer and BFO ***(Action: DAF/HRM)***.

(3) The best practices followed by different country offices, including for noncommunicable diseases, should be documented in order for these to be shared with and replicated in the Region ***(Action: SDE/NCD/WRs)***.

2.3 Presentations and discussions on specific issues of importance *(Agenda item 3)*

2.3.1 *Implementation of Programme Budget 2014–2015* *(Agenda item 3.1)*

Background

Acting BFO presented the status of the implementation of the Programme Budget for 2014–2015. The overall fund utilization as on 31 May 2014 stands at US$ 74 million and expenditure amounts to US$ 43.1 million. The average percentage of expenditure to available resources is 22%, which is in line with other regional offices. The percentage of funds utilization compared with available resources stands at 38%.

The focus of the presentation was to report on the current financial standing with the aim of increasing implementation rates and to emphasize the importance of implementation vis-à-vis South-East Asia Region's future budget allocations.

Discussion points

- The Regional Director emphasized the need to accelerate implementation rates as these are directly linked to future AC, AS and CVCA releases.
- In view of the very close monitoring of the Programme Budget implementation in the Region, particularly by headquarters, and with its implications on the future allocation of funds to the Region, concerted efforts should be made to accelerate financial implementation, expenditures in particular. Special efforts are required in this direction from the country offices since 75% of the allocation is with the countries.
- Countries facing difficulties of specific nature - such as problems with the banking channels, delays in implementation of the ROK Project in the Democratic People's Republic of Korea - would need focused attention for early resolution.
- Issues and challenges related to procurement were discussed. The Regional Director stressed the importance of procurement as an

important vehicle of programme implementation, while increasing the level of implementation. DAF pointed out that procurement acceleration requires work upfront (gathering required information/ specifications). He mentioned that as per audit observations, the South-East Asia Region should develop procurement plans for both goods and services.

- Long-term agreements (LTAs) may be useful to enhance procurement for selected items in countries. LTAs of other UN agencies, too, can be efficiently used.

- The need to further delegate authority to large country offices in order to make their procurements/contracts was discussed. Delays that sometimes occur in the Regional Office in approving contracts were raised.

- Requesters for procurement should be encouraged to provide detailed specifications, information on suppliers, etc. to avoid delay in procuring goods. Information on WHO catalogued items should be shared with all concerned. Administrative officers in country offices should be included in the routing in GSM for clearance of procurement requests.

- Some current practices of maintaining paper-based approval processes, including for travel, were discussed. The need to simplify these processes, including the discontinuation of paper-based systems, was emphasized by the Regional Director.

Major conclusions and action points

(1) All Budget Centres to develop procurement plans for goods indicating quarterly needs during the first three months of the biennium. For 2014-2015, all country offices to develop these plans by 15 August 2014 and share with the Medical Supplies Unit in the Regional Office. ***(Action: All Budget Centres)***

(2) Procurement processes should not lead to delay in implementation. Ways should be suggested for simplification and efficiency in the system and identification of bottlenecks. ***(Action: DAF/MSO/WCOs)***

(3) All country offices to explore the possibility of using LTAs, including those with other UN agencies, to facilitate procurement. ***(Action: All WCOs)***

(4) In order to increase the efficiency of responses to possible queries and to bring an improvement in the overall contract review process, the interested party may be requested to attend the Contract Review Committee (CRC) meetings. Other means of improving efficiency should be looked into. Maintenance and repair component should be embedded in the procurement process right from the bidding process. MSU to share the checklist with WCOs to improve efficiency. ***(Action: DAF/MSO)***

(5) The Information Circular (IC 2014/8) dated 5 May 2014 on Duty Travel Policy should be amended with feedback from WCOs in order to discontinue the practice of off-line approvals (including TRs) wherever necessary. ***(Action: DAF)***

(6) As directed by the Regional Director, immediate action should be taken to unblock the HR funds by not covering positions up to 24 months and limit these to about 12 months. The funds thus made available should be utilized for implementation of activities, specifically those planned before December 2014. Salaries to be protected through CVC funds. ***(Action: All WRs/Directors/DPM/DAF/PLN/BFO)***

(7) With regard to the problems faced by some countries in absorbing the voluntary contributions due to lack of budget space, PLN should provide assistance in providing additional budget space. While PLN should coordinate with PRP/HQ, a communication from the Regional Director to the ADG/GMG on the need for budget space and other related issues including clarification on "pass through" funds, GAVI and GFATM, in particular with regard to the "differently placed countries", should be prepared. ***(Action: DPM/PLN)***

(8) AOs should be included in the GSM approval chain on procurement to ensure compliance. ***(Action: DAF)***

2.3.2 Preparation of Programme Budget 2016–2017 *(Agenda item 3.2)*

Background

The development of the Programme Budget for the 2016–2017 biennium is very different from the previous bienniums, as it has followed a need-based, bottom-up process as per the request of the Member States.

The process of Programme Budget 2016–2017 included the identification of selected priorities at the country level; identification of regional and global priority work including regional and global public goods; consolidation of priorities towards an organization-wide plan; review by Programme Area networks and Category networks; review by Global Policy Group (GPG); and preparation of the draft Programme Budget for consultations with the Regional Committees.

Discussion points

- The perceptions of the WHO Representatives who participated during the Programme Area Network (PAN) and Category Network (CN) discussions showed that better clarity and guidance would have been more useful. During these meetings only the technical issues had been discussed, but budget issues were kept out of the discussions. The frustration of some of the team members on controlling the effects of ceilings for priorities and areas where resource mobilization is possible was conveyed.
- Timelines for discussions were very tight; Programme Area networks discussed mostly through tele/video-conference wherein often deliberations were unclear or rushed. Face-to-face meetings of the Category and Programme Area networks are more productive than teleconferences. Thus we should think of ways to address this as this way of working of PANs and CNs continue.
- Compilation of regional priorities has been completed. However, there is a need to further verify them, and to identify the regional public goods for the 2016-2017 biennium.
- Following the approval of the Programme Budget 2016-2017 by the Sixty-eighth World Health Assembly, the operational planning process would follow.

Major conclusions and action points

(1) To coordinate with PRP/HQ to obtain the draft 2016-2017 Programme Budget document in SEARO in time for the SPPDM meeting which will be held on 18 July 2014. ***(Action: DPM/PLN)***

(2) Increased participation of WRs, in the true spirit of bottom-up planning, in the meetings of Category networks and Programme Area

networks needs to be encouraged and WHO headquarters should be sensitized in this regard. ***(Action: DPM/PLN/WRs)***

(3) Category-wise regional priorities need to be identified against the country priorities in the South-East Asia Region. A list of Regional Public Health Goods to be identified. ***(Action: All technical departments - to be coordinated by PPC)***

2.3.3 Update on WHO reform: Financing Dialogue and bottom-up planning for Programme Budget 2016–2017 *(Agenda item 3.3)*

Background

As part of WHO reform, the governing bodies had requested the Director-General to develop a framework of engagement with non-State actors and separate policies on the engagement with different groups of non-State actors. Based on the inputs received in governing body debates and consultations the Secretariat submitted to the Sixty-seventh World Health Assembly a Draft Framework for engagement with non-State actors containing: (a) an overarching Framework for engagement with non-State actors, and (b) four separate WHO policies and operational procedures on engagement with - 1) nongovernmental organizations, 2) private sector entities (including international business associations), 3) philanthropic foundations and 4) academic institutions.

The historical background of WHO's reform process introducing a new Strategic Resource Allocation methodology was presented. The operational segments of budgeting breakdown, the proposed overarching guiding principles and the criteria specified under each of the segments were presented.

Discussion points

- Caution to be exercised in advocating the involvement of non-State actors, particularly in view of the possible conflict of interests of specific profit-making industries (e.g. tobacco and alcohol).
- The details of the four operational segments of budget allocation were discussed.

- Application of principles and criteria for Strategic Budget Space Allocation among Member States is very complex. The results of Strategic Budget Space Allocation may not be fully available for the 2016-2017 biennium.

Major conclusions and action points

(1) Relevant inputs from the countries and the Regional Office should be provided to the Minister of Health and Family, Maldives, member of the Working Group on Strategic Resource Allocation, so that the Region's views, perspectives and thoughts in this regard could be put forward to the Working Group. ***(Action: DPM/PLN, DAF, WCOs)***

2.4 Operationalizing Region's priorities (Agenda item 4)

2.4.1 Addressing epidemiological and demographic challenges *(Agenda item 4.1)*

A. Eliminating measles: It is possible before 2020

Background

Following the progress in reducing measles mortality in the Region, the ongoing efforts to strengthen routine immunization and the recent success with the polio-free certification, the Region is well-positioned to achieve goal of measles elimination by 2020.

Discussion points

- While achieving high routine immunization coverage will be key, the importance of mass immunization campaigns for eliminating measles should not be underestimated.
- A cost-benefit analysis of measles and rubella/Congenital Rubella Syndrome (CRS) elimination specific to the Region, though difficult, would be a useful advocacy tool.
- Future funding for measles elimination would be an issue for GAVI graduating countries. However, GAVI is likely to provide 3-4 years of

specific additional financial support to these countries based on the needs following a joint appraisal. For some GAVI eligible countries co-financing payments may be made by using partner funds lying with WHO on a case-by-case basis, provided the partner agrees.

- Horizontal collaboration between countries has proved to be very successful in the area of sharing technical expertise.
- Resumption of regional and bi-regional meetings of countries that share borders will be an important mechanism for the management of measles elimination along border areas.
- The WHO-supported polio infrastructure in the five high-priority countries has begun to transition their support from polio to also support measles elimination. While it is important for WHO to have an exit strategy in hand, in practical terms the infrastructure may have to be maintained to support governments, some of which have a goal of measles elimination well before 2020.
- Despite skepticism, the Region successfully eradicated polio and the polio infrastructure in the five priority countries is still operational. In two separate meetings that took place in 2014, health ministers informed the Regional Director that measles elimination is doable in the Region by 2020 and expressed their commitment to the same.
- Success in achieving the 2020 target will depend on accelerated implementation of strategies by India and Indonesia.

Major conclusions and action points

(1) To meet the regional measles elimination target, conduct a cost-benefit analysis specific to the Region. ***(Action: FHR/IVD)***

(2) Explore mechanisms of financial support for GAVI graduating countries and for co-payment for GAVI-eligible countries that may not be able to afford to make this payment. ***(Action: FHR/IVD)***

(3) Advocate at country level for mobilization of in-country resources in support of measles elimination. ***(Action: WRs)***

(4) Regional Office to disseminate and share the regional measles elimination indicators with WCOs to jointly monitor key measles

elimination indicators with health ministers/high-level MoH officials once or twice a year. ***(Action: FHR/IVD, WRs)***

(5) Further expand and strengthen horizontal collaboration as needed. ***(Action: WRs with facilitation by IVD-SEARO)***

B. Noncommunicable diseases: Implementing best buys

Background

- Noncommunicable diseases (NCDs), such as heart disease and stroke, cancer, diabetes and chronic lung diseases, have emerged as leading killers, causing 55% of all deaths in the Region. Four major NCDs share common modifiable behavioural risk factors: tobacco use, insufficient physical activity, unhealthy diet, and the harmful use of alcohol. These behavioural risk factors in turn lead to clinical risk factors such as overweight/obesity, raised blood pressure and raised cholesterol, and ultimately to NCDs. The prevalence of behavioural and clinical risk factors for NCDs is high in the Region.

- The vision and mandate to address NCDs has been defined at the global level by the UN Political Declaration of NCDs and the global action plan and voluntary targets endorsed by the Sixty-sixth World Health Assembly. At the regional level, the Sixty-sixth session of the Regional Committee unanimously approved the Regional Action Plan for the period 2013–2020 and endorsed 10 regional targets for the prevention and control of NCDs in line with the Global Action Plan and voluntary targets adopted by the Sixty-sixth World Health Assembly.

- NCDs can be significantly contained by the prevention and control of the underlying risk factors. A package of "best buys" (Box 1) has been developed by WHO for primary and secondary prevention of NCDs: (i) primary prevention of NCDs through population-wide interventions that include legislative and fiscal policies to reduce exposure to behavioural risk factors; (ii) secondary prevention through early diagnosis and management of metabolic risk factors for NCDs targeted at high-risk individuals. The "best buys" are cost-effective interventions which are feasible to scale up in resource limited settings and those that are of high impact.

Box 1

Risk factor / disease	Interventions
Tobacco use	➢ Raise taxes on tobacco ➢ Protect people from tobacco smoke ➢ Warn about the dangers of tobacco ➢ Enforce bans on tobacco advertising
Harmful use of alcohol	➢ Raise taxes on alcohol ➢ Restrict access to retailed alcohol ➢ Enforce bans on alcohol advertising
Unhealthy diet and physical inactivity	➢ Reduce salt intake in food ➢ Replace transfat with polyunsaturated fat ➢ Promote public awareness about diet and physical activity (via mass media)
Indoor air pollution	➢ Increase access to clean energy and promote use of improved cookstoves
Cardiovascular disease (CVD) and diabetes	➢ Provide counselling and multidrug therapy (including blood sugar control for diabetes mellitus) for people with medium-high risk of developing heart attacks and strokes (including those who have established CVD) ➢ Treat heart attacks (myocardial infarction) with aspirin
Cancer	➢ Hepatitis B immunization from birth to prevent liver cancer ➢ Screening and treatment of pre-cancerous lesions to prevent cervical cancer

- Implementing best buys in countries will require substantial scaling up of national capacities and sustained availability of resources. The role of WHO is critical in building national capacities and catalyzing actions required from a wide range of stakeholders.

Discussion points

- The WRs shared a number of important country-level initiatives including successes with control of tobacco and alcohol, promotion of

physical activity, introduction of WHO PEN (Package of essential noncommunicable diseases) pilot projects and implementation of NCD risk factor surveys. The need for documenting country-level experiences and best practices was underscored and identified as a priority.

- Multisectoral actions and "health in all policies" is a key approach and an entry point for driving forward the NCD agenda. The importance of primary prevention and population-based approaches was considered paramount in reducing exposure of populations to NCD risk factors. It was emphasized that an enabling environment that "makes healthy choice as the default choice" is critical to promote healthy behaviours. The need to build capacity of national and WHO staff in a range of NCD programmatic issues was recognised.

- Three priority risk factors that would contribute the most to reducing NCD-related premature mortality were highlighted— tobacco use raised blood pressure and salt intake. Tobacco control remains the number one priority for prevention and control of NCDs, and raising tobacco taxation is the "best of best buys". Tobacco control requires high political commitment and the formulation and enforcement of strong legislation. With regard to blood pressure control, a key challenge is that a vast majority of those with hypertension remain undiagnosed and untreated due to lack of awareness or lack of access to treatment and counselling. Programmes for early detection and treatment of hypertension are "quick wins" that would significantly reduce NCD-related premature mortality. Reduction in intake of salt among the population of the Region will require culturally appropriate strategies. While most of the dietary salt is added during cooking, the population is increasingly consuming processed food and restaurant food. Therefore, a multipronged strategy is needed: on the one hand to create mass public awareness for avoiding excess salt and on the other to initiate dialogue with and regulate the food industry to reduce salt content in processed food.

- Ageing populations and the emergence of childhood obesity in some countries were identified as key demographic and nutritional transitions that would further increase the burden of NCDs in the coming years. These issues need attention sooner than later.

- Key challenges in addressing NCDs that were highlighted include weak enforcement of legislation particularly for tobacco control; issues

in harmonizing global surveillance indicators into national surveillance frameworks; impediments and lack of support from clinicians to public health oriented approaches for NCD control; and lack of institutionalization and systematic approaches for NCD surveillance.

Major conclusions and action points

(1) Use existing training programmes and tools for building capacity of national and WHO staff in a wide-range of competencies required for implementing NCD best buys: ***(Action: SDE/NCD)***

(2) Showcase, document and disseminate country-level NCD best practices through publications and other mechanisms. ***(Action: All WCOs)***

(3) Support relevant research to generate evidence for developing, implementing and evaluating appropriate strategies and programmes for the prevention and control of NCDs in Member States of the Region. ***(Action: SDE/NCD, all WCOs)***

(4) Use a "whole-of-office approach" across programmes and categories and further enhance horizontal collaborations to support Member States in scaling up NCD best buys. ***(Action: All WCOs, SDE/NCD)***

(5) Prioritize partnerships for technical cooperation and resource mobilization. ***(Action: SDE/NCD and WCOs)***

2.4.2 Promoting universal health coverage *(Agenda item 4.2)*

A. Universal health coverage: Recent developments

Background

- There is considerable focus on the significance of universal health coverage (UHC) for public health at all levels with important contributions from Member States of the WHO South-East Asia Region. The Regional Director's inclusion of UHC as a Strategic Area in her vision statement for the Region and, furthermore, as a Flagship Priority now aligns WHO's efforts in the Region with this international area of focus. At the Regional Conference on Advancing UHC in SEAR (23-25 April 2014 in Paro, Bhutan) Member States reinforced

the four Strategic Directions recommended by the Regional Strategy for UHC and agreed on next steps to inform national UHC strategies, notably, measuring UHC based on the WHO-World Bank framework; health intervention and technology assessments (HTA) in line with the regional and World Health Assembly Resolutions (SEA/RC66/R4 and WH67.23 respectively) and moving forward on benefits packages with "quick wins" on equity such as through improved access to affordable medicines.

- The findings of the World Bank's World Development Report 1993, which were seminal in profiling health in development, have been reiterated by a Special Commission of the Lancet, eliciting a reiteration of the international commitment to UHC, including in the post-2015 development agenda. This commitment is already accompanied by financial support. For example, the World Bank has extended a US$ 200m loan to Myanmar for advancing UHC in that country.

- To deliver on the Regional Director's UHC Flagship Priority, in line with the 12th GPW as well as future international development goals, technical resources in the Region are adequate - a team of well qualified and contextually competent international consultants are available for short-term technical assistance as needed. This arrangement would be further strengthened if staff in WCO were allowed the flexibility for Regional support, say 20-25 percent of their time, including both international staff and NPOs. Additional financial resources would need to be mobilized for the next biennium, for which outputs/outcomes from donor funding extended in 2014-15 would be important. Finally, WHO needs to work across Categories on UHC and departmental focal points would be useful for this.

Discussion points

- Universal health coverage is expected to be retained in the post-2015 development agenda (albeit not in its totality).

- As in the Regional Strategy for Universal Health Coverage, it is important to emphasize the balance between prevention and curative care for feasible and sustainable UHC, particularly in the disease context for NCDs and systems context for dominant (and unregulated) private provision.

- Human resources for health will be critical for UHC, especially at the primary health care level.
- Health technology assessment (HTA) allows comparison and evaluation of choices available for inclusion in a benefit package. For example, the economic impact, cost-effectiveness and budget impact that support informed choices between alternative interventions and technologies (such as prevention versus curative care for NCDs) as well as evidence-based advocacy (such as making a case for increase in "sin taxes").
- Measurement of UHC must include the quality dimension. (Note: this is explicitly discussed in the proposed WHO-WB framework to measure UHC).
- The health financing function must be clearly brought out in the UHC effort as this is likely to be emphasized by countries. (Note: this is in fact the underlying technical approach of the Regional Strategy document).
- The practical way forward on UHC is to reduce systems inefficiencies as identified by the World Health Report 2010 (WHR2010). (Note: "Improving efficiency for better service delivery" is Strategic Direction 2 (of 4) of the Regional Strategy and includes the discussion in WHR2010 as relevant for the Region).
- As noted by the Regional Director, WHO has a clear Regional Strategy for Universal Health Coverage which has been unanimously endorsed by Member States and is being used by countries for their national strategies. While being fully aligned with other Organizational documents, such as the WHR 2010, the Strategy responds to the specific needs of the South-East Asia Region and recognizes the significance of robust health systems for UHC that go beyond financing mechanisms alone. It recommends the comprehensive Strategic Directions for UHC that link conceptually to the PHC approach: focus on health financing as a key area to improve health equity; address inefficiencies in other systems areas to improve service delivery across all programme areas; and, support country capacity development.

Major conclusion and action point

(1) In light of the Regional Director's Flagship Priority as well as ongoing WHO technical support to countries on universal health coverage, WRs/WCO staff may wish to consider revisiting the Regional Strategy for Universal Health Coverage document. ***(Action: WCOs)***

B. Reducing neonatal mortality

Background

Considerable progress has been made in reducing the number of child deaths in the SEA Region since 1990. The reduction in child deaths has been from about 4.5 million deaths in 1990 to about 1.8 million deaths in 2012, a decline of more than 60%. But neonatal mortality has declined at a slower pace over the same period. The reduction has been from about 1.8 million newborn deaths in 1990 to about 1 million in 2012, a decline of less than 50%. At the same time about one million stillbirths occur every year in the Region. Currently, newborn deaths account for about 50% of all under-five mortality in the Region compared with 44% globally.

The main causes of death among newborns include complications of prematurity, birth asphyxia, birth trauma and neonatal infections. It is noteworthy that a majority of newborn deaths take place during first days of life which is also the time when most maternal deaths take place. In the SEA Region, a woman dies every 7 minutes in pregnancy and child birth although maternal mortality ratio (MMR) has declined by more than half, from 590 per 100 000 live births in 1990 to 200 per 100 000 live births in 2010.

Evidence suggests that a large proportion of newborn deaths are preventable by implementation of life-saving interventions across the continuum of care following a life-course approach. Intensified action and guidance are needed to ensure newborn survival in order to reduce newborn and child mortality.

Discussion point

- The meeting noted the report on reducing neonatal mortality presented by the Secretariat.

Major conclusion and action point

(1) Country offices and the Regional Office to take action in support of the Every Newborn Action Plan. ***(Action: WCOs/FHR/MRH)***

2.4.3 Strengthening emergency risk management *(Agenda item 4.3)*

A. Preparedness against MERS-CoV and novel influenza viruses

Background

Since 2012, two new pathogens have emerged that have led to protracted events which are still ongoing. These are: the Middle East Respiratory Syndrome coronavirus (MERS-CoV) and influenza A H7N9 virus. MERS CoV is so far restricted geographically to West Asia with more than 96 per cent of all cases occurring in the Kingdom of Saudi Arabia and the United Arab Emirates. Twelve countries have so far reported importation of cases. There is limited person-to-person transmission so far and most of the secondary cases are reported among health-care workers. The institution of infection control practices has dramatically reduced transmission. Camels are incriminated as a reservoir. So far no confirmed human case has been reported from the South-East Asia Region.

Influenza A H7N9 cases have come up mainly in the People's Republic of China with poultry identified as the source. About 447 cases with 158 deaths with limited person-to-person transmission have been recorded in two waves. No case has yet been reported from the Region.

Globalization and rapid and frequent travel puts everyone at enhanced risk, and hence strengthening preparedness is critical to combat these threats.

Discussion points

- All Member States need to strengthen their response through updating and implementing their national influenza preparedness plans as well as health department's coordination with the veterinary sector.
- Infection control practices in the health-care services need to be strengthened.

- Linkages with WHO collaborating centres within and outside the Region as well as other institutions of excellence should be augmented for appropriate technical support.
- Regional pharmaceutical manufacturers should be encouraged to enhance production and distribution of vaccines and antiviral drugs.
- Risk communication should be carried out with incoming and outgoing tourists and pilgrims in the countries of the Region.
- Nonpharmaceutical preventive and control measures should be promoted since no vaccine or drug is available against MERS-CoV.

Major conclusions and action points

(1) The Regional Office should organize training on infection control practices on a priority basis within the year. ***(Action: CDS and HSD)***

(2) Advocacy must be undertaken with national authorities for revision and updating of the national influenza preparedness plans and enhanced coordination with the veterinary sector. ***(Action: WRs)***

(3) Need for national-level training on various aspects (laboratory, infection control, shipment, surveillance, case-management) may be assessed and met in collaboration with the Regional Office. ***(Action: WRs/CDS)***

(4) Small stocks of oseltamivir and personal protective equipment (PPE) should be established in country offices and the Regional Office for rapid deployment in case of any outbreak in the initial phase itself. ***(Action: WCOs and CDS)***

(5) Stockpiling and use of oseltamivir and PPE for UN staff should be undertaken as per the established practices. ***(Action: WCOs and CDS)***

(6) Suspected/probable cases of MERS-CoV and Influenza A H7N9 must be confirmed by WHO collaborating centres and reference laboratories. ***(Action: WRs and CDS/BLT)***

B. Preparedness for emergencies

Background

Countries in the South-East Asia Region are vulnerable to different types of natural and other hazards such as storms, floods, landslides, earthquakes, tsunamis, volcanic eruptions, conflicts and devastating fires. The magnitude of such disasters and their effect have considerable impact on the morbidity and mortality of the region, which is home to approximately 25% of the world's population. Over the past decade, Asia faced the brunt of 41% of all the disasters that occurred globally. The *World Disaster Report 2013* reveals that in the past decade, 37% of global mortality from disasters was in countries of the Region.

Discussion points

- As a region acutely vulnerable to emergencies, several initiatives of the Regional Office have placed South-East Asia in a better position in terms of preparedness in emergencies. These can be further scaled up as part of the Regional Director's vision for a more responsive WHO in South-East Asia.
- WHO representatives to countries of the Region recognize the importance of this field both for country support and organizational preparedness. WRs also noted the support provided to country offices for various emergencies through the deployment of staff, supplies and funds through South-East Asia Regional Health Emergency Fund (SEARHEF).
- Currently the Organization is doing a risk assessment through a risk register which all WCOs are required to conduct and complete. It was noted that risks that impact our operations as an Organization extend to outbreaks, crises and various other emergencies. As such, the risk register exercise should factor in such hazards and risks, especially since the Organization has a global responsibility to manage such risks.
- The work around preparedness for the Organization is more about organizing the managerial aspects at the regional and country level and linking these through key instruments such as contingency plans,

SOPs (both technical and administrative), with the WHO Emergency Response Framework (ERF) serving as the overarching guide.

- In terms of support to countries to develop these capacities around all-hazards emergency risk management, it is key to work through health systems strengthening and link with all other key public health areas and services.

Major conclusions and action points

(1) Review benchmark assessments of country capacities and incorporate activities to address capacity gaps in the workplans. ***(Action: SDE/EHA)***

(2) Focus on country office and Regional Office preparedness through various activities, such as surge training/WCO readiness workshops/partnering of various WCOs/developing plans. ***(Action: SDE/EHA, all WCOs)***

(3) Review the feasibility of adding larger risks (e.g. outbreaks and natural disasters) which WHO prepares for and responds to as part of the risk register exercise which country offices are completing. ***(Action: SDE/EHA and DAF)***

2.4.4 Promoting the South-East Asia Region's voice in the global health agenda *(Agenda item 4.4)*

A. International health security: Implication for the South-East Asia Region

Background

Global health security and antimicrobial resistance (AMR) have become extremely important in the context of the changing epidemiology of infectious diseases in the current millennium. WHO's vision is of a world safe from infectious and non-infectious health-security related risks, hazards and emergencies. To implement this vision, WHO has several frameworks, the most important of which are the International Health Regulations (2005), the PIP Framework, Codex Alimentarius, and the MoUs with the International Office of Epizootics (OIE) and the Food and Agriculture Organization of the United Nations (FAO). However, given the global economic implications of these events, several important global initiatives

have also been launched. These include the US Global Health Agenda, the G8 Global Health Security and the Global Health Initiative. Of these, the US Global Health Agenda has been initiated by the President of the United States of America, Mr Barack Obama, and was launched on 13 February 2014.

Discussion points

- Several global and regional initiatives are being launched to strengthen global health security. WHO needs to synergize with these to augment the technical support to countries.
- The global initiatives can enhance the visibility of the IHR (2005) on the national agendas, thus facilitating WHO's frameworks.
- WHO should strengthen its normative functions and promote innovations.
- Member States will take a call on sharing information on disease epidemiology with global initiatives as well as the sharing of biological material.
- WHO must enhance its competence and surge capacity through horizontal collaboration.
- WHO should engage proactively with international partners in our work and as far as possible establish formal joint/collaborative mechanisms.
- Global experts should be involved in WHO's activities; the participation of regional experts in global meetings should be encouraged; and ties with the WHO Western Pacific and Eastern Mediterranean regions should be strengthened.
- Implementation of the Regional AMR Strategy, which is in alignment with the proposed Global AMR Action Plan, should be advocated with the national authorities.

Major conclusions and action points

(1) Undertake advocacy with national authorities for the AMR Strategy and involve professional associations in spreading the message on rational use of antibiotics. ***(Action: WRs, CDS/BLT)***

(2) Promote innovative research to identify mechanisms to reverse or minimize resistance against common antibiotics. ***(Action: CDS/BLT and FHR/RPC)***

(3) Work closely with the national authorities and global partners in strengthening national capacity to combat infectious diseases in context of IHR (2005). ***(Action: WRs and CDS/DSE)***

2.5 SEA Regional Committee: How can it be made more effective? (Agenda item 5)

Background

WHO Governance Reform calls for improving the work of the governing bodies, strengthening the global–regional linkages, and enhancing the roles of the Regional Committee. It also aims to harmonize and coordinate practices across the Organization. The governance approach in the South-East Asia Region of having multiple special-purpose meetings (such as Senior Advisers' Meeting, Health Ministers' Meeting, Regional Committee meeting, High-Level Preparatory Meeting, and Meeting of Sub-committee on Policy and Programme Development and Management) not only diverge from the practice followed in other regions but also create an inordinate burden on the Secretariat to organize and support these events. However, these ancillary/auxiliary meetings, *inter alia*, lead to a Regional Committee session that has been characterized as "predetermined" or "scripted", and which participants from other major offices have found too rigid and lacking in spontaneity or interest for them. The Director-General has intimated that she would like to see, as part of WHO Reform, that the Regional Committee for South-East Asia is more harmonized with those of other regions.

Discussion points

- Consolidation of meetings – in particular: (i) merging the SAM, HMM and RC into a 5-day Regional Committee session; and (ii) reducing the HLP-SPPDM from 5 days to 3 days, was discussed. It was mentioned that in lieu of the HMM, the region may consider organizing a ministerial meeting or conference that could serve as a focal point for action on topical lines and would be held on a biennial basis between

other governance meetings. The HLP was seen to be an opportunity for greater technical participation of Member States whereas the Regional Committee was seen to provide a venue for policy-setting.

- On technical discussions, side-events, guest speakers, the meeting welcomed the opportunity to give more prominence to technical matters at the Regional Committee, including discussions on flagship priorities, invitation of distinguished technical experts or other prominent individuals (such as Nobel Laureates from the region, etc.) The use of a "panel discussion" format could also be considered to provoke more interaction among participants.
- On the role and involvement of ministers, the meeting suggested that ministers could be more involved by: i) introducing discussion topics at the Regional Committee; ii) participating in panel discussions; and iii) bridging between the Regional Committee and the Executive Board.
- On the use of technology, it was suggested that like some other organizations, the South-East Asia Region should also consider making these meetings paperless by providing information on tablets, websites and through other electronic media to reduce the carbon footprint and ensure better cost-efficiency.

Major conclusions and action points

(1) The Secretariat to propose to consolidate the governing body meetings as proposed above for the HLP and Regional Committee for implementation from 2015. ***(Action: DAF/DPM)***

(2) WRs to propose to the Regional Director or the Director for Communicable Diseases (CDS) by 11 July 2014 the names of potential candidates for a public health award according to the criteria issued. ***(Action: WRs)***

(3) The Secretariat to finalize with inputs from the WRs side-events, panel discussions, guest speakers and/or technical topics of discussion that may be implemented for the Regional Committee Session in 2014. Particular emphasis to be accorded to innovation/technology in public health. ***(Action: DAF, HSD)***

3. Closing session

The draft conclusions and action points emerging from the meeting were reviewed at the closing session.

Concluding remarks by the Regional Director

The Regional Director emphasized the importance of reviewing and discussing the various issues related to the management of WHO's work in the Region. She thanked the WRs for their participation and deliberations during the meeting and for joining the meeting at a short notice.

While thanking the Regional Office for making all the arrangements for this meeting, the WHO Representative to Sri Lanka, the incumbent Dean of WRs, handed over the responsibility of Dean to the WHO Representative to Indonesia following their internal discussions.

The new Dean of WRs, Dr Khanchit Limpakarnjanarat, while thanking all the WRs, proposed that the next Meeting of WHO Representatives be held in Bali, Indonesia, from 3 to 7 November 2014 and extended a warm invitation to all WRs to that meeting.

Annex 1

Agenda

1. Opening
2. Follow-up actions of meetings:
   - 2.1 Follow-up actions of Meeting of WHO Representatives held in June 2013 and Sixty-fifth meeting of RD with WRs held in SEARO in October 2013
3. Presentations and discussions on specific topics of importance:
   - 3.1 Implementation of Programme Budget 2014–2015
   - 3.2 Preparation for Programme Budget 2016–2017
   - 3.3 Implementing WHO reforms at country office level
     - Non-State actors
     - Strategic Resource Allocation
4. Operationalizing Region`s priorities
   - 4.1 Addressing epidemiological and demographic challenges
     - Eliminating measles: It is possible before 2020
     - Noncommunicable diseases: implementing best buys
   - 4.2 Promoting universal health coverage
     - Universal health coverage: Recent developments
     - Reducing neonatal mortality
   - 4.3 Strengthening emergency risk management
     - Preparedness against MERS-CoV and novel influenza viruses
     - Preparedness for emergencies
   - 4.4 Promoting the South-East Asia Region's voice in the global health agenda
     - International health security: Implications for the South-East Asia Region

5. The Regional Committee for South-East Asia: How can it be made more effective?
6. Meeting with the Executive Committee of the Staff Association
7. Closing

Annex 2

List of participants

WHO Representatives

Dr Khaled Mohammad-Said Hassan
Acting WHO Representative to Bangladesh

Dr Frank Herbert Paulin
Acting WHO Representative to Bhutan

Dr Stephan Paul Jost
WHO Representative to the Democratic People's Republic of Korea

Dr Nata Menabde
WHO Representative to India

Dr Khanchit Limpakarnjanarat
WHO Representative to Indonesia

Dr Akjemal Magtymova
WHO Representative to Maldives

Dr Krongthong Thimasarn
Acting WHO Representative to Myanmar

Dr Lin Aung
WHO Representative to Nepal

Dr Firdosi R. Mehta
WHO Representative to Sri Lanka

Dr Yonas Tegegn
WHO Representative to Thailand

Dr Jorge M. Luna
WHO Representative to Timor-Leste

Secretariat

Dr Sangay Thinley
Acting Director, Programme Management, and
Director, Department of Family Health and Research

Mr John M Kennedy
Director, Administration and Finance

Dr Rajesh Bhatia
Director, Department of Communicable Diseases

Dr Roderico Ofrin
Acting Director, Department of Sustainable Development and Healthy Environments, and
Coordinator, Emergency and Humanitarian Action

Dr Prakin Suchaxaya
Acting Director, Department of Health Systems Development, and
Coordinator, Gender, Equity and Human Rights

Dr Arun Bhadra Thapa
Coordinator, Immunization and Vaccine Development

Dr Renu Garg
Regional Adviser, Noncommunicable Diseases

Dr Alaka Singh
Regional Adviser, Health Economics and Health Planning

Dr Neena Raina
Regional Adviser, Child and Adolescent Health

Dr Martin Willi Weber
Regional Adviser, Making Pregnancy Safer and Reproductive Health

Dr Bardan Jung Rana
Acting Regional Adviser, Disease Surveillance and Epidemiology

Dr Thushara Fernando
Planning Officer

Dr Patanjali Dev Nayar
Programme Management Officer

Dr Gunawan Setiadi
Technical Officer, Country Cooperation Strategy

Mr Robert Chelminski
Acting Budget and Finance Officer

Dr Pem Namgyal
Executive Officer, Office of the Regional Director

Mr Gulshan Malhotra
Administrative Assistant, Office of the Regional Director

Mr R.K. Arora
Programme Planning and Coordination and Governing Bodies Unit

Ms Parul Oberoi
Programme Planning and Coordination and Governing Bodies Unit

Annex 3

Regional Director's opening remarks

WHO representatives, colleagues, ladies and gentlemen,

With great pleasure I warmly welcome you all to the Sixty-sixth Meeting of the Regional Director with WHO Representatives of the South-East Asia Region.

This is our regular annual event, which normally takes place during November. However this time we shifted it to June in view of the HLP and SPPDM. This is also an opportunity for WHO Representatives and Regional Office staff to review and discuss various issues related to the implementation of the current Programme Budget, and discuss the development of the next biennial Programme Budget and several regional priorities. The agenda and programme for the meeting is with you. I would welcome more interaction and I am open to your suggestions as to how we can do this better and differently in the future.

One of the key issues for our attention this time is in the area of the Programme Budget. First and foremost, we need to speed up implementation of the Programme Budget 2014–2015. You are aware that about 75% of the Budget for the Region is with the Member States. Therefore, a higher rate of implementation at the country level is essential to show progress in the Region. As already stated during my opening remarks at the February meeting with WHO representatives, I expect a minimum of 60% implementation of activities and corresponding utilization of funds in the first year of the biennium. If you can exceed that level, that would be even better. We have seen that our biennium start-up has been particularly good from day one. We have noted that funds are available right from the outset, so we have no reasons for delay in our implementation. However I am a little concerned that some of the Member States and Regional Office Budget Centres are lagging behind in their implementation. We will look into those details later.

We are already aware of the unprecedented reduction of US$ 44 million in the biennial budget of this Region owing to low implementation of the 2012–2013 Programme Budget. We have been slow in effecting expenditure.

I wish to urge you all to accelerate timely implementation of our workplans but with quality, in both financial and technical terms.

In line with the above, during the staff meeting on 9 June 2014 I had asked all Budget Centres to have HR costs covered, especially the available flexible funding, only for up to 12 months and use the rest for priority activities. This will see funds being implemented quickly and not being held up by being blocked for salary payments in 2015. I reiterate that retention of funds should be kept at a minimum.

In the preparation for the Programme Budget 2016–2017, WHO is utilizing a new process for developing the Programme Budget, with priority setting at the country level as a first step in the bottom-up planning cycle. I thank you all for the timely inputs. After initial consolidation by the regions through the web-tool, results of the bottom-up process at country, regional and global levels have been reviewed and consolidated through the Programme Area Networks (PAN) into organization-wide Programme Area plans. Proposals from the Programme Area Network are being reviewed by the Category Networks. We will be discussing the updates on the Programme Budget 2016–2017 at this meeting. The Regional Office has hosted the Category 6 Network meeting on 5–6 June 2014.

Colleagues,

I have been quite busy since we last met in February. I attended the GPG Meeting in Manila in March and, from there, I went straight to Myanmar with the Director-General. Then in April I was at the World Bank Spring meeting to support Myanmar's UHC plans for World Bank funds. Towards the end of the same month I was in Bhutan to attend the UHC meeting and followed through to Kathmandu to participate at the meeting on the unfinished agenda of MDG 4 & 5. I was in Sri Lanka last week to launch the World Blood Donor Day global event which was a very rich and satisfying visit for me. Then I was in Geneva with the South-East Asia Region delegation to attend first the GPG, followed by the PBAC meeting, the Sixty-seventh World Health Assembly and the Executive Board meeting, the details of which I need not elaborate to you.

While I was at the World Health Assembly and other meetings, I also took the opportunity to meet representatives of donors, partners and heads of delegations from key donor countries to talk to them about our vision and the work we are doing in the Region. It was an excellent opportunity to

not only put our health agenda on the global platform, but also to reach out to garner support and collaboration, and I had some very positive responses.

The reason why I am elaborating the country visits is to emphasize the close working relations between governments and WHO and it is you at the country level who strengthen this relationship in a continuous manner. I took the opportunity to meet senior government officials during my visits to discuss mutual health priorities and common concerns, and to explore ways and means in which WHO can continue to play a meaningful role in countries. I want to thank all WRs who spent a lot of time to prepare and then facilitate such visits and I have to say that all the visits have been very productive. Although often hectic, I have to say I enjoyed these trips very much.

You have already seen the revised policies on duty travel and regional meetings. I encourage all of you to please plan them well, monitoring them in a timely manner and ensuring follow-up of actions that arise from duty travels or meetings.

I need not reiterate that the Organization is going through rapid changes as WHO reforms are being rolled out. It is not an easy time for all of us. It is during such times that we must come together as one Organization and demonstrate our ability to adapt and yet deliver on our commitments to Member States so that we continue to occupy that special place that we have always had in the universe of the ministries of health. In the process of this reform, we who work at the regional and country level, need to make sure that the regional arrangements of WHO will not be undermined or weakened. We need to ensure that the regional organizations, comprising the Regional Committee, the Regional Office and country offices, will not only continue but become stronger in its structure and functions.

Ladies and gentlemen,

You will remember that I promised to strengthen country offices and to support your work to the best of our means and ability. I am happy to inform you that I have already announced the movement of some technically sound staff to the country offices. Dr Richard Brown will move to Thailand, Dr Alaka Singh will move to Myanmar, and Dr Sudhansh Malhotra to Indonesia. This is to bring expertise and experience from the

Regional Office to strengthen the technical capacity of country offices. I will continue to explore if further movements are necessary.

In the light of WHO reforms, I have also asked for the tabling of an important agenda item at the South-East Asia Regional Committee: how can the sessions be made more interesting. This will also be part of discussions at the upcoming Health Ministers' Meeting.

At this meeting, we will deliberate on how we operationalize the regional priorities, namely addressing epidemiological and demographic challenges, promoting universal health coverage, strengthening emergency risk management and international health security. Your suggestions and feedback would be most welcome.

Ladies and gentlemen,

With these words, I wish this meeting all success. And I also wish you an enjoyable stay in Delhi, even if it is a little hot.

Thank you.

The Sixty-sixth Meeting of the Regional Director with the WHO Representatives of the South-East Asia (SEA) Region discussed various issues related to implementation of the Programme Budget for 2014–2015; preparation of Programme Budget 2016–2017; implementation of WHO reforms at the country level and operationalizing regional priorities.

This report summarizes the discussions, conclusions and action points of this meeting which consisted of five sessions.

The first session reviewed follow-up actions of the Meeting of WHO Representatives held in June 2013 and the Sixty-fifth Meeting of the Regional Director with WHO Representatives in October 2013.

The second session discussed specific issues of importance: Implementation of Programme Budget 2014–2015; preparation for Programme Budget 2016–2017 and implementation of WHO reforms at country office level.

The third session was dedicated to operationalizing regional priorities which included: addressing epidemiological and demographic challenges; promoting universal health coverage; strengthening emergency risk management, and raising the South-East Asia Region's voice in the global health agenda.

The fourth session of the meeting discussed ways of making the sessions of the Regional Committee more effective.

The fifth session adopted the draft report of this meeting, finalized subsequently in consultation with participants.

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