Report of the Regional Director
1 July 2003 – 30 June 2004
The Work of WHO
in the South-East Asia Region

Report of the Regional Director
1 July 2003 - 30 June 2004

World Health Organization
Regional Office for South-East Asia
New Delhi
June 2004
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PREFACE

The 11 Member States of WHO’s South-East Asia Region, hold the key to the state of the world’s health. Home to over a fourth of humankind, and 40 per cent of the world’s poor, the Region also carries a disproportionately high percentage of the global burden of disease. Thus, it has the potential to hasten or hinder progress towards achieving the universal goal of health for all. It is in this context that WHO’s collaborative activities in the Region assume added significance.

The work of WHO has always been guided by the cardinal principle of providing timely and effective support to Member States in their health development efforts. This can best be done by strengthening WHO country offices to respond more efficiently to country needs. During the major period covered in this report, WHO’s collaborative activities in the Region were further strengthened under the able leadership of my predecessor, Dr Uton Muchtar Rafei. The main objective has been to improve the health status of the people, particularly the poor and marginalized sections of society in the context of sustainable development.

The Report provides an overview of the significant contributions and progress made in different areas, the constraints as well as the steps being taken to overcome them. While much has been achieved, there is still considerable ground that needs to be covered. Among the unfinished agenda, we face the challenge of polio eradication and leprosy elimination. We need to strengthen efforts to promote healthy lifestyles and curb the increasing trend in noncommunicable diseases. We have to urgently find solutions to tackle drug-resistant malaria and tuberculosis and the rapidly increasing threat of HIV/AIDS. In addition, we need to be ever vigilant to respond effectively to global health emergencies, especially emerging infectious diseases, just as we did during the outbreaks of SARS and avian influenza.
The United Nations Millennium Development Goals have set out the strategic directions that will help us steer our course. Reiterating the centrality of health to development, the MDGs highlight the need for efficient health systems to respond to the complex and wide-ranging needs of vulnerable populations and challenges to health development, now and in the future.

Above all, what is required is a bold vision by the international community that recognizes health as a right for all, and not as a privilege for a few. To achieve our goals, we must strengthen community-based efforts. In order to have the desired impact on people’s health, we need to stress the role of rational planning and team work. In the current context of severe resource constraints, we need to convince the donor community that investing in health is investing in the future.

Having been closely associated with health development in the Region for nearly three decades, I am aware of the commitment, determination and ability of our Member States to achieve the ultimate goal of a healthy South-East Asia Region. In these endeavours, WHO shares with its Member States a common vision, common ideals and common goals. WHO, in fact, is committed to further strengthen these bonds. It is with these sentiments that I present my first report on the Work of WHO in the South-East Asia Region during the period 1 July 2003 – 30 June 2004.

Samlee Plianbangchang, M.D., Dr.PH.
Regional Director
EXECUTIVE SUMMARY

Communicable Diseases

The outbreak of a serious new disease, namely severe acute respiratory syndrome (SARS), and the occurrence of avian flu affected the Region during the reporting period. However, the very effective and pivotal role played by WHO in outbreak alert and response re-eminisced the important role of the organization. Timely stockpiling of reagents, diagnostic kits and other supplies contributed significantly in dealing with the situation effectively. This was made possible through effective collaboration with WHO headquarters and the Regional Office for the Western Pacific.

Serious efforts were made to continue the implementation of the Regional Strategic Plan for Integrated Disease Surveillance (IDS) through a comprehensive assessment of national surveillance systems, followed by the development of national plans of action in Member States. Draft technical guidelines on the implementation of IDS have also been developed and peer reviewed.

Capacity building in epidemiology, and in epidemic preparedness and response, through training in the Field Epidemiology Training Programme (FETP), continued to receive priority attention.

The draft of the revised International Health Regulations (IHR) was discussed at the first regional consultation with country IHR focal points and experts from WHO headquarters, and from the South-East Asia and the Western Pacific regions, to facilitate country-level consultations. These were followed by national-level consultations with all stakeholders. The second regional consultation on the revision of IHR was held from 29 June – 1 July 2004.
Overall, there has been good progress in leprosy elimination, as shown by the reduction in disease prevalence from 2.46 to 1.93 per 10,000 population during the reporting period. The number of new cases detected declined in all countries except Indonesia. So far, over 11.6 million persons have been cured since the initiation of multidrug treatment (MDT) in 1985. Bangladesh, Bhutan, DPR Korea, Indonesia, Maldives, Myanmar, Sri Lanka and Thailand have achieved the elimination status at the national level and are targeting the sub-national-level elimination. India, Nepal and Timor-Leste are set to achieve the goal by December 2005 with high-level political commitment.

WHO/UNAIDS estimate that 40 million people are currently living with HIV/AIDS worldwide and that nearly six million are in need of antiretroviral therapy (ART) globally. The South-East Asia Region (SEAR), with nearly six million people with HIV/AIDS, has the second highest disease burden following sub-Saharan Africa. Nearly 99% of these people are in India, Indonesia, Myanmar and Thailand, with approximately 900,000 of them needing ART. WHO has recently declared that providing access to ART for the millions of persons who need it is a global health emergency. The first key response to this situation has been the setting of a target to provide three million HIV-infected people in developing countries with antiretroviral drugs (ARVs) by the end of 2005, the "3 by 5" target. Since then, this has guided much of the work on HIV/AIDS of the Regional Office, along with continued emphasis on HIV surveillance, prevention and care. The main challenge is to rapidly increase the coverage of ART from less than 10% (30,000) to about 50% of the proposed regional targets (450,000).

Considerable progress has been made in tuberculosis (TB) control. By mid-2004, as a result of the rapid expansion of Directly Observed Treatment, Short-Course (DOTS) over 85% of the population in the Region had access to good diagnostic and treatment services. The overall treatment success rate under DOTS was nearly 85% the target set for 2005, while case-detection has risen to 46% during the past year. This progress is attributable to wider coverage, continued improvements in the quality of services and growing partnerships with other providers, particularly NGOs, the private health sector, medical teaching institutions, large public employment sectors, and
related programmes such as HIV/AIDS control in countries of the Region.

Even though cases of malaria showed a declining trend during the past five years, with about 2.5 million reported cases, the proportion of *Plasmodium falciparum* malaria has increased to approximately 48%. The spread of multidrug resistance continues to be a cause for concern. The disease affects all age groups, though more evidence is needed to determine the greater vulnerability of children under the age of five years and pregnant women, for planning the malaria control programme. The information available on drug resistance monitoring and consideration of the recommendations made by WHO have led to a revision of the national policy on antimalarials in Bhutan, Myanmar and Thailand, while good progress has been made in Bangladesh, India and Indonesia. The countries are consequently recommending artemisinin-based combination drugs for the treatment of falciparum malaria. They are incorporating the use of insecticide-treated bednets (ITNs) with support from the Regional Office.

Seven of the nine countries endemic for lymphatic filariasis are implementing Mass Drug Administration (MDA). In 2003 alone, 36 million people in the Region received MDA. Despite this, the targeted regional scale-up of MDA could not be achieved due to funding constraints and other problems like delayed supply of drugs. WHO is working with countries of the Region to resolve these issues.

The Region is making concerted efforts to achieve the WHO goal of deworming at least 75% of school-age children by 2010 and ensuring regular treatment of high-risk groups like women of child-bearing age. WHO played a key role in mobilizing partners and resources to assist countries in the control of soil-transmitted helminthiasis (STH).

Rabies and Japanese encephalitis (JE) continue to be major public health problems. Of the estimated 50 000 human rabies deaths occurring globally, the Region accounts for 70% of Outbreaks of JE are annually reported in India, Nepal, Sri Lanka and Thailand with high mortality rates. WHO supported the “Burden of Disease” studies on rabies in India and Myanmar. The results of the study in India lowered the estimated annual human rabies deaths from 30 000 to 18 000 but indicate a
very high incidence of animal bites. WHO assisted Member States in developing and implementing plans of action for the control of rabies.

Eight of the eleven countries of the Region are annually reporting dengue fever/dengue haemorrhagic fever (DF/DHF), the exceptions being Bhutan, DPR Korea and Nepal. In 2003, more than 115,000 cases and 763 deaths were reported from these countries. Case-fatality rates are declining. WHO supported the establishment of ‘DengueNet’, an internet-based global surveillance system for DF/DHF in all the endemic countries, and assisted in the development of five-year strategic plans. A major outbreak of DF/DHF occurred in Indonesia in 2004 which WHO assisted in containing.

Apart from supporting the ongoing research studies in TDR-listed diseases, a joint new initiative between the Regional Office and WHO headquarters – The Small Grants Project – was launched, to promote research in the least developed countries. Bhutan, DPR Korea, Maldives and Timor-Leste were identified as beneficiaries of this project.

Responding to the outbreak of wild polio virus in India in 2002 and the intensive efforts to end polio virus transmission in the Region in 2004 saw a renewed focus on implementing high quality and regular polio supplementary immunization activities in large areas of India. At the same time, countries of the Region had to ensure vigilance against the risk of polio virus importation and sustain high quality surveillance systems.

In order to gain from the lessons learned, the Regional Office has been examining how the polio immunization infrastructure could be utilized to strengthen the quality of immunization services for other vaccine-preventable diseases. During 2003, most countries of the Region began integrating acute flaccid paralysis (AFP) surveillance and laboratory activities with other diseases. There is now additional emphasis on reduction of measles mortality and on the phased introduction of hepatitis B vaccine and auto-disable (AD) syringes across the Region.

Ensuring blood safety through efficient implementation of the WHO global strategy is one of the priority areas for the Region. In this context, the capacity of countries to implement
nationally coordinated blood transfusion services (BTS) has been strengthened. Managers trained in quality control by WHO during the past three years were provided continuous technical support through the Regional Quality Centre and through participation in the Regional External Quality Assessment Scheme.

In order to support the “3 by 5” initiative, a training workshop was conducted in CD4 lymphocytes enumeration. Regional guidelines for laboratory support to HIV/AIDS diagnosis and antiretroviral treatment were drafted and training imparted to strengthen quality assurance in laboratory testing for HIV and diagnosis of opportunistic infections. The accreditation of health laboratories in countries of the Region was advocated through an informal consultation.

**Noncommunicable Diseases and Mental Health**

The Regional Office continued to strengthen the regional capacity for conducting sustainable surveillance of noncommunicable diseases (NCD) and their risk factors. Twenty-seven WHO STEPS surveys were carried out in eight countries. To enhance accessibility to and utilization by countries of surveillance information on NCDs and their risk factors, a Regional NCD InfoBase has been established.

Along with NCD risk factor surveillance, good progress has also been made in the implementation of integrated community-based NCD prevention projects in Bangladesh, India, Indonesia, Maldives and Sri Lanka. This approach is the initial step to promote primary prevention of NCDs.

In addition to disease prevention, WHO also supported efforts of countries to improve NCD management, especially management of intermediate risk factors of NCDs. Steps are being taken to establish a framework and modality to develop the Regional Network for NCD prevention.

Following the adoption of the Framework Convention on Tobacco Control (FCTC), an Intercountry Consultation on Multisectoral Mechanisms for Comprehensive Tobacco Control was organized in July 2003. Draft guidelines for Comprehensive Tobacco Control have been developed and are under review by WHO headquarters. The findings of tobacco
and economics studies in seven countries of the Region were discussed at the WHO/World Bank Consultation on Effective Collaboration between the Health and Financial Sectors in Indonesia in December 2003. Reports of country studies as well as the recommendations of the consultation were distributed widely.

Surveillance is an important area of FCTC implementation. The Regional Office has developed an online database system. This will also be linked to the global portal developed and managed by the Tobacco Free Initiative cell at WHO headquarters. Guidelines for collecting information at the country level, using the Regional Survey Template, have also been provided to Member States. In order to make the tobacco use information among youth more reliable and comparable, the Centers for Disease Control (CDC), Atlanta, USA, has continued to provide technical and financial support in conducting the Global Youth Tobacco Survey in all the 11 countries of the Region.

NGOs play a very important role in supporting national tobacco control efforts. Partnership of the Regional Office with NGOs has been demonstrated by providing funds under the United Nations Foundation project for tobacco studies in India and by inviting potential NGOs to all intercountry meetings.

In line with the WHO World No Tobacco Day theme of 2004, studies are being undertaken in Bangladesh and Myanmar on tobacco control and poverty.

There is increasing awareness about health promotion concepts and approaches in the countries. Although there has been progress in health promotion, it has been comparatively slow due to its inappropriate delivery within the existing health systems.

Following the recommendations of the Executive Board at its 113th session regarding the Global Strategy on Diet, Physical Activity and Health, WHO incorporated the additional comments received from Member States for improving the draft Global Strategy and submitted it to the Fifty-seventh World Health Assembly for consideration. The Regional Office played an important role in providing updated information in the Region.

The Regional Office provided countries with relevant information and advocacy materials for World Health Day
with the theme, “Road Safety is No Accident”. Bhutan, Myanmar, Sri Lanka and Timor-Leste were supported in developing a national strategy for injury prevention. Draft WHO guidelines on pre-hospital trauma care and essential trauma care were developed and used in Member States. In addition, managerial guidelines for surveillance of injuries and their risk factors are being developed. During the reporting period, a new collaborating centre for injury prevention and safety promotion was established in Bangalore, India.

Although constrained with lack of resources, the Regional Office has continuously monitored the progress of Vision 2020 activities in priority countries. It also provided support for an intervention study on the prevention of traumatic corneal ulcer in Bhutan, India and Myanmar.

Besides developing a regional strategic plan for the prevention of deafness and hearing impairment, a regional document “Hearing and Ear Care in South-East Asia” was also published. A Regional Profile on Care of the Elderly was developed to address issues related to the status of the elderly and their care.

In order to assess the magnitude of neuro-psychiatric disorders in the communities, the Regional Office supported surveys in Bhutan, India and Nepal. The information obtained will be used for the development of country-specific mental health policies and plans.

A simple questionnaire for the identification of epilepsy has been developed and field-tested in eight countries and is now ready for use. At the same time, a manual for the management of epilepsy cases has also been developed for use by primary health care personnel.

A manual on rehabilitation of mentally challenged children has been developed for use by health personnel who work in rural and remote areas.

The Regional Office developed a Regional Strategy on Prevention of Harm from Alcohol. Under this strategy, several projects to address problems of alcohol will be initiated by the second half of 2004. In addition, an Intercountry Workshop on the Prevention of Harm from Substance Abuse was held in Yangon in December 2003. A draft strategy on the subject is being finalized.
Family and Community Health

The 11 countries of the Region contribute to about one third of the global child mortality. The Integrated Management of Childhood Illness (IMCI) strategy addresses major causes of child mortality. Nine countries in the Region are at different stages of IMCI implementation. During the reporting period, innovations in IMCI training were taken forward significantly.

Neonatal survival is still a challenge in many countries of the Region. Estimates indicate that about 40% of all childhood deaths are neonatal. A series of activities were organized during the reporting period to accord high priority to neonatal survival. In this context, a publication Strategic Directions to Improve Newborn Health in the South-East Asia Region was developed and distributed in the Region.

Adolescents constitute 18-25% of the population in the countries of the Region. The problems faced during this period include undernutrition, early marriage and early child-bearing, substance abuse, violence, injuries and suicide. Inadequacy of information and skills, poor access to health services and lack of a safe and supportive environment adversely impact their health and development. WHO is providing technical support to the countries in the formulation of a health sector strategy to ensure that health issues of adolescents are mainstreamed into the existing public health programmes. In order to improve the access to and coverage of Adolescent-friendly Health Services (AFHS), country capacity is being strengthened to provide quality health care within the existing health care delivery system. About 50% of new HIV infections occur globally among young people (10-24 years) each year due to their increased vulnerability.

In providing support to reduce maternal and newborn deaths, as per the MDGs, the Regional Office assisted countries to improve access to skilled care at birth and to improve the quality of maternal and newborn health services. It also introduced evidence-based norms and standards for maternal and newborn care, and facilitated the use of appropriate methods for reviewing the cases of maternal deaths. Collaboration with development partners, including UN agencies, NGOs and professional organizations has been effective in creating awareness on skilled care at birth and
related issues, in implementing the best practices for maternal and newborn care, and in managing the maternal and newborn health programme.

The promotion of evidence-based norms and standards has been carried out through the Implementing Best Practices initiative, introduction and promotion of the use of Reproductive Health Library CD-ROM, and introduction, adaptation and utilization of reproductive health services guidelines. Maternal and newborn health and family planning were the major areas that were promoted. The Reproductive Health Profiles of eight Member States were updated to provide the latest data for better programme planning.

The major challenge is to ensure the widest achievable range of safe and effective reproductive health services across the health system, to be integrated into primary health care in the countries. The problems of maternal and newborn health, especially those related to skilled care at birth and quality of care, family planning, and unsafe abortion, continue to be the major issues. As HIV/AIDS is a major problem, the promotion of healthy sexual behaviour and practices are crucial in preventing sexually-transmitted infections.

The Regional Office provided support and guidance for gender mainstreaming in WHO and countries, and addressed the issue of violence against women. Two short courses were held to help health professionals integrate gender and human rights into the curricula for basic medical education, and into reproductive health policies and programmes. The Regional Office developed core indicators for monitoring and measuring women’s health; presented WHO’s Gender Policy to WHO programme managers in the Regional Office and five country offices, and continued to support the Women’s Panel, an informal consultative body established to assist with matters related to the recruitment of women professionals.

Special attention was given to strengthen nursing and midwifery workforce management in the Region. The Regional Multidisciplinary Advisory Group on Nursing and Midwifery played a significant role in this regard. In addition, various initiatives were undertaken at country and regional levels, aimed at improving the quality of nursing and midwifery education, services and management.
The nutritional status of infants and young children is far from optimum in the Region. Under-nutrition continues to be a major problem with unacceptably high levels of moderate to severe stunting. Although the prevalence of Protein Energy Malnutrition (PEM) is decreasing slowly in the Region, with the exception of Thailand, about 30-50% of pre-school children in countries are undernourished (underweight or stunted), the maximum numbers being in Bangladesh, Bhutan, India and Nepal. Most countries have included infant feeding in their national nutrition policies, but exclusive breastfeeding (average about 30% in infants below four months of age) and appropriate complementary feeding rates have not shown substantial improvement. Only four countries (Bangladesh, India, Indonesia and Nepal) have changed their infant feeding policies and are recommending exclusive breastfeeding for six months, in line with World Health Assembly resolution WHA55.25. Iodine deficiency is the greatest single preventable cause of brain damage and mental retardation, and yet most countries have not achieved universal salt iodization and eliminated iodine deficiency disorders.

Sustainable Development and Healthy Environments

During the period under review, the Regional Office provided support in planning and implementing low-cost water, sanitation and hygiene demonstration projects in selected countries. The strategy for strengthening the capacity of the Regional Office to respond to emergencies in water, sanitation and hygiene needs of countries is progressing.

The healthy settings programme has been expanded to nine countries of the Region. Networking has been established with other WHO regions for sharing information and experience in this area.

Arsenic contamination of groundwater is a continuing health risk in five countries of the Region. Regional guidelines for diagnosis and management of arsenicosis cases have been drafted. A draft Standard Operating Procedures (SoP) for arsenic testing in the Region was produced. A teaching module for epidemiologists and programme managers, and a health risk assessment module were produced for professionals and programme managers.
In the area of occupational health, a regional strategy was developed to provide a more systematic approach to the problem.

Management of pesticides and hazardous wastes received attention during the period under review. The management of hospital wastes has assumed significance in view of the growing use of disposable syringes and mixing of infectious and non-infectious wastes. For pesticides management, a new strategy was formulated by the Regional Office which is being implemented in partnership with other players in the area.

Technical assistance was provided to Member States in reviewing their food safety policies and programmes. The focus was on strengthening their capacity for monitoring, assessing and controlling food safety through risk assessment.

The Regional Office has also been active in the area of emergency preparedness and response. It collaborated with other UN agencies, international organizations, NGOs and donors in addressing the growing concerns of health and humanitarian action for the migrant populations in the Region. Workshops were conducted to develop national capacities in dealing with health emergencies and crises.

**Health Systems Development**

In line with the principles of Primary Health Care (PHC), public health was advocated as a discipline in countries of the Region. A model for comprehensive community and home-based delivery of health services was developed and field-tested, e-health/telemedicine models were piloted in certain countries, a core curriculum for undergraduate and postgraduate training in family medicine was developed and evidence-based health systems reform supported in some countries through a variety of research and policy interventions.

Planning for human resources for health and quality of training are issues that are addressed continuously in countries of the Region. This area of work covered accreditation of public health institutes and revision of curricula in undergraduate, postgraduate and allied health professional programmes. The progress made in improving public health
as an essential element of health development was assessed and the road-map for further development in public health provided. The South-East Asia Public Health Education Institutes Network was formally launched and its objectives formulated with the focus on making education programmes more relevant to meet public health challenges of individual countries. An electronic Regional Directory of Training Institutes was initiated with facility for continuous updates. Increased focus was given to improve field epidemiology training in public health curricula.

Education and Training Support (ETS) consisted of fellowships, study tours and in-country training. There has been an increasing trend of short-term training in specialized fields with greater use of regional resources, as well as an upward trend in regional and group training under the fellowships programme.

Considering the focus on achievement of MDGs, particularly those related to health, support was extended to countries in monitoring, reporting and in interventions to achieve the required impact. Development, expansion and use of the tools and methods for health measurement, particularly disease estimations, assessment of the health system performance, the World Health Survey, health financing (particularly national health accounts and social health insurance) were key activities that were successfully implemented in the Region.

Continued support was extended to Member States in promoting and strengthening health research including building capacity among young researchers. A regional training package for health research management was finalized for use by middle-level health research managers in Bangladesh, Indonesia, Sri Lanka and Thailand. Together with 13 countries globally, Indonesia and Thailand are involved in testing the global framework and instruments for analysing national health research systems. The 28th South-East Asia Advisory Committee for Health Research, at its meeting in 2003, recommended a regional vaccine policy as well as research priorities to strengthen measures for the prevention and control of thalassaemia.

The work on Essential Medicines was based on the WHO medicine strategy. Countries of the Region were urged to use
regional mechanisms to purchase drugs in bulk to ensure affordable essential drugs of adequate quality. The focus was on the countries which import the majority of their essential drugs. In addition to the global supply systems, a prequalification scheme was considered for introduction in the countries. Some countries took important steps in institutionalizing rules and regulations in medicines. Since counterfeit medicines continue to cause concern, activities were focused on increasing awareness of the problem. Bi-regional cooperation to respond to this issue was also strengthened. Activities related to the public health provisions of the Trade Related Intellectual Property Rights (TRIPS) were supported. Development of human resources in the use and management of medicines continued.

Steps were taken to promote the production and wide dissemination of valid health-related information in the region. A series of technical publications, newsletters and bulletins were brought out. The Regional Office continued to print documents for free distribution, including reports on various meetings and country missions, monographs, guidelines, training modules and advocacy materials covering various technical areas.

The Regional Office Library further developed its collection so as to provide comprehensive technical information and health literature support to Member States. The Health InterNetwork Access Initiative (HINARI), launched in 2001, continued to expand in 2003 and provided free or nearly free online access to over 2,000 leading biomedical journals to an increasing number of countries. A Health Literature, Library and Information Services (HELLIS) website was launched.

WHO Programme Planning and Management

The Fifty-seventh World Health Assembly was held in Geneva from 17 to 22 May 2004. Some of the important technical and health matters discussed were: HIV/AIDS; Smallpox eradication: destruction of variola virus stocks; Eradication of poliomyelitis; Global strategy on diet, physical activity and health; Road safety and health; Health promotion and healthy lifestyles; Family and health in the context of the tenth anniversary of the International Year of the Family;
Reproductive health; Health systems, including primary health care; Quality and safety of medicines: regulatory systems; Genomics and world health: report of the Advisory Committee on Health Research, and Human organ and tissue transplantation. The Health Assembly also discussed, among others, the internal audit, financial, programme and budget, staffing and legal matters.

The 113th session of the Executive Board was held in Geneva from 19 to 24 January 2004. The important issues discussed included: Health promotion and healthy lifestyles; Genomics and world health; Draft global strategy on diet, physical activity and health; Draft strategy to accelerate progress towards the attainment of international development goals and targets, and the report of the International Civil Service Commission.

At its 114th session, held in Geneva in May 2004, the Executive Board discussed among other items: Cancer control; Disability including management and rehabilitation; Recruitment of health workers from the developing world; Human resources in health; Avian influenza and human health; Dependence-producing psychoactive substances: supplementary guidelines; Manufacture of antiretrovirals in developing countries and challenges for the future; Sustainable financing for tuberculosis control, and Social health insurance.

The fifty-sixth session of the Regional Committee for South-East Asia was held in the Regional Office from 10 to 12 September 2003. After its assignment to the South-East Asia Region by the Fifty-sixth World Health Assembly, Timor-Leste participated for the first time as the eleventh full-fledged member of the Committee.

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

The Committee discussed the report of the Regional Director on the Work of WHO in the South-East Asia Region for the period 1 July 2002 to 30 June 2003. Among other points, the Committee noted: the alarmingly increasing trend of HIV/AIDS cases and the growing number of new cases of
tuberculosis; the efforts of Member States in strengthening national TB control programmes through expansion of DOTS (Directly Observed Treatment Short-course) strategy, and the use of polio immunization infrastructure for other vaccine-preventable diseases and the phased introduction of hepatitis B vaccine and auto-disable syringes.

The Committee also noted the concerns expressed by Member States regarding the mobilization and utilization of extrabudgetary (EB) funds, and called for equitable distribution of EB resources based on population and disease burden.

The Twenty-first Meeting of Health Ministers of countries of the WHO South-East Asia Region was held in September 2003 in New Delhi, India. The Health Ministers reviewed the progress on the Declaration on Health Development in South-East Asia in the 21st Century as well as the follow-up on FCTC. It recommended that Member States should facilitate and speed up the enactment of anti-tobacco control laws. The prevention and control of SARS was discussed and it was recommended that countries should enhance and sustain the vigilance against the re-emergence of SARS and other potential infectious disease epidemics through improvement of national and regional surveillance and response networking.

The 40th meeting of the Consultative Committee for Programme Development and Management (CCPDM), held in September 2003, reviewed the progress of the WHO collaborative programmes, both country and intercountry, implemented during the period January 2002 - June 2003. It also reviewed the work plans for the 2004-2005 biennium. The Committee recommended programme implementation targets of 75% by the end of the first year, and 100% by 31 August of the second year of the biennium 2004-2005.

During the review period, continued efforts were made by the Regional Office and the country offices to mobilize external resources. At the end of the biennium 2002-2003, a total of US$ 132.6 million, extrabudgetary resources was generated for the Region, which marked a 16.2% increase compared to the previous biennium. In addition, there was a notable increase in the amount of resources mobilized at the country level, which was over 50% of the total funds mobilized, as compared to funds allocated to the Region as part of the global resource mobilization exercise.
In view of the increasing importance of extrabudgetary funds to support WHO’s health programmes, the Regional Office has developed an operational strategy and a plan of action for the 2004-2005 biennium. The strategy focuses on: the development of a resource mobilization system, intensified advocacy and communication with donors, and strengthening of capacity building.

WHO expanded its formal relations with other agencies at the regional level in 2003. Memoranda of Understanding (MoU) between the Regional Office and other agencies, such as the UN Office on Drugs and Crimes, International Federation of Red Cross and Red Crescent Societies, and ASEAN Disaster Preparedness Center were concluded in 2003.

Collaboration with SAARC continued, focusing on strengthening the SAARC TB Centre and in TB control activities. WHO also assisted in the SAARC Regional Training course on TB control.

With a view to improving the managerial process for WHO programme development within the context of national health development, the Regional Office continued to provide support to Member States through training and orientation of relevant health officials. Guidance on programme planning, monitoring and evaluation was also provided. Based on the Programme Budget 2004-2005, detailed work plans for country and regional/intercountry programmes were finalized.

In response to the commitment to the governing bodies to report on the WHO programme budget implementation against the stated expected results and indicators in the Programme Budget 2002-2003, systematic performance monitoring and evaluation were undertaken. This was to ensure that the results were achieved efficiently and effectively. Towards this end, the Regional Office carried out end-of-biennium performance assessments and provided inputs to the Organization-wide exercise. The evaluation of implementation of the intercountry programme was continued.

To further improve gender equity in the Organization, internal monitoring and review mechanisms were established through the Women’s Panel Coordinator. In order to sustain the continued improvement, capacity and commitment of a motivated team of staff members, appropriate funds were allocated for staff development and learning activities.
Financial implementation in 2002-2003 under the Regular Budget improved significantly with reduction in the level of “surrenders” by 50% and “reserves” by almost 25%. Setting ambitious targets such as achieving full implementation after 18 months and actively monitoring the expenditure throughout the biennium contributed to the positive outcome. Careful monitoring also allowed the Region to identify savings to fund contingencies such as the outbreak of SARS in 2003 and avian flu in 2004.

In order to enable country offices to better respond to the needs of countries, information and communication technology (ICT) infrastructure in the country offices has been strengthened. This has been achieved by implementing information systems to best suit the needs of WHO work at the country level, and by ensuring connectivity and IT management support. Desktop video broadcast connectivity was established with all country offices.

With the implementation of the new Web-based Supplies Management Information System (SMIS) from January 2004, supplies data are now accessible also by country offices through the Activity Monitoring System (AMS). The e-procurement system is at an advanced stage of development.

A revised organizational structure involving rearrangement of certain programmes and departments at the Regional Office was put into place in March 2004. The use of electronic communication through the intranet was intensified for the purpose of advocating the Organization’s vision and for disseminating the latest health-related information. The Regional Director’s Office continued to play an important role in the smooth implementation of the country cooperation strategy in several countries and in coordinating donor support from various development partners and other aid agencies.

In order to strengthen the area of Public Information and Advocacy, a media/communication strategy is being developed for the Regional Office, even as the information team at headquarters is examining the global strategy. This is based on the fact that WHO’s role and its technical expertise are globally recognized as important, particularly in the context of the recent global outbreaks of SARS and the avian flu. The Regional Office is developing strategies to improve the visibility of its work by building the information and advocacy elements into the technical programmes and their related work plans.
COMMUNICABLE DISEASES

Communicable Disease Surveillance

During the reporting period, several epidemics or outbreaks, including those of avian influenza, dengue and cholera, were reported in the Region (Figure 1.1). To prepare for and respond to such epidemics, the Regional Office provided technical assistance in the form of guidelines, standards and norms, including investigative support services and laboratory diagnostic services, and facilitated information exchange, besides providing material support as and when requested by Member States.

Figure 1.1: Selected reported disease outbreaks in the SEA Region, 2003-2004

- Acute diarrhoea
- Anthrax
- Avian influenza (H5N1)
- Chicken pox
- Cholera
- Dengue/DHF
- Dysentery
- Enteric fever
- Hand, foot and mouth disease (children)
- Japanese encephalitis (J.E.)
- Leptospirosis
- Malaria
- Measles
- Nipah virus
- SARS
- Scrub typhus
- Whooping cough

Source: Country reports and WHO/SEARO
Priority was given to strengthening surveillance mechanisms and epidemic preparedness through a proactive role in the preparation and dissemination of information on possible public health emergencies (disease outbreaks and biological/chemical agents) and through capacity building including training. For example, during the outbreak of severe acute respiratory syndrome (SARS) and avian influenza (in Thailand and Indonesia), timely technical support was provided to all countries. WHO’s role in coordinating the global response to the SARS outbreak and disseminating information through WHO websites, including daily updates and other relevant information, was highly appreciated.

A regional strategic plan for integrated disease surveillance (IDS) was developed in consultation with the countries. Maldives, Myanmar and Sri Lanka have carried out comprehensive assessment of their national surveillance systems with technical and financial support from WHO. All three countries have developed plans of action for the implementation of IDS based on the recommendations of the assessment. Technical and operational support for the implementation of the National Surveillance Programme for Communicable Diseases (NSPCD) was provided to India. In addition, draft technical guidelines on implementation of IDS were developed and peer-reviewed.

Data on common epidemic-prone diseases are received in the Regional Office on a quarterly basis, and feedback provided
to the countries. A regional database on epidemic-prone diseases has been developed and shared with the countries. A training curriculum for the regional database has been developed and the first training programme for the core national data managers was held in New Delhi in April 2004.

The Regional Office continued to provide support to the Field Epidemiology Training Programme (FETP), both long-term and short-term, in India, Indonesia and Thailand. A large number of medical and paramedical staff from Bhutan, DPR Korea, Maldives, Myanmar and Nepal have been trained in epidemic preparedness and response.

Outbreaks of SARS and avian influenza have clearly demonstrated the urgent need for strengthening epidemiological surveillance, preparedness and response in the countries. The inadequacy of the existing International Health Regulations (IHR), in terms of epidemic alert and response, also became abundantly clear. The strengthening of integrated disease surveillance and revision of IHR therefore assume added significance.

In this regard, plans of action were prepared for integrated disease surveillance and response for a number of countries. The IHR revision process is also in progress. Following the

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**Lessons from outbreaks: improve surveillance, preparedness, notification**

The lessons from SARS and avian influenza show the need for strengthening disease surveillance and response, including epidemic preparedness and timely notification of such emergencies in compliance with the requirements of the revised IHR.

Following the report of SARS cases in the Western Pacific Region during the reporting period, the Regional Office scaled up surveillance and epidemic preparedness activities. It provided technical guidelines and regular updates on the global situation of SARS. The Regional Task Force on SARS, established by the Regional Director, and the April 2003 Malé Declaration on SARS provided the basis for scaling up these activities. Overall, surveillance, including screening and preparedness in the countries was enhanced to detect and notify such outbreaks early.

Similarly, since the first human cases of avian influenza were reported in Thailand in January 2004, the Regional Office, in collaboration with the countries and the Ministry of Health, scaled up surveillance and response activities, including epidemic preparedness and laboratory biosafety levels. As part of this effort, in February 2004, WHO, in collaboration with the Ministry of Public Health, Thailand, organized a bi-regional training on detection and control of highly pathogenic H5N1 influenza for national experts.

To further consolidate surveillance and response efforts, the Regional Director has established a Regional Task Force on Emerging Diseases. The Task Force is currently working on developing a strategic vision.
First Regional Consultation on the Revision of the International Health Regulations, a series of national IHR workshops were conducted. The second regional consultation to obtain consensus on the revised IHR was organized in the Regional Office from 29 June to 1 July 2004.

Communicable Disease Prevention, Eradication and Control

Leprosy

Although leprosy prevalence decreased from 2.46 to 1.93 per 10,000 population during the past year, the Region accounted for 70% of the globally registered and 80% of the newly-detected cases in 2003. Nine out of every 10 cases in the Region and two out of every three cases in the world are in India. Eight countries, namely Bangladesh, Bhutan, DPR Korea, Indonesia, Maldives, Myanmar, Sri Lanka and Thailand have achieved the national elimination goal (prevalence rate <1 per 10,000 population). India, Nepal and Timor-Leste are expected to achieve the national goal by 2005 (Figure 1.2).

In India, the prevalence of leprosy, as of March 2004, was 2.44 per 10,000 population. Except Chhattisgarh and Dadra and Nagar Haveli, all states and union territories (UTs) have brought down the prevalence to below 5/10,000 population. Seventeen states and UTs have attained elimination status.
Under the WHO Special Package for Leprosy Elimination, technical support continued to be provided to India through the WHO-recruited state/zonal coordinators in the high-endemic states. The focus was on strengthening the integration of leprosy control into the general health services, and on capacity building, monitoring and evaluation. WHO continued to provide anti-leprosy drugs to the entire country, and to monitor their supply.

In India, the Leprosy Elimination Monitoring (LEM) and case-validation exercises, conducted in 2003, provided evidence of up to 25-28% “over-reporting” of cases. Corrective measures were initiated to eliminate the factors responsible for over-reporting, such as wrong diagnosis and “re-registration” of cases. It is planned to conduct a similar exercise in 2004. WHO actively promoted the Simplified Information System, which is now being used by all the states. It also supported the leprosy management training provided by the National Institute of Health and Family Welfare. In 2003, training was provided to 300 District Chief Medical and Health Officers.

In Nepal, 8,046 new cases of leprosy were detected during 2003. Leprosy prevalence is high in the central, eastern and far-western regions. WHO is assisting the national authorities and supporting seven National Officers – two based at the central level and five in the regions – in the areas of
supervision and monitoring. However, the political situation in the country is adversely affecting the movement of WHO and national supervisors as well as programme activities.

In Timor-Leste, a total of 210 cases have been registered giving a prevalence of 2.5 per 10,000 population. Rapid photo surveys were conducted in three high-endemic districts in 2003; similar surveys are planned for the remaining districts in 2004.

In Bangladesh, Bhutan, DPR Korea, Indonesia, Maldives, Myanmar, Sri Lanka and Thailand, efforts are focused on sustaining elimination at the national level and on further reducing the prevalence. The number of new cases detected has decreased in all countries except Indonesia. Myanmar, Sri Lanka and Thailand are targeting sub-national-level elimination i.e. township in Myanmar, provinces in Thailand and districts in Sri Lanka.

At the meeting of National Programme Managers for Leprosy Elimination, held in Dhaka, in December 2003, the progress of leprosy elimination in countries was reviewed and specific recommendations were made. These included the need to further strengthen the integration of the leprosy control programme into the general health services, to phase out vertical structures within a definite time-frame, and to undertake measures to prevent operational factors like over-diagnosis and “re-registration” of cases leading to a large number of new case detections in some countries.

LEM was conducted in Bhutan and India and is planned for Maldives, Nepal and Thailand in 2004. All countries have adopted the Final Push Strategies recommended by WHO to improve access to early detection and treatment. They have also intensified their advocacy and awareness programmes. The public perception of, and support to leprosy elimination efforts has continued to improve. WHO will continue to provide technical support, supply free MDT drugs and continue to work closely with Member States and various other partners, including The Nippon and Sasakawa Memorial Health Foundations, Novartis, NGOs, the World Bank and others, in order to attain the goal of leprosy elimination in the three remaining countries, and in the Region, by the end of 2005.
Emerging/Re-emerging Diseases
HIV/AIDS

WHO/UNAIDS estimate that 40 million people (with an uncertainty range of 34-46 million) are presently living with HIV/AIDS worldwide and over 20 million people have died from AIDS.

The South-East Asia Region, with nearly six million people with HIV/AIDS, has the second highest disease burden following sub-Saharan Africa. Of these, nearly 99% are in India, Thailand, Myanmar and Indonesia (Figure 1.3). In many countries of the Region, the epidemic is still concentrated in populations with high-risk behaviour such as commercial sex workers and injecting drug users. Thailand, Myanmar and six states in India have an estimated HIV prevalence of over 1% among adults. Official estimates in India for 2003 put the number of people infected with HIV at 4.58 million, the second highest after South Africa, with considerable variation between the states.

Mobile populations such as migrant workers, female sex workers and truck drivers within and across countries pose a major threat to the spread of sexually transmitted infections (STIs) and HIV/AIDS. Efforts to control STIs and HIV/AIDS among difficult-to-reach populations are currently limited. Poverty, illiteracy and other social and cultural factors enhance the vulnerability to HIV.

Figure 1.3: Estimated HIV/AIDS prevalence in the SEA Region (Percentage)

Source: UNAIDS Report 2002
The national responses have not been uniform with respect to the adequacy of funding and in terms of intensity and coverage of effective interventions achieved within countries. Examples of progress include Thailand having reduced HIV incidence since 1996 and India having documented no further increase of HIV prevalence among STI and antenatal care-(ANC) populations since 2002. Although HIV among drug users is decreasing in Myanmar, sentinel surveillance data among new military recruits in Yangon and Mandalay show an increase in HIV prevalence from 0.5% in 1992 to 1.4% in 2000\(^1\), and to 2.09% in 2003\(^2\), which may reflect an increasing trend in the adult population. In Indonesia and Nepal, after a prolonged period of low prevalence, the marked increase of HIV prevalence among injecting drug users and commercial sex workers shows that the situation in countries of the Region remains unstable and highly dynamic. Strengthening of HIV surveillance, including documenting the trend of the epidemic and the impact of interventions, continues to be a priority for the Region.

All countries have established prevention interventions targeted at high-risk groups, such as commercial sex workers and their clients. The enormous scaling-up of a comprehensive programme, with priority to STI management and condom promotion that would target populations with high-risk behaviour, is clearly an imperative considering the increasing HIV epidemics that most countries in the Region are presently confronted with.

Recently, the Governments of Indonesia and Myanmar have started to scale up HIV prevention and care programmes. These are targeted at injecting drug users with particular emphasis on harm reduction, with support from WHO country offices, the Regional Offices for South-East Asia and the Western Pacific and WHO headquarters. Other development partners, such as the United Nations Office on Drugs and Crime (UNODC); Australian Agency for International Development (AusAID), and Family Health International (FHI) are also supporting these programmes.

Interventions to reduce HIV transmission in the general population are being implemented in a number of countries.
in the Region, in the form of national programmes on the prevention of mother-to-child transmission (PMTCT) and voluntary counselling and testing (VCT). Significant progress has been made in India in scaling up the PMTCT programme with a network of more than 300 hospitals providing a minimum package of services which include quality antenatal care, VCT, safe delivery practices, nevirapine prophylaxis and counselling on infant feeding. With technical support from WHO, 629 VCT centres have been established in 38 states and union territories.

Table 1.1: Estimated HIV prevalence and antiretroviral treatment needs in the SEA Region (as of December 2003)

<table>
<thead>
<tr>
<th>Member State</th>
<th>HIV prevalence</th>
<th>Total number of people needing ART</th>
<th>Number of people on ART in 2003</th>
<th>Proposed WHO target by 2005</th>
<th>Treatment gap (number on treatment and WHO target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>13 000</td>
<td>1 950</td>
<td>5</td>
<td>975</td>
<td>970</td>
</tr>
<tr>
<td>Bhutan</td>
<td>&lt;100</td>
<td>15</td>
<td>0</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>…</td>
<td>…</td>
<td>…</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>Indonesia</td>
<td>130 000</td>
<td>19 500</td>
<td>1 100</td>
<td>9 750</td>
<td>8 650</td>
</tr>
<tr>
<td>India</td>
<td>4 580 000</td>
<td>687 000</td>
<td>13 000</td>
<td>343 500</td>
<td>330 500</td>
</tr>
<tr>
<td>Maldives</td>
<td>100</td>
<td>15</td>
<td>0</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Myanmar</td>
<td>420 000</td>
<td>63 000</td>
<td>1 000</td>
<td>31 500</td>
<td>30 500</td>
</tr>
<tr>
<td>Nepal</td>
<td>60 000</td>
<td>9 000</td>
<td>100</td>
<td>4 500</td>
<td>4 400</td>
</tr>
<tr>
<td>Thailand</td>
<td>670 000</td>
<td>100 500</td>
<td>13 000</td>
<td>50 250</td>
<td>37 250</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>4 800</td>
<td>720</td>
<td>25</td>
<td>360</td>
<td>335</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>…</td>
<td>…</td>
<td>…</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>Total</td>
<td>5 877 900</td>
<td>881 700</td>
<td>28 230</td>
<td>440 851</td>
<td>412 621</td>
</tr>
</tbody>
</table>

= data not available

Source: WHO/SEARO

Countries in the Region are striving to enhance access to ART and contribute to the “3 by 5” target – providing three million HIV-infected people in developing countries with antiretroviral drugs (ARVs) – by the end of 2005. Efforts in this direction have guided much of the work on AIDS of the Regional Office, along with continued emphasis on surveillance, prevention and care. The ART coverage is presently less than 10% (about 28 000), which requires a more than ten-fold scaling-up in the next two years (about 440 000 by the end of 2005) (Table 1.1).
In order to tackle the challenges faced by countries when starting ART programmes, the Regional Office has prepared a strategy which provides a framework for action at the country level. The strategy recognizes that scaling-up of ART should form part of the comprehensive care package for people living with HIV/AIDS, and should not compromise on HIV-prevention strategies. It also reaffirms that enhanced HIV prevention and care efforts should be utilized further to strengthen the capacity of national health systems.

Significant progress however is anticipated. Thailand is expected to achieve the WHO target by the end of 2004, while policy announcements to provide ART were made on World AIDS Day 2003 in India, Indonesia, and Nepal. The Government of India launched the ART scale-up initiative on 1 April 2004 with the aim to provide ART to 100 000 people with HIV/AIDS. Indonesia is expected to provide ART to at least 10 000 people by the end of 2005. The Government of Nepal announced a policy commitment to provide ART to people with HIV/AIDS. Implementation started in February 2004 for providing 250 people with ART during the first year. The National AIDS Programme in Myanmar has planned to put 2 000 people on ART in 2004, and to rapidly scale up the programme provided that resources are made available rapidly.

The Regional Office and the country offices have played a significant role in enhancing political commitment, and in partnership building. This involved the establishment of networks of people living with HIV/AIDS, and strengthening collaboration between the Association of South-East Asian Nations (ASEAN), the South-East Asian Association for Regional Cooperation (SAARC), UNAIDS, the UN co-sponsors, nongovernmental organizations and other development partners.

The Regional Office also assisted countries in the preparation of proposals submitted to the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) in Rounds 1, 2, 3 and 4. To date, funds totalling US$ 409 892 029 have been committed to HIV/AIDS programmes in the Region through the Global Fund (Table 1.2). Until now, India, Indonesia, Myanmar, Nepal and Thailand have been successful in receiving funds for HIV/AIDS activities, including for ART. Technical support missions were made available from the Regional Office and for the first time included staff from WHO headquarters in 2004.
The work of WHO in the South-East Asia Region

Additional resources were mobilized from the Fund for HIV/AIDS in Myanmar and from DFID. A joint resource mobilization effort for the “3 by 5” goal, involving WHO headquarters, regions and countries is under way.

Malaria

While malaria has shown a declining trend in morbidity, the proportion of *Plasmodium falciparum* malaria has increased during the last five years (1998-2002) (Figure 1.4).

<table>
<thead>
<tr>
<th>Table 1.2: Funds allocated by the Global Fund to the SEA Region</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member State</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Bangladesh</td>
</tr>
<tr>
<td>India</td>
</tr>
<tr>
<td>Indonesia</td>
</tr>
<tr>
<td>Myanmar</td>
</tr>
<tr>
<td>Nepal</td>
</tr>
<tr>
<td>Thailand</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

*for TB/HIV
Source: WHO/SEARO

In 2002, India accounted for approximately 73.3% of the total reported cases in the Region followed by Indonesia (9.0%) and Myanmar (7.1%) (Figure 1.5).
On the other hand, Myanmar reported the highest number of deaths (60.4%) followed by India (20.5%) (Figure 1.6).

Maldives has remained malaria-free, while a small decline has been observed in Bhutan, DPR Korea, Sri Lanka and Thailand. There has been little change in India. The disease has worsened in other countries, e.g. Myanmar, where the number...
of reported malaria cases increased from 104,753 in 1998 to 173,000 (65%) in 2002.

The constantly changing scenario of malaria requires the adoption of a stratified approach and intensification of surveillance for control. Malaria affects all age groups, especially the poor, the vulnerable, migrants, forest and forest-fringe workers, workers in gems and mining industry, and people working at developmental sites. It often occurs in the form of focal epidemics. While the increase in malaria has been halted, as shown by the declining trend in the reported cases and deaths, the proportion of *P. falciparum* malaria has increased to about 45% and the problem of multidrug resistance is spreading across the borders in most countries of the Region. The disease is directly related to ecological and environmental situations and therefore effective control measures in the countries would require intersectoral collaboration and sustained partnerships. The costs of effective antimalarials and insecticides are increasing. It is estimated that about US$ 3 billion are lost each year as a result of the disease.

Seven countries in the Region have adopted the WHO Roll Back Malaria (RBM) strategy while others are continuing their malaria control efforts through the global malaria control strategy (GMCS). Countries have established networks to monitor drug resistance and are undertaking operational research on transmission-risk reduction. The evidence on drug resistance provided by the networks and consideration of the recommendations made by WHO have led to the revision of the national policy on antimalarials in Bhutan, Myanmar and Thailand. Policy discussions have made good progress in Bangladesh, India and Indonesia leading to the recommendation to use artemisinin-based combination drugs in areas reporting multidrug resistance. The evidence provided by transmission-risk reduction networks has helped the countries to incorporate the use of insecticide treated nets (ITNs) in the prevention of malaria. This can be boosted by the adoption of guidelines for operationalization of ITNs developed by the Regional Office.

An intercountry consultation, held in Manesar, Haryana, India, in September 2003 discussed the strategic plan developed by the Regional Office. Efforts made subsequently by WHO have helped to harmonize the strategic plans and work plans for 2004-2005 at all levels, and made them more result-
oriented. This has taken into consideration the country cooperation strategy while the log frame approach has been adopted in the planning process.

Seven countries in the Region (DPR Korea, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste) have been awarded GFATM funds for malaria, while Bangladesh, Bhutan and India have submitted proposals for consideration at the fourth round of applications for funding. This provides a window of opportunity to scale up the malaria control programme. Indonesia and Sri Lanka have started implementing the GFATM projects; WHO is extending technical support for implementation.

Cross-border collaboration in the Mekong sub-region has been intensified through partnerships. It has undertaken mapping of drug resistance and initiated monitoring of sub-standard and counterfeit antimalarials. Myanmar and Thailand are using the indicators for monitoring and evaluation agreed to at the meeting held in Kunming, China, in October 2002. The status of cross-border collaboration on integrated approach to control of priority communicable diseases in South-East Asian countries (Bangladesh, Bhutan, India, Nepal and Myanmar) was reviewed at a consultation in March 2003. A study on the monitoring of drug resistance in selected districts in Nepal and India was completed in 2003. It has demonstrated the resistance of \textit{P. falciparum} to chloroquine and sulfadoxine-pyrimethamine.

Bi-regional collaboration in malaria control between the South-East Asia and the Western Pacific regions helped in coordinating WHO’s work in Mekong countries. The indicators for monitoring adopted in Mekong countries are being increasingly used in the Western Pacific Region. Intercountry collaboration with support from the two regions is helping to address the problem of \textit{P. vivax} malaria in the Korean peninsula. Short-term consultants visited DPR Korea and a meeting was organized in Shanghai, China, in November 2003. This was followed by the development of work plans to scale up the efforts in DPR Korea with funding from GFATM.

Monitoring and evaluation of the programme are recognized as priorities by countries of the Region. An external evaluation of RBM recommended the intensification of
monitoring and evaluation. Based on the recommendations arising from various consultations, it is proposed to strengthen monitoring and evaluation at all levels of the health system and improve data management with facilities for online sharing of information. The countries of the Region have contributed to the Global Malaria Report 2004 in the form of updated country profiles and selected success stories and case studies to illustrate the best practices, and to identify problems and constraints. An intercountry workshop, held in March 2004 in Yangon, Myanmar, helped to increase the capacity of the countries on using health mapper as a tool for using the stratified approach in malaria control and epidemic response and reports. The problem of malaria during pregnancy is being assessed through a rapid assessment, being undertaken in collaboration with the Regional Office, in Bangladesh, India, Indonesia and Myanmar. A training workshop was held for the principal investigators at the Regional Medical Research Centre of the Indian Council of Medical Research (ICMR), Jabalpur, India, in April 2004 in collaboration with CDC, Atlanta, USA.

Malaria occurs in the form of focal outbreaks/epidemics in the countries of the Region, straining the overstretched health system. The strategy for early prediction of epidemics and control within two weeks of the outbreak was discussed at two intercountry consultations in September 2003 and March 2004. The tools developed by WHO headquarters were shared and the importance of collaboration with integrated disease surveillance emphasized. Countries agreed to establish rapid response teams and discussed strategies in information exchange as the approach for prediction and control of epidemics.

The Regional Office has developed guidelines and tools for strengthening early diagnosis and treatment, operationalized insecticide-treated bednets (ITNs), and updated the database on the intranet. The programme is adopting intercountry collaboration, networking of centres of excellence and WHO collaborating centres and provision of technical support, including standards and guidelines, as WHO strategies in the control of malaria. This evidence-based approach has laid the foundation for effective scaling-up of the malaria control programme in the countries.
Tuberculosis

Major strides have been made in tuberculosis (TB) control. As a result of rapid expansion of DOTS in all countries of the Region, by the end of June 2004, over 85% of the population in the Region had access to good TB diagnostic and treatment services under DOTS, as compared to 60% globally. The overall treatment success rate under DOTS is close to the 85% target set for 2005 while the case-detection rate increased from 17% in 2002 to 46% by end 2003. Given the trend for the past three years, the case-detection target is achievable by 2006 (Figure 1.7). A large part of the increase in case detection is attributable to India, where an unprecedented and phenomenal expansion of DOTS is occurring without compromising on quality.

DPR Korea, Maldives and Nepal have already reached the 70% case detection and 85% treatment success targets set for 2005, while Myanmar is expected to reach these targets in 2004. The progress with DOTS in the Region is clearly driving the overall global progress in TB control.

In order to sustain the momentum, intensified efforts to improve the quality of services and to build new partnerships with other providers, particularly NGOs, the private health
sector, medical teaching institutions and large public employment sectors are being made. Collaboration with NGOs is growing. For example, nearly 60% of DOTS services in Bangladesh are undertaken by NGOs in partnership with the government. In partnership with private providers, DOTS is being scaled up in India, Indonesia, Myanmar and Nepal, and similar efforts are being made in Bangladesh and Thailand. Medical schools in Bangladesh, India, Indonesia, Nepal, Sri Lanka and Thailand teach and practise DOTS; more than 130 medical colleges in India have established DOTS centres in their hospitals. DOTS services are also beginning to be provided in workplaces, e.g. in factories in Bangladesh and India, in tea estates in Sri Lanka, and by the Railways in Myanmar. Collaborative interventions for HIV-related TB are being established jointly by national TB and HIV/AIDS control programmes in India, Indonesia, Myanmar and Thailand. Thailand, with the highest number of people with HIV-TB co-infection, has taken a lead and is providing comprehensive services in the entire north, north-east and central provinces and is now extending them to the rest of the country.

Financial resources for TB control have been augmented and the overall gap in resources in the Region is currently under 10%. This follows grant agreements with GFATM in eight countries and through bilateral agreements with donors and development partners in several countries.

A major challenge is to reach and thereafter sustain the 2005 targets in order to reach the Millennium Development Goals set for 2015. The key constraints being faced by national TB programmes in this regard are the lack of sustained commitment to TB control, particularly in countries where health care has been decentralized to the level of local governments; a continuing lack of sufficient numbers of adequately skilled staff to sustain and improve the core components of DOTS, and low community awareness leading to poor utilization of available services. HIV-associated TB and MDR-TB pose additional challenges.

The Regional Office and the country offices continued to assist Member States in planning, implementing and monitoring TB control activities. The Regional Office organized the annual meeting of national TB programme managers in the countries and the regional Technical Working Group on
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TB (SEAR-TWG), to review the progress, exchange experiences and provide guidance and strategic direction for TB control and TB-HIV collaborative interventions. A South-East Asia Regional Stop TB partnership to obtain greater commitment and resources for TB control in the Region was established in November 2003.

Assistance was provided for the preparation of proposals in support of TB control in successive rounds of applications to GFATM, which resulted in approval of funds to the tune of US$ 209 806 589 over a five-year period. In addition, Bhutan, India and Nepal were assisted during the fourth round. Also, Bangladesh, DPR Korea, India, Indonesia and Myanmar received assistance through the Global Drug Facility (GDF) to ensure regular supplies of quality drugs. The procurement of laboratory equipment and consumables was supported in DPR Korea, Maldives and Myanmar.

The Regional Office supported capacity building within national TB control programmes. This was through preparation of technical and training materials and support for regional and national training courses on data management, laboratory methods for the diagnosis of TB including quality assurance, and drug resistance surveillance and on leadership and management for staff at central and intermediate levels of the national TB programmes. The regional strategic plan for HIV-TB was finalized. Guidelines for the implementation of DOTS in the workplace were

Over 85% of the population in the Region has access to good TB diagnostic and treatment services under DOTS.
developed and disseminated. Advocacy materials such as a video on TB in the Region, and on partnerships for TB control and World TB Day information materials were prepared in conjunction with the Regional Partners’ Forum and World TB Day 2004.

Monitoring missions were undertaken together with key partners and donors in India, DPR Korea and Thailand. Public-private collaborative projects for DOTS in Bangladesh, India, Myanmar, “public-public” partnerships in Indonesia, and the involvement of teaching facilities in Bangladesh, India, Indonesia and Nepal were supported. In order to involve the private industry and business sector, the first regional meeting was organized in the Regional Office in February 2004 which brought together the national TB programme managers and representatives from the business sector from Member States.

Other Communicable Diseases

Rabies

Rabies is endemic in seven of the 11 countries of the Region, and each year 35 000 people die of rabies. WHO supported multicentric studies to collect baseline data in India and Myanmar. The study in India shows a downward revision of annual human rabies deaths – 18 000 from the 30 000 estimated earlier. The annual number of animal bites, however, are estimated at 18 million. The study in Myanmar also suggests a reduction in annual human rabies deaths to <100 cases per year, from an estimated 1 000-1 500. WHO has been advocating replacement of the nerve-tissue vaccines (NTV) with tissue-culture vaccines (TCV). Bangladesh, India, Myanmar and Nepal, which currently provide and use NTV, have decided to phase it out and shift to TCV.

Plague

There have been no reports of plague from countries of the Region since the last outbreak which occurred in Himachal Pradesh, India, in February 2002. India, Indonesia and Myanmar have rodent plague foci. Regional guidelines for plague surveillance and control have been prepared and are being distributed to the Member States.
Soil-transmitted helminthiasis

The predominant soil-transmitted helminthic infections in the Region are those caused by round worms, hook worms and whip worms. The control of these parasitic infections is one of the simplest and most cost-effective interventions for improving children’s health and increasing their cognitive abilities. The WHO goals for 2010 are:

- Regular treatment of at least 75% of all school-age children at risk of infection;
- Ensuring access to deworming drugs at local health facilities, and
- Regular treatment of other high-risk groups like women of child-bearing age.

WHO provided technical support for all aspects of control activities in the countries of the Region and continued to play a catalytic role in mobilizing donor support for deworming activities. The German Pharma Health Fund (GPHF), UNICEF, World Food Programme (WFP), the Sasakawa Foundation, Japan International Cooperation Agency (JICA), and the Asian Centre of International Parasite Control (ACIPAC) were the main partners in deworming activities in selected countries.

Assistance was extended to Myanmar, Nepal and Bangladesh in scaling up the school deworming programme by integrating it with the deworming and vitamin A supplementation campaign for pre-school children. With WHO’s assistance, India and Indonesia held national workshops to develop national plans to control soil-transmitted helminthiasis (STH). WHO played a major role in obtaining funding support and developing national action plans for the control of STH in Timor-Leste. It also continued with its technical assistance for regular countrywide school deworming programmes in Bhutan and Maldives.

In the area of research, WHO collaborated with UNICEF to study the impact of deworming among pre-school children in Nepal. The results showed a 43% reduction in worm-infection rate, 76% reduction in anaemia prevalence, and improvement in the mean haemoglobin level from 11g/dl to 12.2g/dl after only two rounds of deworming. Other countries are being encouraged to conduct operational research in STH.
Dengue fever/Dengue haemorrhagic fever

Eight of the 11 countries of the Region are annually reporting dengue fever/dengue haemorrhagic fever (DF/DHF), the exceptions being Bhutan, Nepal and DPR Korea. In 2003, 115,000 cases and 763 deaths were reported in the eight countries. Significantly, the case-fatality rate is declining in most countries.

A bi-regional (the South-East Asia and the Western Pacific regions) meeting on an internet-based global surveillance system for dengue and DHF called “DengueNet” was held at Kuala Lumpur, Malaysia, in December 2003. This was followed by two national workshops in India during March 2004 – one at New Delhi and the other at Bangalore.

Myanmar conducted a national workshop on Communication for Behavioural Impact (COMBI) in May 2003 for vector-borne disease control where DF/DHF was used as a case study. Guidelines for diagnosis and management of DF/DHF for physicians are being developed for field-testing. Countries were assisted in developing five-year (2003-2007) national strategic plans for the prevention and control of DF/DHF. These national plans are being incorporated into the Regional Strategic Plan which would be used as a project document for the Asia Pacific Dengue Forum in order to mobilize resources for programme implementation.

Lymphatic filariasis

Lymphatic filariasis (LF) is endemic in nine countries of the Region, accounting for 64% of the global burden. The countries have adopted two main strategies to control the disease: (a) mass drug administration (MDA) of diethylcarbamazine (DEC) and albendazole, and (b) disability alleviation.

Bangladesh, India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand are implementing MDA using the two WHO-recommended drugs, namely DEC and albendazole. India is covering part of the population with two drugs and another 50 million population by DEC alone. In 2003, the Region contributed 43% of the global coverage of MDA (two drugs) with a population coverage of 36 million. The coverage target, however, for 2003 for countries of the Region was 100 million. The target could not be achieved due to funding constraints, delayed supply of drugs and non-completion of mapping.

Lymphatic filariasis (LF) in the SEA Region accounts for 64% of the global burden
WHO is assisting the endemic countries in resolving the problems (Table 1.3).

Mapping is an important prerequisite for MDA implementation. Mapping has been completed in Sri Lanka and Thailand and is expected to be completed in all endemic countries by 2005.

WHO supported the countries in MDA implementation, including social mobilization, training and supply of DEC to three countries. The Organization also played an advocacy role in mobilizing some donor support for countries, including free supply of albendazole.

Sri Lanka was supported in embarking on a model project on community home-based prevention of disability due to LF. Technical guidelines on LF disability prevention were distributed to all countries and assistance provided for training. An international workshop on the prevention of LF disability was held in Sri Lanka in November 2003. One meeting each of country LF programme managers of the Indian sub-continent and the Mekong Plus groups and two meetings of Regional Programme Review Groups were held.

A National Task Force for lymphatic filariasis elimination has been established in each endemic country with technical and financial support from WHO. It is expected to play a pivotal role in assisting national programmes to achieve the elimination target.

Table 1.3: Reported MDA coverage in the SEA Region, 2001-2003

<table>
<thead>
<tr>
<th>Member State</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number (millions)</td>
<td>%</td>
<td>Number (millions)</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>0.808</td>
<td>93.00</td>
<td>4.860</td>
</tr>
<tr>
<td>India</td>
<td>14.200</td>
<td>71.00</td>
<td>21.000</td>
</tr>
<tr>
<td>Indonesia</td>
<td>–</td>
<td>–</td>
<td>0.414</td>
</tr>
<tr>
<td>Myanmar</td>
<td>2.000</td>
<td>95.00</td>
<td>7.500</td>
</tr>
<tr>
<td>Nepal</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>1.670</td>
<td>76.90</td>
<td>9.500</td>
</tr>
<tr>
<td>Thailand</td>
<td>–</td>
<td>–</td>
<td>0.119</td>
</tr>
<tr>
<td>Total</td>
<td>18.678</td>
<td>–</td>
<td>43.390</td>
</tr>
</tbody>
</table>

Source: WHO/SEARO
High priority was assigned to social mobilization for achieving high coverage of MDA. The COMBI plan aiming to increase peoples’ compliance for taking medication, also involving advertising firms, was implemented in Sri Lanka and in Tamil Nadu, India. This approach helped immensely in increasing the coverage of MDA.

**Visceral leishmaniasis (Kala-azar)**

About 147 million people in Bangladesh, India and Nepal are affected by kala-azar. The situation has generally remained static during the past five years (Figure 1.8). However, there is an underreporting of deaths. The disease occurs in poor and marginalized communities and nearly 2.4 million disability-adjusted life years (DALYs) are lost each year due to kala-azar globally. Of these, the SEA Region accounts for 400,000 DALYs.

Endemic countries have been striving to control kala-azar during the past decade. An intercountry informal consultation on elimination of visceral leishmaniasis was held at Varanasi, India, in November 2003. All countries have agreed to develop country plans and cross-border collaboration has been established in four border districts. A strategy to eliminate kala-azar has been developed by the Regional Office, which includes: (a) early diagnosis and complete case management; (b) vector surveillance and control through community
participation; (c) sustainable behavioural changes and partnerships; (d) epidemic preparedness and response, and (e) strengthening of capacity for research and training.

The strengths favouring elimination of the disease include strong political commitment in the three countries. The technical factors favouring elimination are: availability of a new potential drug (miltefosine, an oral drug) a rapid dipstick test; positive experiences in the past in controlling the disease using indoor residual spraying; a reasonably good health system, and partnerships between the governments, industry and the control programmes. India, which bears the largest burden of kala-azar, has committed a separate budget with a national plan to eliminate the disease. Bangladesh and Nepal have been requested to prepare their national plans of elimination. These plans will be incorporated into a project document for mobilizing additional resources to eliminate the disease.

Vector control

Vector control assumes high importance in the prevention and control of vector-borne diseases which are the major causes of morbidity and mortality in the Region. Countries have been urged to revive and strengthen the insecticide policy for public health use. Draft guidelines to develop a national policy on the use of insecticides were developed in collaboration with WHO headquarters and other regions.

With a view to strengthening capacity building on disease vector control, the Fifth WHO Regional Training Course on Comprehensive Vector Control (CVC) was held at the Vector Research Centre, Salatiga, Indonesia, in January–February 2004. The CVC training course by the Vector Control Research Centre, Pondicherry, India, is now an annual feature. Besides strengthening the capacity of the Salatiga centre, other countries are being supported to extend the CVC training course to their nationals.

The Tropical Diseases Research (TDR) programme continues to support research focused on malaria (Bangladesh, India, Myanmar, Nepal, Sri Lanka and Thailand), lymphatic filariasis (India, Myanmar, Nepal and Sri Lanka), leprosy and tuberculosis (India), and kala-azar (Bangladesh, India and Nepal), studies on drug resistance of malaria (Myanmar and
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Thailand), vaccine development (India and Thailand), vector control (Sri Lanka), monitoring of drug efficacy (Indonesia, Myanmar and Sri Lanka) and new drug regimen (Bangladesh and Thailand). Studies on lymphatic filariasis emphasized the impact of mass chemotherapy with (DEC) and/or albendazole (India, Myanmar and Sri Lanka), filariasis endemicity (Myanmar and Sri Lanka) and use of insecticide-impregnated curtains (Sri Lanka). Studies on kala-azar focused on the development of an animal model (India), and on a clinical study with aminosidine and miltefosine (India). The twenty-sixth session of TDR’s Joint Coordinating Board (JCB) was held in New Delhi, India in June 2003. The JCB members visited two important TDR research centres at Patna and Pondicherry.

Immunization and Vaccine Development

Eight of the nine eligible countries in the Region have successfully applied for funding for hepatitis B vaccine from the Vaccine Fund (VF) through GAVI. Timor-Leste is yet to apply. VF has committed almost US$ 200 million for support to the strengthening of routine immunization, ensuring injection safety and introducing new vaccines (Table 1.4)

Table 1.4: Status of proposals for GAVI funding from countries of the SEA Region (as of June 2004)

<table>
<thead>
<tr>
<th>Member State</th>
<th>Strengthening of immunization services</th>
<th>Injection safety</th>
<th>New vaccines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>Approved</td>
<td>Approved</td>
<td>Approved</td>
</tr>
<tr>
<td>Bhutan</td>
<td>Not eligible, DPT3 &gt; 80%</td>
<td>Approved</td>
<td>Approved</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>Approved</td>
<td>Approved</td>
<td>Approved</td>
</tr>
<tr>
<td>India*</td>
<td>Did not apply</td>
<td>Did not apply</td>
<td>Approved</td>
</tr>
<tr>
<td>Indonesia*</td>
<td>Approved</td>
<td>Approved</td>
<td>Approved</td>
</tr>
<tr>
<td>Myanmar</td>
<td>Approved</td>
<td>Approved</td>
<td>Approved</td>
</tr>
<tr>
<td>Nepal</td>
<td>Approved</td>
<td>Approved</td>
<td>Approved</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>Not eligible, DTP3 &gt; 80%</td>
<td>Approved</td>
<td>Approved</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>Eligible, but has not yet applied</td>
<td>Eligible, but has not yet applied</td>
<td>Eligible, but has not yet applied</td>
</tr>
</tbody>
</table>

* India and Indonesia, together with China, have a special arrangement of a lump sum $ 40 million support from VF
One of GAVI’s main goals is to achieve 80% coverage of DTP3 in all districts in at least 80% of GAVI-eligible countries by 2005. Therefore, GAVI also provides support for strengthening routine immunization, including the introduction of auto-disable syringes. WHO has committed itself to assisting countries as they strive towards the “80/80” goal.

As of December 2003, 10 of the 11 countries of the Region had integrated hepatitis B vaccine into their routine immunization schedule. The pace of introduction is variable as most countries have planned a phasing-in approach.

Bangladesh introduced the new vaccine in six districts and one municipality in 2003, which will be expanded to at least 50% of the country in 2004. Bhutan has included hepatitis B in its immunization programme since 1997, but in June 2003 the countries switched to a combination of DTP-hepatitis B vaccine. DPR Korea introduced the vaccine in Pyongyang city and four other provinces. India has introduced the vaccine in 14 metropolitan cities and 32 districts. Indonesia utilized GAVI funding to introduce UniJect technology for a birth dose of hepatitis B vaccine in all districts. Myanmar introduced the new vaccine in Yangon and Mandalay and will extend it to other areas in 2004. Nepal covered 22 districts in 2003; in 2004 it is expected to cover at least 45 of the 75 districts in the country. Sri Lanka introduced the vaccine in three of the eight provinces in 2003; three more provinces will be covered in 2004. Timor-Leste is receiving full support from UNICEF for basic EPI vaccines and hopes to introduce hepatitis B vaccine in the near future.

Through the Regional Working Group on Immunization for South-East Asia, WHO has provided technical support to countries in training, advocacy and monitoring necessitated by this innovation. In order to meet the longer-term challenge of sustainability, WHO, along with other partners, is working to support countries to develop a sound financial sustainability plan (FSP) for immunization. In early 2004, WHO supported training workshops in all the seven countries which are required by GAVI to submit a formal FSP by November 2004.

The regional priority is the establishment of a fully functioning National Regulatory Authority (NRA) in all countries. By the end of 2003, South-East Asia became the...
first WHO region to complete the assessment of all NRAs. To date, WHO has certified that NRAs of India, Indonesia and Thailand have met the necessary requirements; all other countries need to improve one or more required functions.

To assist in strengthening NRAs, the Global Training Network (GTN) activities were followed up with in-country Good Manufacturing Practices (GMP) workshops in India and Thailand. An additional workshop on clinical trials was conducted in Thailand. Two workshops on AEFI (adverse events following immunization), and the establishment of a GTN Centre on AEFI in Sri Lanka responded to the increasing demand for AEFI courses and training from the countries.

During the reporting period, WHO conducted an assessment of the vaccine procurement procedures in Maldives and Nepal. As a result of the assessment conducted in Maldives, meetings were held in Sri Lanka to discuss the possibility of grouping its vaccine procurement with Maldives. A pilot project for the procurement of meningitis vaccine is in the early stages of implementation. This type of bulk procurement not only provides countries stronger leverage to negotiate a better price, but also serves to establish cooperation among the NRA, the national control laboratory, and the EPI system.

Elsewhere, the main challenge in 2003 was strengthening the EPI delivery mechanisms to increase access to unimmunized children and decrease dropouts. WHO rose to this challenge by providing technical support to governments and partners to adopt and adapt elements of the global WHO-UNICEF ‘Reach Every District Strategy (RED)’. This has five components:

- Re-establish sustainable outreach services (for underserved populations).
- Monitoring and use of data for action: improving recording and reporting practices to strengthen the use of monitoring and surveillance data.
- Increasing community involvement in immunization services.
- Increasing supportive supervision: providing on-site training for health workers and monitoring of performance.
• Planning and management of resources: using financial, human and logistic resources more effectively and efficiently through grassroots-level micro-planning.

In 2003, elements of the RED strategy were introduced at different levels in Bangladesh, Myanmar and Nepal. The strategy has been incorporated into many of the training modules for immunization at mid-level managers' training in the Region, which aims to strengthen micro-planning initiatives. The strategy will also be expanded in key states in India in 2004.

At the same time, WHO has been assisting the countries to improve the accuracy of information available to health planners at all levels through drafting of a data quality self-assessment (DQS) tool which aims to strengthen reporting and recording practices by:

• standardizing recording procedures at immunization sites;
• standardizing the approach to monitoring and supervision at the health facility level;
• standardizing monthly reporting formats from the health facility to the district and above;
• assessing timeliness and completeness of reports, and
• strengthening the capacity of countries to assess and evaluate the flow of data from health facility to the central level with such tools as DQS and continued coverage surveys as and when required.

In 2003, Nepal was the country of focus for a global pilot of the DQS mechanism. DQS proved to be a highly successful management tool and will be further implemented in India and Indonesia in 2004.

Polio eradication initiative

As of March 2004, the Region accounted for 29% of the global burden of virus-positive polio, with India as the only country in the Region that had polio virus circulation. India reported 225 confirmed polio cases in 2003, representing a more than seven-fold decrease from the 1,600 cases reported in 2002. The number of districts infected also decreased from 159 in 2002 to 88 in 2003. This was due to several factors: an increase
in the number of supplementary immunization rounds in 2003 (two National Immunization Days and four Sub-national Immunization Days (NIDs/SNIDs); improved quality of campaign implementation (through the combined efforts of the Government of India, UNICEF, Rotary, WHO and the Core Group of NGOs); better engagement and participation of minority communities, and the decreased pool of susceptible children who were affected by the large polio epidemic of 2002.

At the end of 2003, the circulation of wild polio virus had been restricted to two principal foci in Western Uttar Pradesh and North Karnataka. The outbreaks in North Karnataka demonstrate the risks faced by states that have previously been polio-free, when gaps in the immunity of young children develop. These risks will remain as long as polio virus continues to circulate anywhere in India.

With good AFP surveillance, Bangladesh, Myanmar and Nepal have been polio-free since 2000. Bhutan, DPR Korea, Indonesia, Maldives, Sri Lanka, Thailand and Timor-Leste have all been polio-free for more than four years.

During the past year, several countries of the Region conducted supplementary polio immunization rounds, with Bangladesh, India and Nepal conducting NIDs which were synchronized to the extent possible. In addition, Sri Lanka and Thailand conducted SNIDs in high-risk areas and provinces. In order to accelerate efforts to interrupt polio virus circulation in 2004, India will conduct five NIDs and one SNID.

At the end of 2003, Bangladesh, DPR Korea, India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand had sustained their non-polio AFP rate of at least 1 per 100,000 children aged

As of 25 May, there were only 201 cases of polio confirmed in the world for 2004. Cases have been primarily confined to six endemic countries: Nigeria, Niger, Egypt, Pakistan, Afghanistan and India. The eight cases in India represent the only transmission in the SEA Region and is the lowest total recorded to date for this period of the year. The substantial decline in cases in India is primarily due to high quality supplemental immunization activities (SIA) carried out nationwide in January, February and April and in key states in May. Additional rounds are planned in July, October and November. The Government of India and WHO recognize that this opportunity represents the best chance ever to finally eradicate polio from the Region. Other countries in the Region have continued their commitment to the global eradication effort by maintaining certification standard surveillance.
less than 15 years (Figure 1.9). Maldives did not achieve surveillance indicators in 2003; however, the population in Maldives is low and AFP cases are expected to occur every 2–3 years. Timor-Leste does not have a surveillance system for AFP. WHO has initiated the establishment of a vaccine-preventable disease surveillance system that includes AFP.

During 2003, WHO conducted reviews of AFP surveillance in Indonesia and Sri Lanka. Additional rapid AFP surveillance assessments were conducted in high-risk states in India. These reviews verify the quality of surveillance data and emphasize opportunities for further strengthening of surveillance as necessary.
All 17 laboratories in the South-East Asia Region polio laboratory network, including the Global Reference Laboratory in Mumbai, India, are fully accredited. The laboratories provide timely and accurate information to allow targeted and appropriate planning and virus response. WHO has developed regional guidelines for the implementation of laboratory containment of wild polio viruses. To date, nine countries have finalized their containment plans of action.

The estimated requirement of resources for polio eradication activities during 2003 were approximately US$ 190 million. Contributions in the past year have come from a wide variety of bilateral and multilateral sources including CDC, CIDA, DFID, DANIDA, EC, Italy, Japan, KfW Germany, Rotary International, UN Foundation, USAID, the World Bank and UNICEF among others. Funding the additional cost of implementing extra polio eradication activities, particularly for the final push in India in 2004 and until the Region is certified polio-free, will be a major challenge for the programme. The estimated requirement of resources for the Region for 2004 is US$ 266.38 million, as shown in Table 1.5.

<table>
<thead>
<tr>
<th>Member State</th>
<th>OPV</th>
<th>Operational</th>
<th>AFP and LAB</th>
<th>Total required</th>
<th>Committed</th>
<th>Shortfall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>5.22</td>
<td>1.57</td>
<td>1.58</td>
<td>8.37</td>
<td>3.22</td>
<td>5.15</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>–</td>
<td>–</td>
<td>0.15</td>
<td>0.15</td>
<td>–</td>
<td>0.15</td>
</tr>
<tr>
<td>India</td>
<td>147.91</td>
<td>91.47</td>
<td>13.2</td>
<td>252.58</td>
<td>213.6</td>
<td>39.2</td>
</tr>
<tr>
<td>Indonesia</td>
<td>–</td>
<td>–</td>
<td>1.62</td>
<td>1.62</td>
<td>0.45</td>
<td>1.17</td>
</tr>
<tr>
<td>Myanmar</td>
<td>–</td>
<td>–</td>
<td>0.57</td>
<td>0.57</td>
<td>0.35</td>
<td>0.22</td>
</tr>
<tr>
<td>Nepal</td>
<td>1.06</td>
<td>1.13</td>
<td>0.90</td>
<td>3.09</td>
<td>1.49</td>
<td>1.60</td>
</tr>
<tr>
<td>Total</td>
<td>154.18</td>
<td>94.1</td>
<td>18.02</td>
<td>266.38</td>
<td>219.11</td>
<td>47.49</td>
</tr>
</tbody>
</table>

Control of other major vaccine-preventable diseases: measles and neonatal tetanus

The number of measles deaths in the Region decreased by 19% compared to the 1999 level.

In 2003, the Technical Advisory Group on Polio Eradication and Immunization Activities endorsed the revised 2002-2005
regional strategic measles mortality reduction plan. The major focus of the plan is to build upon the investments of the polio eradication effort to address other vaccine-preventable disease targets. As part of this effort, the AFP surveillance network has been expanded to measles and NNT surveillance in Bangladesh, Myanmar and Nepal. Initial surveillance data from these expanded systems, together with previous efforts in other countries, have provided enough evidence to formulate measles mortality control strategies for the countries. Building on the successful polio laboratory network, WHO also worked with the countries to establish a Regional Measles Laboratory Network in 2003. All countries have now received laboratory testing kits and additional training in measles laboratory practices. In addition to providing laboratory surveillance for measles, this network identified rubella outbreaks in Bhutan, Myanmar and Indonesia.

During the reporting period, measles supplementary immunization campaigns were conducted in Myanmar, Sri Lanka and Timor-Leste. WHO is supporting the planning of the Region’s largest measles mortality control campaign to date, scheduled for Nepal in 2004, and will support the completion of supplementary immunization campaigns in Myanmar and Sri Lanka as well.

Bhutan, DPR Korea, Maldives, Sri Lanka and Thailand have eliminated MNT. Planned MNT supplementary immunization activities were continued in Bangladesh, Indonesia, Myanmar and Nepal. Following a review and a survey conducted with technical assistance from WHO, the state of Andhra Pradesh in India also was declared to have eliminated MNT in 2003. It is expected that this information will be disseminated to other states and the MNT elimination process accelerated in India.

Issues and challenges

*Can polio virus transmission in India be interrupted in 2004?*

Yes, if the required level of quality can be maintained during the implementation of the NIDs (five) and SNID (one) as well as during large-scale mop-ups that have been planned in 2004. The programme cannot afford to miss significant numbers of children anywhere in India.
What happens when circulation has been interrupted?
Surveillance, instead of declining, will be intensified. The containment and certification processes will be accelerated. Regional certification should take place three years after the last case of wild polio virus is detected in the Region but only in the context of this high quality surveillance.

What will happen to the polio surveillance network and infrastructure in the future?
The Surveillance Medical Officer (SMO) networks in Bangladesh, Indonesia, Myanmar and Nepal have already expanded beyond AFP to now cover other vaccine-preventable diseases. SMOs throughout the Region are also supporting national immunization programmes by helping to monitor and evaluate the routine EPI sessions. These networks are a valuable human resource which have the potential to be utilized in multiple expanded roles. The specific modality and structure will need to be determined for each country.

What are the primary goals for immunization in the countries of the Region?
The TCG has endorsed the following six key targets for 2005:

- Continue the process of certifying the Region as polio-free;
- Sustainable reduction of measles mortality;
- Elimination of neonatal tetanus;
- 80% DPT3 coverage in all countries in all districts;
- Development of strategies for safe injections and waste disposal in all countries, and
- Fully introduce hepatitis B vaccine into EPI in all countries.

Blood Safety and Clinical Technology
Ensuring safe blood is one of the priority areas for the South-East Asia Region. The strategy includes: strengthening of coordinated blood transfusion services; promotion of voluntary non-remunerative blood donation; screening of
Ensuring safe blood is one of the priority areas for the South-East Asia Region

donated blood for transfusion-transmissible infections; rational and appropriate use of blood and its components and, most importantly, implementation of the quality system in blood transfusion services (BTS).

WHO assisted in the organization of a regional workshop on management of BTS. Support was extended to DPR Korea and Sri Lanka for strengthening blood transfusion services through training of various categories of health professionals and identification of needs for supplies and equipment. Both these countries are being supported extensively to revamp their BTS.

WHO had launched a Quality Management Project in 2000 and since then quality has become the focus in all activities related to improving blood transfusion services. A regional consultation for strengthening quality assurance in screening for HIV and viral hepatitis in blood banks was organized in Bangkok in 2003. Continuous technical support to more than 120 managers in quality control who have been trained through various WHO training courses during the past three years is being provided through the Regional Quality Centre, Bangkok. In addition, the Regional External Quality Assessment Scheme for blood group serology and transfusion-transmissible infections, mainly anti-HIV antibody, is in operation in all countries through the Ministry of Public Health, Thailand, and the WHO Collaborating Centre for AIDS, Victoria, Australia.

Laboratory support

Under the “3 by 5” initiative, CD4 lymphocytes enumeration is a prerequisite for the initiation of antiretroviral therapy. In order to increase the capacity of national laboratories, a training workshop was conducted at Bangkok in November 2003, for scientists currently engaged in CD4 lymphocytes enumeration in high-burden countries. Draft regional guidelines on laboratory support for care and diagnosis of HIV/AIDS have been formulated and will be disseminated to the countries after finalization. To strengthen quality assurance in laboratory testing for HIV, a workshop was organized in India for middle-level microbiologists. A training workshop on laboratory diagnosis of opportunistic infections in patients
with HIV/AIDS was conducted in Bangkok in July 2003, for microbiologists from HIV high-burden countries including India, Indonesia, Myanmar, Nepal and Thailand.

In order to promote quality in health laboratories in the countries, an informal consultation on accreditation of health laboratories was organized in Bangkok in October 2003.

A training workshop for middle-level microbiologists was held at Vellore, India, in October 2003 to strengthen laboratory-based antimicrobial resistance monitoring. Participants were also oriented towards the use of WHO-developed computer software, WHONET 5 for rapid analysis of data.

Technical support was provided to all countries in the field of laboratory testing for avian influenza. The participation of representatives from six countries in a bi-regional training workshop on avian influenza organized by WHO/Centre for Disease Control/National Institute of Health, Thailand at Bangkok in February 2004 was supported.

A rapid, user-friendly and economical screening kit for anthrax, developed in the Region, was made available to all countries. Another rapid and user-friendly kit for leptospirosis has been evaluated for its sensitivity and specificity and will be provided to the countries.
A new edition of the Regional Office publication *Quality Assurance in Bacteriology and Immunology* was printed and disseminated to all countries. Other publications developed and disseminated included: *Newsletters on Quality Assurance in Health Laboratory Services and Blood Transfusion Services* (QA News); *Gonococcal Antimicrobial Susceptibility Programme (GASP) Newsletter*; *Model Standard Operating Procedures (SOP)* for blood transfusion services; *Laboratory Manual on Anthrax*; *Regional Status of Blood Centres*, and various technical material on avian influenza.
Noncommunicable Diseases Surveillance

Noncommunicable diseases (NCDs) are the leading cause of death and disability worldwide. In 2002, NCDs accounted for 51% of all deaths and 44% of the disease burden in the Region. As the Region is going through a demographic and epidemiological transition, further increases in the total number of deaths and DALYs lost, as well as in age-specific incidence and mortality rates of major NCDs are expected (Figure 2.1). The economic and social development of Member

Figure 2.1: Trends in disease burden, by broad disease category, SEA Region, 1998-2002

Broad disease categories:
Group I: Communicable diseases, maternal and perinatal conditions and nutritional deficiencies
Group II: Noncommunicable conditions
Group III: Injuries

States is increasingly being threatened by the heavy and growing burden of NCDs.

The rise in NCD morbidity and mortality is largely attributable to demographic, socioeconomic and cultural transformation that is enhanced by globalization. This results in unfavourable shifts in distribution and in the mean population level of several major behavioural and physiological risk factors for NCDs. The nine major risk factors for NCDs are: high blood pressure; tobacco use; high blood cholesterol level; low fruit and vegetable intake; indoor smoke; physical inactivity; overweight; alcohol consumption, and urban air pollution. Taken together, these largely modifiable risk factors contribute to more than 40% of all deaths in the Region. Tobacco consumption alone claims an estimated 1.1 million deaths every year.

The health gaps between developing and developed countries, and between rich and poor communities are widening. This is also very true in the NCD context. As epidemiological transition progresses, the burden of NCDs shifts from the rich to the poor, both across and within countries. Some major risk factors for NCDs like tobacco use, low consumption of fruits and vegetables and indoor smoke, are much more common among the poor. Others, such as high blood pressure, abnormal blood lipids and sugar levels, are becoming increasingly common in urban slums and rural communities. Recent evidence from India highlights the association between low income and cardiovascular diseases. A low socioeconomic status is linked to an increased level of complications and poor outcomes of chronic diseases such as diabetes.

In the Region, NCDs should no longer be regarded as a problem confined to the affluent segments of society. They are clearly emerging as a major public health challenge. Wide application of robust public health measures to address this challenge is urgently required. In this context, WHO is fostering coordinated intersectoral action focused on health promotion and reduction of exposure to common, modifiable risk factors at individual, community and population levels. WHO is supporting the implementation of integrated epidemiological surveillance and population-based interventions on major risk factors. At the same time, equitable and cost-effective management of major NCDs, with optimal
utilization of the existing capacity of health systems, is being promoted.

To a great extent, NCDs are either preventable or amenable to effective interventions. Implementation of strong health promotion and disease prevention policies, strategies and programmes can positively modify the current NCD epidemiological trends. Capacity building, focusing on human resources development for planning, implementing, monitoring and evaluating public health response to the growing threat of NCDs, should be regarded as the top priority of the regional NCD programme.

In recent years, the Regional Office has contributed to strengthening the regional capacity for conducting epidemiological surveillance of NCDs with particular focus on sustainable collection of standardized information on major risk factors. Countries have been supported in adapting and implementing a standard WHO NCD risk factor surveillance approach. In eight countries of the Region, 27 WHO-supported STEPS surveys are being conducted. Facilitating mechanisms have been introduced to assist countries in adopting the common NCD risk factor surveillance framework. These include: production of standard implementation tools and guidelines; establishment of an advisory body – Regional Statistical Support Group; conducting a series of training for planning and analysing survey data, and establishment of an equipment pool for regional surveys.

The broad application of the WHO-promoted standard NCD risk factor surveillance approach in the Region provides a unique opportunity to generate strong evidence for action. In order to enhance accessibility and utilization of the existing information on major NCDs and their risk factors for advocacy, policy development and programme evaluation purposes, a Regional NCD Information Base has been established in the Regional Office.

In the second half of the 20th century, prevention strategies for NCDs covering broad populations as well as individuals at high risk were developed. The results of community-based NCD prevention programmes implemented in developed countries clearly demonstrate that even modest risk factor reduction through adoption of healthy lifestyles bring significant public health benefits. However, the applicability
and effectiveness of population-based strategies focused on risk avoidance and risk reduction remain to be proved in the context of developing countries. In order to collect evidence on the feasibility and effectiveness of community-based integrated NCD prevention programmes, demonstration projects are being implemented with WHO support in Bangladesh, India, Indonesia, Maldives and Sri Lanka.

Adjusting health systems to provide equitable and cost-effective management of major NCDs continues to be a major challenge in low-resource settings. In order to address this challenge, the process of developing comprehensive, integrated, evidence-based guidelines for prevention and cost-effective management of major NCDs at the primary health care level has recently been initiated in the Region.

WHO is playing a significant role in fostering partnerships, coordinating intersectoral collaboration and facilitating the process of national, regional and global networking. The demonstration projects on integrated community-based prevention are regarded as an important component of the national networks for NCD prevention and control that are being established in four countries. Building on the experience of other WHO regions that have established regional networks, the Regional Office has initiated a regional network for integrated prevention and control of NCDs and linked it to the global forum of regional networks. The NCD Prevention and Control Network in the Region is providing an important platform for the exchange of experience and sharing of expertise and resources, for the implementation of collaborative intercountry projects and programmes. The regional and national networks are expected to contribute significantly to the development and implementation of strong national public health policies and strategies aimed at addressing the growing burden of NCDs in the Region.

**Tobacco**

Following the adoption of the Framework Convention on Tobacco Control (FCTC) by the Fifty-sixth World Health Assembly in May 2003, an Intercountry Consultation on “Multisectoral Mechanisms for Comprehensive Tobacco Control” was organized in Bangkok in July 2003. The
consultation recommended a multisectoral approach to tobacco control, based on the findings of the studies conducted in Bangladesh, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand, on the existing and potential multisectoral mechanisms for comprehensive national tobacco control. Guidelines for comprehensive national tobacco control have been prepared in accordance with the recommendations of the consultation.

A WHO/World Bank (WB) Intercountry Consultation on effective collaboration between the health and financial sectors was organized in Jakarta in December 2003. The consultation discussed the findings of studies conducted in seven countries of the Region on economics of tobacco control. It concluded that an increase in tax on tobacco products can reduce tobacco consumption and generate additional revenue. The report of the seven country studies as well as the recommendations of the consultation have been disseminated among countries and international organizations such as the World Bank, International Monetary Fund, and the Asian Development Bank, and regional intergovernmental organizations such as ASEAN and SAARC.

Surveillance is one of the key areas of FCTC and WHO attaches due importance to the issue. An Intercountry Consultation on Tobacco Information and Surveillance System was organized in October 2003 in New Delhi to finalize the Regional Survey Template in order to obtain standardized information on tobacco control. Appropriate survey instruments have been proposed for use by countries to collect relevant information/data. Meanwhile, in order to facilitate the sharing and exchange of tobacco control information, the Regional Office is developing an online database system. This system will be linked to a global portal to be managed by the Tobacco Free Initiative cell at WHO headquarters. Guidelines for collecting information for the Regional Survey Template have also been finalized.

The Centers for Disease Control (CDC), Atlanta, USA, collaborated with the Regional Office, particularly in the area of tobacco prevalence among students. Currently, the Global Youth Tobacco Survey and the Global School Personnel Survey are being undertaken in 11 states of India and in Bangladesh, Bhutan, Indonesia, Maldives, Myanmar, Nepal and Thailand.
The Work of WHO in the South-East Asia Region

An Analysis and Training Workshop was organized in Bangkok in February 2004 to analyse and interpret the data collected from the studies. The researchers were also trained on writing the survey report, including recommending the use of the collected data for tobacco control interventions.

Meanwhile, efforts are being made to advance the FCTC process in the Region. The FCTC issue was included as an agenda item at the Twenty-first meeting of Ministers of Health, held in New Delhi in September 2003. The meeting called for early signing and ratification of FCTC by countries of the Region. In order to further facilitate the signing and ratification process of FCTC, a sub-regional Awareness Raising Workshop was organized in Kathmandu in March 2004. The workshop identified the problems that some countries are confronting and provided possible solutions to help facilitate them to sign and ratify FCTC. A national capacity building workshop was also organized simultaneously. All aspects of national capacity building in the area of tobacco control were discussed in order to enhance the knowledge of countries to help them build necessary capacity to develop and implement comprehensive tobacco control programmes in the Region in the context of FCTC.

WHO Framework Convention on Tobacco Control

Ever since the inception of the Tobacco Free Initiative (TFI) as a cabinet project of the WHO Director-General in July 1998, the Framework Convention on Tobacco Control (FCTC) process gained ground and earned political support in the SEA Region. The countries of the Region have played an active role in the whole FCTC process, starting from its introduction in the WHO Executive Board in January 1999 to its adoption by the Fifty-sixth World Health Assembly in May 2003.

Following its adoption, the Regional Office has oriented its anti-tobacco programme to FCTC. However, the lack of capacity in terms of governance, infrastructure and resources has been a formidable obstacle. Industry influence over politics, economy and society as a whole has complicated matters further.

Meanwhile, WHO has been supporting countries in strengthening national capacity through development of national plans of action, effective infrastructure for tobacco control programmes, communication and public awareness for tobacco control and partnership. Research, training and education, monitoring, surveillance and reporting/exchange of information have also generated political commitment and multisectoral support. With a view to assisting countries in developing guidelines for comprehensive national tobacco control, WHO undertook research in areas like multisectoral mechanisms for tobacco control, economics of tobacco control, tobacco control and poverty, women and tobacco, oral tobacco use, regulation and testing of tobacco products, tobacco and youth etc. Based on the research findings, appropriate interventions are being made to address the complex nature of the tobacco epidemic.

Ten of the 11 Member States have signed the Convention and four have ratified it.
In accordance with the decision of the Fifty-sixth World Health Assembly, an open-ended Intergovernmental Working Group (IGWG) met in Geneva in June 2004 to discuss the various aspects of FCTC, including possible protocols to the Convention. A regional meeting will be held on the eve of this meeting in Geneva to formulate a common regional position on IGWG. The Regional Office supported the participation of one delegate from each of the Least Developed Countries in the Region.

Research has been a priority for the Regional Office in the area of tobacco control for devising appropriate tobacco control interventions. In order to assess the overall impact of tobacco on women, a regional situation analysis on the subject was undertaken. Given the widespread production and use of oral tobacco in the Region, another regional situation analysis on the impact of oral tobacco is being undertaken. In accordance with the provisions of FCTC, the Region is also laying emphasis on product regulation. In order to assess the existing testing facilities for tobacco products, a situation analysis on the existing laboratory capacity and facilities in the Region is under way.

The theme for World No Tobacco Day 2004 was “Tobacco Control and Poverty”. Studies are being undertaken in Bangladesh and Myanmar to assess how closely tobacco use and poverty are linked. In order to present forceful and credible evidence to show that the revenue generated by the tobacco industry is far less than the amount spent on treating tobacco-related diseases, a study on the health costs of tobacco use is being undertaken in Bangladesh.

WHO’s partnership with NGOs in the area of tobacco control is well established. Under the second phase of UNF Channelling the Outrage Project, the Regional Office has funded projects being run by 20 NGOs. The main objective of this project is to facilitate the signing and ratification of FCTC. An NGO workshop on FCTC will also be organized in July 2004 in Bangkok, to discuss practical ways to facilitate the process of signing and ratification of FCTC.

Health Promotion

During the period under review, there has been increasing awareness of health promotion concepts and approaches in
Member States. This can be seen from the following developments:

- Most countries are giving importance to strengthening community actions and improving personal skills for health promotion, although different countries have different approaches.

- More countries are establishing multisectoral coordination mechanisms for effective delivery of health promotion at the national level. At the local level, all countries have initiated a “healthy settings” approach, e.g., healthy cities, health-promoting schools and health-promoting hospitals.

- Most countries now have a better understanding of health promotion concepts and plan activities beyond mere development and dissemination of IEC materials. Of the five strategies for health promotion as per the Ottawa Charter, three (supportive environment; community action, and personal skills) have been covered through the intercountry programme and country work plans.

Among the facilitating factors for these developments were the demonstration of the effectiveness of health promotion in some countries and greater willingness by governments to work with NGOs and other development partners.

Awareness of health promotion concepts and approaches is steadily increasing in Member States.
Although most countries have made some progress, more could have been achieved if health promotion activities were delivered through well-developed health systems. In order to address this problem, an Interregional Consultation on the Approach to Integrating Health Promotion into PHC was held in Bangkok in November 2003. This consultation recommended that WHO develop guidelines for the development of national comprehensive health promotion strategies and take necessary steps to integrate health promotion into health systems.

Following a long process of consultations with Member States, other UN agencies and development partners, the Fifty-seventh World Health Assembly, in May 2004, adopted the draft WHO Global Strategy for Diet, Physical Activity and Health. In order to assist the delegates from the Region attending the World Health Assembly to have a better understanding of the Global Strategy, the Regional Office, in close coordination with WHO headquarters, provided updated information to countries on the subject.

Injuries and Disabilities

An estimated 1.5 million deaths and 56 million disability-adjusted life year (DALY) losses are reported as a result of injuries in the Region. Of all injury-related burden, road traffic injuries account for 6.2 million severe injuries, and millions more receive treatment for moderate and minor injuries. The current epidemic of injuries, particularly road traffic injuries, is expected to rise by 144% in the Region, due to rapid motorization, increased mobility and inadequate attention to road safety (Figure 2.2). As a result of injuries, as well as other risk factors, the number of persons with disabilities is also increasing.

World Health Day 2004 was observed with the theme “Road Safety is No Accident”. This helped to create public awareness about the fact that road traffic injuries are preventable. It is being increasingly recognized that a deliberate effort is required to promote road safety and prevent deaths and disabilities as a result of road traffic accidents. A high-level policy advocacy has been achieved in support of road safety from heads of state of three countries in the Region. Other advocacy
initiatives, such as dissemination of the World Report on Road Traffic Injury Prevention and creating public awareness through discussions on issues of road safety, have also been taken.

Bhutan, Myanmar, Nepal, Sri Lanka and Timor-Leste were supported in drafting their respective national policies on injury prevention. Other countries are in the process of developing their respective policies.

An international course on road safety was organized and completed in New Delhi in December 2003. About 30 participants from the Region were trained on road safety management. This helped in creating a critical mass of change agents in the area of road traffic injury prevention and safety promotion.

The results of the human resources and infrastructure survey undertaken in Bangladesh, India, Indonesia, Myanmar, Nepal, Sri Lanka, and Thailand have been compiled as a regional resource for injury prevention. The survey also included secondary data on burden of injuries and a one-month hospital survey to describe the pattern of injuries.

Based on the draft WHO guidelines on pre-hospital trauma care system and essential trauma care, a regional approach for pre-hospital trauma care has been developed through a consultative process.
A regional framework for training on injury and violence prevention in medical and nursing education has been developed. This was achieved through a consultative process involving leaders of medical and nursing schools and councils in the countries of the Region.

A document on road safety is being developed with the WHO Collaborating Centre for Research and Training in Safety Technology, Indian Institute of Technology, Delhi. The publication will compile and critically analyse the current practices being undertaken by the countries and provide a synthesis that could be shared by all.

The process of constituting a Regional Forum for Injury and Violence Prevention has been initiated. The Forum is expected to strengthen political commitment, mobilize resources and monitor action towards prevention of injuries and violence in the Region. The Regional Office has been working closely with the regional partners in the area of injury and violence prevention. One of the areas of collaboration has been in Bangladesh where a joint programme has been developed with UNICEF for the prevention of injuries among children.

A new collaborating centre for injury prevention and safety promotion has been established in Bangalore, India. This is the third such WHO collaborating centre in the Region, the other two being in Delhi and Bangkok.

A handbook on child abuse has been developed. It will help medical officers in identifying symptoms and signs of child abuse, managing cases, obtaining referral support and campaigning against child abuse.

Managerial guidelines for surveillance of injuries and their risk factors are being developed. The guidelines will assist countries of the Region in compiling data on the basis of which action plans can be developed, implemented, monitored and evaluated.

**Prevention of blindness and deafness**

Support was provided to Bangladesh, Indonesia and Nepal in evaluating the progress made towards Vision 2020: Right to Sight. In collaboration with WHO headquarters, the Regional Office mobilized resources for the prevention of childhood
blindness. It also provided technical inputs for developing proposals and in supporting and implementing the programme in Member States.

A multi-country intervention study on the prevention of traumatic corneal ulcer was undertaken during the period under review. The data from Bhutan, Myanmar and India are being compiled in order to identify the effectiveness of antibiotic versus antibiotic-antifungal combination for the prevention of traumatic corneal ulcer.

The Vision 2020: Right to Sight programme remains the major focus of partnership for prevention of blindness.

Guidelines for the prevention and management of corneal ulcer have been developed in collaboration with the Aravind Eye Hospital, Madurai, India, (a WHO collaborating centre). The guidelines, which are the first on the subject, have been reviewed by well-known scientists from all over the world and are ready for dissemination.

A regional strategic plan for the prevention of deafness and hearing impairment has been developed through a consultative process. The plan lays the foundation for strengthening the deafness programme in countries of the Region.

A regional document “Hearing and Ear Care in the South-East Asia Region” was published. It provides a comprehensive account of the problem and the human resources and infrastructure needed to tackle the situation.

A regional forum has been constituted for the prevention of deafness and hearing impairment. The forum has already developed its framework for partnership, and has initiated action on immediate priorities. Meanwhile, guidelines for formulating national programmes for the prevention of deafness are being developed.

Ageing and health

The issues related to ageing and care of older persons are gradually taking shape in countries of the Region. The preparation of a Regional Profile for Care of the Elderly was the first step in the public health approach towards documenting the extent of issues and challenges ahead.
**Mental Health and Substance Abuse**

The Regional Office, in collaboration with WHO headquarters, has developed a programme to assist countries in updating/developing modern mental health legislation, policies and services. India is the only country to have enacted a modern mental health legislation in 1987. Some other countries (Bangladesh, Indonesia and Sri Lanka) have initiated the process of updating their laws. Since most mental health laws in the countries are based on the British Lunacy Act of 1912, the Regional Office initiated steps to review the experience of India in revising its law and issues related to its implementation, in order to see how this experience can be adapted by other countries.

Modules and software, developed by WHO headquarters, which serve as resource material for sensitizing senior policy-makers and health professionals, have been adapted for use in the countries. In collaboration with the India country office, a workshop was held in Ranchi, in November 2003 in which mental health professionals and senior planners from many states participated. This workshop will be followed by national-level workshops in some other countries.

Sensitizing senior policy-makers and planners about mental health policy and services is an important step in assigning appropriate priority to mental health. It also helps in developing services in keeping with the recent advances in medical science.

The fifty-fourth session of the Regional Committee had urged the Regional Director to assist Member States in conducting surveys on the magnitude of neuropsychiatric disorders in the community so that countries could use these data for planning and priority-setting. Indonesia and Nepal have already completed such surveys. Bhutan and Maldives have recently completed the surveys and results are being analysed. India is conducting a multicentric survey. Based on these surveys, the Regional Office is planning to organize an intercountry workshop to discuss the magnitude of neuropsychiatric disorders in the Region, and to develop strategies to address them.

Despite the availability of cheap and efficacious medicines, the treatment gap for persons with epilepsy continues to be as high as 90% particularly in rural and remote areas. Moreover, myths about epilepsy prevent patients and families
from seeking modern medical treatment. Thus, morbidity among persons affected by epilepsy remains very high. The Regional Office, in collaboration with experts from the countries, has developed manuals for the identification and management of epilepsy in the community. After extensive testing these manuals have now been printed for dissemination to the countries. With adequate training and enhancement of the capacity of the countries in the use of the manuals, it is anticipated that an additional 8-10 million persons with epilepsy will be identified and managed. In view of the stigma related to epilepsy, a video has been prepared which counters many of the myths and misconceptions associated with the condition. This video can be screened to bring awareness in the community that epilepsy is a medical condition like any other illness.

A similar programme on the identification and management of persons suffering from psychosis and on removal of the stigma attached to it is being developed and is being tested.

Mentally challenged individuals, both children and adults, need rehabilitation services in order to be reintegrated into their families and the community. Experts from Thailand and India have developed a manual for implementation in rural and remote areas for the rehabilitation of children who are mentally challenged. This manual has been printed and disseminated in Member States.

Tamana Foundation, India, a well-known centre for the training of trainers in institution-based rehabilitation of the mentally challenged, is assisting the Regional Office to develop a curriculum to set up similar training centres in other countries. Unless the mentally challenged are rehabilitated, they will remain a liability on the family, community and the state. Thus, this project will have a significant impact on reducing the burden of caring in the family.

In most countries, there is great concern about the well-being of the adolescent population. This group is subject to tremendous psychosocial pressures, which, as believed by experts, may lead to mental illness later in life. In order to promote positive mental well-being among adolescents, the Regional Office has developed and printed eight modules entitled: Coping with Stress; Conflict Resolution; Strengthening Bonds with Others; Handling Peer Pressure; Self-esteem Enhancement; Dealing with Emotions; Prevention of Harm from Alcohol, and a Trainers’ Guide for implementation of these
modules. These modules have been tested in India, Indonesia and Thailand and have been found to be very useful.

Populations in most countries of the Region are rapidly ageing. Consequently, issues related to the elderly are increasingly attracting the attention of policy-makers, nongovernmental organizations, communities, families and the elderly themselves. Also, there is increasing awareness of the mental health needs of the elderly, including development of the field of psychogeriatrics that is virtually non-existent in the countries.

Against the above backdrop, an intercountry workshop was held in New Delhi, India, in July 2003, with the objectives to: (a) review and adapt the curriculum for the training of general practitioners to deliver mental health services to the elderly at the primary health care level; (b) review and adapt the curriculum for the training of psychiatrists and neurologists, in order to enhance their skills related to psychogeriatrics and neurological disorders of the elderly, and (c) identify the mental and neurological needs of the elderly in selected countries, and develop innovative and culturally appropriate ways to meet these needs. It is planned to prepare a CD-based training material for distribution to all practitioners in the countries.

Prevention of harm from alcohol and substance use

Harm from alcohol use is rapidly emerging as a cause of concern in many countries of the Region. Alcohol abuse is a
particularly serious problem in rural and remote areas where a disproportionate amount of family income is spent on alcohol leaving very little money for food, education, housing and health.

The Ministers of Health of countries of the Region, at their meeting held in New Delhi in 2003, considered the issue of harm from alcohol and recommended that the Regional Office should develop and disseminate practical projects and programmes to assist countries in implementing an Action Plan for Alcohol. The Regional Office has developed a strategy based on the prevention of harm from alcohol to the individual, the family and the community. Projects undertaken by the Regional Office to address this issue in the countries include: (a) Development of a monograph on the regional supply, demand and use of alcohol in the general population; (b) Development of self-learning material for community volunteers on the prevention of harm from alcohol; (c) Economic analysis of the direct and indirect costs of alcohol consumption; (d) Launching of a model community-based programme in Sri Lanka for the prevention of harm from alcohol; (e) Development of a strategy for the prevention of harm among adolescents, both in rural and urban schools; and (f) Development of a manual on life skills education for adolescents on how to say “No” to alcohol. Based on all these projects, a comprehensive model will be developed for nationwide strategies for the prevention of harm from alcohol that can be adapted by the countries.

In addition to harm from alcohol use, abuse of other intoxicating substances is also emerging as a cause of concern to communities and policy-makers. Of particular concern is the abuse of “legal substances”, such as glue and petrol. Although legal, these substances, if abused by sniffing, can be very harmful. Moreover, these substances often act as a “gateway drug” for the use of more dangerous substances later. Other substances of abuse and injecting drug use are also priority issues being addressed by the Regional Office.

An intercountry workshop was held in Yangon, in December 2003 at which problems related to substance abuse in the community, particularly among adolescents, was discussed, and a draft strategy to address this problem developed. This strategy will now be tested in the community.
Child and Adolescent Health

Countries of the Region have achieved significant progress in reducing child mortality in the last two decades. Even so, the under-five mortality rate is still an area of concern in several countries. While neonatal mortality remains relatively high in most countries, the Region collectively accounts for about one third of the global child mortality. In addition to national governments, the Regional Office collaborates with UN agencies, donors, NGOs, institutions and professional bodies to address the problems in these areas.

Integrated Management of Childhood Illness

The Integrated Management of Childhood Illness (IMCI) strategy addresses major causes of child mortality - acute respiratory infection, diarrhoea, measles, malaria and malnutrition. IMCI is firmly established in the Region. Nine countries are at different stages of IMCI implementation:

- Bangladesh, Bhutan, Nepal, Indonesia and Timor-Leste: Expansion phase;
- India and Myanmar: Early implementation phase, and
- DPR Korea and Maldives: Introduction phase.

During the reporting period, WHO supported a review of the early implementation phase of IMCI in Bangladesh and Timor-Leste. Based on the recommendations of the review, both countries have formalized plans for the expansion of IMCI. Bangladesh has decided to include IMCI as a component of the World Bank-assisted Health, Nutrition and Population Sector Programme.
India finalized the country adaptation of IMCI which includes management of the newborn and is called the Integrated Management of Neonatal and Childhood Illness (IMNCI). Two Training of Trainers courses were conducted at the national level. Field-level training of health workers has commenced in three districts. It is proposed to include IMNCI in the World Bank-supported national Reproductive and Child Health (RCH) II programme. The Regional Office supported the World Bank missions and also assisted in the formulation of a plan of action for the introduction of IMNCI in RCH II.

Progress was achieved in including IMCI in pre-service training. India introduced IMCI training for undergraduate medical students in five medical schools. The National Institute of Public Cooperation and Child Development, India, introduced IMCI in the pre-service curriculum of Integrated Child Development Services Scheme (ICDS) workers. In Nepal, eight medical schools have introduced IMCI in the curriculum. The faculty of the Council for Technical Education and Vocational Training – the apex national institution responsible for training paramedical staff – were trained in IMCI.

Assistance was provided to DPR Korea to initiate IMCI. Adaptation of the generic IMCI was accomplished and support provided for initiating the planning process.

Innovations in IMCI training were taken forward. Field-testing of a specially-designed IMCI package for private medical practitioners was initiated by the Indian Academy of Paediatrics. The Indira Gandhi National Open University, New Delhi, has included IMCI in distance learning courses for doctors and nurses.

With a view to assisting countries in making available current information and data regarding child health for policy and strategy formulation, the Regional Office has initiated compilation of country-specific child health profiles. During the reporting period, child health profiles in respect of Bangladesh, Indonesia and Nepal were drafted; these will be published in the latter half of 2004.

**Neonatal health**

The improvement in child survival in the past two decades has been due mainly to the reduction of deaths in children
above the age of one month. Neonatal survival is still a challenge in many countries of the Region. Estimates indicate that about 40% of all childhood deaths are among neonates. It has been estimated that neonatal mortality needs to be halved if the Millennium Development Goal (MDG) of reducing under-five mortality by two thirds is to be achieved (Figure 3.1).

Figure 3.1: Under-five mortality in the SEA Region, 1990-2015

![Figure 3.1: Under-five mortality in the SEA Region, 1990-2015](image)

Note: The MDG goal for under-5 mortality is to reduce the rate by two thirds between 1990 and 2015.
Source: WHO/SEARO

A series of activities were organized during the year to accord high priority to neonatal survival in the countries. A draft regional strategic framework was developed and peer-reviewed by an international group of eminent experts in July 2003. This resulted in the publication of a document: Strategic Directions to Improve Newborn Health in the South-East Asia Region. The document will be shared with all countries and partners involved in neonatal, child and reproductive health.

The Regional Office initiated work on a regional situation analysis on newborn health and on an advocacy document. These documents will assist countries in evolving national strategies and initiating interventions for neonatal survival and development.

Adolescent health and development

Adolescents comprise 18–25% of the population in the Region. Adolescents face health problems that include undernutrition,
early marriage and early child-bearing in the deprived, and obesity, substance abuse, violence, injuries and suicide among the other segments of the population. Due to the lack of disaggregated data, the inadequacy of information is a major constraint in advocating for adolescent health and development. As a result, adolescents are not prominently visible in public health programming. During the reporting period, progress was achieved in the following areas:

The need for a health sector strategy to mainstream adolescent health (AHD) issues into the existing national programmes cannot be overemphasized. The existing policies at the country level include adolescent health and development but no country in the Region has an exclusive policy on AHD. Technical support was provided to Bangladesh and Myanmar to formulate a health sector strategy. A five-year strategic plan was developed in Myanmar. It was endorsed at a consensus meeting of stakeholders from all relevant sectors and development partners. A draft strategy is under preparation in Bangladesh. In India, a framework of strategic directions has been prepared to strengthen adolescent health under the RCH II programme of the Ministry of Health and Family Welfare. A combined policy and strategy on Child and Adolescent Health is under preparation in Indonesia. The health sector strategy on AHD in Member States identifies what the health sector will do, besides identifying collaboration with non-health sectors.

The available evidence suggests that when in need, many adolescents do not seek care from the available public health services that are often not geared to respond to their special needs. The strategy to meet the needs of adolescents is Adolescent-friendly Health Services (AFHS). There are 10 AFHS centres in India, and 10 pilot centres in Indonesia, while one is functioning in Nepal. In Thailand, ‘Friends Corners’ have been expanded in the provinces with support from the Department of Public Health. Technical support was provided for the advanced international training programme on sexual and reproductive health rights of young people, organized by the Swedish International Development Agency (SIDA) to introduce the concept of AFHS. Staff from WHO headquarters and the Regional Office conducted a three-day training programme for participants from different countries.
The information base on health care-seeking behaviour of adolescents in the Region needs to be strengthened. Tools and guidelines for mapping of facilities and services and health care-seeking behaviour of adolescents are being developed and will be field-tested in India. After the results are received, it is proposed to use these protocols in selected countries to gather evidence on health care-seeking behaviour of adolescents and the preparedness of health facilities to provide AFHS.

Country-specific profiles on adolescent health and development have been initiated in Bangladesh, Myanmar and India. Technical inputs were provided in updating India’s profile on AHD, which has been developed under the aegies of the UN Inter-Agency Working Group (UN IAWG). Data from published surveys and micro studies are being collated and compiled in the formulation of country profiles. Efforts have been initiated in Thailand, Indonesia, Nepal and Maldives to undertake this task in 2004.

About 50% of new HIV infections occur globally among young people each year. Because of their large numbers and vulnerability, the Region is focusing on HIV in young people (10-24 years). Of the 11.8 million young people living with HIV/AIDS, 1 100 000 are in South-East Asia and 740 000 in East Asia and the Pacific. Bangladesh, India and Myanmar have been identified as priority countries to be provided with technical support in 2004-2005. A draft regional strategy on HIV and Young People and an advocacy booklet were prepared by the Regional Office. Under the Global Fund to fight HIV/AIDS, TB and Malaria (GFATM), discussions were held on strategies to be adopted in order to focus on young people as part of the “3 by 5” initiative during the working group meeting held in the Regional Office. Bangladesh has received US$ 19 million from the Global Fund to support HIV and Young People activities. WHO will provide technical support in the preparation of operational plans for the implementation of these activities. Preliminary discussions were held in India and Myanmar in order to move the HIV and Young People initiative forward.

Programme managers in selected countries have been contacted to include age and gender-specific information in their routine surveillance and surveys. A framework for providing information on selected indicators was prepared and shared with Member States.
Collaboration and coordination with different donors and development partners and with relevant programmes within WHO helped in mainstreaming AHD into the health and non-health sectors.

In order to address the Millennium Development Goals related to reduction of maternal mortality, it is necessary to focus on adolescent pregnancy in the countries where early marriage and adolescent pregnancy are common. More than half of the girls are married by the age of 18 years in Bangladesh, India and Nepal and child-bearing often begins soon after marriage. Regional inputs were provided for the document “Global review on Adolescent Pregnancy”, prepared by WHO headquarters. Representatives from Member States attended the global meetings on adolescent pregnancy and married adolescents and shared the regional perspective. A regional review on adolescent nutrition is also being finalized.

Modules on Life Skills Education (LSE) for health promotion of out-of-school adolescents, developed under the umbrella of the UN-IWG on Population and Development in India were printed by the United Nations Population Fund (UNFPA)/IAWG Secretariat. Technical support was provided for the formulation of preliminary guidelines for the desk review of the draft modules for the 2004 AFHS, which has been included as the main agenda for the IAWG members.

A UN Multi-bi Group on Education, under the United Nations Educational, Scientific and Cultural Organization (UNESCO), has been formed in India. Discussions were held to develop possible linkages between education and health so as to improve the health care-seeking behaviour of adolescents at school. A framework for collaboration with different partners and bilateral agencies is being prepared by the secretariat of the Group.

Reproductive Health

In providing support to achieve the MDG for reducing maternal and newborn deaths, the Regional Office assisted Member States to improve access to skilled care at birth, and to improve the quality of maternal and newborn health services. It also introduced evidence-based norms and standards for maternal and newborn care, and facilitated the use of
appropriate methods for reviewing cases of maternal deaths. Collaboration with development partners, including UN agencies, NGOs and professional organizations has been effective in creating awareness on skilled care at birth and related issues, in implementing the best practices for maternal and newborn care, and in managing the maternal and newborn health programme.

Promotion of evidence-based norms and standards has been carried out through the Implementing Best Practices initiative, introduction and promotion of the use of Reproductive Health Library CD-ROM, and introduction, adaptation and utilization of reproductive health services guidelines. Maternal and newborn health and family planning were the major areas that were promoted. The Reproductive Health Profiles of eight countries were updated in order to provide the latest data for better programme planning. Countries have been working on different elements of reproductive health according to their specific problems, such as post-abortion care activities in India and Myanmar, with the aim of further reducing maternal mortality.

The major challenge is to ensure the widest achievable range of safe and effective reproductive health services across the health system that would be integrated into primary health care in the countries. The problems of maternal and newborn health, especially those related to access to skilled care at birth and quality of care; family planning, and unsafe abortion,
continue to be the major issues for the Region. As HIV/AIDS is a major problem globally and in the Region, promotion of healthy sexual behaviour and practices are crucial in preventing sexually-transmitted infections.

Reproductive and sexual health are fundamental to individuals, couples and families, and to the social and economic development of communities and nations. However, reproductive and sexual health continue to be major public health problems. The estimated maternal mortality ratio (MMR) in the Region varies from 44 in Thailand to 740 per 100,000 live births in Nepal. The average life-time risk of death from maternal causes in the Region is 1 in 58, ranging from 1 in 24 in Nepal, to 1 in 900 in Thailand.

The level of contraceptive use has increased substantially during the last few decades. However, in some countries it has become static, while in others there is a predominance of non-reversible methods, high rates of discontinuation, limited use of male contraceptive methods and limited use of contraception among married and unmarried adolescents. The substantial unmet need for contraception has led to unintended pregnancies and subsequently to induced abortion. In India alone, approximately 6.7 million induced abortions take place annually in unauthorized centres that provide abortion services of varying degrees of safety. Unsafe abortions account for approximately 13% of all pregnancy-related deaths.

During 2003-2004, a number of activities related to reproductive health were conducted in the Region. As maternal and newborn health is a priority programme, most of the activities in reproductive health were conducted in relation to the maternal and newborn programmes. An intercountry workshop on Reproductive Health Library (RHL) was conducted in Songkhla, Thailand, in August 2003 to familiarize country participants on RHL CD-ROM. The participants critically reviewed the draft regional training module on evidence-based RH practices provided by RHL CD-ROM. The training module is being finalized.

A regional workshop on family planning was conducted in order to identify key family planning issues and country needs as well as to introduce evidence-based norms and standards for family planning services in order to improve maternal and newborn health. Bangladesh, Bhutan, India,
Indonesia, Myanmar, Nepal, Sri Lanka and Thailand have developed or updated their reproductive health profiles. In India, a meeting on Implementing Best Practices was conducted, involving 21 partner agencies to promote evidence-based practices in the broad area of reproductive health. Follow-up activities pertaining to this meeting are being undertaken in four states of India.

In Indonesia, guidelines for family planning audit and emergency contraception have been completed and guidelines on women’s health services for refugees adapted and field-tested. Competency-based training on the use of manual vacuum aspiration for post-abortion care has been initiated in India. In Myanmar, basic health staff and voluntary health workers were trained in the provision of reproductive health service. Also, advocacy meetings and training on post-abortion care were held. In Bhutan, laboratory technicians were trained in the screening of cervical cancer.

In 2003, the Regional Office organized, in collaboration with the Regional Office for the Western Pacific, a bi-regional consultation on global reproductive health strategy development in Colombo. In this consultation the draft WHO strategy was critically reviewed by participants from 17 Asia-Pacific countries. Using country-level experiences and lessons learnt in implementing reproductive health strategies, policies and programmes, the participants proposed key issues and recommendations for incorporation in the draft strategy. The final strategy, with inputs from all regions, was finally endorsed by the World Health Assembly in 2004.

**Making Pregnancy Safer**

Maternal and newborn mortality and morbidity remain one of the main public health problems in the Region. Estimates suggest that some 174 000 maternal deaths out of the global total of 529 000 took place in the Region in 2000. Approximately 78% of maternal deaths in the Region occurred in India alone, while about 20% occurred in Bangladesh, Indonesia, Nepal and Myanmar. High MMR countries include Bangladesh, Bhutan, India, Myanmar, Nepal and Timor-Leste.

The coverage of antenatal care at least once during pregnancy ranged from 23% in Nepal to 99% in DPR Korea,
Sri Lanka and Thailand. The proportion of deliveries attended by skilled attendants ranged from less than 20% in Bangladesh and Nepal, to 98% in DPR Korea. Most of the deliveries in the countries, except Sri Lanka, Thailand and DPR Korea, were conducted at home. Access to essential obstetrics care in most countries, except DPR Korea, Sri Lanka and Thailand was very limited because of lack of transport, high cost of services, and lack of knowledge on danger signs during pregnancy, childbirth and the postpartum period. Moreover, a large number of women, particularly the poor and marginalized, do not always have effective access to such life-saving technologies.

In addition, of the more than four million newborns dying each year - and nearly as many babies are stillborn – globally, the South-East Asia Region accounts for nearly 40% of the global neonatal mortality, with an estimated 1.6 million newborns dying every year. Furthermore, the figures on maternal and newborn health problems are likely to be underestimated. Constraints such as poor civil registration systems and weak surveillance systems in many countries contribute to the inaccurate estimates.

Towards supporting the countries to achieve the MDG goal of reducing maternal mortality by 75% in 2015 from its level in 1990, and newborn mortality at least by half, a number of activities were carried out during the reporting period. Improving access to skilled care at birth and improving the

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<td>The strategic objective of Making Pregnancy Safer is to ensure the availability, access and use of skilled care at birth to all women and their newborns, especially the poor and vulnerable groups. The international development goals have set a target of 90% globally for deliveries attended by skilled attendants by 2015. The achievements of DPR Korea, Sri Lanka and Thailand are comparable to that of any developed country. However, the goal remains a major challenge for the South-East Asia Region as in some Member States the proportion of deliveries attended by skilled attendants is still well below 50%. For instance, in Nepal, the proportion of deliveries attended by skilled attendants was only 13.5% in 2002, while the figure for Timor-Leste stood at 19.5%. The figures for Bangladesh, Bhutan and India were 21.8%, 23.7% and 42.3% respectively. Nonetheless, most countries in the Region are aware of the importance of skilled care at every birth. Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal and Timor-Leste are working on different issues of skilled care at every birth. Bangladesh, India, Nepal and Timor-Leste are in the process of strengthening human resources for maternal and newborn health while Bhutan, Indonesia, Maldives and Myanmar are attempting to improve the quality of maternal and newborn health.</td>
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quality of maternal and newborn care continue to be the priority issues in the Region.

Technical support was provided to Indonesia for the Making Pregnancy Safer programme and for evaluation of the in-service competency-based training for skilled attendants. Similar support was also provided for training – and its evaluation – of primary health care providers in Bangladesh to become qualified skilled birth attendants. In Nepal, the development of a human resources strategy for safe motherhood is under way.

In order to ensure quality of care of maternal and newborn health services, evidence-based norms and standards for maternal and newborn care are continuously being promoted. Recently, WHO published *Pregnancy, Childbirth, Post-partum and Newborn Care: A Guide for Essential Practice and Managing Newborn Problems*. It includes technical standards for maternal and newborn care at the primary health care level. This guide will be introduced to the countries for adaptation and use according to their respective needs.

The review of cases of maternal deaths and their causes has benefited the countries in stimulating necessary action. This approach is much better than simply counting cases and calculating ratios. Currently, Bangladesh, India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand are conducting such reviews.

In October 2003, the SEA Regional Office participated, in collaboration with WPRO, UNICEF and UNFPA, in a bi-regional workshop on the progress of maternal mortality reduction in Manila. The two regions have similar socio-cultural backgrounds and similar maternal and newborn health problems. Experiences on successes and failures in reducing maternal mortality were shared. Eight countries from the SEA Region participated in the workshop and priority problems in each country were identified. This forum is used for further collaboration in addressing problems related to maternal and newborn health in the two regions.

Collaboration with relevant programmes and development partners is considered an important approach in addressing problems relating to maternal and newborn health. Four
countries (Bangladesh, India, Indonesia and Myanmar) are being assisted in analysing the magnitude of the problems of malaria in pregnancy and in finding effective measures to address them. There has been continued collaboration with the UNFPA Country Support Team (CST) in addressing the issue of skilled care at birth. It was strengthened through a workshop involving representatives of countries from South Asia and the Middle East.

Challenges persist with regard to improving access to skilled attendance and the quality of care. Countries and international partners supporting the Safe Motherhood Initiative are committed to achieve the following targets for skilled birth attendants: where MMR is very high, at least 40% of all births should be assisted by skilled attendants by 2005; 50% by 2010, and 60% by 2015; while globally, 80% of all births should be assisted by skilled attendants by 2005; 85% by 2010, and 90% by 2015. The major challenge for the Region is to achieve these targets as well as to improve access to essential obstetrics care and improve the quality of maternal and newborn care.

Women’s Health

The Regional Office is focused on addressing the impact of gender inequality on neglected areas of women’s health, specifically violence against women. The specific achievements in these areas during the reporting period are highlighted below, together with an indication of priorities for the future.

Integrating gender considerations into the training and curricula of health professionals is a critical part of gender mainstreaming in health. A lack of understanding of gender among health professionals can result in the implementation of health services and programmes which do not meet the needs of women or address major societal determinants of health. The Regional Office is involved in mainstreaming gender and rights in the curricula of basic medical education and in-service training for health professionals.

In collaboration with the Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute of Medical Sciences and Technology, Thiruvananthapuram, India, the Regional Office developed a training course on gender in medical education, and pilot-tested a two-week course in November 2003. Medical educators from across the Region participated
and, with an enhanced understanding and appreciation of gender in health and medicine, developed unique strategies for integrating gender into the curricula of their own institutions.

The Regional Office pilot-tested a course developed by WHO headquarters entitled *Transforming Health Systems: Gender and Rights in Reproductive Health*, in Yangon in December 2003. This two-week course offers both conceptual and technical skills and tools for practitioners to integrate the promotion of rights and gender equality into their policies, planning and programmes. The participants developed various strategies towards integrating gender and rights into reproductive health policies and programmes.

In order to raise awareness of gender-based health disparities and to promote the use of sex-disaggregated health statistics for health policies and programmes, WHO headquarters and the regional offices initiated the development of a core set of indicators to monitor and measure women’s health and gender-based health disparities in health status and access to health services. The Regional Office recommended additions and modifications to the variables included in the statistics prepared routinely by it, and proposed core variables for a new data booklet/wall chart on Gender, Health and Development in the Region. The latter will be finalized in collaboration with WHO headquarters and the other regional offices and disseminated in 2005.

Finally, the Regional Office worked on ways that could contribute to introducing gender awareness into community-based interventions to reduce NCD risk factors. This work is expected to continue with the development of a case study of one project to identify gender-related constraints and opportunities in the prevention of risk factors for NCDs.

In addition, the Regional Office provided support and guidance on gender mainstreaming in health to WHO programme managers in the country offices. It also continued to support the Women’s Panel, an informal consultative body established to assist with matters related to the recruitment of women professionals.
Nursing and midwifery

The Regional Office continues to collaborate with Member States and WHO headquarters in promoting the effective use of nursing and midwifery resources. The aim is to contribute to the scaling-up of the health system responses for the realization of the Millennium Development Goals. Various initiatives undertaken at country and regional levels are focused at improving the quality of nursing and midwifery education, services and management.

Special attention was given to strengthen nursing and midwifery workforce management in the Region. The Regional Multidisciplinary Advisory Group on Nursing and Midwifery played a significant role in this initiative. As recommended by the former Advisory Group on Nursing and Midwifery Workforce Management, the Regional Committee adopted a resolution in September 2003 urging Members States to provide support and adequate resources to implement key interventions towards achieving a well-managed nursing and midwifery workforce.

The newly-formed Advisory Group on Nursing and Midwifery held its first meeting in April 2004. The objective was to provide advice to the Regional Office and countries on priority areas of work to address important issues confronting nursing and midwifery in the Region, together with the
proposed strategies for making effective use of nursing and midwifery resources. The newly-developed guidelines for nursing and midwifery workforce management were disseminated widely and support provided to promote their adaptation and implementation.

Continued attention was given to building the capacities of nurses and midwives for strengthening their responses to priority health problems and for improving services management. For example, a regional programme on training of trainers on nursing and midwifery management in HIV/AIDS prevention, care and support was developed in collaboration with relevant WHO collaborating centres. The objective was to build national capacity and to enable nurses and midwives to effectively support the “3 by 5” strategy.

The regional offices of the South-East Asia and the Western Pacific regions jointly developed guidelines on infection prevention and control in health care facilities in response to SARS and other emerging epidemics, which was much appreciated by the countries. Action was also taken at the country level to build the capacity of health care personnel for good infection control practices.

**Nutrition**

The nutritional status of infants and young children is far from optimum in the Region. Under-nutrition continues to be a major problem with unacceptably high levels of moderate to severe stunting. Forty per cent of the 10.5 million deaths annually among children under five years of age in countries of the Region are associated with under-nutrition. Although the prevalence of Protein Energy Malnutrition (PEM) is decreasing slowly, with the exception of Thailand, about 30-50% of pre-school children in countries are undernourished (underweight or stunted), the maximum numbers being in Bangladesh, Bhutan, India and Nepal.

Most countries of the Region include infant feeding in their national nutrition policies, but exclusive breastfeeding (average about 30% in infants below four months of age) and appropriate complementary feeding rates have not shown substantial improvement. Only four countries (Bangladesh, India, Indonesia and Nepal) have changed their infant feeding
policies and are recommending exclusive breastfeeding for six months, in line with World Health Assembly resolution WHA55.25.

Iodine deficiency is the greatest single preventable cause of brain damage and mental retardation, and yet most countries have not achieved universal salt iodization and eliminated iodine deficiency disorders (IDD). Iron and folate deficiency and the resulting anaemia affect more than 60% of women of childbearing age and millions of young children in the Region. These conditions, which are afflicting a large section of the vulnerable groups, pose challenges to health care and national development.

Technical assistance was provided to the Indian Council of Medical Research for conducting a workshop to develop a comprehensive micronutrient strategy (for vitamin A, iron and IDD. Participation in an international conference organized by salt manufacturers and the Salt Commissioner of India, and in a national multisectoral workshop to address IDD, has led to the initiation of new partnerships and strengthened the existing ones for tackling this problem in India. After Bhutan, Thailand had an international assessment of its IDD Control Programme in April 2004. WHO, UNICEF and ICCIDD jointly organized the assessment and their respective representatives were included in the team.
A review of the maternal nutrition situation was conducted in Bangladesh, India, Indonesia and Thailand, with particular focus on their anaemia control programmes. Regional guidelines are being developed in this regard.

Technical support was provided to the International Asia Pacific Conference on Infant and Young Child Feeding. WHO supported two participants from Myanmar and Sri Lanka at this meeting which was held in New Delhi in November 2003.

Technical and financial support was provided to three countries to draft a framework for a national strategy in line with the global strategy on infant and young child feeding.

The Eighth Meeting of the Nutrition Research-cum-Action Network was held in May 2004 in New Delhi. This meeting shared experiences in priority research conducted recently in the countries, and agreed on a common understanding of the possible nutrition advocacy tools and future nutrition research.

As one of the capacity-building activities for the Network members, research was supported in Myanmar to study the prevalence of iron deficiency anaemia in adolescent school girls, and to explore the dietary intake of iron in this population. This project provided information to adolescent school girls, school authorities and teachers on the importance of iron in the body.

A website link on the internet has been prepared by the Regional Office for the Nutrition Research-cum-Action Network. Access to this site will facilitate both collaborating centres and the countries to share information about recently-completed and ongoing research as well as future training programmes, and to place requests for technical assistance.

Technical assistance for research and training activities was provided to the four WHO collaborating centres for nutrition (two in India and one each in Indonesia and Thailand) as per the priority and needs of the respective countries.
SUSTAINABLE DEVELOPMENT
AND HEALTHY ENVIRONMENTS

Sustainable Development

The World Commission on Environment and Development defined sustainable development as “a process in which the exploitation of resources, the direction of investment, and the orientation of technological development and institutional change meet the needs of the present generation without compromising the ability of future generations to meet their own needs”.

The World Summit on Sustainable Development, held in Johannesburg, South Africa, in 2002, reaffirmed the importance of investment in people as the key to sustainable development and highlighted the central place of health within that agenda. Concentration on five sectoral issues – water, energy, health, agriculture and biodiversity (WEHAB) – demonstrated the centrality of health in sustainable development. The health agenda addresses a variety of issues that intersect health, environment and development. These can be categorized into two key areas: health care and disease control, and environmental health and lifestyle issues.

In addition to the traditional environmental risks, such as inaccessibility to clean water and air and basic sanitation, people in the Region face growing threats to their health from exposure to modern urban, industrial and agro-chemical pollution. They are beset with a variety of communicable and vector-borne diseases with many having an environmental etiology or being linked to pollution, thereby hindering sustainable development. The problem is aggravated by rising noncommunicable diseases due to changing lifestyles, increasing life spans and patterns of consumption and production. The situation is further
compounded by widespread poverty, illiteracy and population explosion and its consequences.

The focus on understanding health in a broad development context and on making health a force for poverty reduction and economic growth is a crucial area of WHO’s work. One of the important aspects of WHO’s role is to engage in political processes that would put health at the top of the poverty reduction agendas at global, regional and national levels.

The countries of the Region have been improving energy services and strengthening the related infrastructure in order to cope with traditional environmental threats: but the rapid pace of urbanization and population pressure continue to expose large numbers to health risks associated with lack of clean water and basic sanitation. Similarly, while environmental standards are being developed in the countries and their enforcement strengthened, the “conflict” between economic growth and environmental protection continues to expose human health to modern environmental risks.

The paramount need for inter- and intra-sectoral planning and action for minimizing environmental risks to human health cannot be overemphasized. Yet, the mechanisms for intersectoral planning and action need to be appropriately strengthened in most countries.

The area of Food and Nutrition is closely connected with sustainable development and hence with social/human development, which, in turn, is interlinked with economic growth and poverty reduction. Therefore, it is encouraging that all Member States have developed national plans of action for nutrition. Most countries in the Region have also adopted national food policies. Yet, food insecurity continues to haunt many. Analyses have shown that the problem is not so much with adequacy of food production as with its distribution. Food is mostly available; yet it is not accessible to all due to poverty.

In the South-East Asia Region, as elsewhere, it is the poor who suffer disproportionately from unsafe environmental conditions and food insecurity. Just as poverty is both a cause and a consequence of ill-health, it is also caused by growing environmental risks – both modern and traditional – and, in turn, it aggravates those risks. Therefore, action on health
and environment in the perspective of sustainable development leads not only to improved environment and better health, it also contributes to poverty alleviation and economic growth.

The need to develop action plans on health and environment has been highlighted during the recent years. Through the health and environment (H&E) initiatives, WHO assisted the Member States in identifying and assessing health hazards and issues in such sectors as agriculture, industry and environment. Priority areas such as clean water and air, food safety and safe use of chemicals have been taken up for coordinated planning and intersectoral action. National macro development plans are laying increasing emphasis on these areas. Nine countries have initiated/developed H&E programmes and adopted or drafted plans of action involving intersectoral partnerships. The challenge is to operationalize these plans of action.

Following the World Summit on Social Development, the Ministers of Health of countries of the Region deliberated upon “Health in Development”, leading to the production of a monograph on “Poverty and Health: Regional Issues”. WHO facilitated intersectoral seminars for the development of national strategies on health and poverty reduction in Nepal and Sri Lanka. The progress on the “Declaration on Health Development in the South-East Asia Region in the 21st Century”, adopted by the Ministers of Health in 1997, was reviewed by the Ministers at their meeting in September 2003. They recommended that WHO should continue to monitor the progress on implementation of the policy actions enunciated in the Declaration.

The countries of the Region have reacted very positively to the Report of the Commission on Macroeconomics and Health (CMH). While Bangladesh, India, Myanmar and Sri Lanka have established National Commissions on Macroeconomics and Health, Bhutan, Indonesia, Nepal and Thailand have adopted other mechanisms for developing macrohealth investment plans for scaling up essential health interventions. Implementation of these plans would translate the Commission’s blueprint for development into reality. Besides transforming the health scenario, investment in health, accompanied by the strengthening of health system and greater attention to reproductive health and family planning, would
curb population growth, increase spending on health and nutrition and education, raise productivity, increase saving rates and thus stimulate economic growth. It will also contribute greatly to poverty reduction through protecting the only asset, namely, a healthy body, of the poor and thus prevent ill-health leading to impoverishment. A pro-poor health system would also prevent marginalized families from slipping into poverty. Economic growth with equity, *inter alia*, through investment in health contributing to poverty reduction, will lay the foundation for sustainable development.

Besides general advocacy for health in sustainable development through the meetings of Ministers of Health and certain sessions of ESCAP etc., regional conferences of parliamentarians have been held on “Health and Development”; “Women, Health and Environment”; “Economic Crisis and its Impact on Health”; “Health of the Vulnerable Populations”; “Impact of Tuberculosis and Malaria on Poverty”, and on the Report of the Commission on Macroeconomics and Health. These have served to enhance advocacy for intersectoral policies, programmes and actions that are required for health development, particularly that of the poor and the vulnerable groups, in the perspective of sustainable development.

**Health and Environment**

**Water supply and sanitation**

The fifty-sixth session of the Regional Committee adopted a resolution on Water, Sanitation and Hygiene Determinants of Health – Role of Health Ministries\(^1\), which acknowledged the importance of these basic risk factors for health in the Region. Respiratory infections related to poor hygiene, and diarrhoeal diseases related to unsafe water, inadequate sanitation and poor hygiene, together cause more than 2.1 million deaths every year in the Region, more than all other communicable diseases combined. Similarly, diseases related to unsafe water, sanitation and hygiene are responsible for the loss of over 56 million disability-adjusted life years (DALYs), more than the combined disease burden of all other communicable diseases.

\(^1\)SEA/RC56/R8
Weaknesses have been found in drinking water quality surveillance programmes in all countries of the Region. Access to sanitation facilities is estimated at only 42% of the population, and studies have found hand-washing rates as low as 14%.

The Regional Committee resolution called upon Member States to strengthen the capacity of health ministries to fulfil their role as evidence-based advocates for improvement of water supply and sanitation services, and promoters of hygiene and low-cost interim interventions. To assist the countries in this task, WHO is assessing national health policies, programmes and health sector resource allocations related to water, sanitation and hygiene risk factors. WHO is also preparing guidelines to assist national authorities in stimulating intersectoral dialogue on the role of health authorities in the area of water, sanitation and hygiene, and to identify entry points in health sector programmes for strengthening intersectoral collaboration.

The Regional Committee also requested the Regional Director to develop a regional plan of action to support countries’ efforts at strengthening the capacity of health authorities, and to launch the regional plan at an intersectoral, ministerial conference. A framework for the regional plan of action is being developed in consultation with Member States. Detailed planning for the ministerial conference is also under way in collaboration with UNICEF and other international development partners.

During the reporting period, the Regional Office supported Bangladesh, India, Indonesia, Myanmar, Nepal and Sri Lanka to plan and implement low-cost water, sanitation and hygiene demonstration projects. The two-year West Delhi Slum Project (India), concluded in October 2003, successfully demonstrating the effectiveness of household-level treatment of drinking water as a strategy for reducing childhood diarrhoea.

In collaboration with WHO’s Emergency and Humanitarian Action (EHA) programme, activities were initiated to implement the regional strategy for strengthening the capacity of the Regional Office to support water, sanitation and hygiene needs of countries in emergencies. Information resources were developed, including a Water, Sanitation and Health (WSH) in Emergencies website, and an in-house
A training course was conducted for WSH and EHA focal points. Having strengthened its in-house capacity in this regard, the Regional Office will direct future efforts at capacity building in countries.

Healthy settings

Healthy settings activities have been practised in the Region for the past 10 years. The programme, launched in Bangkok in 1993, has been extended to nine countries of the Region. Furthermore, the Regional Office has been networking with other WHO regions to learn from their experiences and for sharing information. This initiative is seen as an effective approach to supplement capacity building at the community level, which is important for the success of decentralization being promoted by many countries in the Region.

In Maldives, the Healthy Villingili island in Gaaf Alif Atoll was evaluated after one-and-a-half years of operation, as was planned at its initiation. The availability of drinking water has almost doubled; privately-funded community sewers have been laid with community participation; nutrition has been enhanced through improved efforts at home gardening; mosquito and fly nuisance/breeding has been controlled; better solid waste disposal has been accomplished; antenatal care and ARI services have been improved, and better awareness has been created on the ill-effects of smoking.

In Sri Lanka, the government is keen to establish a Healthy Colombo programme under the Colombo Municipal Council. Support was provided by the Regional Office in preparing a proposal for action that could begin in mid-2004.

A web-based database on healthy settings has also been created and is in its pilot stage for direct country information input.

Arsenic poisoning

Arsenic contamination of groundwater continues to pose a health risk in Bangladesh, India, Myanmar, Nepal and Thailand. It is estimated that approximately 40 million people are at risk of developing arsenic-related disease as a result of the arsenic present in their drinking water at concentrations exceeding the WHO guideline value of 0.01 mg/L.
In order to help health professionals in the proper diagnosis and management of arsenicosis cases, regional guidelines on arsenic mitigation have been drafted. These guidelines are based on a series of national and regional consultations during which a consensus protocol was formulated and field-tested.

In order to build regional capacity, three other important documents on critical issues were produced: (1) draft Standard Operating Procedures (SOP) to ensure uniformity in arsenic testing in the Region; (2) problem-based epidemiology module for teaching arsenic-related health issues to epidemiologists and programme managers, and (3) comprehensive health risk assessment module developed in collaboration with the Agency for Toxic Substance and Disease Registry, Atlanta, USA. This module will be used for assessing the relative health risks of arsenic exposure from food and other significant sources. In addition, efforts are being made to establish a network to bring together researchers and programme managers for an exchange of scientific information, tools and guidelines on arsenic mitigation.

**Occupational health**

A situation analysis of occupational health in countries of the Region has shown that occupational hazards are prevalent among the Region’s workforce of approximately 560 million. The response of countries to the occupational health situation did not show a high degree of coordination in priority areas. Therefore, in order to guide them on a more systematic approach, a regional strategy on occupational health and safety in countries was formulated. This regional strategy was further developed at a bi-regional workshop involving the South-East Asia and the Western Pacific regions that aimed to strengthen occupational health in the Asia Pacific Region. Technical and financial support has also been provided to the WHO collaborating centres on occupational health in Thailand and India to carry out an assessment of the training capacity in the Region and to formulate national plans on occupational health.

**Chemical safety**

The promotion of environmental health in the Region needs to address all aspects related to the sound management of toxic
substances in order to reduce, at the source if possible, their negative impact on human health. During the reporting period, the Regional Office focused on the management of pesticides and health care wastes. Both issues represent a major public health threat when managed poorly.

The volume of hazardous wastes being produced is increasing. Of the global deluge of 150 million tons of hazardous wastes, a significant proportion is produced and dumped in the SEA Region. Health care wastes are officially listed as the second most hazardous wastes - after radioactive wastes - by the UN Basel Convention.

Although only up to 20% of health care wastes are infectious in nature, when infectious and non-infectious wastes are not separated but mixed together, the total volume of wastes produced by the health sector needs to be considered as 100% infectious. The estimated volume of health care wastes produced in the Region is approximately 1,000 metric tons, daily. This calculation is based on the number of hospital beds multiplied by 1 kg of wastes.

Consequent to the introduction of plastic auto-disable syringes for immunization and therapeutic purposes, millions of infectious plastic syringes and needles will significantly increase the volume of health care wastes per beds.

The Regional Office, together with the Indira Gandhi National Open University (IGNOU), New Delhi, India, has developed a distance learning certificate course on “Promoting Municipal bin used for the disposal of mixed medical waste.”
health through the sound management of health care wastes”. The course was developed in a participative manner, with inputs of four national workshops (organized by the countries for this purpose during 2003–2004) having been successfully integrated into the main contents written and reviewed by a panel of 30 regional experts.

Study centres in Bangladesh, India, Indonesia and Nepal will coordinate with IGNOU to supervise the first batch of estimated 120 e-students later this year.

Children’s environmental health

In the wake of the World Health Day 2003 theme, the Regional Office supported several activities organized by countries of the Region. Most of them were oriented towards better awareness and training. Among these was a 26-minute video film to enhance the awareness on the health risks incurred by street children/ragpickers. It was produced by the children themselves and has been screened with significant success, along with theatre plays, in schools. A most promising educative tool is the school-based interactive CD game. While playing, children learn how to reduce environmental threats to health. Other high-quality training materials for teachers were also produced and are now being used. All the products are a result of joint efforts between ministries of health of countries of the Region and environment- and public interest-minded NGOs.

Management of pesticides

WHO estimates that globally more than six million poisonings occur in humans. The Region carries at least one sixth of this burden, with more than one million poisoning cases, annually. Many of them are estimated to result from increased pesticides use. An effective tool to promote the sound management of chemicals is the “National Chemical Profiles”. Four countries that developed the profiles (Bangladesh, Indonesia, Sri Lanka and Thailand) presented their current status at an intercountry workshop on chemical safety, held in the Regional Office in November 2003. Four other countries (Bhutan, India, Myanmar and Nepal) are currently developing/reviewing their profiles.
Management of pesticides is also being addressed through the implementation of the new WHO policy for the use of public health pesticides. This strategy focuses on community engagement through informed decision-making, supporting the concept of Integrated Vector Management – IVM. The Regional Office contributed to the framing of this new strategy and is currently involved closely in its implementation through several WHO/United Nations Environment Programme (UNEP)-sponsored IVM/Integrated Pest Management (IPM) pilot projects that have been planned in the countries.

In close collaboration with the countries and UNEP, the Regional Office addressed the need to develop an alternative to the use of DDT for vector control. Within the scope of the now internationally legally-binding, Stockholm Convention on Persistent Organic Pollutants or POPs, several proposals were submitted for Global Environment Facility (GEF) funding.

Food Safety

Globalization of the food trade and development of international food standards have raised the awareness of food safety and its impact on the exports potential. Further, with the adoption (and in some instances rejection) of foods produced by new technologies, including genetic engineering, irradiation of food, and modified-atmosphere packaging, food safety considerations are beginning to not only include safety issues but also health benefits, environmental effects, ethical issues and socioeconomic consequences.

There has been a shift in food safety policies in the Region, away from traditional enforcement as the primary control mechanism. In many countries, these had proven either ineffective or too expensive to administer. New policies are being introduced with a preventive basis for regulatory measures for food safety as the main thrust. Food safety programmes are increasingly focusing on a farm-to-table approach as an effective means of reducing foodborne hazards. This holistic approach to control food-related risks involves the consideration of every step in the chain, from raw material to food consumption.

Food safety in the Region is also moving, in many countries, to include risks linked to chemical contamination of POPs. The
estimates of the exposure of specific sub-populations are often hampered by inadequate data on dietary intake and on levels of contamination of food. The first attempt to develop a regional knowledge base for organochlorine pesticide residues in food commodities was made during the reporting period. This will be followed up by establishing a regional database on chemical contaminants to help quantify the differences in exposure to chemicals in different countries.

The technical assistance provided by WHO to the ongoing review of national policies and programmes for food safety in the countries—as stipulated in the 1998 SEAR Strategy on Food Safety—has brought concrete results. The support focused on strengthening the national capacity for monitoring, assessing and controlling food safety through risk assessment. Draft Regional Food Safety modules were prepared. Curricula on food safety were produced in Bangladesh and India. Another local food safety training module for street vendors was field-tested in slum areas in New Delhi. A theoretical framework for the management and safety of street foods was also produced. All these elements are now being promoted in countries of the Region. An important awareness tool, in the shape of a popular poster called “the five keys to food safety”, was translated into 17 regional languages and distributed for use in food safety courses.

Such adapted food safety educational messages have also been included in the content of the children’s environmental health-related board games and CD ROM games prepared by WHO.

Emergency Preparedness and Response

Natural hazards and complex emergencies continue to affect populations in the countries. The estimates over a 10-year period (1993–2002) show that 38% of the world’s disasters have occurred in the Region. Almost two thirds (59.5%) of the total deaths in disasters worldwide were in the South-East Asia Region. Of those affected by disasters in the world, 37% are from the Region. With regard to Asia’s refugees (7% of the world’s total), 19% are from countries of the Region (e.g. Bangladesh, Bhutan, DPR Korea, India, Indonesia, Myanmar, Sri Lanka and Timor-Leste). And 2.7% of Asia’s (6% of the world’s) refugees are based in countries of the Region (e.g. Bangladesh, Bhutan, DPR Korea, India, Indonesia, Myanmar, Sri Lanka and Timor-Leste).
Bangladesh, India, Indonesia, Nepal and Thailand). The reported number of people affected by disasters in the Region is shown in Table 4.1

However, it is important to note that urbanization and internal and external migration of populations continue to put people at risk for new hazards brought by development. Together with development partners, WHO is addressing this issue as well.

UN agencies, international organizations, NGOs and donors continue to be active partners in addressing the growing concerns in health and humanitarian action in the Region. WHO’s support to countries of the Region includes administrative, technical and financial management and on-the-spot action for emergencies occurring in the countries.

In general, the work of the Region in emergency preparedness and response in the past year can be summarized in five areas: (1) information dissemination on current best practices; (2) human resource development; (3) support for

<table>
<thead>
<tr>
<th>Member State</th>
<th>Total number of people reported killed (1993-2002)</th>
<th>Total number of people reported killed 2002</th>
<th>Total number of people reported affected (1993-2002)</th>
<th>Total number of people reported affected 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>9,132</td>
<td>1,232</td>
<td>73,368,083</td>
<td>1,671,640</td>
</tr>
<tr>
<td>Bhutan</td>
<td>222</td>
<td>–</td>
<td>1,600</td>
<td>–</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>270,678</td>
<td>3</td>
<td>10,064,811</td>
<td>65,844</td>
</tr>
<tr>
<td>India</td>
<td>77,125</td>
<td>3,185</td>
<td>802,063,399</td>
<td>342,021,333</td>
</tr>
<tr>
<td>Indonesia</td>
<td>6,958</td>
<td>509</td>
<td>6,650,012</td>
<td>150,800</td>
</tr>
<tr>
<td>Maldives</td>
<td>10</td>
<td>–</td>
<td>. . .</td>
<td>–</td>
</tr>
<tr>
<td>Myanmar</td>
<td>571</td>
<td>21</td>
<td>462,519</td>
<td>50,000</td>
</tr>
<tr>
<td>Nepal</td>
<td>3,894</td>
<td>633</td>
<td>1,147,785</td>
<td>266,072</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>590</td>
<td>25</td>
<td>4,675,163</td>
<td>907,100</td>
</tr>
<tr>
<td>Thailand</td>
<td>2,417</td>
<td>218</td>
<td>29,493,836</td>
<td>8,818,457</td>
</tr>
<tr>
<td>Timor-Leste*</td>
<td>. . .</td>
<td>–</td>
<td>. . .</td>
<td>–</td>
</tr>
<tr>
<td>South-East Asia Region</td>
<td>371,597</td>
<td>5,826</td>
<td>927,927,208</td>
<td>353,951,246</td>
</tr>
</tbody>
</table>

Table 4.1: Reported number of people killed or affected by disasters in the SEA Region, 1993-2002

Source: Adapted from : International Federation of Red Cross and Red Crescent Societies, World Disasters Report 2003

*Since May 2002 Timor-Leste is an independent country

= no disaster reported,  . . . = data not available
THE WORK OF WHO IN THE SOUTH-EAST ASIA REGION

intercountry collaboration; (4) inter-departmental technical cooperation for preparedness, and (5) expansion of the linkages with development partners.

A lessons learnt workshop for the floods which occurred in Sri Lanka in 2003 was conducted in December of the same year in Colombo. Documentation of the proceedings was distributed widely within the country to stakeholders and humanitarian workers to contribute to preparedness planning for similar events in future.

The publication of the Structural and Non-Structural Vulnerability Assessments in Nepal, developed jointly by WHO, the Ministry of Health (MoH) and the National Society for Earthquake Technology in Nepal, was completed in January 2004. The aim was to disseminate the methodology and share the experience of Nepal in the mitigation of earthquakes throughout the Region.

A working agreement: MOU between WHO and IFRC

Since its signing in September 2003, the Memorandum of Understanding (MoU) between the Regional Office for South-East Asia of the World Health Organization (WHO) and the International Federation of the Red Cross and Red Crescent Societies continues to work towards fulfilling its objectives. Joint activities in Bangladesh, India and Sri Lanka focus on HIV/AIDS. In Indonesia, both organizations are finalizing a management framework consisting of a joint working committee, regular coordinating meetings and joint work plans to implement the MoU. In Nepal, mass casualty management training continues to be carried out by the Nepalese Red Cross Society, the Ministry of Health and WHO. Collaboration in emergency response is evident in DPR Korea, where WHO and the national society worked together in the aftermath of the Ryongchon explosion in April 2004. In both Thailand and Myanmar, joint activities with their respective national societies are in the planning stages. Community health promotion and first aid training are the areas of collaborative work in Timor-Leste. The MoU also continues to drive the process to establish national societies in Bhutan and Maldives which WHO is actively supporting.
For human resources development, the Third and Fourth Public Health and Emergency Management in Asia and the Pacific (PHEMAP) courses were conducted in Bangkok in August 2003 and April 2004 respectively. PHEMAP is an ongoing collaborative effort between the regional offices for South-East Asia and the Western Pacific, and the Asian Disaster Preparedness Centre (ADPC), Bangkok. About 60 persons were trained during the reporting period.

A WHO Crisis Management Workshop was also conducted in Kathmandu in November 2003 by the WHO Nepal country. This enabled staff members to assist in strengthening WHO/Nepal’s operational emergency response capacity and updating its emergency preparedness and response plan.

Increasing intercountry initiatives have been the focus of EHA work in the Region. Many of these activities are led by EHA focal points in WHO country offices.

In March 2004, a border health meeting was held in Chiang Mai, Thailand. This event brought together various stakeholders in the Border Health Programme that focuses on improvement of primary health care services.

Bangladesh and Nepal have commenced an intercountry collaboration specifically with a mass casualty management training programme using the Multi-User System for Training Emergency Response (MUSTER). This system has been used widely in Nepal with over 600 personnel trained in the subject using the method.

As there are many players in humanitarian action, one of the main goals of EHA is to coordinate and collaborate efficiently and effectively with partners during all phases of a crisis. To address this, a Memorandum of Understanding (MoU) was signed between the Regional Office and the International Federation of the Red Cross and Red Crescent Societies (IFRC) in September 2003. The MoU intends to strengthen partnership in areas such as prevention and control of communicable diseases including HIV/AIDS, and voluntary blood donation. Initiatives in water and sanitation and mental health in post-conflict situations will also be explored. Progress has been made in countries with pilot programmes in the areas mentioned.
Organization of Health Services

The principles of primary health care continue to guide the Organization in the formulation and implementation of its programmes. This was reiterated at a WHO/Government of Spain-supported Global Meeting on Future Strategic Directions on Primary Health Care, held in Madrid, Spain, in October 2003 to commemorate the 25th anniversary of the Alma-Ata Declaration. The meeting inter alia reviewed the lessons of the past 25 years, including definitions and strategies, and attempted to identify future strategic directions for PHC. Representatives from five countries of the Region and two NGOs participated in the meeting. As an outcome of this meeting, public health has received adequate attention as a discipline in the countries of the Region, especially with significant input to ministries of health on “new public health” addressing changing needs, including global trade agreements.

The programme was actively involved in the finalization of a model for comprehensive community and home-based delivery of health services. The model was developed and field-tested in Bhutan, Nepal, Sri Lanka and Thailand. The process of promoting the model in the countries of the Region is under way.

At the request of the government, a WHO team provided inputs into rebuilding the health system in North-East Sri Lanka. The WHO country office had developed a comprehensive proposal for the short-term recovery of the health system in this area. The project was funded by the World Bank with WHO providing technical assistance.
The Regional Office is promoting the concept of telemedicine. As a first step, ministries of health and information technology in the countries will be briefed on the advantages and uses of health telematics in order to strengthen their health systems. The Regional Office already has pilot sites operating in Bhutan, Sri Lanka and Maldives. The deliberations at the Consultation on e-health, held in Geneva in February 2004, emphasized the need to identify best practices for providing effective models of health services delivery through integration of e-health services. The Regional Office continues to assist countries to assess their telematics needs and to provide technical assistance accordingly.

As a follow-up to the Meeting of the Regional Scientific Working Group, held in Colombo in June 2003 to develop a core curriculum for undergraduate and postgraduate training in family medicine, a situation analysis is being prepared. There is also a plan to introduce family medicine in national health systems of the countries. Technical support is also being provided in the area of scaling-up ART as it provides an opportunity to strengthen health services based on PHC.

In the area of health sector reforms, evidence-based health systems reform was supported in the countries through a variety of research and policy interactions. The Regional Office is involved in promoting a better understanding of the rationale and process of decentralization of health care services. Member States are also being provided evidence-based information/documentation in this regard.

Health system development aims to promote health, reduce excess mortality, morbidity and disability and respond to people’s legitimate demands in a way that is equitable and financially fair. In view of the core nature of the subject which cuts across all disciplines, Health Systems Development was placed under the charge of a regular professional staff member keeping. While finalizing the strategy for health sector reforms in the current biennium, due consideration has been given by the Regional office to the following factors influencing health care:

- Ongoing reforms in the health sector, decentralization of public services and fostering active private sector participation in financing health care activities;
Recommendations of the Commission on Macroeconomics and Health (CMH) emphasizing the importance of investing in health as a means to improve economic development, highlighting the need for intersectoral health and community action;

- Concepts developed at Alma-Ata;

- The Millennium Development Goals (MDGs), Agenda 21, and the Johannesburg Summit which emphasize strengthening of health services as a crucial measure to improve health services for all, especially in the poorest countries, and

- The advent of several new structures such as the Global Alliance for Vaccine Immunization (GAVI) and the Global Fund to fight AIDS, TB and Malaria, which provide impetus to new ways of promoting access to treatment within effective health care delivery systems.

Equity in health remains an important goal for health systems and the delivery of health services.

Human resources for health

Human resources for health planning and quality of training are issues that are addressed continuously by Member States. In Bangladesh, a study was conducted on Health Workers Situation Analysis and Projection on Future Needs to generate evidence for proper health workforce planning. Accreditation of public health institutes is an issue being addressed in Bangladesh, Nepal and Sri Lanka. The curricula in undergraduate, postgraduate and medical assistants training schools were revised in Bangladesh while undergraduate programmes in allied sciences have received emphasis in Sri Lanka. The capacity of teachers of medical and paramedical institutes was enhanced through orientation on effective teaching and objective assessment methods and dissemination. Problem-based learning is being piloted in Bangladesh.

As a follow-up of the landmark “Calcutta Declaration” on public health, an informal consultation on “Future Guidelines in Public Health – Calcutta Declaration and Beyond” was held in December 2003. It assessed the progress made in improving public health as an essential element of health development. It
also provided guidelines for further development in public health. As a follow-up of this consultation, the South-East Asia Public Health Education Institutes Network (SEAPHEIN) was formally launched at Mahidol University, Bangkok, in April 2004. The objectives of this Network include: (a) enhancing information exchange among Member States; (b) making educational programmes more relevant to meet public health challenges of individual countries; (c) developing collaborative programmes in education and research; (d) enhancing the capacity of members through faculty and student exchange, and exchanging training materials and methods; (e) facilitating the implementation of accreditation programmes in public health education, and (f) providing consultation and technical advice to improve national public health programmes in the countries.

As a follow-up of the intercountry Meeting on Information and Faculty Exchange in Health and Related Sciences and Specialities, held in Chandigarh, India, in November 2002, an electronic Regional Directory of Training Institutions was initiated with facility for continuous update. This directory provides up-to-date information on the fellowships programmes and is also useful for the countries in their training programmes as well as for training programmes funded by other agencies.

Major emphasis is being given to the development of public health education in the countries. An Institute of Public Health is being planned for Myanmar. An expert advisory group has been constituted to assist in implementing the recommendations of the various regional meetings on public health.

Education and training support

WHO has consistently been pursuing the fellowships programme, supporting education and training of health professionals in various fields of medical and public health sciences in countries of the Region. Currently, this consists of fellowships, study tours and in-country training. The system to train fellows under a contractual mechanism had been followed in a few countries. There has been an increasing trend of short-term training in specialized fields with greater use of regional resources. Such training is being provided in the areas of field epidemiology; comprehensive vector control; cold chain
and solar power; epidemic preparedness and outbreak response, and management of malaria. There has been an upward trend in regional and group training under the fellowships programme.

During the reporting period, 320 letters of award were issued; 222 fellowship applications were received. Fellowship Termination of Studies Report (FTSR) were received in 51% of cases. Intensive efforts were made to obtain Utilization of Fellows’ Services Report (UOSR) from fellows who had undergone fellowships of three months and above. Table 5.1 gives a broad picture of implementation of fellowships in the Region.

Table 5.1: Implementation of fellowships in the SEA Region, 1 July 2003 to 30 June 2004

<table>
<thead>
<tr>
<th>Member State</th>
<th>Applications received</th>
<th>Fellowships awarded</th>
<th>Fellowships Termination of Studies Report received</th>
<th>Utilization of Fellows’ Services Report received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>6</td>
<td>51</td>
<td>56</td>
<td>2</td>
</tr>
<tr>
<td>Bhutan</td>
<td>20</td>
<td>12</td>
<td>1</td>
<td>–</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>66</td>
<td>38</td>
<td>39</td>
<td>–</td>
</tr>
<tr>
<td>India</td>
<td>10</td>
<td>83</td>
<td>43</td>
<td>–</td>
</tr>
<tr>
<td>Indonesia</td>
<td>15</td>
<td>10</td>
<td>3</td>
<td>–</td>
</tr>
<tr>
<td>Maldives</td>
<td>22</td>
<td>27</td>
<td>9</td>
<td>–</td>
</tr>
<tr>
<td>Myanmar</td>
<td>34</td>
<td>33</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>Nepal</td>
<td>20</td>
<td>44</td>
<td>25</td>
<td>1</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>20</td>
<td>12</td>
<td>11</td>
<td>–</td>
</tr>
<tr>
<td>Thailand</td>
<td>8</td>
<td>9</td>
<td>5</td>
<td>–</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>–</td>
</tr>
<tr>
<td>Total</td>
<td>222</td>
<td>320</td>
<td>203</td>
<td>19</td>
</tr>
</tbody>
</table>

For the first six months of the biennium 2004-2005, against a total obligation of US$ 308 680, US$ 3 080 have been liquidated. The rate of liquidation for 2002-2003 at the end of the current reporting period stood at 94%.

The Regional Office assisted the African, Eastern Mediterranean and the Western Pacific regions in arranging placements for their fellows in the SEA Region. Four fellowships from Africa, 4 from the Eastern Mediterranean
and 26 from the Western Pacific regions were implemented with the support of the Regional Office.

Applications for 34 study tours were processed for implementation by the Technical Units.

Fifty-three meetings/group educational activities (GEAs) were held, of which 7 were policy meetings, 23 were advisory meetings and 23 were intercountry technical meetings.

The web page of the Education and Training Support (ETS) Unit on the WHO website has been posted with comprehensive information related to frequently asked questions (FAQs) on: fellowships; stipend rates, and living conditions in the countries frequented by fellows. It also contains forms that can be downloaded by fellows. The web page also gives the past and future details of various meetings hosted by the Regional Office.

The ETS Unit is fully involved in the coordination of various activities relating to the web page initiative of the Regional Directory of Training Institutions.

The ETS Unit continues to use the electronic Documents Management System (eDMS) under which all fellowships files are scanned, indexed and stored in electronic form. An extended database has also been added for incorporating key data pertaining to: Fellowship Application Forms; Fellowship Placement Requests; Final Fellowship Estimates; Letter of Award; Payment Instructions; Travel Order; Fellowship Termination of Studies Report and Utilization of Fellows’ Services Report, so as to facilitate the generation of user-friendly reports. This would facilitate easy retrieval and access to information in addition to providing indexing and CD backup, thereby contributing to the efficient management of fellowships. So far, data relating to the previous three biennia, namely 1998-1999, 2000-2001 and 2002-2003 have been archived. DOS-based data and DMS-based data for the biennium 2002-03 have been fully reconciled to ascertain the stability of DMS for fuller migration effective July 2004.

Evidence for Health Policy

A strong health information system (HIS) is essential for sound programme development and implementation, and a prerequisite for strategic decision-making. Currently, the
capacity of countries to generate and use health information is not very strong and is often focused exclusively on disease-specific programme areas. The current thrust of the Regional Office on health outcomes is therefore being used as an opportunity to strengthen the existing health information system. The outcome-based measures are priority tasks for the UN Millennium Development Goals (MDGs), which represent an important opportunity for promoting improved health outcomes for the poor. The MDGs provide a focus and a way of both reorienting work and defining parameters for accountability. WHO places great emphasis on support to countries and development partners in their efforts to achieve health-related MDGs. The draft Regional Strategy on Health Information in the Region, based on reviews of national HIS, emphasizes the fact that strengthening of national HIS would require concerted efforts of all stakeholders, including partners at country and regional levels. The work on MDGs is considered to be one of the main tools for strengthening national HIS and for bringing together HIS stakeholders. MDGs are of increasing strategic importance for WHO as the majority of the goals, targets and indicators are related to health. They have been used to focus and reorient the work of the WHO collaborative programme, as well as a benchmark to assess the health development impact and organizational performance. In order to support countries effectively in achieving the MDGs, WHO adopted a process that involved working closely with the countries in developing a consensus in the matter of reporting progress, while continuing to provide normative and technical support to countries.

A Regional Consultation on Reporting on Data Sets on UN MDGs and WHO Core Health Indicators was held in the

### UN Millennium Development Goals

Six out of the 8 goals, 9 out of the 18 targets and 18 out of the 48 indicators of the United Nations Millennium Development Goals are related to health and health-related areas. They underpin health improvement and place health at the centre of development and eradication of poverty. Four countries in the Region have already submitted reports on the progress towards achieving the MDGs. All countries are initiating national-level activities in collaboration with the UN agencies and other development partners in order to achieve the Millennium Development Goals. They are also working with the respective UN country teams in preparing the national progress report. WHO is working with Member States and development agencies in facilitating and coordinating MDG-related activities at national and regional levels, with particular emphasis on technical support, monitoring and reporting, resource mobilization and advocacy.
Regional Office in May 2004. Its recommendations focused on: reporting on MDGs; data sources; intersectoral collaboration and working with partners/stakeholders at the country level; collaborative activities for strengthening national health information, and definitions and measurement tools and methods. Based on the consultation, follow-up activities, including reporting on MDGs, were initiated in the countries.

One of the tools for health measurement – model-based estimates – has been used in some countries of the Region. India, Indonesia and Thailand conducted studies on the burden of diseases during the reporting period. A consultative process with countries involving their inputs on the methodologies used by them for disease estimations is considered a crucial step in the implementation of any innovative approach. In continuation of the consultative process and interaction between WHO and Member States related to the assessment of the burden of diseases, a Regional Training Workshop on Tools and Methods for Health Measurement was held in Yangon, Myanmar, in March/April 2004. Representatives from Bangladesh, India, Myanmar, Nepal and Sri Lanka attended the workshop which emphasized the need to improve reliability, validity and comparability of the country data used for disease modelling. Work in the area of disease modelling may guide a serious debate on national health priority-setting where critical information gaps have been identified.

The objectives of the health system performance assessment included: building an evidence base on the relationship between the design of the health system and its performance; empowering policy-makers for evidence-based decision-making and monitoring and evaluating the attainment of critical outcomes and the efficiency of the health system. Indonesia was the only country in the Region which initiated and finalized activities related to its sub-national health system performance assessment. The provincial and district health system performance was assessed in five provinces of Java island. The final report was presented to the Ministry of Health, Government of Indonesia. The results of this exercise would guide further work on this subject, while the experiences gained would be shared with the countries.

The World Health Survey (WHS), which is complementary to national efforts in ensuring periodic data input in a
cost-effective way by covering important gaps in health information, was conducted in five countries of the Region (Bangladesh, India, Myanmar, Nepal and Sri Lanka). Data collection was completed and the first exercise in analysis and report-writing was organized in collaboration with WHO headquarters. WHS supports national capability to monitor health systems components and assists decision-makers to address the issue of strengthening evidence-based health systems. Some countries conduct health surveys on a routine basis. Incorporation of the modules addressed in WHS into these routine nationwide surveys might be considered to make this activity more sustainable.

An update on the progress made by countries in implementing the Declaration on Health Development in the South-East Asia Region in the 21st Century was submitted to the fifty-sixth session of the Regional Committee for South-East Asia, and to the Twenty-first Meeting of Health Ministers in September 2003. It was noted that the principles and policy actions stipulated in the Declaration had been adopted and integrated into medium-term and long-term national health development plans and activities in countries through concrete steps leading to the achievement of notable success in several areas. Significant progress was evident in major disease control programmes. Social development being the cornerstone of overall development, due emphasis was placed on: strengthening health systems and promoting health care; intersectoral collaboration, and participation of communities and NGOs towards forging a stronger partnership for health in the countries of the Region. An environment needs to be created for sustainable health development by dedicating more resources and commitment. Concerted and focused efforts, strong commitment and additional resources are required in order to reach the unreached populations.

Social Health Insurance (SHI) is a form of financing and managing health care based on risk pooling. It protects people against financial and health burden and is a relatively fair method of financing health care. A major policy challenge was to accelerate the development of community-based risk-sharing schemes and to expand them to cover more people. Following a meeting of experts in early 2003, a Regional Consultation on Social Health Insurance was held in the Regional Office in July 2003. The consultation reviewed
regional experiences on SHI schemes (particularly those of India, Indonesia and Thailand), developed an outline and content of the working paper for the Technical Discussions on SHI during the fortieth meeting of the Consultative Committee for Programme Development and Management (CCPDM), and reviewed the policy options for promotion and expansion of SHI schemes in the Region. During the consultation, countries expressed the need for WHO’s technical support in reviewing the country situation, providing evidence-based research findings, developing policy options, providing models for consideration, facilitating policy debates among stakeholders, and in donor coordination.

In order to provide guidance on key areas and types of information required to obtain an overview of a country’s health system and to systematize the collection of information for evidence-based decisions at the national level, and also for comparisons across a range of countries, work on updating the national health system profiles was initiated in the countries. The profiles would assist policy-makers and also enable them to establish linkages with special health programmes and thereby have access to more detailed technical data.

Responding to the growing demand for feedback on appropriate data for policy-makers for their action, the Regional Office took the initiative to disseminate quantitative evidence through a brochure, Basic Indicators 2002, which was issued in September 2003. It was an update of the previous...
edition issued for the 2000 indicators. Since these data are subject to many limitations, including fragmentation, non-comparability due to difference in definitions, concepts and measurement units, as well as inconsistency, caution needs to be exercised when using the data published for trend analysis or intercountry comparisons. It was for the first time that data on health-related indicators of MDGs were provided in the brochure. Work on improvement of the database of core health indicators was continued in collaboration with other WHO regions.

Research Policy and Promotion

The main subjects discussed during the twenty-eighth meeting of the South-East Asia Advisory Committee for Health Research (SEA-ACHR), held in Maldives in August 2003, were: policy and strategies for research in prevention and control of thalassaemia; research for measuring TB prevalence, and regional vaccine policy. As recommended by the twenty-fourth meeting of SEA-ACHR in 1999, a Task Force comprising prominent regional experts was established to develop the regional vaccine policy. The work of the Task Force was reported and the regional vaccine policy, which is now available, is expected to complement and support the development of a national vaccine policy and vaccine research agenda in countries of the Region.

The issue of developing and strengthening collaboration with other WHO regions on health research has been addressed by ACHR members globally and regionally during the past five years. The first bi-regional meeting of the Eastern Mediterranean and the South-East Asian countries was held in Maldives in August 2003, with support from WHO headquarters and regional offices. Eminent scientists and researchers from both regions shared information and experiences on health research. Besides SEA-ACHR members, researchers from India, Pakistan, Iran, Saudi Arabia, Yemen and Oman participated. The meeting identified common issues and mechanisms for strengthening further collaboration. The meeting agreed to stimulate operational research in collaborative and networking methods in the following four specific technical subjects: (a) maternal and child health and nutrition; (b) surveillance and emerging diseases; (c) ethics
and public health including genetics and biotechnology, and (d) health research and system capacity development. As a follow-up, the Indian Council of Medical Research (ICMR) is in the process of developing multi-country research proposals on the above themes.

It was also suggested that such a bi-regional mechanism should be used for sharing information, carrying out orientation and training exercises, developing protocols and guidelines, and undertaking projects of common interest. The ICMR and the Pakistan Medical Research Council were interested to lead the bi-regional work.

The report of the bi-regional meeting was shared at the annual conference of the American Public Health Association in late 2003.

As a follow-up of the recommendation of the twenty-eighth meeting of ACHR, a project called “the Small Grants Research Programme” was established in the Regional Office in collaboration with the Special Programme for Tropical Diseases Research and Training (TDR) at WHO headquarters. The project supports operational research on dengue, lymphatic filariasis, malaria and leishmaniasis, especially research being carried out by institutions in countries with limited capacity for research (Bhutan, DPR Korea, Maldives and Timor-Leste). A WHO “fellow” joined the Regional Office in January 2004 and reviewed nine research proposals received from three countries, of which three have initially been accepted.

The 29th SEA-ACHR was held in Yangon, Myanmar, from 14 to 16 June 2004. It was attended by 13 members, 8 special invitees, representatives from the Eastern Mediterranean Region and the Global Forum on Health Research. Two Regional Directors emeritus, Dr U Ko Ko and Prof Dr Uton Muchtar Rafei, also attended the session as special invitees.

The ACHR focused on discussions on health research priorities on emerging infectious diseases (EID) and highlighted the importance of Member States according priority to this subject. It emphasized the need for health research to further strengthen the surveillance, prevention and control of emerging diseases. The ACHR requested WHO to establish a network of disease surveillance and research institutions in order to assist
Member States prepare the rapid and effective response to possible epidemics of EID.

An intercountry consultation involving experts in genetics and related disciplines from Bangladesh, Bhutan, Indonesia, Myanmar, Nepal and Thailand, was held in September 2003. Following intensive debate on the ethical, legal and social implications (ELSI) of human genetics research, the experts agreed to impress upon the concerned national authorities the need to initiate appropriate actions in the priority areas of human genetics. In the area of ELSI of human genetics, ACHR recommended empowering the ethical review committees with appropriate technical knowledge and skills for reviewing research proposals in human genetics. Some countries expressed the need for regional guidelines to direct them in developing their national guidelines on human genetics research.

The magnitude of international collaborative research (ICR) in the Region has increased in the last few decades. The conduct of clinical trials involving humans has highlighted a number of ethical issues, especially those situations in which researchers from developed countries wish to conduct research in developing countries. In collaboration with the National Institute of Health, USA and ICMR, an intercountry consultation was organized in Chennai, India, in January 2004. Research ethics committees and policy-makers responsible for
research ethics in the countries of the Region reviewed and
provided opinions on the ethical and legal aspects of ICR. The
consultation noted the high demand made by countries for
regional guidelines to assist them in developing their national
guidelines. Since traditional medicine is widely practised in the
Region, it is recommended that countries collaborate in
developing ethical guidelines for research in traditional
medicine.

The testing of teaching guidelines on medical ethics, started
in 2002 in seven medical schools in Bangladesh, Indonesia,
Myanmar, Sri Lanka and Thailand, has concluded. The
orientation of the faculty members concerned on how to carry
out testing using the WHO teaching guidelines has proven to
be effective in updating their knowledge and skills. Some
medical schools have used the guidelines to review and update
their existing medical ethics curriculum. Additional medical
cases specific to the medical schools concerned have been added
to the guidelines which will be revised on the basis of the
feedback. Thereafter they will be produced and disseminated
widely.

In order to ensure a worthwhile return on the investment
of public funds on research, spending on health research has
to be managed efficiently and effectively. Hence, there is a
need for good research managers with the requisite managerial
skills. After the finalization of the 10 modules on health
research management by a group of research experts and
selected ACHR members in early 2003, Thailand and Indonesia
took the lead to conduct orientations using the modules. Both
countries have assigned focal points, formed core groups of
trainers, identified the target audience for the training, and
selected the appropriate modules for developing the course
content. Indonesia selected middle-level research managers, e.g.
those working in research institutions/research departments/
universities/NGOs, and prospective research managers
including young researchers, as the target groups. Thailand
focused on training for policy-makers and local donors for
health research.

WHO collaborating centres (WHO CCs) and national centres
of excellence (NCE) are the main institutions to carry out the
WHO research programme in countries of the Region. To
streamline the process of designation and redesignation of a
WHOCC, WHO headquarters has finalized and circulated the revised forms for designation as well as the evaluation checklists. The use of these forms is now mandatory for new designations and re-designations. Based on the decision of the Global Screening Committee (GSC), which is the screening mechanism for approval of proposals by the WHO Director-General, the Regional Office Screening Committee has recommended the automatic discontinuation of 13 overdue centres.

As of April 2004, the total number of active WHO collaborating centres in the Region was 72. Twenty-two new proposals for designation are under review by the Regional Office (Table 5.2).

Table 5.2: Status of WHO collaborating centres in the SEA Region, April 2004

<table>
<thead>
<tr>
<th>Member State</th>
<th>Within period</th>
<th>New proposals</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>2</td>
<td>–</td>
<td>2</td>
</tr>
<tr>
<td>Bhutan</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>1</td>
<td>–</td>
<td>1</td>
</tr>
<tr>
<td>India</td>
<td>35</td>
<td>8</td>
<td>43</td>
</tr>
<tr>
<td>Indonesia</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Maldives</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Myanmar</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Nepal</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>2</td>
<td>–</td>
<td>2</td>
</tr>
<tr>
<td>Thailand</td>
<td>25</td>
<td>8</td>
<td>33</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Total</td>
<td>72</td>
<td>22</td>
<td>94</td>
</tr>
</tbody>
</table>

As a sequel to the Regional Director’s directives, the Regional Office has constituted a Technical Group to initiate the process or mechanism to identify national centres as regional centres.

The WHO Expert Advisory Panels (EAPs) and Expert Advisory Committees (EACs) support the technical programmes with appropriate advice and collaboration. Members of the expert advisory panels or committees contribute their knowledge and expertise through correspondence or participate in meetings, or involve themselves in collaborative work.
World Health Assembly resolution WHA55.24 called on the Director-General to encourage nominations of experts from the developing countries. WHO is working closely with the scientific communities in the Region to identify experts to be selected and appointed as EAP/EAC members.

As of April 2004, there were 101 experts from the Region on 48 WHO Expert Advisory Panels. The country-wise and gender-wise representation on WHO EAPs is as follows: Bangladesh (one female); Myanmar (two males, two females); India (30 males, 11 females); Thailand (16 males, 8 females); Indonesia (13 males, 3 females); Nepal (4 males, 1 female); Sri Lanka (7 males, 4 females) and Thailand (16 males, 8 females). The female-male ratio of EAP membership from the South-East Asia Region is the most favourable for any WHO region. No EAP member has been identified from Bhutan, DPR Korea and Maldives.

In order to provide information on national and regional experts in the Region, Thailand took the lead to develop a web page on Thai experts. This initiative will be followed by India, Indonesia and Nepal.

**Essential Medicines: Access, Quality and Rational Use**

In the field of Essential Medicines, there was progress in varying degrees. In one particular area, there was a major shift in direction based on past experiences. The fifty-fifth session of the Regional Committee had urged countries to use regional mechanisms to purchase drugs in bulk to ensure affordable essential drugs of adequate quality. However, coordination between countries on this proved to be difficult as each country had its own requirements as well as financial and administrative rules and regulations. Some countries were major exporters of medicines while others were importing a majority of their requirements. Thus, it was difficult to reconcile the needs of all the countries.

The work plan for the 2004-2005 biennium (developed in 2003) concentrated on countries which import a majority of their essential drugs. Increasing the efficiency of the individual country’s public procurement system was feasible; hence the
initial step would be to have the public sector procurement in countries evaluated by local resource persons with technical support from WHO. A subsequent meeting to share the experience and knowledge could enhance the effectiveness of the public procurement system. In addition, the global supply systems such as the Global Drug Facility for TB and HIV/AIDS pre-qualification scheme could be introduced in the countries.

In the area of regulation, some countries took major steps to institutionalize rules and regulations in medicines. Bhutan, which had been regulating pharmaceuticals through a simple notification issued in 1974, replaced it with the “The Medicines Act of the Kingdom, 2003” which provides a legal basis for regulating medicines. The drafting of this Act started in 1996 with the help of WHO and, after extensive discussion and review, it was finally approved by the national assembly in August 2003.

Further work needs to be done in framing the regulation to implement the Act. Bhutan, through its Essential Drugs Programme, has now reached a stage when the full panoply of medicine regulation is required; it also has to deal with imperatives of health care financing and the inclusion of the private sector in medicines regulation.

In Timor-Leste, a “state-of-the-art medical stores” was opened, which made a significant difference to drug supply management (including regulations) is a priority for all Member States.
management, supply and distribution. The goodwill for the new nation in medicines donation was channelled through an Essential Medicines List developed in collaboration with WHO. This made it easier for the prescribers to manage drug supply. Standard Treatment Guidelines (STGs) fashioned for use by nurses (as there was a shortage of doctors), also developed in collaboration with WHO, meant that best use was made of the available drugs.

In DPR Korea, with the gradual improvement in the difficult socioeconomic conditions, strategies to improve access to medicines were being explored. An informal “Essential Medicines List”, developed by the WHO country office was accepted by most of the international donors, which facilitated a continuous supply of medicines that the prescribers became familiar with. In addition, the Medicines Handbook, developed by the Ministry of Health in collaboration with WHO, provided information for the appropriate use of drugs that were being supplied. Greater coordination between the Ministry of Public Health and WHO was through the sharing of information. A joint venture pharmaceutical factory in Pyongyang could be a good source of essential drugs but regulatory assistance in ensuring quality and Good Manufacturing Practices would be required from WHO.

The International Conference of Drug Regulatory Authorities (ICDRA), organized by WHO in collaboration with a ministry of health is held bi-annually. Seven of the 11 Member States of the Region participated in the Eleventh ICDRA held in February 2004 in Madrid, Spain. The countries, as a group, focused upon access to drugs (mainly drug prices) and called for greater collaboration between Drug Financing Authorities (DFA) and Drug Regulatory Authorities (DRAs). Registration of drugs that are unaffordable would have little impact on public health. The countries felt that registration should include a component of evaluating the cost-effectiveness and therefore affordability. The meeting was also important for manufacturers of medicines in the Region such as Bangladesh, India, Indonesia and Thailand.

Counterfeit medicines continued to figure prominently in the media in countries of the Region. However, it was difficult to assess the exact magnitude as factual data were missing.
Thailand took an active part in the project to combat counterfeit drugs in the Greater Mekong Sub-region funded by USAID. The activities were focused upon increasing awareness of the problem (especially the health consequences) among officials in law enforcement, legal and customs authorities and providing them with the knowledge to respond to the issue. Bi-regional cooperation was increased through participation of countries from the South-East Asia and the Western Pacific regions in the project. Indonesia, though not from the Greater Mekong Sub-Region, had been involved from the beginning; their focus was to increase public awareness of the problem of counterfeit drugs through “TV spots”. Countries also participated in global activities to combat counterfeit drugs. At a pre-meeting on combating counterfeit drugs held before ICDRA, the countries participated and raised issues that had particular relevance to them. This pre-meeting initiated work on a possible international convention to combat counterfeit drugs.

The focus on the public health provisions of the Trade Related Intellectual Property Rights (TRIPS) continued in 2003-2004. Indonesia and Thailand participated in the TRIPS council meeting formulating a stand which took full advantage of the public health provisions. Both countries, with support from WHO, were able to include representatives from the Ministry of Health in the trade delegations to the TRIPS Council thereby ensuring that health aspects were considered when trade issues were being discussed. In Sri Lanka, compulsory licensing was incorporated into the Intellectual Property Legislation. A major contributory factor was the WHO-supported meeting held in the country in early 2003. SEARPharm Forum (the Professional Association of Pharmacists in the Region) brought about collaboration among the countries. A meeting on medicines prices based on the WHO manual, held in Chennai, India, in December 2003, demonstrated the differences in essential drugs in the Region, the complexities of pricing and the potential for improvement.

The Twenty-sixth Annual Meeting of National Centres Participating in WHO’s Programme for International Drug Monitoring was held in New Delhi in December 2003. India, Sri Lanka and Thailand, each with a national pharmacovigilance centre, participated in the meeting. Bangladesh also participated and it is hoped that this would spur the development of a
pharmacovigilance centre in that country too. Previously, countries in the developing world depended to a large extent on the adverse drug reaction monitoring systems of countries in the developed world. However, with new drugs being registered simultaneously in developed and developing countries, and drugs for tropical diseases such as malaria and leishmaniasis being used for the first time in the developed world, pharmacovigilance is becoming increasingly important to the developing world. National pharmacovigilance centres would need to be strengthened and provided with resources.

Development of human resources in the use and management of medicine is an important issue. The SEA Region held workshops in pharmacoeconomics promoting rational drug use. These have resulted in some carefully focused projects on specific issues that are relevant to countries. In addition, as part of country capacity building, a course for Indian participants was held in promoting rational drug use at the Institute of Health Care Management, Jaipur, India, in February 2004.

Activities to promote rational use of drugs included a meeting of Editors of independent Drug Information Bulletins (DIB) in Kathmandu, Nepal, in February 2004, with participants from India, Nepal and Sri Lanka. WHO provided major resources for this workshop which was aimed at strengthening DIBs and also establishing a regional network of DIBs. The Second International Conference on Improved Use of Medicines was held in Chiang Mai, Thailand, in March–April 2004. It dealt with the problem of encouraging appropriate and rational use of drugs. WHO provided major inputs to the meeting. Health Care Financing Drug Information, and the “3 by 5” initiative on HIV/AIDS were some of the major issues that were discussed.

The fifty-sixth session of the Regional Committee, in September 2003, adopted a resolution requesting Member States to collaborate in the development and enhancement of traditional medicine including herbal medicines. Preparations are under way to organize a meeting of countries with similar systems of traditional medicine in order to enhance their mutual collaboration. Additionally, a regional workshop was organized in Bangkok in June 2003 to develop guidelines on the regulation of herbal medicines.
Knowledge Management and Dissemination

The Regional Office continues to promote the production and wide dissemination of valid health-related information in the Region. Concerted efforts were made to ensure adherence to quality control norms and procedures with regard to the production, printing and publishing of WHO information materials.

Volume 7, No.2 of the Regional Health Forum, covering topics like health policy, reproductive health, environmental health, etc. was issued. Volume 8, No.1 of the Forum focused on the World Health Day theme for 2004 – Road Safety. The special issue had contributions from a wide array of experts from countries of the Region as well as from other regions. The Forum continues to serve as a useful platform for debate and exchange of views and ideas on health-related issues of regional interest.

Comprehensive briefing was provided to the Regional Office staff, both Professional and General Service, on the new WHO (Editorial) Style Guide, issued by WHO headquarters. The Guide outlines the house style or the preferred spelling, punctuation, terminology and formatting to be used for WHO printed and electronic information materials. Copies of the Style Guide were also distributed to relevant staff in the Regional Office and in country offices.

A series of technical publications, newsletters and bulletins on health laboratory services; bacteriology and immunology; dengue and adolescent health were brought out. The Regional Office continued to print documents for free distribution, including reports on various meetings and country missions, monographs, guidelines, training modules and advocacy materials covering different technical areas. Documentation related to the fifty-sixth session of the WHO Regional Committee for South-East Asia, including the report of the Technical Discussions, were printed and distributed. Volume 3 of the Handbook of Resolutions and Decisions of the Regional Committee for South-East Asia was updated. Documents pertaining to the meetings of the WHO governing bodies, such as the World Health Assembly and the Executive Board, held during 2003 and 2004, were also disseminated to the Regional Office staff as well as national health authorities.
With a view to making WHO publications easily available to health personnel and the general public, reprint rights for low-cost editions of 20 titles were awarded to commercial publishers. Permission was also granted to pharmaceutical firms to print and freely distribute five WHO publications. Translation rights in respect of 25 WHO titles, including three Regional Office publications, were granted; the languages included: Bengali, Hindi, Korean, Bahasa Indonesia and Thai as well as a number of major Indian languages.

The Regional Office website carrying comprehensive bibliographical descriptions and abstracts of recent WHO publications was updated regularly.

The Regional Office, in collaboration with WHO headquarters, participated in Book Fairs, held in Chennai, Kochi, New Delhi (India), Colombo (Sri Lanka), Kathmandu (Nepal) as well as in the World Water Day 2004 Workshop, the Medicare India 2004 Event and Environmental Health Consultation, held at New Delhi and Bangalore respectively. A large number of books, documents and pamphlets were displayed/distributed during these events which helped to create greater visibility and awareness among the public about WHO and its programmes.

The entire sales operations of WHO publications have been computerized in the Regional Office. This has helped to meet expeditiously and efficiently the increasing demand for WHO publications in the Region. As a result of these efforts, a sales turnover of $299,000 including $9,290 received against royalty was recorded during the period under review.

The Regional Office Library further developed its collection so as to provide comprehensive technical information and health literature support to the countries, United Nations agencies, biomedical researchers, health care providers and WHO staff. Information resources were enhanced by adding electronic formats of publications, documents and materials produced by the Regional Office to the Library’s collection. New materials were added to the Photo Library Database of the Region.

In order to provide higher quality technical support to Member States, the Library, in collaboration with WHO headquarters, continues to provide direct access to over 1,000.
biomedical journals and selected international databases through the project named “Global Information Full-Text (GIFT)”. The databases and their corresponding full-text documents are interlinked to provide seamless access to information for WHO’s technical staff in the Regional Office and at the country level, at any time and from any place.

The Health InterNetwork Access Initiative (HINARI), launched by WHO in 2003, continues to provide institutions in developing countries with free or nearly-free online access to leading biomedical journals. Six countries of the Region, namely Bangladesh, Bhutan, Maldives, Myanmar, Nepal and Timor-Leste, are eligible to have online information access to more than 2,200 journals. A total of 64 institutions from these countries have registered with HINARI and are accessing and downloading articles from medical journals.

The Library (HINARI coordinator for the Region), continues to promote and provide technical support to “HINARI Enabled” libraries and institutions in the countries. A HINARI bi-regional training workshop involving the South-East Asia and the Western Pacific regions, organized by TDR/HQ, was held in New Delhi in November 2003.

Following the recommendation of the Health Literature, Library and Information Services (HELLIS) Network libraries, a HELLIS website www.hellis.org was launched. Organized in collaboration with Chulalongkorn University, Bangkok, the website is a virtual library of health literature emanating from the WHO South-East Asia Region. It is a cooperative information portal of the HELLIS Network Libraries in the Region that provides information resources from the HELLIS network such as national medical databases, selected health science journals from publishers in the Region and comprehensive information on health science libraries across the 11 countries of the Region.
6

PROGRAMME PLANNING
AND MANAGEMENT

Governing Bodies

World Health Assembly

The Fifty-seventh World Health Assembly was held in Geneva from 17 to 22 May 2004. The Health Assembly elected Dr M N Khan (Pakistan) as President and Dr R M de Aranjo (Timor-Leste) as one of the Vice-Presidents. Dr Jigme Singay (Bhutan) was elected President of Committee B while Prof. M Mizanur Rahman (Bangladesh) was elected Rapporteur of Committee A.

The Health Assembly adopted 19 resolutions and four decisions. There are 13 resolutions which have implications for the South-East Asia Region.

From the SEA Region, Thailand became a Member of the Executive Board for a three-year term, replacing Myanmar, which completed its term.

Discussions on technical and health matters included: HIV/AIDS; Smallpox eradication: destruction of variola virus stocks; Eradication of poliomyelitis; Global strategy on diet, physical activity and health; Road safety and health; Health promotion and healthy lifestyles; Family and health in the context of the tenth anniversary of the International Year of the Family; Reproductive health; Health systems, including primary health care; Quality and safety of medicines: regulatory systems; Genomics and world health: report of the Advisory Committee on Health Research, and Human organ and tissue transplantation. The Assembly also discussed, among others, the internal audit, financial, programme and budget, staffing and legal matters and reviewed the progress reports on implementation of resolutions.
Executive Board

The 113th session of the Executive Board was held in Geneva from 19 to 24 January 2004. The important issues discussed included among other things: Health promotion and healthy lifestyles; Road safety and health; Genomics and world health; Human organ and tissue transplantation; Draft global strategy on diet, physical activity and health; Reproductive health; Draft strategy to accelerate progress towards the attainment of international development goals and targets; Family and health in the context of the tenth anniversary of International Year of the Family, and the report of the International Civil Service Commission. The other management matters discussed, and resolutions passed, related to collaboration with nongovernmental organizations; WHO/UNICEF/UNFPA Coordinating Committee on Health. The Board approved the appointment of the Regional Director for the South-East Asia Region, and expressed its appreciation to Dr Uton Muchtar Rafei, the outgoing Regional Director. The Board also discussed Regular budget allocations to regions, and staffing matters relating to the recruitment strategy integrating gender and geographical balance.

The 114th session of the Executive Board was held in Geneva from 24 to 27 May 2004. Important technical matters discussed included: Cancer control; Disability including management and rehabilitation; Recruitment of health workers from the developing world; Human resources in health; avian influenza and human health; Dependence-producing psychoactive substances: supplementary guidelines; Manufacture of antiretrovirals in developing countries and challenges for the future; Sustainable financing for tuberculosis control, and Social health insurance. A decision was taken to merge the Administration, Budget and Finance Committee, the Progress Development Committee and the Audit Committee into a single committee called Programme, Budget and Administration Committee.

Regional Committee

The fifty-sixth session of the Regional Committee for South-East Asia was held in the Regional Office, New Delhi, India from 10 to 12 September 2003. After its assignment to the South-East Asia Region by the Fifty-sixth World Health
Assembly, Timor-Leste participated for the first time as the eleventh full-fledged member of the Committee. The Committee nominated Dr Samlee Plianbangchang as Regional Director of the South-East Asia Region of WHO for a five-year term from 1 March 2004. The Committee also adopted a resolution declaring Dr Uton Muchtar Rafei as Regional Director Emeritus.

The Committee discussed the report of the Regional Director on the work of WHO in the South-East Asia Region for the period 1 July 2002 to 30 June 2003. The Committee appreciated the technical support provided by WHO to the countries in finalizing their proposals for submission to the Global Fund for AIDS, Tuberculosis and Malaria.

The Committee noted:

- the alarmingly increasing trend of HIV/AIDS cases and growing number of new cases of tuberculosis and the annual occurrence of 750,000 deaths due to tuberculosis;
- the efforts of Member States in strengthening national TB control programmes through expansion of the DOTS (Directly Observed Treatment, Short-course) strategy;
- the technical support provided by WHO for achieving the leprosy elimination target in eight countries;
- the use of the polio immunization infrastructure for other vaccine-preventable diseases and the phased introduction of hepatitis B vaccine and auto-disable syringes;
- the importance of ratifying the Framework Convention on Tobacco Control (FCTC) by the Member States, and
- the importance of cross-border collaboration for prevention and control of communicable diseases like SARS, dengue, malaria, Japanese encephalitis, etc.

The Committee also noted the concerns expressed by Member States regarding the mobilization and utilization of extrabudgetary (EB) funds, and called for equitable distribution of EB resources based on population and disease burden.

Health Ministers’ Meeting

The Twenty-first Meeting of Health Ministers of countries of the WHO South-East Asia Region was held in September 2003
in New Delhi, India. At this meeting, the Health Ministers reviewed the progress on the Declaration on Health Development in the South-East Asia Region in the 21st Century, and recommended that WHO should continue to monitor the progress on implementation of the policy actions enunciated in the Declaration.

The Ministers reviewed the follow-up on FCTC and recommended that countries should facilitate and speed up the enactment of anti-tobacco laws. The prevention and control of SARS was discussed and it was recommended that countries should enhance and sustain the vigilance against the re-emergence of SARS and other potential infectious disease epidemics through improvement of national and regional surveillance and response networking.

The Ministers also deliberated on purchasing quality essential medicines. The Regional Office was requested to explore the possibility of regional pooled procurement of drugs and vaccines, including the feasibility of bulk purchase from those countries from whom other UN organizations, such as UNICEF, were already making bulk purchases.

Consultative Committee for Programme Development and Management

The Fortieth meeting of the Consultative Committee for Programme Development and Management (CCPDM), held in the Regional Office in September 2003, reviewed the progress of WHO collaborative programmes, both country and
intercountry, implemented during the period January 2002 - June 2003. It also reviewed the work plans for the 2004–2005 biennium. The Committee recommended programme implementation targets of 75% by the end of the first year, and 100% by 31 August of the second year of the biennium 2004-2005. It emphasized the need for an increase in extrabudgetary resources for the Region for the 2004-2005 biennium in view of the high disease burden, and recommended the adoption by the Regional Committee of a resolution to this effect.

The CCPDM noted the reports by country representatives on their attendance at the meetings of the coordinating bodies of WHO global programmes (TDR and HRP). It made recommendations to the Regional Committee on the regional implications of the decisions and resolutions of the World Health Assembly and the Executive Board.

The CCPDM reviewed the report of the joint evaluation of the Supplementary Intercountry Programme on “Multi-disease Surveillance and Response, including health hazards, and intercountry cooperation in health development”, carried out in six countries of the Region (India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand), by composite teams of high-level country representatives, Regional Office and HQ staff, and experts from WHO collaborating centres. The CCPDM requested the Regional Office to continue to carry out similar joint evaluations/reviews of not only supplementary intercountry programmes but also other regional priority programmes.

The Committee was presented with technical updates on Severe Acute Respiratory Syndrome (SARS), Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), and Emergency and Humanitarian Action (EHA). It recommended that technical and material support from WHO to countries in the Region should be continued, to make them better equipped and prepared to deal with epidemics such as SARS. It also recommended that WHO should continue to assist countries in obtaining fund approvals from GFATM, and work closely with countries in building up their capacities for effective implementation and technical monitoring/evaluation.

The Committee further recommended that countries take action to set up appropriate focal points, if not already done,
in the government to deal with emergency preparedness and related issues. Technical Discussions on “Social Health Insurance” were also held in conjunction with the meeting of CCPDM. The recommendations of CCPDM as well as those arising out of the Technical Discussions were submitted to the fifty-sixth session of the Regional Committee.

Resource Mobilization and External Cooperation

Resource mobilization

During the review period, continued efforts were made by the Regional Office and the country offices to mobilize external resources for WHO activities to support health development in the countries. At the end of the 2002-2003 biennium, the total amount of extrabudgetary resources generated for the Region was US$ 132.6 million, which marked a 16.2% increase compared to the previous biennium. Also, during the biennium 2002-2003, a notable increase was made in the amount of resources mobilized at the country level, which was over 50% of the total funds mobilized, as compared to funds allocated to the Region as part of the global resource mobilization exercise.

The Meeting of Interested Parties (MIP-2003) was organized by WHO headquarters in November 2003. It served as a forum for the WHO Secretariat, its Member States, donor agencies, civil society organizations and the private sector, to discuss WHO’s major programme implementation at all levels of WHO headquarters, regions and countries.

Participants from the Regional Office and from several countries of the Region to MIP 2003 shared with other partners the progress made in the regional and country health programmes. They also shared their experiences, the need for further progress, and the issues and challenges involved in this respect.

In view of the increasing importance of extrabudgetary funds to support WHO’s health programmes to meet the expectations of countries for additional external resources, particularly in the context of the resource mobilization target for 2004-2005, the Regional Office has developed an operational strategy and a plan of action for the 2004-2005 biennium.
This strategy focuses on: the development of a resource mobilization system; intensified advocacy and communication with donors, and strengthening of capacity building.

In order to advocate and highlight its commitment to work with donor agencies, the Regional Office initiated several contacts with donors and other development agencies during the period under review.

Furthermore, in order to ensure effective resource mobilization, development of the Regional Office Information System on Extrabudgetary Funds has been initiated and is progressing well.

**External cooperation**

WHO and the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) have strengthened their partnership to contribute to health development through multisectoral collaboration in the Region. Investment in Health for Development and Tackling HIV/AIDS as a Development Challenge was the main theme of the First Meeting of the ESCAP Committee on Emerging Social Issues, held in May 2003. With technical support from the Regional Office, ESCAP also organized an inception workshop on Increasing Investment in Health for Economic Development in November 2003, to follow up on the Report of the Commission on Macroeconomics and Health. A resolution on Enhancement of Capacity Building in Public Health was adopted at the Sixtieth session of ESCAP, held in April 2004.

WHO expanded its formal relations with other agencies at the regional level in 2003. Memoranda of Understanding (MoU) between the Regional Office and other agencies, such as the UN Office on Drugs and Crimes, International Federation of Red Cross and Red Crescent Societies, and ASEAN Disaster Preparedness Centre, were concluded.

WHO and ASEAN reviewed the implementation of their Memorandum of Understanding (signed in 1997) in December 2003 and agreed to develop a new framework of collaboration to further strengthen their cooperation.

 Collaboration with SAARC continued, focusing on strengthening of the SAARC TB Centre and TB control in
countries of SAARC, through WHO’s technical support. WHO also assisted in the SAARC Regional Training course on TB Control.

Interaction with the private sector was also renewed to improve the health outcomes in the countries. In February 2004, WHO hosted a meeting on TB Control in the Workplace - Enhancing the Role of the Corporate Sector.

A new WHO policy on its relations with nongovernmental organizations (NGOs) has been under debate at the Executive Board and the World Health Assembly since January 2003. This proposed new policy intends to regulate WHO’s interaction with international, regional and national NGOs through two different but interrelated modalities - Accreditation Policy and Collaboration Policy.

**General Management**

**Programme planning, monitoring and evaluation**

With a view to improving the managerial process for WHO Programme Development within the context of national health development, the Regional Office continued to support countries through training and orientation of relevant health officials, and guidance on programme planning, monitoring and evaluation. Based on the Programme Budget for 2004-2005, detailed work plans for country and regional/intercountry programmes were finalized and formalized after approval by the Regional Director. These work plans were uploaded into the Activity Management System (AMS) and made available upfront in order that the process of implementation of WHO collaborative programmes could start from the very first day of the biennium, i.e. 1 January 2004.

The fifty-sixth session of the Regional Committee, held in September 2003, expressed concern at the decreasing WHO Regular Budget allocations and emphasized the need for a better understanding about this among WHO country staff and the national authorities. In the light of the above, a Consultation on Country Work Plans and Country Regular Budget Allocations for the 2004-2005 biennium was held in the Regional Office in December 2003. Senior officials at policy-
making levels in countries of the Region participated, along with relevant staff of WHO country offices, including a few WHO Representatives. They were also briefed on the managerial aspects of the WHO collaborative programme, including evaluation of the implementation of the 2002–2003 Programme Budget. The processes and time-frame involved in the preparation of the Eleventh General Programme of Work (GPW) covering the period 2006–2015 were discussed and guidance provided. It was further emphasized that the quality of detailed work plans and of monitoring, evaluation and reporting which would reflect WHO’s capability, accountability and credibility, be improved.

Training was provided in the use of AMS to WHO country staff members, who were also briefed on the various planning and monitoring aspects of programme implementation. Programme planning and management support was provided to WHO staff in country offices with regard to preparation of work plans, AMS, programme changes and implementation of work plans, including monitoring.

A Manual for Preparation of Programme Budget and its Operationalization, prepared by WHO headquarters, was circulated among WHO staff in the Region, to assist them in the development of goals, WHO objectives and indicators, and Organization-wide expected results, baselines and targets. It provides guidelines on the first stage of operational planning, namely the development of office-specific expected results, and their corresponding indicators, baselines and targets. Recognizing the importance of office-specific expected results as a bridge between strategic planning and operational planning, the Manual provides guidance for the development and operationalization of the Programme Budget and will be used extensively in the preparation of the Programme Budget for 2006–2007.

Preparatory work on formulation of the Proposed Programme Budget for 2006–2007, as well as the Eleventh General Programme of Work was undertaken at the meeting of regional planning officers where regional inputs were provided. Orientation and briefing to technical staff in the Regional Office as well as the WHO Representatives were also provided. Furthermore, inputs were provided to WHO headquarters on the scope of each Area of Work (AoW),
including coordination of regional/country inputs towards the formulation of expected results, as well as the regional contribution on challenges and issues involved in each AoW.

In response to the commitment to the governing bodies to report on the implementation of the WHO programme budget against the stated expected results and indicators in the Programme Budget 2002-2003, systematic performance monitoring and evaluation were undertaken to ensure that the results were achieved efficiently and effectively. Towards this end, the Regional Office carried out the end-of-biennium performance assessments and provided inputs to the Organization-wide exercise. This exercise was carried out at the level of AoW to assess the contributions of each office to the Organization-wide expected results, by preparing a report addressing a set of six specific questions covering all of the office-specific expected results within an AoW. This assessment revealed that the shift from budget-based approach to results-based management had had a positive impact by enhancing the technical quality of WHO collaborative programmes, both at country and regional levels.

The evaluation of implementation of the intercountry programme was continued. In accordance with the decision of the fifty-sixth session of the Regional Committee, an in-depth evaluation of the supplementary intercountry programme with the content area of “Intensification of cross-border collaboration in priority communicable diseases”, was initiated. The evaluation is being carried out in four selected countries, namely, Bangladesh, India, Myanmar and Thailand, by joint teams comprising members drawn from WHO, the countries and experts from WHO collaborating centres.

**Human resources development**

The current Organizational Chart of the Regional Office is at Annex 1. This reflects the changes made recently to meet the Region’s long-term objective of organizational development with a view to making WHO more efficient, transparent, fair and relevant and better able to respond effectively to the needs of its Member States.

Following the introduction of contractual reforms in the second half of 2002, the execution of human resources (HR)
reforms during the reporting period resulted in the transition of 12 contracts of long-term short-term (LTST) staff to fixed-term status and improved the employment conditions of temporary staff while recognizing the results-based WHO programme activities.

In order to broaden and diversify the knowledge base of the Organization, staff mobility/rotation was effected by the reassignment of 13 professional staff members to different posts as well as through interagency transfers.

Technical support to countries was facilitated and strengthened through the services of 96 short-term professionals, 28 short-term consultants and 18 short-term national professional officers. Additional support services were provided through 150 short-term general service staff.

With the introduction of e-recruitment, the operational aspects of staff recruitment were simplified to manage vacancies, database of applicants and related system data, candidate review and screening and efficient dissemination of vacancy announcements.

As a continuing process of improving gender equity in the Organization, internal monitoring and review mechanisms were established through the Women’s Panel Coordinator who emphasized the need for short-listing of female candidates. Equally, constant efforts were made to recruit staff of unrepresented/under-represented nationalities in line with the targets set by the governing bodies.

Of the 16 new appointments made during the reporting period, only 5 (31%) candidates were females, the reason being that the vacancy notices did not attract enough qualified female candidates. An in-depth study will be undertaken through a working group to improve the employment of women. The new appointments included nine nationals from unrepresented and under-represented countries, which account for 56% against the target set at 60%.

Of the 150 established posts in the professional grade in the Region, 105* were occupied. Table 6.1 shows the distribution of professional staff in established offices and field offices as well as the proportion of serving professional female staff.

*including three inter-regional posts

With the introduction of e-recruitment, the operational aspects of staff recruitment were simplified
To provide better career opportunities and recognize the career aspirations of local staff, the seven extended grade (ND.X) posts were converted into the National Professional Officer (NPO) category, initially on a trial basis. South-East Asia is the first WHO Region to introduce the category of NPOs.

Twenty-three staff members in the professional category, three in the NPO category and 126 in the General Service (GS) category were granted “service appointments” with effect from 1 July 2003.

The Regional Office continued to provide administrative support to country offices, particularly the newly-established offices, by seconding senior GS staff to WHO Representatives’ offices. This presents developmental opportunities for staff, in addition to strengthening country offices. This has been recognized as the best practice on the subject, and is being taken as a model by other regional offices.

From the perspective of promoting national capacity in projects at the country level, 1,422 special services agreement holders were hired, of which 1,138 provided support for National Polio Surveillance Programmes in Bangladesh, India, Indonesia and Myanmar alone.

In order to sustain the continued improvement, capacity and commitment of a motivated team of staff members, sufficient budget allocation was made for staff development and learning activities. Support was provided by way of on-the-job training, workshops as well as several in-house briefing/orientation programmes on different technical, managerial and administrative areas. A systematic analysis

<table>
<thead>
<tr>
<th>Location</th>
<th>Established posts</th>
<th>Staff in position</th>
<th>Percentage of female staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>Male</td>
</tr>
<tr>
<td>Established offices</td>
<td>102</td>
<td>79</td>
<td>57</td>
</tr>
<tr>
<td>(RO + WRs’ offices)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Field office</td>
<td>48</td>
<td>26</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td>150</td>
<td>105</td>
<td>74</td>
</tr>
</tbody>
</table>

Table 6.1: Distribution of professional staff and representation of women professional staff in the SEA Region (as of 30 June 2004)
of the training needs is currently being conducted, which aims to facilitate the targeted staff development for the whole Region.

**Budget and financial management**

The attention given to financial implementation in 2002–2003 produced the desired results as the Region’s “reserves” and “surrenders” dropped substantially from the previous biennium (Figure 6.1 and Annexes 2 and 3). The Regional Office had established “reserves” of US$ 9.7 million at the end of the last biennium, compared with US$ 12.7 million at the conclusion of 2000-2001, a reduction of nearly 23.63%. Surrenders, which represent funds retained by the Region but subsequently returned unspent to WHO headquarters, dropped almost by half, from US$ 3.7 million to US$ 2.1 million, reflecting improved utilization. Setting ambitious targets such as achieving full implementation after 18 months and actively monitoring the expenditures throughout the biennium contributed to the positive outcome. Careful monitoring also allowed the Region to identify savings to fund contingencies such as the outbreak of SARS in 2003 and avian flu in 2004.

For 2004–2005, CCPDM recommended slightly relaxed implementation targets – 75% in the first year of the biennium and full implementation after 20 months – partly in recognition of the progress the Region has made in financial management,

\[\text{Figure 6.1: Regular Budget reserves: SEAR “established” vs “surrendered” funds, 1994-1995 – 2002-2003}\]
which permits it to focus more on programmatic rather than financial results in this biennium (see Annexes 4-7 for budgetary implementation).

Extrabudgetary funds surpassed Regular Budget resources in the Region for the first time in 2000-2001, and continued to grow in 2002-2003, as illustrated in Figure 6.2. The EB projection for the current biennium is for US$ 191 million, an increase of 47.58% from 2002-2003. Donor funds continued to flow into the Region throughout the biennium. The present allocation of US$ 72 million represents contributions from donors received up to 30 June 2004. The largest share of donor funds continues to be for polio eradication. The Regional Office is giving greater emphasis to raising funds locally in order to secure the funding needed to deliver its expected results for 2004-2005.

In contrast to the growth in EB funding, the Region’s RB allocation has dropped by more than US$ 5 million since 1998-1999 as a result of World Health Assembly resolution WHA51.31. Since the Least Developed Countries are exempt from reductions resulting from that resolution, all the cuts over the last three bienniums have been absorbed by India, Indonesia, Sri Lanka, Thailand and RO/ICP. The Region’s total RB allocation for 2004-2005 is nearly the same as the last biennium because the reductions it took for WHA51.31 were
offset by an additional Regular Budget allocation for Timor-Leste (US$ 1.5 million). WHA51.31 will expire at the end of the current biennium unless it is re-authorized by the World Health Assembly in May 2005. At the World Health Assembly in 2004, the Director-General was asked to propose to the Executive Board in 2005 a new model for the allocation of funds from all sources to regions.

A shrinking Regular Budget and the lack of any adjustments for inflation has meant that a greater share is needed for fixed costs while the portion for activities has become smaller, particularly in respect of the Regional Office and intercountry allocations. In addition, the appreciation of local currencies such as the Indian rupee against the US dollar – in which WHO budgets are denominated – has the effect of making lesser funds available for local costs. However, funding for WHO’s presence in countries increased in 2004-2005, in line with the global effort to strengthen capacity in countries and decentralize operations. Increased support to countries is reflected in the addition of technical and administrative staff, improved connectivity and increased security in the WRs’ offices.

**Informatics and infrastructure services**

WHO’s initiative of strengthening its presence in countries requires considerable support by Information and Communication Technology (ICT). In order to enable country offices to better respond to the needs of States, ICT infrastructure in those country offices has been strengthened by implementing information systems to best suit the needs of WHO work at the country level, and by ensuring connectivity and IT management support. All country offices in the Region have dedicated internet connectivity, access to the Regional Office and HQ intranets, and reliable e-mail facility. Nine country offices have secure access to WHO databases, and planning is under way for the remaining country offices. Desktop Video broadcast connectivity has been established with all country offices. A toll-free voice facility (VOIP) is available between the Regional Office and country offices in DPR Korea, India, Nepal and Thailand. Regular ICT management support was provided to various country offices in the Region.
Information and knowledge sharing has been an important facilitating factor in enabling the Organization to achieve its mandate. The Region’s websites played an instrumental role in disseminating prompt updates and guidelines on the prevention and control of avian influenza during the recent outbreaks of this disease in the Region, especially in Thailand. Websites for all Areas of Work have been redesigned with the new format and hosted on the internet. The WHO country offices in Bangladesh, Bhutan, India and Indonesia have their own websites. Websites for the WHO country offices in India, Maldives, Sri Lanka and Thailand have been developed with standardized corporate design using the Website Builder Tool (WBT). The development of websites for the remaining country offices is under way. The Regional Office remains committed to further promoting e-Health for Health Care Delivery (e-HCD) in order to support the countries in achieving the goal of extending equitable and quality basic health service delivery, especially to remote areas. An innovative and cost-effective e-HCD has been developed in order to facilitate the exchange of information for diagnosis, treatment and prevention of diseases. As a concluding step for the Bhutan Pilot project, an in-depth evaluation of the implemented sites has been planned. Based on the evaluation, WHO will provide inputs to the development of national master plans for e-HCD.

On the basis of the lessons learnt from Bhutan, a pilot project has been launched at eight sites in Sri Lanka. For Maldives, implementation of the pilot e-HCD project is under way at four regional hospitals, including locations at the extreme north and south.

Strengthening the Organization’s business processes for improving efficiency has been an important agenda and ICT is contributing in this direction by improving the information systems as well as associated business practices in the Region. During the reporting period, nine additional technical and administrative information systems were developed and/or implemented. The active participation and enthusiasm of the country office staff helped in moving forward with AMS. Two workshops were organized to train country office staff. All interested staff in the Regional Office and the country office in India were trained on the upgraded desktop software.
In order to support technical programmes in the Regional Office and country offices in dealing with disease surveillance and providing timely action, the application of the Geographical Information System (GIS) as a data analysis and presentation tool in the Regional Office was further strengthened. Consistent and authoritative GIS data have been collected from Bhutan, Myanmar, Sri Lanka, Thailand (some issues pending) and Timor-Leste in order to develop a standardized GIS spatial database. Efforts are currently under way to ensure the availability of consistent and standardized GIS spatial data for the remaining countries of the Region. A SEARO Integrated Data Analysis System (SIDAS) has been developed as a single integrated tool for collection, updating, analysis and dissemination of health data. Training programmes on GIS were organized for interested staff in the Regional Office and the country office staff in India.

ICT support was provided for various activities under country workplans, such as development and upgradation of ICT infrastructure, and providing support for systems like Surveillance Project Management System (SPMS); TB Programme Information System (TPIS); National Institute of Communicable Diseases (NICD); Central Bureau for Health Intelligence (CBHI), and web portal for information exchange in health and health-related specialities to collect the required information from institutions.

**Procurement services**

During the reporting period, the Regional Office procured supplies amounting to US$ 10.17 million for Member States and the Regional Office. Of this, US$ 1.38 million was spent using the Regular Budget funds and US$ 8.79 million using other sources of funds. The procurement included purchases made for individual countries on a reimbursable basis. The supplies included laboratory and hospital equipment; vehicles; office automation and informatics equipment; drugs, vaccines and biologicals; books and literature; water purifying chemicals, insecticides, bed nets, etc.

The Regional Office continued its efforts to procure various essential items and also provide logistic support to the WHO Global Programme on Eradication of Poliomyelitis and the DOTS strategy programme in India and DPR Korea.
Procurement was also made under the emergency projects in DPR Korea for country hospitals and district clinics. Supplies were also arranged for countries during the SARS epidemic.

With the implementation of the new web-based Supplies Management Information System (SMIS) from January 2004, supplies data are now accessible also to country offices through AMS. The e-procurement system is also at an advanced stage of development and would be operational soon as WHO headquarters is now establishing global umbrella contracts. It would further facilitate the country office staff to retrieve relevant information on products, suppliers and pricing directly from the system, and also to place orders without involving the Regional Office.

General support services

The installation and commissioning of an auto mains failure panel and a new 625 KVA generator have improved the security of power and lighting in the Regional Office. The power failure rate has also come down and considerable savings have been effected in electricity consumption through the use of energy-efficiency equipment.

The installation of a 500 ton chilling machine has ensured continuation of the air conditioning system with the use of more economical and environmentally friendly equipment. The introduction of direct inward dialling to the Regional Office and commissioning of a fibre optic cable from the telephone company have resulted in improved telecommunications.

Landscaping of the lawn was undertaken to improve the outdoor environment of the Regional Office.

The Reception and Conference Block areas were refurbished. Waterproofing of an annex roof was also carried out. New refrigerators, bottle coolers and ice-making machines were installed in the cafeteria.

Economical fares were negotiated with preferred airlines, as well as tariffs with individual hotels. These measures have resulted in significant cost savings.

Stationery and other consumables were procured at competitive rates without compromising on quality. Only need-based procurements were made, avoiding overstocking.
Field security services

A post of Field Security Officer (FSO) was established in the Regional Office in December 2003. The two main duties of FSO are: “Prevention” (advise staff and country offices, to conduct training of staff in security awareness, and to assess security situations) and “crisis control” (to assist whenever and wherever needed in crisis situations).

Since January 2004, FSO has visited Indonesia, Myanmar, Sri Lanka, Maldives, Nepal and Timor-Leste to discuss security issues, conduct office security surveys, and recommend improved security measures. Security awareness training courses for staff were also conducted. Furthermore, a security briefing was provided to the WHO Representatives during their Fifty-third Meeting with the Regional Director.

Medical services

A well-equipped fitness centre was established during the period under review, which is being used regularly by staff and their families. As part of the common UN country security plan, a medical system plan, capable of a coherent and effective “emergency medical response” in situations of health-related risks and emergencies, was prepared.

In an effort to scale up the UN system response and promote the “WHO Policy on HIV-AIDS in the workplace”, an information document regarding HIV post-exposure preventive (PEP) treatment along with an emergency protocol at the country level was developed and implemented.

Staff health promotion activities were initiated through education and awareness programmes by inviting guest speakers to make presentations on important and relevant health issues.

WHO’s Presence in Countries

Support was provided to countries by strengthening the WHO country offices, and through decentralization of various functions in order to achieve optimum output in terms of maximizing the technical support to national programmes.
Support was provided to countries by strengthening the WHO country offices, and through decentralization of various functions.

The Regional Director’s Office continued to play an important role in the smooth implementation of the country cooperation strategy (CCS) in several countries, coordination of various activities between WHO headquarters and country offices, and also in coordinating donor support and assistance received from various development partners and other aid agencies.

The Fifty-third Meeting of the Regional Director with the WHO Representatives was held in February 2004 in Bali, Indonesia. The meeting reviewed important issues arising out of the Global WHO Representatives Meeting, and deliberated on subjects such as preparation of the Programme Budget 2006-2007; contributions towards the Eleventh General Programme of Work, and effective implementation of PB 2004-2005. The WHO Representatives reviewed their roles in the context of achievement of the UN Millennium Development Goals, and the challenges arising out of the Director-General’s “3 by 5” initiative, as well as managerial issues including strengthening staff development and learning, and effective utilization of WHO collaborating centres and Expert Advisory Panel members.

The Fifty-fourth Meeting of the Regional Director with the WHO Representatives was held in March 2004 in the Regional Office. This meeting was more in the nature of an exchange of views on main policy issues between the new Regional Director and WHO Representatives.

Public Information and Advocacy

Over the past decade, the relevance of information, communication and media activities within the Regional Office have grown significantly, with information and advocacy being seen as among the core functions of WHO. In line with this emphasis, the Media and Public Information unit of the Regional Office was renamed as the Public Information and Advocacy unit.

In order to strengthen this area of work, a media/communication strategy is being developed for the Regional Office even as the Information team at headquarters is
examining the global strategy. This is based on the fact that WHO’s role and its technical expertise are globally recognized as important as brought out during the global outbreaks of SARS and avian flu. The Regional Office is working to develop strategies that improve public visibility of its ongoing work, by building the information and advocacy elements into the technical programmes and their related work plans.

The regional focus on emerging diseases took centrestage this year too. In January-February 2004, the outbreak of the H5N1 avian influenza in Indonesia and Thailand, and unconfirmed reports of outbreaks in two other countries, evoked considerable media interest. The Regional Office networked with experts in the countries concerned and media queries were suitably tackled by its experts and also by relevant staff in country offices. The policy of the Regional Office was to be proactive and provide information to the media, including a set of “Frequently Asked Questions” which was shared with all the countries.

As an outcome of dealing with SARS, the Regional Office is developing an advocacy video on “Good infection control practices in health care facilities”. The video depicts a good example from a hospital in Bangkok. It also shows what a small hospital (in India in this case) can achieve even with a low budget. The video will be available to countries later this year.

The fifty-sixth session of the Regional Committee and the Health Ministers’ meeting, held in New Delhi in September 2003, provided an opportunity to create several exhibits and posters and a video that presented a ten-year perspective on health development in the Region. Once again, video interviews with Health Ministers were undertaken, and each Minister was provided with a copy of a ready-to-broadcast, professional video.

Media support was provided for the STOP TB Partners’ Forum meeting held in New Delhi in March 2004. This included planning and negotiations to bring in the noted Indian musician A. R. Rahman as the STOP TB Partnership Ambassador, as well as ensuring media interaction during his visit at the Forum.
Regional Director’s Development Fund

Various country and intercountry programme initiatives continued to be supported by the Regional Director’s Development Fund. These included: setting up of a Task Force on Public Health Education; establishment of the Institute of Public Health in Myanmar, and development of a vision paper for emerging diseases. Support was also provided to the WHO office in Thailand to deal with matters relating to avian influenza through the provision of human resources and funding of operational costs.
Annexes
Annex 1
Organizational Structure

Regional Director

Regional Director's Office
- Administrative Support to RD (ARD)
- Internal Review and Technical Assessment (IRTA)

Deputy Regional Director (DRD)
- Sustainable Development and Healthy Environments (SDE)
- Relations with Other International Organizations and External Partners (ER)
- Resource Mobilization (RM)
- Public Information and Advocacy (PIA)
- Sustainable Health Policy (SHP)

Director, Programme Management (DPM)
- Communicable Diseases (CDS)
- Family and Community Health (FCH)
- Health Systems Development (HSD)
- Noncommunicable Diseases and Mental Health (NMH)

WHO Country Offices
- WHO Representatives (WRs)

Director, Administration and Finance (DAF)
- Programme Planning and Coordination (PPC)
- Immunization and Vaccine Development (IVD)
## Annex 2
### Budgetary Implementation, 2002-2003
#### by country/RO/ICP

All sources of funds  
(as of 31 December 2003)

<table>
<thead>
<tr>
<th>Member State</th>
<th>Regular Budget</th>
<th>Extrabudgetary Funds</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>9 655 600</td>
<td>7 061 868</td>
<td>16 717 468</td>
</tr>
<tr>
<td>Bhutan</td>
<td>2 102 800</td>
<td>161 245</td>
<td>2 264 045</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>2 927 400</td>
<td>4 291 974</td>
<td>7 219 374</td>
</tr>
<tr>
<td>India</td>
<td>13 088 400</td>
<td>43 061 613</td>
<td>56 150 013</td>
</tr>
<tr>
<td>Indonesia</td>
<td>9 323 700</td>
<td>12 887 019</td>
<td>22 210 719</td>
</tr>
<tr>
<td>Maldives</td>
<td>2 041 500</td>
<td>–</td>
<td>2 041 500</td>
</tr>
<tr>
<td>Myanmar</td>
<td>6 775 800</td>
<td>3 430 310</td>
<td>10 206 110</td>
</tr>
<tr>
<td>Nepal</td>
<td>7 321 800</td>
<td>8 557 787</td>
<td>15 879 587</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>4 687 400</td>
<td>1 130 883</td>
<td>5 818 283</td>
</tr>
<tr>
<td>Thailand</td>
<td>5 439 700</td>
<td>796 217</td>
<td>6 235 917</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>1 153 900</td>
<td>793 377</td>
<td>1 947 277</td>
</tr>
<tr>
<td><strong>Country Total</strong></td>
<td><strong>64 518 000</strong></td>
<td><strong>82 172 293</strong></td>
<td><strong>146 690 293</strong></td>
</tr>
<tr>
<td><strong>Inter-Country/RO</strong></td>
<td><strong>26 704 000</strong></td>
<td><strong>18 252 932</strong></td>
<td><strong>44 956 932</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>91 222 000</strong></td>
<td><strong>100 425 225</strong></td>
<td><strong>191 647 225</strong></td>
</tr>
</tbody>
</table>

RB - Total allocation – US$ 91,222,000; implementation 100%
EB - Total allocation – US$ 129,423,574; implementation 78%
### Annex 3

**Budgetary Implementation, 2002-2003**

by area of work (in descending order)

All sources of funds  
(as of 31 December 2003)

Expressed in US$

<table>
<thead>
<tr>
<th>AOW Code</th>
<th>Area of Work</th>
<th>Regular Budget</th>
<th>Extrabudgetary Funds</th>
<th>Total</th>
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<td>16 649</td>
<td>18 095 541</td>
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<td>7 705 984</td>
<td>8 980 414</td>
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<td>5 016 873</td>
<td>7 270 095</td>
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<td>Health and Environment</td>
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<td>5 639 870</td>
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<td>5 588 509</td>
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<td>3 331 521</td>
<td>5 411 169</td>
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<tr>
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<td>HIV/AIDS</td>
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<td>2 529 337</td>
<td>4 884 020</td>
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<td>Surveillance, Prevention and Management of Noncommunicable Diseases</td>
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<td>275 948</td>
<td>3 993 650</td>
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<td>Child and Adolescent Health</td>
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<td>1 017 336</td>
<td>3 894 636</td>
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<td>Informatics and Infrastructure Services</td>
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<td>–</td>
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<td>Evidence for Health Policy</td>
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<td>290 354</td>
<td>3 174 680</td>
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<td>Research Policy and Promotion</td>
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<td>393 340</td>
<td>2 825 361</td>
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<td>Tobacco</td>
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<td>633 772</td>
<td>2 613 085</td>
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<td>374 304</td>
<td>2 449 649</td>
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<td>Making Pregnancy Safer</td>
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<td>201 891</td>
<td>2 431 728</td>
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<td>1 991 136</td>
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<td>659 759</td>
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<td>78 825</td>
<td>1 184 825</td>
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<td>Nutrition</td>
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<td>1 116 832</td>
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<td>Health Information Management and Dissemination</td>
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<td>129 393</td>
<td>1 043 559</td>
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<td>FOS 04.4</td>
<td>Food Safety</td>
<td>888 940</td>
<td>–</td>
<td>888 940</td>
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<tr>
<td>FNS 08.3</td>
<td>Financial Management</td>
<td>848 653</td>
<td>–</td>
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<td>Women’s Health</td>
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<td>10 778</td>
<td>833 927</td>
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<td>BMR 08.1</td>
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<td>–</td>
<td>754 492</td>
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<td>683 924</td>
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<td>Governing Bodies</td>
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<tr>
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<td>–</td>
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| RB - Total allocation – US$ 91 222 000; implementation 100% |
| EB - Total allocation – US$ 129 423 574; implementation 78% |

**Total**  
91 222 000  
100 425 225  
191 647 225
Annex 4
Budgetary Implementation of Activities, 2004-2005
by intercountry
Regular Budget
(as of 30 June 2004)

<table>
<thead>
<tr>
<th>Member State</th>
<th>Allotted</th>
<th>Committed</th>
<th>%</th>
<th>Uncommitted</th>
<th>%</th>
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<td>1,833,462</td>
<td>31</td>
<td>3,990,838</td>
<td>69</td>
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<tr>
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<td>1,255,500</td>
<td>511,262</td>
<td>41</td>
<td>744,238</td>
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<td>633,442</td>
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<td>1,390,158</td>
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<td>9,089,800</td>
<td>1,728,117*</td>
<td>19</td>
<td>7,361,683*</td>
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<td>983,245</td>
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<td>2,996,255</td>
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<td>337,581</td>
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<td>535,919</td>
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<td>3,322,389</td>
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<td>28,259,851</td>
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</table>

*In addition, US$ 280,686 has been fully committed by end June 2003. Thus the total implementation is as follows: Commitment - 2,008,803 (22%); Uncommitted balance - 7,080,997 (78%).

---

THE WORK OF WHO IN THE SOUTH-EAST ASIA REGION
Annex 5
Budgetary Implementation, 2004-2005
by area of work (in descending order)

Regular Budget
(as of 30 June 2004)

<table>
<thead>
<tr>
<th>AOW Code</th>
<th>Area of Works</th>
<th>Allotted</th>
<th>Committed</th>
<th>%</th>
<th>Uncommitted</th>
<th>%</th>
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<td>7 377 407</td>
<td>72</td>
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<tr>
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<td>Surveillance, Prevention and Management of Noncommunicable Diseases</td>
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<td>1 163 568</td>
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<td>2 192 632</td>
<td>65</td>
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<td>601 861</td>
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<td>1 573 239</td>
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<td>Health and Environment</td>
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<td>513 480</td>
<td>24</td>
<td>1 656 920</td>
<td>76</td>
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<td>1 579 804</td>
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<td>1 388 809</td>
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<td>691 110</td>
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<td>231 668</td>
<td>29</td>
<td>562 732</td>
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<td>561 647</td>
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<td>495 435</td>
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<td>26 765</td>
<td>8</td>
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<td>GBS 07.1</td>
<td>Governing Bodies</td>
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<td>82 358</td>
<td>32</td>
<td>171 142</td>
<td>68</td>
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<td>76 073</td>
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<td>116 027</td>
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<td>43 697</td>
<td>64</td>
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<td>7 198</td>
<td>37</td>
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<td>–</td>
<td>0</td>
<td>15 000</td>
<td>100</td>
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Total | 43 738 700 | 12 020 312 | 27 | 31 718 388 | 73 |
Annex 6
Budgetary Implementation, 2004-2005
by intercountry
Extrabudgetary Funds
(as of 30 June 2004)

<table>
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<tr>
<th>Member State</th>
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<th>Committed</th>
<th>%</th>
<th>Uncommitted</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>4 938 492</td>
<td>2 827 054</td>
<td>57</td>
<td>2 111 438</td>
<td>43</td>
</tr>
<tr>
<td>Bhutan</td>
<td>120 000</td>
<td>13 666</td>
<td>11</td>
<td>106 334</td>
<td>89</td>
</tr>
<tr>
<td>DPR Korea</td>
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<td>1 325 359</td>
<td>42</td>
<td>1 840 397</td>
<td>58</td>
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<td>28 985 548</td>
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<td>8 387 224</td>
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<td>1 828 342</td>
<td>55</td>
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<td>27</td>
<td>2 378 032</td>
<td>73</td>
</tr>
<tr>
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<td>2 375 303</td>
<td>51</td>
</tr>
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<td>389 339</td>
<td>45</td>
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<tr>
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<td>64 459</td>
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<td>127 735</td>
<td>66</td>
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<td>19 644 283</td>
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<td>6 458 741</td>
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</tbody>
</table>

Expressed in US $
Annex 7
Budgetary Implementation, 2004-2005
by area of work (in descending order)

Extrabudgetary Funds
(as of 30 June 2004)

<table>
<thead>
<tr>
<th>AOW code</th>
<th>Areas of Work</th>
<th>Allotted</th>
<th>Committed</th>
<th>%</th>
<th>Uncommitted</th>
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