The Work of WHO in the South-East Asia Region

Report of the Regional Director
1 January - 31 December 2010

World Health Organization
Regional Office for South-East Asia
Report of the Regional Director
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WHO’s collaborative efforts with Member States in the South-East Asia Region span more than six decades. During this prolonged and rewarding period of collaboration our aims have remained consistent: the achievement of improved health outcomes, the strengthening of health systems, and fair and equitable access to health care by all.

The Work of WHO in the South-East Asia Region, covering the period 1 January 2010 to 31 December 2010, highlights progress made in health development and in achieving the Organization’s strategic objectives and expected results. The body of the Report provides a summary of programme delivery highlights for the areas of work in which WHO was engaged in 2010 in the South-East Asia Region.

Such highlights include WHO’s efforts in the fight against polio, which is in its last stages, as well as against leprosy, which has been eliminated in most countries of the Region. As in previous years, HIV/AIDS, tuberculosis and malaria continued to be a major focus of WHO technical support. In addition, national noncommunicable disease policies, strategies and programmes were reviewed in recognition of the ever increasing burden and relevance of this group of diseases. Elimination of risk factors are key to the reduction of noncommunicable diseases and various prevention and control measures were supported in relation to tobacco, alcohol, psychoactive substances, unhealthy diets, physical inactivity and unsafe sex. Similarly, WHO continued to address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender responsive, and human rights-based approaches.

While efforts have not been lacking, outcomes in relation to maternal and child health underscore the need to accelerate action toward the achievement of MDGs 4 and 5. Supporting the development of national strategies and plans, standards, implementation guidelines, training packages and monitoring tools were key WHO initiatives within this important area.
The South-East Asia Region is particularly prone to natural disasters and numerous preparedness, risk reduction, emergency response and capacity building activities were implemented during the year. Serious environmental threats are also present in the Region, especially due to unsafe drinking water, chemical pollutants and inadequate sanitation. A multisectoral campaign on urbanization and health and efforts to enhance strategies for delivery of occupational health services were supported in this area. Development of approaches and support interventions were similarly supported to improve outcomes in the areas of nutrition, food safety and security.

As regards health services strengthening, WHO provided technical assistance to help improve health financing, develop evidence-based policies and strategies and enhance capacity in support of the development of national health policies, strategies and plans. Efforts to strengthen the public health workforce in Member States also received focused attention. Optimal use of good quality medicines is crucial to ensure rational use, reduce drug resistance and achieve health outcomes in relation to both communicable and noncommunicable diseases. Initiatives to strengthen related infrastructure were supported as were measures to improve availability, ensure adequate policy frameworks and improve the supply and distribution, regulation and storage of good quality essential medicines.

While pride in these achievements is justified, the Report also identifies daunting public health challenges which remain to be addressed. At a time of on-going global financial constraint, it is important that Member States of the Region remain confident that they can continue to rely on the understanding and support of WHO. It is with these thoughts that I present this Report on *The Work of WHO in the South-East Asia Region*.

Dr Samlee Plianbangchang
Regional Director
Communicable diseases

Overview

1. Each year the South-East Asia Region advances steadily toward the goal of reducing the burden of communicable diseases, some of which have plagued humankind since time immemorial. The campaign against polio is in its last stages; most countries have eliminated leprosy. Meanwhile, however, new diseases and threats continue to emerge, such as Pandemic (H1N1) 2009. WHO continues to assist countries in building their capacity to ensure good surveillance and response to outbreaks in a timely and effective manner, addressing the prevalent tropical diseases and providing immunization against vaccine preventable diseases.

2010 programme delivery highlights

2. There has been a significant reduction in polio cases (>95%) in the past year in India, the only country in the Region with endemic transmission of polio. Interrupting the remaining chains of wild poliovirus transmission and high-quality surveillance are important regional priorities.

3. With Timor-Leste achieving leprosy elimination by the end of 2010, all 11 Member States in the South-East Asia Region have now eliminated leprosy as a public health problem at the national level (prevalence rate less than 1 case per 10 000 population). There was a remarkable reduction in the number of new cases detected annually, in the Region. However, as per the latest data, 68% of the global new cases were detected in the Region.
4. Capacities of Member States were strengthened for implementation of IHR, in responding to Pandemic (H1N1) 2009, and outbreaks of other diseases such as cholera, dengue and leptospirosis. Strategies for prevention and control of zoonoses and acute respiratory and diarrhoeal diseases were developed and mechanisms for implementation established.

5. WHO-SEARO supported the countries to respond to Pandemic (H1N1) 2009 through surveillance, risk communication, mobilization of antivirals, vaccines and other related logistics support. A Regional Consultation on a Public Health Research Agenda for Influenza was organized in August 2010.

6. A functional indicator-based surveillance system is in place in all Member States, with timely (at least weekly) reporting established for five or more priority epidemic-prone diseases (the diseases are defined by Member States, but typically include dengue, acute watery diarrhoea, leptospirosis, and Acute Respiratory Infection for all ages). Laboratory-based surveillance with a list of notifiable diseases has been established in Bangladesh, India, Sri Lanka and Thailand. Furthermore, India is developing a strategy for surveillance of epidemic-prone vaccine preventable diseases.

7. Monitoring of progress in implementation of IHR (2005) was undertaken. A regional review was conducted on the status of legal requirements for IHR. Eight Member States have completed the survey tool.
8. SEARO in collaboration with WPRO has drafted a new bi-regional Asia Pacific Strategy for Emerging Diseases (APSED 2010) for 2011-2015 to follow on from the previous APSED 2005. The scope of the new strategy has been expanded to reflect an all-hazards approach to preparedness, surveillance, risk assessment and outbreak response and the strategy was endorsed by the Technical Advisory Group in July 2010.

9. Satisfactory progress has been made in coordinating and supporting priority research on prevention and control of communicable diseases of public health importance. SEARO supported and facilitated tropical disease research, in developing generic protocols for research on the impact of climate change on human health and for strengthening of research capacity.

10. A mechanism for response operations in emergencies was established, and a regional stockpile is fully operational and managed efficiently.

**Equitable access to vaccines**

11. In 2009, according to WHO/UNICEF estimates Bangladesh, Bhutan, DPR Korea, Maldives, Myanmar, Sri Lanka and Thailand achieved ≥90% DTP3 coverage nationally. Indonesia and Nepal achieved ≥80% DTP3 coverage. Timor-Leste achieved ≥70% DTP3 coverage while India achieved ≥60% coverage. Bangladesh, Bhutan, Nepal and Sri Lanka have introduced *Haemophilus Influenzae* type B vaccine into their national EPI programmes. In addition, Bhutan introduced HPV vaccine.

**Figure 2: DTP3 coverage in SEAR countries**

![Figure 2: DTP3 coverage in SEAR countries](image)

Source: WHO/UNICEF Estimates
The Work of WHO in the South-East Asia Region

12. All countries in the Region have introduced the 2nd dose of measles vaccine in their national immunization programmes and all except India have reached 90% measles mortality reduction goal compared to 2000. The coverage with measles 1st dose increased from 61% in 2000 to 76% in 2009. In September 2010, India started measles catch-up campaigns to immunize 134 million children in 14 states.

13. The polio laboratory network consists of 16 accredited laboratories in the Region. Due to low circulation of polio virus, the laboratory network has expanded its services to include environmental surveillance and related research. Similarly, the measles laboratory network comprising 21 laboratories is now performing virus isolation and molecular detection to provide information on genotypes of measles and rubella virus in circulation. The polio and measles laboratory experience has been effectively used to strengthen the surveillance of Japanese encephalitis/acute encephalitic syndrome and for better understanding of the disease burden of rotavirus and invasive bacterial diseases (IBD) in the Region.

Cessation of oral poliomyelitis vaccination globally

14. With regards to polio eradication, after the interruption of wild poliovirus transmission in the Region, all countries will need to maintain acute flaccid paralysis (AFP) surveillance standards for at least three years to achieve global certification standards. All countries in the Region except India have demonstrated interruption of wild poliovirus transmission and submitted documentation that has been accepted by the Regional Commission for Certification of Polio Eradication (SEARCCPE). All countries in the Region are using oral poliovirus vaccine (OPV) in their routine immunization schedules and any supplementary immunization activities. Once polio eradication is achieved in the Region, the precise timelines for stopping OPV usage will be established. WHO provides regular support to all Member States for reviewing AFP surveillance indicators, evaluating polio eradication certification standards and conducting polio importation risk assessments. Specific support for India has included deployment of WHO staff from other countries in the Region for monitoring and evaluating immunization activities, mapping migrant populations and conducting outbreak investigations and response.

Neglected tropical diseases

15. All 11 Member States achieved elimination of leprosy as a public health problem at the national level. Seven countries have achieved elimination at subnational levels. Sustained technical assistance focusing
on national capacity building, funding and supply of drugs to the Member States were instrumental in these achievements. Eight of the nine countries achieved the desired target of treatment coverage of populations at risk of lymphatic filariasis. Sri Lanka and Maldives have reached a point of elimination of lymphatic filariasis and are preparing for verification. Soil transmitted helminthiasis, schistosomiasis, trachoma, kala-azar and yaws elimination activities are in progress. In regard to zoonotic diseases, five countries have established formal mechanisms of collaboration between public and animal health authorities at the national level.

Surveillance and monitoring of communicable diseases of public health importance

16. Seven countries have surveillance systems and conduct training for all communicable diseases of public health importance. All countries in the Region submitted the WHO/UNICEF joint reporting forms on immunization surveillance and monitoring in accordance with established timelines.

17. Laboratory support for disease surveillance and outbreak investigations for common endemic diseases (cholera, viral

Ending polio transmission in India

India is the only country in the South-East Asia Region with endemic transmission of wild poliovirus (WPV). Within India, polio transmission has remained endemic in focal areas of only two of the 35 states and union territories – Uttar Pradesh and Bihar. At the end of 2010, as a result of concerted efforts over the previous 12-24 months in India, the number of polio cases decreased by over 95% as compared to 2009. In 2010, there were only 42 wild polio cases detected – the lowest number since surveillance was initiated in 1997. Success and lessons learnt in building a highly sensitive surveillance network for polio has been expanded to include and strengthen surveillance for other vaccine preventable diseases and in monitoring routine immunization activities.

Strategies adopted to stop polio transmission in India represent a multi-pronged approach. Eradication challenges have been approached systematically with specific programmes: the 107 high-risk block initiative in historically polio endemic areas of western Uttar Pradesh and central Bihar has focused on rapid improvement in sanitation, availability of clean water, hygiene and prevention/control of diarrhoea; migrant populations that have played an important role in sustaining and spreading polio have been targeted for surveillance and immunization activities; and, the introduction of bivalent oral polio vaccine (bOPV) has provided an additional tool for epidemiological-based supplemental immunization activities. With continued, sustained effort in 2011, one can look forward to a polio-free India and Region.
hepatitis, malaria, dengue fever, Japanese encephalitis, etc.) is available in all the Member States. National laboratory networks that support these functions and are coordinated by a designated national public health laboratory are operational in SEAR. India and Thailand have several national laboratories/centres that provide disease-specific referral support to intermediate and peripheral laboratories.

18. Eight of the 11 Member States are participating in the Global Influenza Laboratories Network (FLUNET) through their respective national influenza centres. Seventy-one laboratories (from the health and veterinary sectors) from seven countries are participating in the Global Salmonella Surveillance Network. Sixteen enterovirus laboratories are members of the Global Poliomyelitis Laboratories Network while 15 measles laboratories comprise the measles network.


Knowledge and tools for prevention and control of communicable diseases

20. The first SEA Regional Conference on Epidemiology was organized in March 2010 by WHO-SEARO in collaboration with the Indian Association of Epidemiologists and the International Clinical Epidemiology Network (INCLEN) and many other partners. The conference called for a time-bound roadmap in Member States and for a periodic review of progress made in implementation of the Delhi Declaration on Epidemiology. Follow-up national level meetings were supported by WHO in almost all countries.

21. Regional research priorities were identified and research capacities strengthened through training and workshops on research methodology and management. Nine small grants research projects were supported by TDR in Bangladesh, India and Nepal. Various peer reviewed publications were also supported during the year.

Strengthening of core capacities required by IHR (2005)

22. Five countries have completed assessments and developed a national action plan to build core capacities for surveillance and response in line with their obligations under the International Health Regulations (2005). Six countries of the Region have national laboratory systems which are engaged in at least one external quality control programme for epidemic-prone communicable diseases.
23. Salient WHO contributions to these areas of work included capacity building for countries’ implementation of IHR and for response to Pandemic (H1N1) 2009 and other diseases. Outbreak response was also supported by WHO-SEARO at country level.

Detection, assessment and response to epidemics and other public health emergencies

24. Nine countries have national preparedness plans and standard operating procedures in place to enable them to be ready for and respond to major epidemic-prone diseases. However, from a regional perspective, no coordinated mechanisms are in place in SEAR for supplying vaccines for use in mass interventions against major epidemic-and pandemic-prone diseases, except for polio and measles. As of end – 2010, Indonesia is the only Member State to have global event-management systems in place in SEAR to support coordination of risk assessment, communications, field operations and monitoring.

25. During the Pandemic H1N1 (2009), WHO coordinated the deployment of vaccines to six Member States. Comprehensive guidelines for prevention and control of dengue and chikungunya were developed and training to support the implementation of the Asia-Pacific dengue control strategy was completed.

26. WHO also assisted Member States in strengthening capacity to detect, assess and respond to epidemics and other public health emergencies. Efforts were made to increase geographical coverage, particularly in hard-to-reach areas. Since the current capacities for detection, assessment and response are more towards communicable diseases, attention was also drawn to encompass the all-hazards approach, i.e chemical, nuclear and radiological, in line with the IHR (2005) requirements.

Effective operations and response to declared emergencies due to epidemic- and pandemic-prone diseases

27. Deployment and distribution of stockpile commodities including oseltamivir, personal protection equipment (PPE), specimen kits, reagents and team support equipment was successfully undertaken in areas of public health care concern and humanitarian assistance. The regional stockpiles in Bangkok and Delhi have efficiently and rapidly responded to urgent requests for a wide range of public health emergencies and needs of most of the countries in the Region.
Overview

1. HIV/AIDS, tuberculosis and malaria are priority diseases under the MDGs, and a major focus of both WHO technical support and donor activity. In the South-East Asia Region, more than 70% of the population lives in areas where malaria is transmitted. The Region also accounts for half a million deaths due to tuberculosis every year. Some 3.5 million people are living with HIV/AIDS. WHO-SEARO is providing technical support for the creation or improvement of national plans for prevention and care, better surveillance, attention to most vulnerable groups, and for appropriate training. Assistance is also being provided in the development of grant proposals to ensure further support in these critical areas.

2010 programme delivery highlights

HIV/AIDS

2. All countries of the Region have HIV/AIDS national strategic plans, four of which were updated in 2010 with WHO support. To assist countries further, training modules on planning for the health sector response to HIV/AIDS were developed and a regional-level training was conducted. A strategy to halt and reverse the HIV epidemic among people who inject drugs in Asia and the Pacific for 2010-2015 was developed, as well as guidelines on priority interventions required by the health sector to meet the HIV and sexual health needs of men who
have sex with men (MSM) and transgender people (TG) in the Asia Pacific Region.

3. Bhutan, DPR Korea, Nepal and Maldives developed Global Fund Round 10 proposals with assistance from WHO. The Regional Office mobilized financial resources to provide technical support to the Member States on Global Fund-related activities and conducted meetings to technically review country Global Fund proposals.

4. A review of the national harm reduction and oral opioid substitution therapy strategy in Myanmar was conducted and activities for the H-13 project (collaborative project with the United Nations Office on Drugs and Crime and AUSAID) on Prevention of Transmission of HIV Among Drug Users in SAARC countries were supported in Bhutan, Nepal, Bangladesh, Sri Lanka, Maldives and India. HIV databases and estimations were updated for eight countries. A 2010 Regional Progress Report was published, and a strategy document on HIV surveillance in low-prevalence countries was also developed. Training needs assessment was conducted in seven countries among district-level staff for surveillance and a two-week Field Epidemiology Training Programme curriculum was developed.

**Tuberculosis**

5. Countries in the Region have continued to make steady progress with tuberculosis (TB) control. The number of notified TB cases has been steadily increasing with more than 2 million TB patients initiated on treatment during 2009. Based on data from the national TB control programmes in Member States in 2009, nine countries in the Region have now achieved or surpassed the 85% treatment success target; the overall treatment success rate achieved in the Region as a whole was 88%. Major achievements during the year were establishment and scaling up of interventions for TB-HIV, multidrug resistant TB (MDR-TB) and further expansion of private and public partnerships for the provision of TB care. As a result of the on-going efforts, TB prevalence and mortality rates have declined by almost a third as compared to the baseline in 1990, while slower decline in incidence continues to be maintained.

6. All countries have national five-year TB strategic plans. All 11 Member States have the capacity for quality-assured smear-microscopy, and six countries for culture and first-line drug susceptibility testing. Ten countries have established programmatic interventions for TB-HIV and four are scaling up TB-HIV collaborative activities nationwide. Green
Light Committee approved projects for programmatic management of drug-resistant TB have been undertaken in nine countries. Seven of these countries are gradually expanding MDR-TB services to enrol an increasing number of patients with MDR-TB for treatment.

Figure 1: Estimated TB prevalence, incidence and mortality: SEA Region, 1990–2009

7. Three countries reported potential stock-outs of some first-line drugs in 2010, which were addressed through emergency procurements. A potential for stock-outs of streptomycin still exists in several countries due to a global shortage. The global shortage of quality assured kanamycin led to a fewer number of MDR-TB patients enrolled for treatment in 2010.

8. Although funding for operational research (OR) has been mobilized through the global fund (GF) for almost all countries in the Region, the capacity to undertake quality research is still lacking in many countries. Impact assessments were carried out in three countries and technical assistance for TB surveillance including drug resistant surveillance was provided to four countries. Monitoring missions or joint reviews were undertaken in three countries.

Malaria

9. Seven out of ten malaria-endemic countries have demonstrated a significant increase in coverage of key interventions such as Insecticide Treated Nets/Long Lasting Insecticidal Nets/Indoor Residual Spray. Three
countries in the Mekong Sub-Region namely, Thailand, Myanmar and Cambodia have border projects on malaria control, and two countries namely, India and Bhutan in South-East Asia strengthened border collaboration on malaria. On the Thai-Cambodia border, significant progress is being made in containment of artemisinin resistance. Myanmar’s Artemisinin Resistance Containment Framework was drafted and donors have already expressed strong indications to support it. Progress has been made in strengthening quality control of malaria microscopy in at least three countries. However, progress is slow in some other countries.

Figure 2: Availability of effective insecticide treated nets/long lasting insecticidal nets (ITNs/LLINs) among the population at risk (API>1) in the SEA Region, 2005-2009

Source: Country Reports, 2009

10. Significant advances have been made in strengthening surveillance, monitoring and evaluation at both regional and country levels. A regional protocol for malaria disease burden estimation was developed. In Myanmar, a computerized database was developed and implemented jointly by the WHO-Country Office and the national programme. External programme reviews were conducted in two countries. Two subregional networks were established for drug resistance monitoring. Advocacy for action on malaria was carried out, and a significant increase in funds for 10 malaria-endemic countries was observed. Progress was also made in capacity building, for example through regional training workshops and operational research. Technical and management support is being strengthened in all malaria endemic countries for effective and efficient implementation of Global Fund against AIDS, Tuberculosis and Malaria (GFATM) grants and the Three Diseases Fund.
Guidelines, policy, strategy and tools for treatment and care

11. Thailand is the only country in the Region to have achieved 80% coverage for antiretroviral therapy (ART) and the prevention of mother-to-child transmission. With the introduction of the new WHO guidelines recommending initiation of ART at an earlier stage, this achievement will be difficult to replicate in some other countries. Three high-burden Member States achieved the target of 70% of persons with sexually transmitted infections diagnosed, treated and counselled at primary point-of-care sites.

Figure 3: Number of people with advanced HIV infection receiving antiretroviral treatment, by country, 2003-2010

Source: 2010 universal access country reports, South-East Asia Region

12. Overall the Region continues to bear more than one third of the global burden of tuberculosis, an estimated pool of nearly five million cases to which more than three million are added each year. This is despite a more than 25% decrease in prevalence rates since 1990. Decrease in prevalence rates have been achieved due to a good case-notification and treatment success rate of more than 85% for the Region as a whole.

13. Significant progress is being made in achieving coverage of malaria control interventions. Thirty per cent of the population at risk of malaria in the Region has been covered under long lasting insecticidal nets and indoor residual spraying. Bhutan, Sri Lanka and Thailand have achieved significant success in this direction.
14. Important WHO-SEARO contributions to work in this area included support for the updating of HIV/AIDS national strategic plans, development of training modules, and development of a regional protocol for malaria disease burden estimation.

Support for prevention, treatment and care interventions

15. All countries in the Region have comprehensive policies and medium-term plans for responding to HIV, tuberculosis and malaria. All five of the Region’s HIV high-burden countries (India, Indonesia, Myanmar, Nepal and Thailand) are scaling up their comprehensive prevention packages among most-at-risk populations. Support was provided in the expansion of treatment and care including provider-initiated HIV testing and counselling in sexually transmitted infection and family planning services. Elimination of new HIV infections among children is being targeted. Thailand has achieved universal coverage for testing and counseling for all pregnant women and in 2010 94% of all HIV-positive pregnant women were receiving antiretroviral drugs for prevention of mother-to-child transmission of HIV. This has led to reduction in perinatal HIV transmission rates and averted more than 20,000 paediatric infections. TB-HIV activities are implemented country-wide in Thailand and are being expanded in India, Myanmar and Indonesia. WHO contributions included the provision of technical and management support, including financial management (particularly in Myanmar) in scaling up key interventions for malaria control, assisting countries with

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**Successful TB-HIV collaboration in Myanmar**

Myanmar has a high burden of HIV TB co-infection with an estimated 240,000 people living with HIV and a TB incidence of 171/100,000 people per year. To address the co-morbidity and co-infection, the Ministry of Health in collaboration with WHO set up a high level coordinating body with participation from PLHIV (people living with HIV) networks, NGOs, national TB and HIV control programmes, township health centres and district hospitals.

The unique features of the programme included strong collaboration between TB and HIV/AIDS programmes at all levels; rigorous follow-up and intensive monitoring; and civil society participation especially PLHIV networks.

This permitted the implementation of the full spectrum of WHO recommended TB-HIV collaborative activities in several townships in Myanmar.
preparation of Global Fund Round 10 proposals and providing technical and management support for implementation of grants.

**Equitable access to essential medicines, diagnostic tools and commodities**

16. All 11 Member States of the Region have implemented quality-assured HIV/AIDS screening of all donated blood. All targeted countries have received support to increase access to affordable essential medicines for tuberculosis with supply integrated into national pharmaceutical systems. Similar support was received by all endemic countries (Bangladesh, Bhutan, India, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste) to increase the access to Artemisinin based Combination Therapy (ACT) for falciparum malaria. Community health volunteers were empowered to help ensure delivery of malaria control services in hard-to-reach areas endemic to malaria.

**Strengthening surveillance, evaluation and monitoring**

17. Ten countries have provided WHO with annual programmatic data and information on the achievement of targets for inclusion in the annual global reports on control of HIV/AIDS, and malaria. All 11 countries have provided information for tuberculosis. India, Indonesia and Thailand provided drug resistance surveillance data to WHO for HIV/AIDS. Bangladesh initiated TB drug resistance surveillance in 2010; estimates on drug resistance surveillance were available from India, Indonesia, Myanmar, Nepal and Thailand. Eight countries report malaria drug resistance data. WHO-SEARO contributions to work in this area included supporting external programme reviews and conducting impact assessments and provision of technical assistance for TB surveillance. Guidelines on malaria surveillance were drafted and a protocol for malaria disease burden estimation was developed.

**Political commitment, mobilization of resources and partnerships**

18. All countries of the Region have functional coordination mechanisms in place for HIV/AIDS, TB and malaria control. The majority of these involve communities, persons affected by the diseases, civil society organizations
and the private sector in the planning, design, implementation and evaluation of HIV/AIDS, tuberculosis and malaria programmes. Such involvement is being further strengthened where required. Advocacy for action on malaria was conducted with a concurrent increase in resources for malaria-endemic countries.

**New knowledge, intervention tools and strategies**

19. WHO contributed to work in this area through development of Geographic Information System tools for HIV surveillance in India and Nepal, and five country-level software for ART monitoring (in India, Indonesia, Myanmar, Nepal and Thailand). Software for HIV drug resistance surveillance data was also developed by SEARO. Software for data management of TB are being developed in Bangladesh, India, Indonesia, Myanmar, Nepal and Thailand. A web-based query tool for data sharing and analysis has been developed for malaria. Research to confirm resistance to artemisinin is being supported in Myanmar.
Overview

1. Noncommunicable diseases (NCDs) are increasingly affecting low- and middle-income countries; it is now recognized that these are not just diseases of affluence, but affect all sectors of society. In South-East Asia, NCDs account for 55% of all deaths (Figure 1) and it is expected that the NCD mortality will increase by 21% over the next decade. Combating NCDs is an important and growing part of WHO’s work in the South-East Asia Region as well as globally.

Figure 1: Estimated percentage of deaths, by cause, SEA Region, 2008


2. Some countries are participating in the WHO-sponsored programme on reducing the large mental health gap, i.e., the gap between the number of people who need mental health services and those who are receiving them in the community.
The programme is intended to empower the existing health-care delivery system at the primary level to deliver essential mental health care, thus making it practical and sustainable.

3. There has been a significant increase in political, financial and technical commitment on the part of Member States to prevent and control injuries and violence. National plans are proving instrumental in reducing mortality and morbidity from injuries and violence. Member States are working to obtain injury and violence data through existing national surveillance and information systems, or piloting or establishing new systems. Reports were produced on the status of road safety and child injuries, including recommendations which were disseminated regionally. Disability affects 0.6% to 6% of persons in the Region. A rights-based approach to disability is being advocated in Member States.

2010 programme delivery highlights

4. Data was compiled to develop a regional NCD profile. Technical support was provided to select community-based NCD prevention projects and information on their outcomes was disseminated.

5. National NCD policies, strategies and programmes were reviewed and support was provided to either formulate or update them. NCD risk factor surveillance was undertaken in several Member States based on the WHO STEPS surveillance approach. The WHO Package of Essential NCD (PEN) interventions is being successfully implemented in selected Member States with WHO technical support.

6. The tobacco epidemic is deeply implicated in the rise of NCDs. Among various activities in this important area, SEARO has published tobacco cessation manuals designed for use by doctors, nurses and health workers and disseminated them to all Member States.

7. As regards tobacco cessation work, Bhutan, Myanmar and Nepal have completed national tobacco cessation workshops and India has started district tobacco control programmes in 42 districts of 21 states.

8. Member States are participating in the programme on reducing the large mental health gap (mhGAP), which exists in the community. This programme has been launched in Bhutan and Bangladesh. Other countries (Indonesia, Myanmar, Nepal, Thailand and Timor-Leste) are implementing
pilot projects to reduce the mhGAP. These programmes will empower the existing health care delivery system at the primary level to deliver essential mental health care, thus making it practical and sustainable.

9. In the area of road safety and child injuries, three reports/documents on the status of road safety, and child injuries, including recommendations, have been disseminated in all Member States in the Region. WHO has also supported the formation of a multisectoral committee for close cooperation in injury and violence prevention in Member States.

Advocacy and support for tackling noncommunicable diseases

10. Progress in implementing the Regional NCD Framework was reported to the Sixty-third Session of the Regional Committee in September 2010. An assessment of national capacity in this area was conducted in all Member States. This assessment showed that ministries of health of all 11 Member States of the Region report having a structure with dedicated staff and budget in place for the prevention and control of NCDs. A regional training programme on strengthening capacity of Member States in developing, implementing and evaluating national programmes for prevention and control of NCDs was conducted in Maldives.

Support for the development and implementation of policies, strategies and regulations for NCDs

11. Nine Member States have a national integrated NCD policy in place. A review of the status of NCD policies, strategies, plans and regulations was undertaken in all 11 Member States through a questionnaire and areas of concern were identified. Technical support was provided to Indonesia to update the national strategy on prevention and control of NCDs.

Improvements in capacity for NCD data collection and analysis

12. Indonesia and Thailand are systematically collecting data on major NCDs through national health reporting systems. Verbal autopsy is being used in India to make national estimates for major NCDs in selected geographical areas. The capacity of Member States to prevent and control NCDs was assessed; data was compiled to develop a regional NCD profile. Technical and financial support for conducting NCD STEPs surveys was
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provided to India, Maldives and Myanmar.

Compiling evidence on cost-effective NCD interventions

13. WHO has been assisting Member States in the Region to develop evidence-based guidelines for the identification and management of the most common and most disabling mental, neurological and behavioural disorders. The conditions being addressed include epilepsy, psychosis and depression. Ten Member States are participating in these programmes.

Multisectoral, population-wide programmes and capacity-building of health systems

14. Based on WHO models India, Sri Lanka and Thailand have community-based projects to reduce suicide. India, Sri Lanka and Thailand are implementing projects for the safe storage of pesticides for prevention of suicide. Pilot projects have shown a dramatic reduction in suicide through this approach. Bhutan also moved toward initiation of a project to reduce

Innovative financing in support of NCDs in Thailand

The Thai Health Promotion Foundation (ThaiHealth) was established in 2001 because of the need for more resources for tobacco control and other health promotion activities. It has grown to become the main funder of health promotion in Thailand, providing over 90% of the financing for tobacco and alcohol control interventions. ThaiHealth functions as an autonomous state agency outside the formal structure of the Thai Government.

ThaiHealth mandated that tobacco and alcohol companies pay an extra 2% of excise tax, so called “sin tax”, to fund tobacco and alcohol control and other health promotion activities. Through this innovative financing ThaiHealth established an awareness of and commitment to health promotion in Thai society. ThaiHealth acts as a catalyst as well as a change agent with the vision to provide “Sustainable Health for Thai Citizens”.

ThaiHealth is chaired by the Prime Minister with the Minister of Health as Deputy Chair and includes nine independent experts in various fields related to health promotion with representatives from nine ministries.

In summary, by using a 2% surcharge tax on tobacco and alcohol, ThaiHealth has produced major changes in tobacco, alcohol, road safety and other health-related policies. Thousands of lives and hundreds of millions of US dollars have been saved through ThaiHealth’s health promotion impacts.
suicides. As regards injuries, reports and evidence-based documents on road safety, profiles of child injury prevention and fact sheets on child injury have been disseminated widely.

Improving the ability of health and social systems to prevent and manage NCDs

15. India and Thailand are implementing projects on community-based rehabilitation of persons with intellectual impairments. Thailand has taken a leadership role in developing a model for such programmes which can be adapted in other countries. Sri Lanka has taken steps toward implementing such a project. WHO-sponsored programmes on reducing mental health gaps in the community have been officially launched in Bhutan and Bangladesh, and other countries (Indonesia, Myanmar, Nepal, Thailand and Timor-Leste) are implementing pilot projects. All countries except India, DPR Korea, Sri Lanka and Timor-Leste have completed the WHO Assessment Instrument for Mental Health System (AIMS). After completing the WHO AIMS, Member States have advanced to the next step, i.e. enhancing the mental health systems to deliver essential mental health care; nine Member States are participating through the existing primary health care system.

16. WHO-SEARO has conducted training for five Member States in public health approaches to hearing impairment. New guidelines on community-based rehabilitation have been released in the Region.

17. Bhutan, Maldives, and Sri Lanka have introduced PHC-based screening for cardiovascular disease (CVD) risk factors and management of NCDs using the WHO-promoted PEN approach and with WHO-SEARO technical support.

18. India and Thailand showed especially good progress in strengthening tobacco cessation. India has started district tobacco control programmes in 42 districts of 21 states. National tobacco cessation workshops were supported by WHO-SEARO in Bangladesh, Bhutan, Maldives, Myanmar, Nepal and Sri Lanka.
Overview

1. As witnessed at the United Nations Summit on the Millennium Development Goals in September 2010, the areas of health addressed by MDGs 4 and 5 are of particular concern because progress in improving the health of women, children and youth has not matched the successes achieved in meeting other health-related MDG targets. The cross-cutting and multisectoral nature of interventions make achieving MDGs 4 and 5 more complex despite efforts made by Member States. WHO has worked with Member States of the Region to develop national strategies and plans, standards, implementation guidelines, training packages and monitoring tools.

2. Commitment of governments and international agencies to achieve MDGs 4 and 5 was enhanced in 2010. In the South-East Asia Region (SEAR), WHO contributed to high-level advocacy at both regional and country levels in efforts to accelerate achievement of MDGs 4 and 5. Technical support was provided to Member States to develop and strengthen national strategies and plans for maternal, newborn, child, adolescent and reproductive health (MNCAH). WHO also supported countries to develop or adapt evidence-based guidelines and tools for scaling up programmes to improve MNCAH. Member States were supported to strengthen the health information related to newborn, child and adolescent health at national and sub-national levels. Assessment of the quality and coverage of newborn, child and adolescent health services was supported at different levels of the healthcare delivery system in selected countries. Programme review and management capacity has also improved.
2010 programme delivery highlights

3. The contraceptive prevalence rate (CPR) for the Region averaged 57.5%, with high rates reported from Thailand (81%) and DPR Korea, Sri Lanka and Indonesia (exceeding 60%). Antenatal care with at least one visit (ANC 1) for the Region reached only 75% with Sri Lanka, Thailand and Indonesia exceeding 90%. Skilled attendance for births, which is a potentially powerful intervention to reduce maternal and neonatal deaths, is disappointingly low in the Region at 49%. Acceleration to improve this is needed in Bangladesh (18%), Nepal and Timor-Leste (both at 19%).

4. National consultations to review policies and strategies for active healthy ageing were organized in India and Maldives.

5. SEARO and WHO country offices have worked together to support ministries of health and collaborate with partner agencies towards the reduction of morbidity and mortality and improvement in MNCAH and for active and healthy ageing among the population in the Region. Major contributions in this area include advocacy; capacity building; development and adaptation of standards, guidelines and training packages; and strengthening capacity for short programme reviews and effective management, including monitoring of MNCAH programmes. Member States were assisted to strengthen policies and strategies to scale up coverage of life-saving evidence-based MNCAH interventions while ensuring quality of implementation.

Figure 1: Contraceptive prevalence rate (CPR), antenatal care with at least one visit (ANC 1) and skilled attendance for births (SBA) in SEAR countries

Source: World Health Statistics, 2010
Scaling up towards universal access

6. Regional strategic frameworks for newborn and child health and for adolescent health are under development. Myanmar has developed a national 5-year child health strategic plan and a two-year implementation plan. Bangladesh has strengthened the maternal, newborn and child health component of its Health, Nutrition and Population Sector Plan (HN PSP) and Nepal has strengthened the child and adolescent health component of its National Health Sector Plan (NHSP-II). Financial barrier is one of the fundamental constraints in accessing maternal and reproductive health care by women in many Member States. However, Bangladesh and India have introduced demand-side financing (conditional cash transfer) to overcome this barrier. Short Programme Reviews (SPR) for child health have been supported at the national level in Bangladesh and Myanmar, and at the subnational level in India and Sri Lanka. SPRs for maternal/reproductive health have been supported in Bangladesh and Sri Lanka.

Strengthening national research capacity

7. WHO has actively provided technical support to research activities in countries, especially through the annual joint planning meeting and meeting of the Research Advisory Panel under RHR/HRP. Technical and financial assistance was provided by the Regional Office to all the four collaborating centres in India to study the current situation of infertility in India with the aim of developing guidelines on prevention and management of infertility. Technical assistance and financial support was also provided to four countries (India, Indonesia, Nepal and Myanmar) to conduct a study on maternal death reviews/audits carried out in these countries. SEARO collaborates in multicountry studies through design, execution and monitoring of the research activities. Pervasive social and economic disparities among various populations in the Region have been identified as contributing factors in lack of access to newborn and child care. Technical assistance was also provided to develop research proposals in Bangladesh and India on adolescent health. Work on strengthening regional and national networks for the neonatal-perinatal database at the WHO Collaborating Centre at the All India Institute of Medical Sciences, New Delhi was also initiated.

Improving maternal care at country level

8. All SEAR countries have national policies and programmes for maternal health and newborn health, as part of the overall MNCAH programme. Variable degrees of success have been recorded in reducing maternal
mortality ratio (MMR) and most countries are making progress in achieving MDG5. There are several socio-economic and cultural barriers to access of services, which require the intervention of several non-health sectors, underscoring the importance of a multisectoral approach, which has been advocated strongly throughout 2010. WHO-SEARO also advocated for more resources for maternal health, and for strengthening multisectoral approaches to address barriers to access.

9. Salient WHO-SEARO contributions in 2010 included organization of a consultation with countries to review the latest estimates of MMR and the models used for the estimation, and to plan for a better information system to improve quality of data. Technical support was provided to countries for the conduct of maternal death reviews/audits, and a multi-country study neared completion in five Member States. A dialogue with professional societies (obstetricians and midwives) was held in September 2010 to expand their role in use of guidelines in managing obstetric complications. Consensus was reached in September 2010 on the need for an accreditation mechanism for skilled birth attendants and the related standards and criteria, which is another measure needed for tracking MDG5. Technical assistance was provided to Bangladesh to conduct a mid-term review of the Menstrual Regulation (MR) project in December, the report of which will be used for further resource mobilization from external donors. A review of the reproductive health programme, of which maternal health is an integral component, was also conducted in Bhutan in November 2010.

**Improving neonatal survival and health at country level**

10. WHO has provided technical assistance for capacity building and skills development to improve neonatal survival and health, especially through Essential Newborn Care Course (ENCC) training. Capacity building through training, improved management and an effective monitoring system for newborn care services has been supported in selected countries.

**Improving child health and development, taking into consideration international and human-rights norms and standards**

11. SEARO has closely worked with WHO country offices to support strengthening of NCH strategy in the Member States in order to expand
coverage of and promote universal access to evidence-based interventions. Technical assistance was provided to develop, adapt or strengthen guidelines and tools for effective implementation and capacity building of health-care providers.

12. Referral care for newborns and children was strengthened in Bangladesh and India. WHO supported Member States to update the Integrated Management of Childhood Illness (IMCI) package based on recent technical guidelines, as well as to expand the geographic coverage of IMCI strategy. The report of the Regional Meeting on Early Childhood Development (ECD) was finalized, printed and disseminated. Support was provided for development of a proposal for adaptation and piloting of an ECD package to study feasibility and effectiveness in India, and assessment of hospitals for quality of care of sick children was supported in Bangladesh. Close collaboration with UNICEF and other partners has been very useful in this area.

Evidence-based policies and strategies on adolescent health

13. Member States were supported to develop or strengthen adolescent health strategies and plans for implementation of Adolescent and Sexual Reproductive Health. Development of national standards and implementation guidelines for adolescent-friendly health services was supported. Support to adapt capacity-building packages for the health-care providers was also provided. Assessment of quality and coverage of adolescent-friendly health services has been supported in selected countries in order to study impact. Data on adolescent pregnancy from Member States has been collated, and regional and country factsheets on HIV and Young People (HIV-YP) are being updated.

Strategy to attain reproductive health goals and targets

14. While all countries have plans to implement the Global Reproductive Health Strategy, accelerating implementation remains a challenge. In March 2010, a meeting was held to review the broad range of possible indicators to measure universal access to reproductive health. The scope of reproductive health within this strategy is broad, and not all countries have covered all aspects. Priority areas are family planning and preventing unsafe abortions; besides being indicators for MDG 5(B), these interventions also contribute to MDG 5(A) in reducing maternal deaths.
September 2010, a regional meeting conducted jointly with UNFPA was held to review the situation of cervical cancer control activities in countries especially in light of the introduction of the human papilloma virus vaccine in the market, to ensure that control strategies are holistic and in line with evidence-based practice.

**Preventing unsafe abortions in Bangladesh**

Unsafe abortions contribute to a relatively high proportion of maternal deaths in Bangladesh. The government has implemented a menstrual regulation programme since 1974 to provide safe and quality services for menstrual regulation. The access to these services is still not optimal for vulnerable and marginalized women such as in rural and remote areas, disaster-prone areas, sex workers; and opportunities have not been used to reach women in occupational settings such as workers in garment industries. In 2007 funding was provided by the Government of Netherlands to improve access and achieve equity for these women through a public-private partnership, through which local NGOs provide maternal reproductive (MR) services and encourage demand generation for MR. A mid-term review of the programme conducted in December 2010 shows that the public-private partnership may be an effective, efficient and culturally acceptable approach to increase the coverage of MR services.

**Ageing as a public health issue**

15. The regional strategic framework on active healthy ageing was developed. A national consultation on healthy ageing and the review of the national policy for older persons were organized in India. Technical assistance was provided to formulate a national strategy on active ageing in Maldives. Similar technical assistance has been proposed for Sri Lanka and Nepal.
Overview

1. The South-East Asia Region is particularly prone to natural disasters, usually of a hydro-meteorological and seismic nature. In fact during 2000-2009, the total number of people killed in natural disasters in the 11 Member States of the Region comprised 62% of the total deaths globally (Figure 1).

Figure 1: Total number of people killed in (natural) disasters from 2000–2009

Source: World Disasters Report 2010 International Federation of Red Cross and Red Crescent Societies, Geneva, Switzerland

2. As such, health action in emergencies was a vital area of WHO country support in 2010. Preparedness, risk reduction and capacity building strengthening activities were implemented
as planned. Various response operations were also launched during the year by country offices with support from SEARO in affected countries, including Indonesia (the Mt. Merapi eruption, Padang earthquake and Mentawai tsunami); Myanmar (Cyclone Giri); and recovery operations in Sri Lanka (post-conflict situation in the North East).

**2010 programme delivery highlights**

3. During 2010 a tool was prepared for assessing preparedness and response in countries, using the SEAR benchmarks developed in the previous biennium. The tool was applied in Nepal during 2010. Other activities included an advocacy campaign for safe hospitals using social media across all 11 Member States, and a Regional Meeting on Primary Health Care (PHC) in Emergencies through which a framework for applying the PHC approach in emergencies was developed. A methodology for vulnerability assessment for climate change–related emergencies was finalized and readied for piloting in 2011.

4. Stockpiles of essential emergency health supplies were established in Delhi and Bangkok. These contain emergency kits that can be deployed for response or prepositioning. The South-East Asia Regional Health Emergency Fund (SEARHEF) was made operational with budget allocations reserved from AC funds, and generic response workplans were developed. WHO staff who work as focal points for the emergency and humanitarian action programme and for ongoing operations are in place in all SEAR countries. Among them, fixed-term and support staff in key countries such as Bangladesh, Indonesia, Nepal, Sri Lanka and Thailand are also in place.

5. As part of ongoing efforts to build capacity, various training programmes were supported, including the Inter-Regional Public Health and Emergency Management for Asia and the Pacific (PHEMAP); Global Health Cluster Coordination Training; and WCO operational readiness workshops, in which over 70 people from various institutions participated. With regard to normative work, draft guidelines for essential public health needs in emergencies with primary care providers were completed. Collaborative work with the nursing unit to develop case studies of roles of nurses in emergencies was also supported.
Strengthening of national emergency preparedness

6. All countries have plans covering various types of hazards. Those that are classified as targets are in the process of (1) updating their existing ones, as with the case of Nepal, with its revised mass casualty management (MCM) plan, and Thailand, which is revising its system; or (2) finalizing their current drafts as their emergency health management systems are still being set-up as in the case of Bhutan.

7. The Regional Office has taken a holistic approach to health emergency management and has developed a set of metrics around the 12 benchmarks for emergency preparedness and response, which have been agreed upon by the Member States of the Region. The method applied depends more on self- or group assessment, as opposed to expert evaluation. This method is very useful in terms of developing future programming and intersectoral coordination. Currently, Nepal has applied the assessment tool.

8. Another key aspect is integrating preparedness and disaster risk reduction in health systems strengthening through the PHC approach. The regional meeting on PHC in Emergencies identified best practices and a framework on how to improve the application of primary health care in emergencies in all its phases—preparedness, response, and recovery. The PHC approach also brings the community itself closer to the work for preparedness and response, a practical approach for many countries in the Region where health systems and disaster management mechanisms have resource gaps.

9. In terms of capacity building with staff responsible for emergencies at national and sub-national levels the following courses were conducted (1) Inter-Regional Public Health and Emergency Management with Asian Disaster Preparedness Centre (ADPC) in August 2010; and (2) the Health Cluster Coordinator Training held in Jakarta, Indonesia in November 2010. A total of 40 participants from SEAR countries attended these courses.

10. On the issue of making health facilities safer so that they can function in emergencies, all 11 Member States are part of an advocacy campaign and have also committed to the Kathmandu Declaration on Protecting Health Facilities from Disasters. Regarding specific activities, three countries have a system in place and six have activities ongoing.
### South-East Asia Regional Health Emergency Fund (SEARHEF)

Cyclones, tsunamis, floods and earthquakes are common events which often leave hundreds of thousands of people devastated. Immediate assistance is always the need of the day and so financial, human and technical resources need to be available urgently. In many cases global and UN funding mechanisms take time to be consolidated. At the same time needs to respond are growing. The South-East Asia Regional Health Emergency Fund (SEARHEF) was created to fill this gap.

Aside from the regular budget which SEAR Member States provide as core funding*, the Royal Thai Government and the Government of Timor-Leste have also contributed to the Fund.

Since 2008, SEARHEF has been used to cater to immediate needs during emergencies such as Cyclone Nargis (Myanmar), Kosi River Floods (Nepal), Sri Lanka conflict and the Sumatra Earthquake (Indonesia). Recent examples of SEARHEF utilization include: Procurement of supplies for burn patients and the necessary antibiotics for the care of burn victims in a Dhaka fire which killed over 100 people in July 2010; Development of health staff and procurement of essential medicines and supplies during the eruption of Mt Merapi (Yogyakarta, Indonesia) in October 2010; Provision of basic health services for post-conflict populations in Sri Lanka.

Reference: South-East Asia Regional Health Emergency Fund – Making a Difference; World Health Organization, Regional Office for South East Asia, New Delhi, India, 2009

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Disasters associated with natural hazards and conflict-related crises

11. The operational platform for surge capacity in the Regional Office has been established with funding, human resources, logistics stockpile and capacity building components. Funding was provided through SEARHEF, which provides support within 24 hours of a request from a Member State, and seeks to cover immediate needs prior to the arrival of resources from larger funding mechanisms (eg CERF, Flash Appeal). Human resources are also available for surge capacity support. Two stockpiles of essential emergency/health kits are stored and managed in Bangkok and Delhi. Stocks are released as per need in acute emergencies or pre-positioning for monsoon floods. In the area of capacity building, WCO operational readiness workshops were conducted in Nepal and Sri Lanka to orient WCO staff and develop operational/contingency plans to be used during emergencies.

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* USD 1 million for Biennium 2012-2013 as per RC resolution: SEA/RC63/R1 Proposed Programme Budget 2012-2013
Needs assessment and planning during transition and recovery phases

12. Countries where sudden emergencies occurred have developed plans for contingencies and health response especially for regular hazards such as cyclones and floods. Recovery strategies and plans have been developed only for countries that have experienced major emergencies recently such as Indonesia and Sri Lanka. There remains considerable work for WHO on this issue to develop evidence-based tools related to planning for recovery and rehabilitation for the health sector post-disasters.

Communicable disease control in natural disasters and conflict situations

13. All emergencies to which WHO responds require the establishment of early warning surveillance and reporting systems for diseases with epidemic potential. In all emergencies this is refined depending on the hazard, locality affected or the season of occurrence. Mechanisms are in place to activate these systems in the aftermath of an emergency, and are usually integrated with the routine surveillance and reporting system.

National preparedness, alert and response mechanisms for food-safety and environmental health emergencies

14. A few countries have established plans on chemical, biological and radio-nuclear emergencies (CBRN) but need further work in improving them. Others are working on CBRN as well as environmental emergencies such as those related to climate change. For the Region, the focus of work is more on climate change–related risk reduction. As for the International Food Safety Authorities Network (INFOSAN), all SEAR countries are signatories to the network except Myanmar, where a designated focal point handles foods safety emergency issues.

Communications, partnerships and coordination

15. For the Region, in the area of disaster risk management, the focus is on strengthening the role of WHO as communications, partnerships and coordination lead of the health cluster. This is viewed in two aspects: (1) its role in the cluster approach and in the Inter-Agency Standing Committee (IASC) in countries and (2) providing technical assistance in emergencies to all partners. Countries with ongoing operations (eg, Indonesia, Nepal,
Sri Lanka) have the requirements of implementing the cluster approach within IASC standards as core to their work. For other countries, health cluster support materials were distributed to further advocate this working mechanism.

**Acute, ongoing and recovery operations**

16. WHO-SEARO through the Emergency and Humanitarian Action Unit functions as the secretariat to the South-East Asia Regional Health Emergency Fund which supported emergency operations in the following events by (see box):

- Procurement of essential medicines and supplies for care of burn victims in a Dhaka fire in July 2010.
- Ensuring mobility of health staff and procurement of essential medicines and supplies during the eruption of Mt Merapi (Yogyakarta, Indonesia) in October 2010.
- Continued provision of basic health services for post-conflict populations in Sri Lanka.

17. Technical and operational support was also provided to the following emergencies: (1) the Mentawai tsunami in Indonesia in October 2010 where WHO assisted with coordination and information management on site. (2) Continued support to Padang earthquake recovery (September 2009) (3) Cyclone Giri in Myanmar through provision of Inter-Agency Health Kits from SEAR stockpile as well as technical support to set-up early warning and surveillance and continued provision of basic health services.

18. Support was provided for the delivery of needed items, technical needs, coordination and monitoring and evaluation for the Republic of Korea funded project in DPR Korea for improvement of women’s and children’s health. The project is a multi-year programme comprising a holistic package of equipment and supplies provision for emergency rooms, delivery rooms and operating rooms in health facilities. It also has a strong focus on building capacities in technical and clinical skills of health staff.

19. These activities are funded by emergency funds, UN mechanisms (eg CERF, Flash Appeal) or direct donor contribution.

20. SEARHEF and the regional stockpiles in Delhi and Bangkok for emergency health supplies have greatly helped in the provision of speedy responses. In countries where the health cluster is operational, implementation of interventions is easier. Moreover, country capacity for emergency response dictates the role WHO plays in supporting health interventions.
Overview

1. Noncommunicable diseases are increasing in the Region. They can be prevented by eliminating risk factors such as tobacco use, unhealthy diet, lack of physical activity, and harmful use of alcohol. Tobacco use is one of the most important risk factors in the Region although its prevalence varies from country to country and from area to area within a country. In India, tobacco use among adults varied from 9% in Goa to 67% in Mizoram. The Region is home to about 250 million smokers and nearly the same number are users of smokeless tobacco.

2010 programme delivery highlights

2. The Regional Office co-ordinated collection and compilation of data from all Member States on risk factors for NCDs and disease outcomes. Member States were also supported in developing tobacco control legislation, action plans and guidelines on healthy diet and physical activity. Bhutan, DPR Korea, and Maldives have enacted comprehensive tobacco control legislation which has important tobacco control provisions aligned to the WHO Framework Convention on Tobacco Control. The Regional Office coordinated with all Member States in collecting data for the Global Tobacco Control Report and its validation. Development and publication of tobacco control profiles for four Member States were supported. To facilitate cessation, the Regional Office
The Work of WHO in the South-East Asia Region

developed a manual for doctors and dentists and for nurses and health workers. National tobacco cessation training workshops were supported in Bangladesh; Myanmar and Nepal. Member States were supported for development of IEC materials on tobacco control.

3. A regional workshop was conducted on the development of an evidence-based school health programme utilizing results from the Global School-based Health Survey (GSHS). Countries developed outlines of draft national school health promotion plans of action. A regional strategy on school health programme was developed based on recommendations from all countries. The GSHS includes risk factors such as tobacco, physical activities, mental health, and injuries. A Global School-based Health Survey was conducted in Maldives and a national school health policy was developed, based on the findings of the survey.

Health promotion and prevention of major risk factors

4. Member States were provided with technical support to establish effective multisectoral and multidisciplinary collaboration in health. India, Sri Lanka, and Thailand used a multisectoral approach to health promotion at sub-national and/or national levels.

National systems for surveillance of major risk factors

5. Bangladesh, Indonesia, Maldives and Thailand have a functioning national surveillance system for monitoring major risk factors to health among adults based on the WHO STEPwise approach to surveillance. Bangladesh was provided support to analyze, disseminate and make use of results of national NCD risk factor surveys. Bhutan is in the process of establishing the system. Support was provided to conduct the STEPwise survey in Maldives with an extended questionnaire on tobacco. Technical support was provided for India’s Global Adult Tobacco Survey Report and its dissemination. The Tobacco-free Initiative (TFI) unit coordinated with Bloomberg Philanthropies, Center for Disease Control (CDC) and CDC Foundation and mobilized resources for conducting the Global Adult Tobacco Survey in Indonesia. The Global Youth Tobacco Survey (GYTS) was conducted in all Member States at national level except in DPR Korea. To conduct repeat the Global Youth Tobacco Survey, Global School Personnel
Survey and Global Health Professional Survey in Bangladesh, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand, research coordinators were trained at a regional training workshop. To assist Member States, the Regional Office mobilized resources from CDC, Atlanta and provided technical assistance.

**Tobacco use**

6. Adult tobacco prevalence data was gathered through national representative surveys, such as the Global Adult Tobacco Survey (GATS) or STEPS. Myanmar and Nepal also have adult prevalence data at national level (STEPS). Bangladesh, India and Thailand have adult surveillance data at national level based on GATS. To support GATS in three countries, the Regional Office mobilized resources and provided technical assistance.

7. Youth tobacco prevalence data is available for 10 Member States. Cigarette smoking among students varied from 1.2% in Sri Lanka to 32.4% in Timor-Leste. Use of other tobacco products varied from 3.5% in Maldives to 24.1% in Timor-Leste.

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**Bhutan’s unique tobacco control efforts**

Bhutan is unique in its tobacco control efforts and is the only country that has banned the cultivation, production and sale of tobacco products. The people of Bhutan had lobbied to ban tobacco and this community movement led to several districts being declared tobacco-free.

While smoke-free areas were declared in 2005, legislative action was taken with the enactment of the Tobacco Control Act in 2010.

The Act bans:

- Cultivation, harvesting, manufacture, supply or distribution and sale of tobacco products in the country;
- Smoking in all public places including commercial centres, recreation centres, health facilities, educational institutions, public gatherings/spaces and in public transportation;
- All kinds of advertisement and promotion of tobacco products.
Alcohol, drugs and other psychoactive substances

8. Four Member States have developed, with WHO support, strategies, plans and programmes for combating or preventing public health problems caused by alcohol, drugs and other psychoactive substance use. Harm from alcohol use has been recognized by most Member States as a significant public health problem. Member States are concentrating on the strategies recommended by WHO after appropriate adaptations. The most commonly used strategies are: alcohol policy, community action to reduce harm from alcohol and control of home-brewed illicit liquor. Pilot projects are being implemented in Sri Lanka and Thailand and demonstrate a significant positive impact on reducing harm from alcohol use. Bhutan and Myanmar are currently implementing community-action programmes to reduce harm from alcohol use.

Unhealthy diets and physical inactivity

9. Seven Member States have adopted multisectoral strategies and plans for healthy diets or physical activity in the context of their national NCD strategies and programmes. Three other Member States were actively...
supported in 2010 to develop dedicated action plans and/or guidelines on healthy diet and physical activity. A set of 10 training modules for policy makers and programme managers was pilot tested and revised. These tools were made available for training at country level.

Consequences of unsafe sex

10. Indonesia and Thailand generated evidence on the determinants and/or consequences of unsafe sex during the reporting period. The Regional Office found that no systematic analysis of socio-cultural determinants of unsafe sexual behaviour and their impact on health in South-East Asia Region was available, except on issues related to HIV/AIDS in some countries. SEARO has planned to conduct a situation analysis on social and cultural determinants of unsafe sexual practices among selected population groups in the Region.
Overview

1. The Regional Office continued to address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender responsive and human rights-based approaches. Analysis of social and economic data relevant to health indicated that underlying reasons hindering achievement of MDG targets were the social determinants of health.

2. WHO provided technical and funding support to all countries of the Region to implement activities to address the social determinants of health with particular focus on raising awareness of the underlying causes, gender disparities and methodologies applying health and human rights-based approaches in programme planning and implementation. Three countries convened meetings to strengthen inter-sectoral collaboration necessary for addressing the social determinants of health.

2010 Programme delivery highlights

3. WHO-SEARO has been engaged with all the Member States to highlight and address the social determinants of health. One of the key achievements has been the implementation of the regional strategy to address social determinants of health in three of the Member States. The health sector in Maldives has made significant progress in working with other stakeholders to highlight social disparities in health and to advocate for a human rights-based approach to health.

4. Analysis of data and information on determinants of health such as gender has enabled identification of health inequalities such as the increase in gender-based violence that led to the commemoration of the “16-day activism” against gender-based
violence. A mid-term review of the implementation of the strategy for integrating gender analysis and action into the work of WHO highlighted the need to accelerate efforts for gender mainstreaming in WHO’s programmes at all levels.

**Social and economic determinants of health**

5. WHO provided technical support to Maldives, Sri Lanka and Thailand for the implementation of the regional strategy to address the social and economic determinants of health. In collaboration with WHO, Sri Lanka initiated the “Light-house project” where actions addressing social disparities in health were documented. Maldives produced the Report on Social Disparities in Health which was launched at a national forum with multisectoral partners. Thailand has strengthened intersectoral collaboration at national level to address social determinants of health through establishment of the Social Inequity Research Network to coordinate activities between a number of institutions in the health and non-health sectors. Five countries of the Region have incorporated disaggregated data and analysis of health equity in terms of gender, income, and geographical areas in published reports.

**Intersectoral collaboration to address social and economic determinants of health, including public health implications of trade and trade agreements**

6. The Regional Office continued to provide technical assistance to the Member States on issues related to intellectual property and trade. In particular, support was provided to India and Thailand for strengthening their capacity in intellectual property and trade and incorporating these in their Mid-Term Strategic Plan 2011-2015. Several tools to support country level work, including Intellectual Property Rights and Trade Issues in Public Health for Innovative, Multi-stakeholder Collaboration and Thailand’s International Trade and Health Programme: Action 2011-2015, were developed during the year.

**Collection, collation and analysis of social and economic data relevant to health**

7. Policy making requires information on both social determinants and health outcomes. Collection, collation and analysis of social and economic
data relevant to health have therefore been an ongoing process in the Member States. Monitoring social determinants also requires information from beyond the health sector as many of the determinants are within the purview of other sectors. WHO works with sectors other than health to improve country vital registration systems, gender analysis and in developing indicators to monitor human rights-based approaches to health. In establishing and implementing vital registration systems, countries of the Region have been supported by WHO to develop indicators that would link social determinants such as gender to health inequalities. SEARO along with Nepal participated in the meeting on ‘Policy dialogue for better evidence to improve women’s health through gender and health statistics’ (Washington, DC, October 2010). Tools for assessing rights-based access to health have been promoted in the Region and the baseline tools pertaining to neonatal health and human rights have been implemented in Indonesia. Developing health and human rights factsheets has enabled countries to assess their situation. Factsheets have been developed in Maldives and are being used to advocate for increased rights. In addition new tools including factsheets on toxic waste and on older persons’ health are being developed by WHO. Five countries of the Region have incorporated disaggregated data and analysis of health equity in terms of gender, income, and geographical areas in published reports.

Ethics- and rights-based approaches to health

8. Human rights is an overarching and cross-cutting principle that is relevant to all public health work. Good progress was made towards increasing knowledge and understanding of health and human rights in the Region. Rights-based approaches have been promoted through various advocacy and capacity building efforts made by SEARO, such as organization of training activities, providing orientation on health and human rights, and development and distribution of advocacy materials, and through giving technical support to countries. A website on Health and Human Rights was launched at the SEARO website in June 2010, and information on activities was regularly shared through this channel. Mental health and human rights issues were raised in an article that was co-written with the WHO HQ Mental Health unit, and the ILS Law College of Pune, India, and published in an external publication titled "Human Rights Education in the Asia-Pacific". At the country level, WHO Nepal promoted rights-based approaches to water and sanitation, and WHO Sri Lanka reported on health-related rights to the Committee on Economic, Social and Cultural Rights.
9. Gender equality is one of the key components for achievement of accessibility and equity in health. SEARO joined HQ and all Regions to conduct a mid-term review on the implementation of the “Strategy for integrating gender analysis and action into the work of WHO”. The review indicated little change in gender mainstreaming in WHO’s health programme at all levels.

10. In 2010, financial support was provided to all WHO Country Offices in the Region to organize gender mainstreaming activities.

11. SEARO conducted an analysis of India’s MDG data through the gender lens and submitted the results to the Ministry of Health and Family Welfare. In addition, the unit conducted a study on HIV and gender status of migrant worker families in Bangladesh and Nepal to generate more evidence on gender. All technical units are encouraged to use the gender lens to analyze their health programmes.

12. Factsheets on gender-based violence, covering nine Member States and one regional factsheet were developed as baseline data. All 11 Member States commemorated “16-day activism” against gender-based violence.

**Rights-based approaches for water and sanitation in Nepal**

On 28 July 2010 the United Nations General Assembly declared the right to safe and clean drinking water and sanitation as a human right that is essential for the full enjoyment of life and all human rights.

Rights-based approaches for improving the water and sanitation situation of marginalized communities were incorporated by WHO in Nepal through a regional conference on Appropriate Water Supply, Sanitation and Hygiene (WASH) solutions for the Informal Settlements and Marginalized Communities. The conference was organized in May 2010 by the Nepal Engineering College in collaboration with the Imperial College, London and Preston University, Pakistan.

Water and sanitation are underlying determinants of health that are necessary for the realization of the right to health. Right to sanitation and water means access to safe and sufficient sanitation and water, at an affordable cost without discrimination. A rights-based approach identifies the right-duty relationships behind the water and sanitation problem, and focuses on building the capacities of the duty-bearers (government, water and sanitation authorities) to fulfill their obligations and of the rights-holders (marginalized communities) to demand their rights.
Healthy environments and environmental threats to health

Overview

1. The South-East Asia Region continues to be vulnerable to environmental threats due to rapid urbanization and industrialization combined with high population growth. These threats have a direct impact on health such as cancers due to chemical pollutants, diarrhoeal diseases due to unsafe drinking water and sanitation which are aggravated by climate change. The Member States with support from WHO-SEARO have worked together to assess and address some of the priority environmental health risks in the Region. The issues are cross-sectoral and require the support of other sectors such as environment, water and sanitation, labour and agriculture. Work under this strategic objective is intended to strengthen the capacity of Member States to create healthier environments, provide support for the implementation of primary prevention activities and promote healthy public policies. Such work is meant to address the root causes of ill health resulting from unsafe drinking water, climate change, exposure to chemicals, poor sanitation and workplace hazards. Countries in the Region are on track to achieve the drinking water Millennium Development Goal and countries are being supported to improve water quality through the introduction of risk assessment and risk management of drinking water supplies, development of water quality monitoring guidelines and promotion of household water storage and treatment methods. The Region is lagging behind in its sanitation MDG.
2010 Programme delivery highlights

2. In 2010, countries were supported to strengthen coordination amongst the sectors through mechanisms such as the campaign on urbanization and health and enhancing strategies for delivery of occupational health services. Implementing a strategic approach to International Chemicals Management, a regional conference of Parliamentarians on Climate Change and Health, the Asia Pacific Ministerial Forum on Environment and Health and the regional high level meeting on health and environment were some other activities supported by WHO-SEARO.

3. During the first year of the biennium, all countries of the Region were engaged in the 1000 Cities 1000 Lives campaign on Urbanization and Health. Country-level assessments of occupational health were also conducted, which informed development of occupational health strategies to meet the Global Plan of Action on Workers’ Health. Advocacy was conducted with health and environment ministries on the health impact of climate change and for preparation of the 16th Conference of Parties to the United Nations Framework Convention on Climate Change (UNFCCC). Appropriate and sustainable sanitation technologies were also developed along with Water Quality Standards and Guidelines.

Assessment and normative work on major environmental hazards

4. Myanmar and Sri Lanka conducted assessments on environmental threats and Timor-Leste carried out water quality assessment to determine the safety of drinking water both in terms of chemical as well as microbiological safety. Drinking water quality standards and guidelines were also developed in Timor-Leste.

5. WHO-SEARO provided both technical and financial support in carrying out the assessments in the three countries. Following the water quality study in Timor-Leste, WHO-SEARO facilitated a national-level workshop to deliberate on the study findings and to discuss the draft framework for development of the water quality guidelines and standards. Subsequently, the guidelines were prepared by WHO-SEARO and are now in the process of endorsement by the government.
6. WHO-SEARO worked with the country offices to conduct an assessment of consumption of asbestos in the Region. This assessment showed that consumption of asbestos continues to increase in most countries. In particular the assessment showed that consumption of asbestos in Bhutan had increased significantly since 2006. Based on this information, Bhutan, with support from SEARO developed and submitted a funding proposal to the Quick start programme of the Strategic Approach to International Chemical Management (SAICM).

**Primary prevention interventions to reduce environmental hazards to health, enhance safety and promote public health**

7. Primary prevention interventions have been effectively implemented in all Member States of the Region. Good progress has been made with respect to increased awareness of risks and strategies to mitigate risks through the SAICM project implementation in Sri Lanka and Thailand. Additional funding received from SAICM has facilitated progress in the work in the Region in promoting chemical safety. In addition, in Nepal public health in urban settings has been enhanced through capacity building and networking and in Myanmar there has been good progress in applying healthy setting approaches. Some Member States have also implemented primary prevention interventions such as promotion of sanitation and ensuring water safety to prevent water-borne diseases. WHO mobilized about US$ 1 million from Ausaid to improve water quality through water safety plans in Bangladesh, Bhutan and Nepal. Myanmar, Thailand and Sri Lanka

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**Towards safe water supply in Timor-Leste**

Safe water is a pre-condition for health and development and a basic human right. From November 2009 until April 2010, a water quality study was conducted in four districts of Timor-Leste. The study was very useful in understanding the water quality situation in the country and in selecting the parameters that need regular monitoring.

From the findings of the study, it became evident that micro-biological agents were primarily responsible for contamination of drinking water, rather than chemicals.

Following the study, MoH and other relevant ministries including the Department of Infrastructure, with support from WHO, formulated water quality monitoring guidelines and national water quality standards. It is expected that these guidelines will be the first step towards ensuring availability of safe drinking water to the entire country.
completed the activities planned for the biennium and the remaining countries are in the process of implementation.

**National occupational and environmental health risk management systems, functions and services**

8. Nine Member States of the Region implemented national activities towards the achievement of the objectives of the Global Plan of Action (GPA) on Workers’ Health. These countries also reported on their activities at the regional consultation hosted by SEARO to update the Occupational Health Strategy in July 2010. A significant achievement was that the countries identified new strategies for implementing the GPA, the most important strategy being implementation of basic occupational health services that are integrated within health systems. SEARO had been working with the WHO Collaborating Centre for Research and Training in Occupational Health at Sri Ramachandra Medical College and Research Institute in Chennai to develop a basic occupational health service model. With WHO technical support, Sri Lanka and Thailand made significant progress in establishing basic occupational health services and setting up healthy workplace initiatives with the engagement of the community.

**Policies to improve health, the environment and safety**

9. Efforts in this area have focused on the incorporation of workers’ health into other policies in Member States. SEARO provided technical support to Bhutan to review its workers’ health-related legislation with the aim of developing standards and operational manuals for the management of health risks to workers.

10. SEARO provided technical support to Indonesia, Sri Lanka and Thailand to execute the funds provided by SAICM Quick Start Project (QSP) to implement multisectoral initiatives on chemical safety. SEARO also supported Sri Lanka to update their chemical profile developed earlier by the Ministry of Environment and assisted the Ministry of Public Health of Thailand to develop and implement a comprehensive multisectoral workplan to develop a priority list of chemicals and calculate the burden of disease associated with these chemicals.
Health-sector leadership for creating healthier environments

11. Health-sector leadership was enhanced through the engagement of Member States in World Health Day and through their participation in the 1000 Cities 1000 Lives campaign. Advocacy materials were produced on the links between urbanization and health and several countries initiated actions such as the renewed focus on the settings approach to health improvements in cities. SEARO supported two countries to update their National Environmental Health Action Plans (NEHAPs). WHO-SEARO also contributed to Healthy Workplaces: a model for action published by WHO. A situation report for Water Quality in South-East Asia Region was also published. Technical support was provided to the National Environment Health Action Plan Workshop, Regional Consultation on Health of the Urban Poor convened by SEARO and the High-Level Officials’ Meeting & Second Ministerial Regional Forum on Environment & Health in South-East and East Asia Countries. WHO-SEARO also contributed to the preparation of the Joint Monitoring Programme on Water Supply and Sanitation report which was published in 2010 by WHO and UNICEF. SEARO organized a high-level meeting for health and environment ministries in October 2010 to prepare for taking up the health concerns from climate change at the 16th Conference of Parties of the UNFCCC in Cancun, Mexico in Nov-Dec 2010.

Health problems resulting from climate change

12. WHO-SEARO organized a Regional Parliamentarians Conference on Protecting Human Health from Climate Change in October 2010 to advocate the impacts of climate change on health and to garner their support in taking up adaptation measures in countries. Retrospective studies to understand the health impacts of climate change are underway in four countries in the Region. All countries except DPR Korea are also in the process of developing and implementing national health plans to address the impacts of climate change and WHO is providing technical support in preparing these plans. Myanmar and Timor-Leste have national health action plans to enable the health sector to adapt to the health effects of climate change. WHO-SEARO mobilized about USD 600 000 from the Global Environment Facility for Bhutan to implement health adaptation measures. The project started in mid-2010 and ends in 2014.
Overview

1. Rising food prices, food insecurity, compromised food safety and under-nutrition amongst the vulnerable population persist as public health challenges for Member States in the Region. WHO continued to develop effective approaches and support interventions to address these challenges. Technical support was provided to Member States to develop and strengthen national strategies and plans in the areas of infant and young child feeding, growth monitoring, responding to food safety emergencies, establishing appropriate nutrition support at hospitals and development of dietary messages to ensure adequate health and prevent diseases. Close collaboration with partner organizations, WHO collaborating centres and academic institutions was maintained in the delivery of technical support and assistance.

2. Findings from the Global Nutrition Policy Review conducted in 2010 with the participation of most Member States of SEAR indicated that several Member States had four key areas to address: nutrition interventions to overcome undernutrition, obesity and chronic diseases, micronutrient deficiencies and to promote infant and young child nutrition (including the implementation of the International Code for the marketing of Breast-Milk Substitutes). (Figure 1).
3. Data from the World Health Statistics (2010) indicate that the rate for exclusive breastfeeding in infants up to the age of six months remains far from optimal. Figure 2 provides the status of exclusive breastfeeding in SEAR Member States. All Member States responding to the Global Nutrition Policy Review had indicated the national adoption of the 'Infant Code'. However inadequate enforcement of the infant code and aggressive marketing of breast-milk substitutes by the commercial sector among other factors, have given rise to this situation.
2010 Programme delivery highlights

4. SEARO and WHO country offices have worked together to support ministries of health and collaborate with partner agencies towards the improvement of nutrition, food security and food safety in the Region. Major contributions in this area include capacity building in updating food legislation and food inspection; promotion of healthy food markets and development of food safety communication materials; promoting infant and young child feeding in different circumstances; effective growth monitoring incorporating the WHO growth references and standards. Technical collaboration and communication with the Codex Trust Fund and the International Food Safety Authorities Network (INFOSAN) were enhanced along with increased participation of Member States in Codex Committee Asia and the Global INFOSAN meetings.

5. A regional consultation on hospital nutrition found that significant gaps to ensure optimal nutrition care and support to hospitalized patients existed in a large proportion of secondary and tertiary care hospitals in this Region. Dietary messages for promoting better nutrition and preventing chronic diseases following a life-course approach were identified at a regional workshop on food-based dietary guidelines organized in collaboration with other partner organizations and academic institutions. These dietary messages have broad regional implications and can be adopted or adapted in the Member States effectively. To assist Member States in addressing food safety emergencies, particularly foodborne disease outbreaks, the Regional Office organized a workshop with strong collaboration of partner organizations.

Partnerships and coordination for intersectoral actions, increased investment and research

6. Coordination mechanisms to promote intersectoral approaches and actions in the areas of nutrition, food safety and security now exist in five Member States while four Member States have included nutrition, food-safety and food-security activities and a mechanism for their financing in their sector-wide approaches. Nine Member States had participated in the global review of nutrition policies and plans of action and this information has been included in the regional nutrition strategy under development. WHO contributed to work in this area through strengthening of partnerships with WHO-WPRO, UNICEF, Codex Trust Fund, INFOSAN and FAO at regional meetings and workshops on food safety emergency preparedness, food fortification and food-based dietary guidelines.
Norms and standards for assessment and response to malnutrition, and zoonotic and non-zoonotic foodborne diseases

7. Production of guidelines and standards are now coordinated by WHO-HQ through the global Nutrition Guidance Advisory Group (NUGAG) with regular participation of several experts from the Region. WHO-SEARO has continued to provide technical information on policy statements, systematic reviews and revision of guidelines to Member States and respond to technical queries.

Monitoring, surveillance, assessment and evaluation of nutrition

8. An important achievement in this area has been the thorough dissemination of WHO new growth standards and references to Member States and their gradual incorporation into revised national growth charts. WHO’s new growth standards for children below five years of age have been adopted by 10 Member States of the Region although little progress has been achieved in the utilization of the new WHO growth references for school children and adolescents. All Member States have established nutrition monitoring and assessment systems though the range and scope of such systems vary. Seven Member States have nationally representative surveillance data on major forms of malnutrition. WHO provided technical support to strengthen the capacities of these systems.
Development, strengthening and implementation of nutrition plans, policies and programmes

9. During the reporting period, emphasis was placed on strengthening the national Iodine Deficiency Disorders (IDD) control and prevention programme and fortification of foods with iron and folic acid. Seven Member States of the Region have implemented at least three high-priority actions recommended in the Global Strategy for Infant and Young Child Feeding. All 11 Member States have national micronutrient deficiency control and prevention programmes. Six Member States have implemented strategies to promote healthy dietary practices for preventing diet-related chronic diseases. Five Member States have included nutrition in their responses to HIV/AIDS. In addition, national preparedness and response for early nutritional interventions in emergency situations have been developed by five Member States.

Surveillance, prevention and control of zoonotic and non-zoonotic foodborne diseases, food-hazard monitoring and evaluation

10. Four Member States established or strengthened intersectoral collaboration for the prevention, control and surveillance of foodborne zoonotic diseases. Three Member States initiated plans for the reduction in the incidence of at least one major foodborne zoonotic disease. Salient WHO contributions to work in this area included conducting a regional workshop on food safety emergency preparedness (including foodborne diseases surveillance). Additional work in zoonoses surveillance and disease outbreaks was also undertaken through the Veterinary Public Health Unit in the Regional Office.

International standard-setting and development of national food-control systems, with links to international emergency systems

11. Member States participated in the global INFOSAN meeting and the Codex Commission Asia workshop, both held in 2010. WHO contributions in this area included support to nine Member States to participate in international standard-setting activities related to food, such as those of the Codex Alimentarius Commission. Ten Member States have built national systems for food safety with international links to emergency systems. The regional database on national INFOSAN and Codex Committee focal points is routinely updated and shared with WHO headquarters.
Overview

1. In addition to addressing public health issues like control of communicable diseases and maternal and child health, Member States of the Region are strengthening health systems to meet the challenges posed by the evolving epidemiologic and demographic transitions. The widening inequities in health outcomes within and among countries, rising burden of noncommunicable diseases, increasing numbers of the elderly and the challenges imposed by climate change and disasters and emergencies need innovative approaches for delivery of effective health interventions and services.

2. While all countries have increased their budgets for health, allocations in most countries continue to remain below the recommended level of 5% of Gross Domestic Product (GDP). The situation is further compounded by the fact that within the already small allocations for the health ministries, the allocations for primary care are disproportionately low.

3. Evidence-based policy and strategy formulation is hampered due to the twin effects of lack of availability of robust evidence and information and weak professional public health capacity. The Region needs immediate attention to strengthening capacity for policy/strategy formulation and health planning. WHO-SEARO has initiated action to strengthen such capacity. Six countries were assisted in this using the Joint Assessment of National Health Strategies and Plans (JANS) tool.

4. While most countries have invested in producing doctors, nursing and midwifery personnel and paramedical workers there
is a gap in the availability of public health professionals. The paucity of this category of workers contributes to reducing the effectiveness and efficiency of public health interventions. Countries are being assisted to strengthen public health workforce.

5. As illustrated in Figure 1, the Region has the highest out-of-pocket expenditures on health among all WHO Regions. Member States were provided technical and policy support to raise additional funding for health, reduce financial barriers to access, improve social protection and efficiency as well as equity of resource use.

![Figure 1: Health financing depicting high out-of-pocket expenditure in 2009 in SEA Region](image)

Source: National Health Accounts – 2009

6. Timely availability of information and evidence is a basic requirement for sound policy formulation. In addition, countries need capacity not only to generate good quality data and evidence but also evaluate the information and evidence to inform policy and strategy. Member States need to continue to strengthen efforts towards building an effective health management information system.

**2010 programme delivery highlights**

7. WHO-SEARO continued to work with Member States to strengthen PHC-based health systems in 2010. Countries were assisted in assessing their national health policies and strategies to identify strengths and gaps. A major initiative was launched to further build and strengthen capacity
for national health planning. SEAR and national staff were trained in developing national health policies, strategies and plans. Advocacy and capacity building for revitalizing PHC was further strengthened. The South-East Asia PHC Innovations Network was established to provide a platform for information exchange, evidence generation and intensified advocacy for PHC-based health systems strengthening.

8. Countries were supported in resource mobilization for health systems strengthening (HSS) through GAVI and the Global Fund. SEARO initiated the development of a Rapid Health Assessment Tool to assist countries to identify gaps and needs that could be included in GAVI, Global Fund and other proposals to other funding agencies for HSS.

9. Valid and timely availability of health information is a basic need for sound health planning. Countries were supported to further strengthen the Health Management Information Systems through capacity building to strengthen the vital registration system and application of International Classification of Diseases (ICD). Support was provided to monitor progress towards the MDGs.

10. Member States were supported to further strengthen human resources for health. Special emphasis was accorded to strengthening the public health workforce. Networking for sharing of information and experiences to improve health personnel education and practice was promoted.

11. With the rapid introduction of sophisticated diagnostic and therapeutic technology, patient safety is increasingly becoming an area of concern. Tools and guidelines were provided to countries in order to strengthen patient safety efforts.

12. Health financing for universal coverage is an area that received renewed attention. A Health Financing Strategy: Asia Pacific Region 2010-2015 was developed. Key tools, norms and standards to guide policy development and implementation have been developed and disseminated. These focus on resource tracking and allocation, budgeting, financial management, economic consequences of disease and social exclusion, organization and efficiency of service delivery, including contracting, or the incidence of financial catastrophe and impoverishment.

Management and organization of integrated, population-based health-service delivery

13. Six countries of the Region regularly updated databases on numbers and distribution of health facilities and health interventions. Most countries,
participated in the e-health survey and contributed to the Global e-health survey report that was published in 2010. Systematic health systems strengthening supported by GAVI is ongoing in seven Member States. Responding to country needs, SEARO initiated the development of Rapid Health System Assessment. A field test was undertaken in Indonesia and the tool is under finalization. The tool is designed to rapidly identify gaps in the health system in order to prioritize areas of health systems strengthening support that can be included in proposals to funding organizations like GAVI, the Global Fund and others.

14. Advocacy for strengthening of health systems by revitalizing primary health care was continued. As a follow-up to the Regional Conference on Revitalizing Primary Health Care held in Jakarta, Indonesia in 2008 a Regional Consultation on Innovations in Primary Health Care was organized in Chiang Mai, Thailand, from 17-19 August 2010. This provided a forum to share country experiences and initiatives for revitalizing primary health care. The consultation led to the establishment of

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**Sri Lanka utilizes GAVI-HSS window to revitalize primary health care in post-conflict districts**

Sri Lanka was allocated a grant of USD 4.5 million from the GAVI health system strengthening (HSS) window to develop a competent primary health care workforce and effective infrastructure to strengthen maternal and child health (MCH) services in post-conflict districts. The project, spread over 2008-2012, aims to ensure basic primary health care infrastructure and staff with appropriate skill-mix to provide good quality MCH services. The project is under implementation in 10 post-conflict districts with high levels of poverty and adverse health indicators. One of the important features of the project is increasing the capacity of mid-level managers to supervise and monitor implementation.

Significant progress was recorded in health systems strengthening in the 10 districts by 2010. Health facilities in eight regional training centres were repaired and refurbished. Essential equipment was also supplied to these facilities and 135 in-service training programmes for primary health care workers of the Family Health Bureau conducted. Infrastructural improvements in 35 MCH clinics in the 10 under-served districts have been carried out. Three districts were supplied with four-wheel-drive vehicles to transport vaccines and commodities as well as staff for outreach activities.

Immunization coverage levels in the project districts have increased and are nearing the national average. Some districts have strengthened the emergency preparedness response systems. Others have developed community mental health services with social services support.

The sustained efforts of the Government of Sri Lanka in deploying GAVI-HSS funds will see a rapid recovery in the health system infrastructure in the post-conflict districts.
the South-East Asia PHC Innovations Network (SEA-PIN) that will provide a forum for information exchange, research in PHC and capacity building for revitalizing primary health care.

National capacity for governance and leadership

15. Bhutan, India and Thailand conducted comprehensive national health planning processes in consultation with stakeholders during 2010. Efforts to assist countries improve their planning processes were addressed, in part, through roll-out of an inception workshop of the Global Learning Programme (GLP) on national health policies, strategies and plans. The GLP is a global effort to respond to the country needs for strengthening national health policies, strategies and plans. SEAR staff participated in global trainings in May and June 2010. A regional task force was created to follow up the process in countries. A training workshop for the regional task force in Jaipur, India was followed by two inception workshops held in Kathmandu, Nepal, and Bali, Indonesia in which seven SEAR countries participated.

DPR Korea reaching out to remote populations with eHealth/Telemedicine

With a view to improving access and availability of specialist and diagnostic services to people in remote areas, the Ministry of Public Health, DPR Korea, with support from WHO-SEARO launched a telemedicine project to strengthen the health system by improving access and providing quality health care services especially in mountainous and rural areas.

The pilot telemedicine project was initiated in 2008, connecting the central Kim Man Yu hospital in Pyongyang with the North Pyongyang provincial hospital located in Sinuiju and the Mangyongdae district hospital. Following the initial success of the pilot project, the telemedicine network was scaled up to all the remaining eight provincial hospitals in 2009. By the end of 2009, Kim Man Yu hospital in Pyongyang was connected to all provincial general hospitals.

Early results of telemedicine services have been promising. A large number of consultations between provincial and central hospitals took place resulting in savings of referrals from the provinces to Kim Man Yu hospital. At the same time, expert/specialist advice could be made available to patients in remote areas. Further, continuing medical education sessions for health personnel in remote and far-flung areas (e-CME sessions) have become very popular and are contributing to strengthening technical capacity in the country. To date, a total of 441 tele-consultations and 164 tele-education sessions have taken place through this network.

Given the potential contributions of telemedicine facilities in improving access to essential and emergency health services and accelerating the achievement of MDGs 4 and 5, WHO-SEARO has agreed to support expansion of these services.
Coordination of mechanisms to achieve national targets for health system development and global health goals

16. In many countries donor agencies supporting the health sector need to be better coordinated. Bangladesh, Nepal and Timor-Leste have harmonized the inputs of major stakeholders with national policies, in compliance with the Paris Declaration on Aid Effectiveness. WHO country offices actively led the donor community and supported the government in strengthening the health system. Nepal is the only country in the Region that belongs to IHP+ (The International Health Partnership and Related Initiatives) category that was specifically committed to implement strong and comprehensive country and government-led national health plans in a well coordinated way. The 2010 report indicated an increase in the national budget for health in Nepal.

17. Technical support was provided to Bangladesh to further develop and strengthen community health clinics and to Nepal to strengthen the newly created PHC unit in the Ministry of Health and Population. Bhutan was supported to launch the Bachelor in Public Health Programme. This is an input to upgrade and professionalize the community-based health workforce (health assistants).

18. Planning for health of the urban poor requires a multisectoral approach to mount coordinated action. A Regional Consultation on Health of the Urban Poor was organized in Mumbai, India in October 2010. The consultation, inter-alia, concluded that effective implementation of the primary health care approach is necessary to address the health care needs of the urban poor.

19. A significant issue impacting the working of health systems is decentralization. Responding to this need a regional seminar on decentralization of health services was organized in Bandung, Indonesia in July 2010. This led to agreement on strategic approaches for decentralization of health care services within the context of health care reforms. The seminar recommended the development of need-based policies for decentralization, development of a framework to involve and regulate the private sector, to improve primary care services and strengthening of referral systems to ensure continuity of care and to develop and strengthen human resource development.
Country health-information systems

20. The Sixty-third session of the Regional Committee endorsed the Regional Strategy for Strengthening Health Information Systems (HIS) and urged Member States to further commit investment in HIS and institutional capacity for HIS and to accelerate implementation of plans on strengthening national HIS using the Regional Strategy. Bangladesh, Bhutan, Indonesia, Myanmar and Thailand realigned their HIS national strategies using the Health Metrics Network (HMN) assessment reports and/or regional HIS strategy. Maldives revised the Health Master Plan. In Sri Lanka, HIS was reformed to cater for evidence-based decision making. In Timor-Leste, input was provided for strengthening HIS while developing the National Health Strategy 2011-2030. SEARO supported Indonesia, Maldives and Myanmar for training on managing HIS. Indonesia focused on capacity building in several districts through database development, Demographic and Health Survey (DHS) data analysis and use of evidence to support managerial/clinical decision-making. DPR Korea implemented the pilot Integrated HIS.

21. India was supported to review and strengthen the use of ICD 10 and in development and dissemination of related advocacy materials and guidelines. Nepal has improved the quality of hospital information systems in selected hospitals through ICD 10 training of medical coders and data management training of statistical officers and medical coders. In Sri Lanka, a computerized hospital HIS has been piloted.

22. Seven countries have provided to SEARO the MDG reports produced in 2007 or later. These reports were analyzed and an interim regional perspective in achievement of MDGs was shared with WHO Executive Board members from SEAR.

23. In Maldives, assessment of the coverage and completeness of the Vital Registration System was undertaken, the causes of deaths validated and training on verbal autopsy conducted. As recommended by the Sixty-third session of the Regional Committee, resource mobilization initiatives were undertaken through the Health Metrics Network (HMN) along with partner agencies totalling nearly USD 1 million. Proposals from Bangladesh, India, Indonesia and Thailand as well as a joint proposal of SEARO and WPRO on formation of regional policies have been approved.
24. As regards eHealth, WHO provided technical inputs to the development of an eHealth strategy for Maldives aiming to improve the quality and affordability of health care with a focus on access for all. Noting the successful result shown by the Ministry of Public Health, DPR Korea, in the utilization of the telemedicine network supported by WHO in 2008/2009, a plan for further expansion has been initiated.

Knowledge and evidence for health decision-making

25. Work has been initiated on development of a Regional Health Observatory (RHO) in collaboration with WHO headquarters to further facilitate reporting and utilization of data consistently. The first stage of implementation has been completed that included extraction of regional data from the Global Health Observatory (GHO). Work has been initiated on development of the Asia Pacific Health Observatory on Health Systems and Policies (APO) together with WHO's Regional Office for the Western Pacific. Other key partners of the APO are the World Bank, Asian Development Bank and AusAID in addition to Member States in the two Regions. In addition to the APO on Health Systems and Policies, observatories on Health Care Financing and Human Resource for Health have been established.

26. In Nepal, HMIS is developing a complete master list of health facilities with global positioning system (GPS) coordinates, including public and private facilities. Health facility mapping in 27 districts was completed in 2009 and is regularly updated. Health facility mapping in another 30 districts is ongoing using a questionnaire based on the standard WHO service availability mapping which also provides basic information on the services offered and the service readiness of the facility. HMIS is now able to map services using Google Earth in these districts and link these to geographic and other characteristics.

National health research for development of health systems

27. Following World Health Assembly Resolution WHA63.21, the 31st South-East Asia Advisory Committee for Health Research (SEA-ACHR) held in Kathmandu, Nepal in July 2009, recommended that a regional strategy for research for health be developed. The Strategy on Health Research for South-East Asia Region is under finalization and will be presented to the 32nd session of the SEA-ACHR in October 2011.
28. Maldives, Bhutan and Timor-Leste were supported to strengthen health research. Experts visited these countries and their reports were discussed at a meeting convened in the Regional Office. Follow-up visits are planned to focus on assisting these countries to implement the recommendations, including possibilities for a twinning mechanism between the research units and other research organizations in neighbouring countries to be implemented through horizontal collaboration among countries.

29. The 31st SEA-ACHR also recommended the establishment of a Sub-Committee on Vaccine and Drugs Development, which was formed in May 2010 with membership from Bangladesh, India, Indonesia and Thailand. The progress made by the Sub-Committee will be reported to the upcoming SEA-ACHR.

30. Research ethics has become a priority area in the Region and Ethical Review Boards (ERB) are being established in Member States of the Region. However, ERBs in most countries need support for improving the quality of their reviews. Capacity strengthening of ERB members continues to be supported by many organizations such as the Forum for Ethical Review Committee for Asia and Western Pacific Regions, and the National Institute of Health USA in collaboration with national ERBs in India, Indonesia and Thailand. In 2008 SEARO signed an MOU with the Indian Council for Medical Research (ICMR) on research ethics, with the objective of strengthening collaboration between the two organizations in capacity building through training and workshops, and to make the ICMR’s technical expertise available in solving issues related to ethics in health research. A situation analysis of knowledge and capacity of WHO country office staff on ethics review of proposals involving human subjects was conducted in July 2010. Following the recommendations, WHO HQ in collaboration with SEARO conducted training on research ethics for WHO staff. The HQ guidelines to conduct ethics review were adapted and disseminated to WHO SEAR staff in the Region for further usage.

Knowledge management and eHealth policies and strategies

31. All Member States in the Region have some form of policy in knowledge management to bridge the “know-how” gap and digital divide, though differences in interpretation of “knowledge management” persist. Access to international health information was provided mainly through Health InterNetwork Access to Research Initiatives (HINARI), supplemented by the Document Delivery Service (DDS) of the Regional Office. Infrastructural
support, technology transfer and information access points have been provided in the form of e-Library establishments, training workshops, WHO Publication Distribution Service (PDS), Index Medicus for South-East Asia Region (IMSEAR) and the WHO Global Health Library. National institutional repositories have also been established in Member States to promote identification, management and dissemination of fugitive literature in digital format. As with knowledge management, each Member State has its own policy, strategies and regulatory frameworks for e-Health, though differences in interpretation of eHealth exist.

Health-workforce information and knowledge

32. During the reporting period, WHO conducted advocacy with countries to develop and update health workforce databases. Nine countries have a national policy and planning unit for human resources for health. To enhance nursing and midwifery contributions to the human resources for health (HRH) team, Member States were encouraged to develop nursing and midwifery workforce plans as an integral part of national health workforce plans. The regional guidelines on nursing and midwifery workforce plan were disseminated to all countries. Assistance was given to DPR Korea to prepare an evaluation report on the implementation of the three-year nursing and midwifery programme to be submitted to the Ministry of Health for policy decision and draft a five-year strategic plan for nursing and midwifery development. Special efforts were also made to promote networking for sharing of information and experiences to improve health personnel education and practice. WHO supported the fourth meeting of the Network of Medical Councils and national meetings of medical councils to strengthen regulation for improved medical education and practice. Support was also given to the SEAR Associations of Medical Education for organizing a regional meeting and publishing its journal.

Production, distribution, skill mix and retention of health workforce

33. WHO advocated for the development of comprehensive national HRH plans as an integral part of the national health plans, particularly in those countries facing HRH crisis. Six countries in the Region report that they have a multi-year human resources for health (HRH) plan in place. Five countries have investment plans for scaling up training and education of the health workforce. Tools and guidelines for HRH planning and evaluation of fellowships have been piloted in Bangladesh, Nepal and Sri Lanka. Technical support for this work was also provided.
34. WHO-SEARO made concerted efforts to address the problem of limited professional public health capacity in countries. Support was provided to Member States for implementation of recently developed Preventive and Social Medicine curriculum guidelines. Guidelines for improving public health teaching in undergraduate medical curriculum were developed. Efforts were also made to promote the deployment and retention of public health/community health nurses to enhance accessibility to health services and health of the community. A study visit on community nursing in Thailand was organized for Bhutanese and Maldivian nurses. Capacity building of primary health care providers in preventive and curative care in Bhutan was supported through factsheets, training and updating of knowledge. Special consideration is given towards the development of the community health nursing programme and service in Maldives. Special attention was paid to improving the quality of health professional education. Support was given for implementation of quality assurance in medical education. A training module and facilitators’ guide for teaching medical ethics were also developed and their use in the countries was promoted. Technical advice was also given to the Nursing Council and Nurses’ Association in Maldives to set standards of education and standards for opening new schools.

Health-system financing

35. Countries of the Region are adopting different models of health systems and they are at different levels in terms of equitable financing through a mix of government expenditure and social insurance. Many countries of the Region have very high proportions of health expenditures from out-of-pocket payments—the most regressive form of health financing, which is associated with high catastrophic spending on health as well as impoverishment. WHO-SEARO provided support and collaborated with Member States to address and reduce out-of-pocket expenditures. A Health Financing Strategy: Asia Pacific Region 2010-2015 was developed and a Regional Strategy for Universal Health Coverage for the SEA Region is being formulated. Nine Member States were provided with technical and policy support to raise additional funds for health; to reduce financial barriers to access, incidence of financial catastrophe, and impoverishment linked to health payments; or to improve social protection and the efficiency and equity of resource use. In Thailand policy briefs were prepared, disseminated and their use supported. These briefs document best practices on revenue-raising, pooling and purchasing, including contracting, provision of interventions and services, and handling of fragmentation in systems associated with vertical programmes and inflow of international funds.
Norms, standards and tools for tracking resources, estimating the economic consequences of illness, and the costs and effects of interventions, financial catastrophe, impoverishment, and social exclusion

36. Key tools, norms and standards to guide policy development and implementation have been developed and disseminated in eight countries according to expressed need that comprise resource tracking and allocation, budgeting, financial management, economic consequences of disease and social exclusion, organization and efficiency of service delivery, including contracting, or the incidence of financial catastrophe and impoverishment. Country capacity building to use these tools, norms and standards is very important and was included in 2010-2011 work plans. The Regional Office made efforts to provide Member States with technical support for using WHO tools to track and evaluate (a) the adequacy and use of funds, (b) to estimate future financial needs, (c) to manage and monitor available funds, and (d) to track the impact of financing policy on households. Six Member States were supported to conduct health systems assessment including health financing assessments.

Health-financing policy and interpretation

37. WHO presence and leadership in international, regional and national partnerships and use of evidence in order to increase financing for health is taking place in three countries of the Region. Nine Member States were provided support to build capacity in the formulation of health financing policies and strategies and the interpretation of financial data, or with key information on health expenditures, financing, efficiency and equity to guide the process. DPR Korea prepared a 2010-2015 mid-term strategic health plan and is developing an implementation plan. Capacity building seminar/workshops on Strategic Purchasing for Social Protection were held together with Chulalongkorn University the WHO Collaborating Centre in Health Economics. A regional consultation was held in August 2010 on National Health Planning to make recommendations for Member States and for WHO. Based on the recommendations, the Regional Office and country offices are moving forward to assist Member States in strengthening national health policies, strategies and planning capacity building at national and sub-national levels.
Norms, standards and tools to support Member States to quantify and decrease the level of unsafe health care provided

38. Hand hygiene improvement tools and guidelines, a surgical safety checklist and implementation guides were disseminated to all Member States in the Region. Technical support was provided for workshops/CME/awareness programmes for showcasing and presenting of the tools and guidelines in three countries, covering nine programmes. The patient safety curriculum guide was also presented at a regional medical council meeting. Five SEAR countries participated in the first two global patient safety challenges: hand hygiene improvement and implementation of the safe surgery checklist. In the Region, over 1000 health care facilities have registered for the “clean hands save lives” initiative. Tackling antibiotic resistance, the third patient safety challenge, an important cross-cutting area, is being covered by other programmes. World Organ Donation Day, (27 November) was supported in India. The Regional Office supported patient safety initiatives in three countries by providing technical resources to workshops/CME/awareness programmes in health care-associated infection (HCAI) prevention and control, safe surgery and other patient safety initiatives at national and sub-national levels. Patient Safety Research projects were funded by WHO Headquarters in two countries and the Patient Safety Curriculum pilot was supported in India and Nepal.
Overview

1. Medicines constitute one of the six building blocks of health systems and are a critical part of health systems. Access to medicines of assured quality is an essential part of making headway in reducing both communicable and noncommunicable diseases. Medicines are costly, constituting up to 40% of public sector health care budgets in some countries and in the SEA Region up to 80% of patients must pay for their medicines out-of-pocket. While medicines may cure and alleviate suffering, they will only do so if they are of an adequate quality and taken in the correct way. Unfortunately, poor availability and high prices of essential medicines, poor medicines quality and irrational use of medicines are common globally and also in the Region. Unfortunately, compliance with clinical guidelines in primary care is less than 30% in the public sector and even lower in the private sector in some countries of the Region. This situation results not only in lack of patient benefit but may also cause harm in terms of adverse drug reactions and events, antimicrobial resistance and sometimes in catastrophic out-of-pocket expenditure by patients. In order to achieve optimal use of good quality essential medicines, there must be an adequate infrastructure and policy framework within the health system to ensure adequate supply and distribution, regulation and usage.

2. WHO-SEARO is providing support to build infrastructure and capacity within Member State health systems to ensure adequate availability and use of good quality medicines. Such support covers many areas, including the development of an adequate policy framework, development or updating of national essential medicines lists (EMLs) and standard treatment guidelines (STGs), provision of technical support to improve drug supply and use
and building the capacity of regulatory authorities to regulate medicines and vaccine safety, quality and efficacy. The rational use of medicines is an important focus for public health in the Region as growing drug resistance in a number of areas threatens gains that have been made, for example in combating malaria, tuberculosis and HIV/AIDS.

3. Table 1 shows data from the WHO country pharmaceutical sector database on what national medicines policies are in place, based on a questionnaire filled in by ministries of health once every four years. It can be seen that many countries do not have basic policies to encourage rational use of medicines.

<table>
<thead>
<tr>
<th>Table 1: Medicines policies to encourage rational use of medicines globally and in the South-East Asia Region</th>
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<tr>
<td><strong>National Policies implemented</strong></td>
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<tr>
<td>Sample size of countries responding to questions in the policy questionnaire</td>
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<tr>
<td>Prescription audit in the last 2 years</td>
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<tr>
<td>National strategy to contain antimicrobial resistance</td>
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<tr>
<td>Antibiotic non-availability over-the-counter</td>
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<tr>
<td>Public education on antibiotics undertaken</td>
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<tr>
<td>Drug and Therapeutic Committees in &gt;half of general hospitals</td>
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<tr>
<td>National Drug Information Centre for prescribers</td>
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<tr>
<td>Obligatory Continuing Medical Education for doctors</td>
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<tr>
<td>Training for medical students on EML and STGs</td>
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<tr>
<td>National EML used in public sector procurement</td>
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<td>National EML updated in the last 2 years</td>
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<tr>
<td>National STGs updated in the last 2 years</td>
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*If a country did not respond to a particular question, it was assumed that the policy did not exist in that country.

4. Countries of the Region have a rich history of traditional medicine (TM) and WHO-SEARO is engaged in technical assistance to enhance their use. Work of the regional traditional medicine programme includes: (1) National policy development; (2) Ensuring safety, efficacy and quality of traditional medicines with an emphasis on herbal remedies; (3) Improving access to TM health care (4) Promoting appropriate use of TM; and (5) Human resource development.

2010 Programme delivery highlights

5. National medicines policies have been developed in six countries of the Region and national essential medicines lists have been updated in eight countries. Technical support on medicines procurement was provided to three countries and technical consultant visits for drug quality to two countries. Technical visits relating to the rational use of medicines were also made to two countries, and the assessment of regulatory capacity was undertaken in five countries. Nine countries were supported to attend the 14th International Conference of Drug Regulatory Authorities (Singapore, December 2010). A regional meeting on the rational use of medicines was organized, at which delegates from nine countries attended. One of the success stories of 2010 was the Better Medicines for Children (BMC) project in India in which Essential Medicines Lists for children (EMLc) have been prepared for two states, i.e., Chhattisgarh and Orissa.

6. The vaccine producing countries including India, Indonesia and Thailand have a functioning regulatory authority which allow these countries to apply for WHO pre-qualification of their vaccine for procurement through the United Nations procurement agencies. Parallel review with India and Canada for the market authorization of Meningococcal A vaccine and between Thailand and Australia NRA for the market authorization of Japanese Encephalitis vaccine was supported. Training workshops on Adverse Events Following Immunization were conducted in Bangladesh, Bhutan and India. An Expert Committee on AEFI causality assessment was established in Bangladesh to provide “hands-on” practice.

7. World Blood Donor Day was celebrated in all Member States on 14 June to enhance awareness about the importance and need of voluntary blood donations.

8. The key achievements in traditional medicine (TM) included the development of two monographs, provision of technical support for two workshops on strengthening health systems for TM, and information exchange
The Ministry of Health, Indonesia was assisted in translation and publication of Guidelines for the Use of Herbal Medicines in Family Health Care. This is the sixth edition, and was published in English for the first time. These remedies have been used for more than three generations in Indonesia and the recipes are used to treat common ailments. The ingredients are readily available and are well known in Indonesia as well as in several countries in the Region, thus laying a basis for exchange of information and intercountry cooperation.

This publication focusing on the use of medicinal plants in maintaining family health will be very useful in rural and isolated communities where accessing conventional health care services is difficult. Medicinal plants used for preparing the remedies were selected based on recipes from various Indonesian communities. They have evidence for safety and efficacy derived from pre-clinical studies.

Treatment of ailments is based on general symptoms such as fever, cough, stomach-ache, itching and wound. For each recipe, the ingredient(s), method of preparation, direction for use and precautions are provided where necessary.

In addition, treatment of ailments based on specific conditions are also given. They are toothache, headache, muscle pain, worm infestation, anaemia and loss of appetite. Furthermore, treatment and health care of the mother as well as geriatric health conditions are also covered.

Access, quality and use of essential medical products and technologies

9. Six countries received support to implement official national medicines policies; three received support to strengthen national drug procurement; and four received support for national policy and regulation of blood products. In two countries, Bangladesh and Sri Lanka, WHO provided technical assistance for the development of recommendations on how to strengthen drug supply and regulation. Consultant visits were arranged to DPR Korea to provide technical support on national TM policies between the 11 Member States of the Region. Information exchange was also facilitated through the Herbal Net website. Two officials from the Department of Medical Research, (Lower Myanmar), were trained with WHO support to study methodologies for determining efficacy and side effects of herbal products, clinical trials and drug development. A consultant from India was assigned to provide technical support in the research work in Myanmar.
to manufacturing units on good manufacturing practice (GMP) and to Bangladesh to strengthen the national Drug Testing Laboratory. This was part of a larger government plan to produce vaccines in Bangladesh for which the government launched an ambitious plan to build the National Regulatory Authority to meet WHO standards for vaccine quality. Five countries completed a baseline survey on health technologies. The First Global Forum on Medical Devices meeting in September 2010 hosted by Thailand was supported by WHO-SEARO.

10. Under the Global Better Medicines for Children (BMC) project, which is the outcome of World Health Assembly resolution WHA 60.20, the BMC India project started in February 2010. The Indian Academy of Paediatrics, the national professional association of paediatricians in India, working in close collaboration with WHO-SEARO has prepared the draft of a model EMLc, which takes into consideration the disease profile of children in India. Baseline surveys on availability and prices of selected essential medicines for children were done in Chhattisgarh and Orissa. They showed less than 17% were available in the public sector and only about 50% in the private sector. This prompted the stakeholders of the two States to prepare EMLc, based on the WHO model, with technical support from WHO-SEARO. To further consolidate the programme in these two states, training of pharmacists in drug supply chain management will be conducted. It is also planned to establish drugs and therapeutic committees in the district hospitals of these states and provide training to the members.

11. National formularies and pharmacopoeias were provided to assist in identification of safe and effective traditional therapies and herbal products. The National Institute of Traditional Medicine, Bhutan, was assisted in a study on public awareness, attitude and practice of Bhutanese people on their traditional medicines (Sowa-rigpa).

12. Formulation and implementation of national blood policy is one of the key elements of WHO’s Strategy for Safe Blood. Nine Member States have a National Blood Policy or Act in place. Thailand revised this policy to incorporate the advances made in transfusion sciences. To strengthen quality assured screening of blood for infectious markers in Bangladesh, Bhutan and Nepal, resources were mobilized from the Organization of the Petroleum Exporting Countries (OPEC) Fund for International Development for building national capacity during 2010-2013. Increase in the voluntary blood donations has been observed with the regional figure now at 71% of total blood donations.
International norms for quality, safety, efficacy and cost-effective use of medical products and technologies

13. Five countries have reported that the functionality of the national drug and vaccine regulatory authority had been assessed or supported by WHO. Activities related to supporting and advocating for the implementation of international norms and standards in the Member States have been undertaken. In addition, nine Member States were supported to send delegates to the 14th International Conference of Drug Regulatory Authorities held in Singapore in December 2010.

14. WHO Monographs on Selected Medicinal Plants and Standard of ASEAN Herbal Medicine were shared with Member States of the Region for improving the quality of traditional remedies.

Use of medical products and technologies by health workers and consumers

15. An inter-country meeting on the rational use of medicines was organized in July 2010 and was attended by nine Member States. A regional meeting on antimicrobial resistance and antibiotic use was also held (June 2010), along with an inter-state meeting in India on “Better Medicines for Children”. Visits were conducted to Bangladesh, Sri Lanka and two Indian states in order to provide technical assistance. Eight countries are using Essential Medicines Lists updated within the last five years.

16. The publications on Guidelines for the Use of Herbal Medicines in Family Health Care and Traditional Herbal Remedies for Primary Health Care provide guidance on rational, safe and appropriate use of herbal medicines. These publications can be used by health care providers and consumers. They aim to improve availability and accessibility to cost-effective treatment of commonly encountered health problems with herbal remedies.
Overview

1. The primary role of the World Health Organization is to provide leadership and to strengthen global health governance and foster partnership and collaboration with countries, the United Nations system and other stakeholders in order to fulfil its mandate of advancing the global health agenda as set out in the Eleventh General Programme of Work. The work the Organization focussed on in 2010 stemmed from the Medium Term Strategic Plan which has guided the Organization in development of operational plans from 2008 onwards. Its achievements in relation to leadership and direction, WHO country presence and cooperation, global health partnerships and developing health knowledge and advocacy material for Member States are detailed below.

2010 programme delivery highlights

2. During the first year of the biennium, SEARO contributed to global health governance, the future of financing, WHO reform work and other corporate initiatives, while enhancing focus on country work and aligning its actions with national and regional priorities identified in the WHO Country Cooperation Strategies (CCS) and regional consultation reports. Mechanisms were also established within countries to lead the national heath development agendas through fostering effective partnerships. Work was also initiated to update CCS documents in various countries and to organize a regional partnership forum.
Leadership and direction

3. The Regional Office’s contribution to effective leadership and direction of the Organization was exercised through enhancement of governance, and improved coherence, accountability and synergy. WHO’s leadership and management role at regional and country levels was strengthened, while ensuring the Regional Office’s participation in policy dialogue at global level. This has allowed the Regional Office and country offices to effectively engage with and implement policy directions and guidance from governing bodies and to synchronize regional and country strategies with the global agenda. Meetings of the regional governing bodies, including the Regional Committee, and the Sub-committee on Policy and Programme Development and Management were organized to discuss programme budget and other technical issues. These ensured the effective participation of Member States from the Region in the meetings of the regional and global governing bodies that provide policy guidance and legitimacy to the work of the Organization while working as the Secretariat, to report on the implementation of those policies as part of its accountability. Work in 2010 also involved strengthening of communication, media relations and advocacy between the Organization and its Member States as well as with other development partners through capacity strengthening and utilization of appropriate technology.

WHO country presence and cooperation

4. The Regional Office is in the process of strengthening mechanisms for designing and implementing Country Cooperation Strategies (CCS) aligned with prioritized country health challenges while focussing on harmonization and alignment with national development plans and contributions from other development partners. CCSs of seven countries are due to be renewed in 2011. Efforts have been initiated to assist the respective WHO country offices to develop their new CCSs in 2011 with strategic agendas well tuned to address the priority health challenges of respective countries while also focusing on WHO’s core competencies. Based on the country needs, the managerial and technical capacity of WHO’s country offices for development and management of WHO collaborative programmes at country level is being strengthened. WHO country teams in United Nations Development Assistance Framework (UNDAF) roll-out countries have in some cases assumed leadership roles with the UNDAF. Leadership of the health cluster within the UN reform context has also been exercised. Capacity building of seven WHO country offices (WCOs) in “Harmonization and Alignment” as part of the Global Learning Programme to enhance the ability of WHO country teams to engage and harmonize their work with
other United Nations agencies and other relevant development partners has also been undertaken.

**Global health partnerships**

5. The year under review witnessed continued and strengthened collaboration with health development stakeholders including UN system organizations, intergovernmental organizations, regional groups and donor agencies at country and regional levels. All WCOs assumed increasing responsibilities in leading/proactive engagement in national health development agendas which have been further strengthened through the Global Learning Programme (GLP) initiated by WHO HQ and being rolled out in the Region. SEARO does not host any partnerships but works proactively with several global partnerships including GFATM, GAVI, IHP+, Stop TB Partnership, Partnership for Maternal, Neonatal and Child Health and Roll Back Malaria. WCOs have been involved in facilitating informed decision-making by Member States on issues pertinent to the UN and other global/regional initiatives, which have been supplemented by periodic organization of high-level meetings, including meetings of the Health Ministers and Parliamentarians from Member States of the Region to discuss concerted actions to address health and health-related issues of common interest to Member States and provide recommendations for interventions by the Regional Office and country offices. WHO has strengthened its engagement in regional coordination mechanisms and initiatives, such as the United Nations Development Group for Asia and the Pacific, and the Economic and Social Commission for Asia and the Pacific, establishing a liaison position to the latter, and continued its engagement with regional groups including Association of Southeast Asian Nations (ASEAN) and South Asian Association for Regional Cooperation (SAARC). Support was also provided to WCOs to strengthen coordination and collaboration with development partners and donors to mobilize voluntary contributions for the implementation of WHO workplans.

**Health knowledge and advocacy materials**

6. SEARO further improved the quality of regional and country level documents and publications in 2010. Distribution of WHO publications was expanded through free distribution and sales to ministries of health and other government institutions, academia, policy-makers, other health sector stakeholders, and the general public. Support was provided to upgrade and update health and medical knowledge in the Region through management support and by providing equipment, books and publications, including e-library to Member States and other health stakeholders.
Overview

1. The area of Administration and Finance underwent a major change in the beginning of 2010 when the new Enterprise Resource Planning system, the Global Management System (GSM), was rolled out in SEAR simultaneously with two other Regions of WHO. A major challenge in the administrative and enabling areas in 2010 was the realignment of business procedures to the methodology defined by the new software. While significant progress was made in 2010, this work is still in progress. Once all the new procedures are firmly in place in the Region, substantial efficiencies are expected across the Organization, with streamlined processes and transparent reporting.

2. A restructuring exercise associated with the GSM roll-out took place in the Department of Administration and Finance, and internal controls are being streamlined across the Region. The introduction of International Public Sector Accounting Standards (IPSAS) in January 2010 also played an important role in the strengthening of controls, transparency and accountability in the Organization.

2010 programme delivery highlights

3. SEAR successfully rolled out GSM during the year for use by the Regional Office and all 11 country offices. The information and communications technology infrastructure was also strengthened across the Region and information security was
enhanced. Associated with the GSM roll-out, internal audits of support programme areas were carried out with a view to restructuring the Department of Administration and Finance.

4. Direct support was provided to several country offices during the year to resolve outstanding administrative issues through exchange of experiences and horizontal collaboration. Various internal review missions were also conducted with a view to streamlining internal controls and assessing programme delivery as well as accountability.

5. As regards staff development, the Regional Staff Development and Learning (SDL) Committee led the development and launching of a comprehensive SDL strategy.

6. Regarding building maintenance, a number of energy-saving measures were undertaken in the World Health House resulting in substantial cost savings for water and electricity.

**Strategic and operational planning, monitoring and evaluation**

7. The Regional Office contributed to the development of Programme Budget 2012-13 and all SEAR workplans were subjected to a peer review by way of improving their technical quality and ensuring coherence. Special efforts were made to ensure that workplans were informed by national health development priorities as expressed in CCS documents. Very good compliance was also recorded during the year in the monitoring of workplans and expected results with all country offices submitting end-of-year monitoring reports.

**Financial management**

8. International Public Sector Accounting Standards (IPSAS) were introduced in early 2010 and work was undertaken during the year to make all SEAR processes IPSAS-compliant. SEARO’s flexible voluntary contributions of USD 41.7 million were fully utilized in biennium 2008-09. At the end of 2010, SEARO had recorded USD 35 million of flexible voluntary contributions, of which USD 17.1 million has been utilized. It is expected that full utilization of the target resources of USD 46 million will be utilized by the end of biennium.
9. During 2010, eImprest, a new country office accounting tool, was implemented in all SEAR country offices. Though some technical issues persist, the eImprest system will enable the Region to monitor all CO expenditures much more efficiently, accurately and on time as expenditures are recorded in the GSM the day after they are recorded in eImprest. This is a great enhancement from the last biennium, when expenditures were uploaded to the financial database two to three months after taking place.

**Human resource management**

10. With the introduction of GSM in January 2010, the Personnel Unit organized regional and country-level training and workshops on all aspects of HR processes and procedures. In addition, Personnel conducted refresher courses both at the inter-regional level with WPRO and at country level.

11. Revised recruitment and selection guidelines, for both professional and general service staff, were developed and implemented in 2010, in close consultation with the Staff Association. In addition, draft guidelines were prepared for the recruitment and selection of national professional officers (NPOs), which will be implemented in 2011.

12. In 2010, 72% of the professional vacancies were filled using the defined competitive selection process and/or reassignments. Selection of female candidates continued to be strongly encouraged in order to achieve the target of parity in gender distribution among professional staff as set by World Health Assembly resolution WHA 56.17.

13. In an effort to reduce costs, the selection process was conducted through e-testing for written tests and through video-conferencing facilities for interviews for all vacant professional positions.

**Information systems**

14. The primary focus of the information technology staff in 2010 was supporting the smooth implementation and transition to the GSM. As indicated earlier, the conversion to this system involved extensive technology and communication upgrades as well as end-user support. With the successful roll-out of GSM, all SEAR offices are now using consistent, real-time management information.
15. Several projects commenced in 2010 to incorporate SEAR information technology (IT) systems management into the global WHO IT initiatives. The result of these initiatives will be to increase communications capability throughout WHO and to reduce ongoing IT support costs through the synergies gained with implementing standard global practices.

16. Based on a review of the information technology-related functions required by SEAR, and the staffing and initiatives planned for 2010-11 and subsequent years, a reprofiling of the Information Technology unit commenced in 2010. That exercise will close in mid-2011, with a newly structured Information and Communications Technology (ICT) unit and updated workplans.

**Administrative support services**

17. In keeping with the increasing risk of climate change on human health, an assessment of environmental impact of the SEARO building operations was undertaken in 2009. Efforts were made to contribute towards reducing energy consumption, improving video-conferencing facilities and encouraging staff to make greater use of video/tele-conferencing.

18. Specific measures to reduce energy consumption included replacing the old air conditioning system with an energy efficient plant along with environmentally safe equipment, installing a photovoltaic (solar panel) system on the roof of the Regional Office building to generate and supply power to the building, installing a solar water heating system for supplying hot water, installing motion sensors in corridors to shut down lighting when corridors not in use, and insulating both the main and annex building roofs.

19. These measures resulted in a decrease of 20.53% in electricity usage during 2010 compared to the same period for 2009, with a corresponding saving of USD 47200 on electricity billing. For 2011 the goal is to achieve an additional 3%-5% energy savings by efficiently controlling the operations of this new equipment.

**Working environment, staff well-being and safety**

20. Some improvements to the Regional Office premises and other infrastructure were recorded in 2010 in efforts to enhance overall quality of services.
21. During the year, renovation of the existing car park in the premises was completed. Such improvement added 40 additional spaces which avoided staff parking on the adjacent streets. Furthermore, boom barriers were installed in the service road in front of the premises adding an extra layer of security for access to the compound.

22. A survey for detecting asbestos was conducted in selected areas of the Regional Office, with no significant findings. Given the geographical location of the WHO compound, a vulnerability survey to ascertain the structural integrity of the Regional Office in the event of a significant seismic activity was conducted. The salient points of the report highlight that both the main and annex buildings require significant strengthening to meet local building codes to withstand an earthquake and the effect of monsoons on the subsoil. Remedial works are substantial and costly. SEARO management is reviewing the results of the report to determine what actions and funding will be necessary to begin any repair or rebuilding projects.

23. As regards staff safety, all SEAR offices have a country office evacuation plan in place and evacuation exercises are expected to be conducted every six months in line with Minimum Operating Safety Standards (MOSS). Fire drills were also conducted at all offices during the year. SEARO has introduced the new UN security programmes throughout the Region under the revised UN Security Management System (SMS).
List of strategic objectives and Organization-wide expected results

Strategic objective 1
To reduce the health, social and economic burden of communicable diseases

1.1 Policy and technical support provided to Member States in order to maximize equitable access of all people to vaccines of assured quality, including new immunization products and technologies, and to integrate other essential child health interventions with immunization.

1.2 Effective coordination and support provided in order to achieve certification of poliomyelitis eradication, and destruction, or appropriate containment, of polioviruses, leading to a simultaneous cessation of oral poliomyelitis vaccination globally.

1.3 Effective coordination and support provided to Member States in order to provide access for all populations to interventions for the prevention, control, elimination and eradication of neglected tropical diseases, including zoonotic diseases.

1.4 Policy and technical support provided to Member States in order to enhance their capacity to carry out surveillance and monitoring of all communicable diseases of public health importance.

1.5 New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases developed and validated, with scientists from developing countries increasingly taking the lead in this research.

1.6 Support provided to Member States in order to achieve the minimum core capacities required by the International Health Regulations (2005) for the establishment and strengthening of alert and response systems for use in epidemics and other public health emergencies of international concern.

1.7 Member States and the international community equipped to detect, assess, respond to and cope with major epidemic and pandemic-prone diseases (e.g. influenza, meningitis, yellow fever, haemorrhagic fevers, plague and smallpox) through the development and implementation of tools, methodologies, practices, networks and partnerships for prevention, detection, preparedness and intervention.

1.8 Regional and global capacity coordinated and made rapidly available to Member States for detection, verification, risk assessment and response to epidemics and other public health emergencies of international concern.

1.9 Effective operations and response by Member States and the international community to declared emergencies situations due to epidemic and pandemic prone diseases.

Strategic objective 2
To combat HIV/AIDS, tuberculosis and malaria

2.1 Guidelines, policy, strategy and other tools developed for prevention of, and treatment and care for patients with, HIV/AIDS, tuberculosis and malaria, including innovative approaches
for increasing coverage of the interventions among poor people, and hard-to-reach and vulnerable populations.

2.2 Policy and technical support provided to countries towards expanded gender sensitive delivery of prevention, treatment and care interventions for HIV/AIDS, tuberculosis and malaria, including integrated training and service delivery; wider service-provider networks; and strengthened laboratory capacities and better linkages with other health services, such as those for sexual and reproductive health, maternal, newborn and child health, sexually transmitted infections, nutrition, drug dependence treatment services, respiratory care, neglected diseases and environmental health.

2.3 Global guidance and technical support provided on policies and programmes in order to promote equitable access to essential medicines, diagnostic tools and health technologies of assured quality for the prevention and treatment of HIV/AIDS, tuberculosis and malaria, and their rational use by prescribers and consumers, and, in order to ensure uninterrupted supplies of diagnostics, safe blood and blood products, injections and other essential health technologies and commodities.

2.4 Global, regional and national systems for surveillance, evaluation and monitoring strengthened and expanded to keep track of progress towards targets and allocation of resources for HIV/AIDS, tuberculosis and malaria control and to determine the impact of control efforts and the evolution of drug resistance.

2.5 Political commitment sustained and mobilization of resources ensured through advocacy and nurturing of partnerships on HIV/AIDS, tuberculosis and malaria at country, regional and global levels; support provided to countries as appropriate to develop or strengthen and implement mechanisms for resource mobilization and utilization and increase the absorption capacity of available resources; and engagement of communities and affected persons increased to maximize the reach and performance of HIV/AIDS, tuberculosis and malaria control programmes.

2.6 New knowledge, intervention tools and strategies developed and validated to meet priority needs for the prevention and control of HIV/AIDS, tuberculosis and malaria, with scientists from developing countries increasingly taking the lead in this research.

Strategic objective 3

To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment

3.1 Advocacy and support provided to increase political, financial and technical commitment in Member States in order to tackle chronic noncommunicable diseases, mental and behavioural disorders, violence, injuries and disabilities together with visual impairment, including blindness.

3.2 Guidance and support provided to Member States for the development and implementation of policies, strategies and regulations in respect of chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities together with visual impairment, including blindness.

3.3 Improvements made in Member States’ capacity to collect, analyse, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities together with visual impairment, including blindness.

3.4 Improved evidence compiled by WHO on the cost-effectiveness of interventions to tackle chronic noncommunicable diseases, mental and neurological and substance-use disorders, violence, injuries and disabilities together with visual impairment, including blindness.
3.5 Guidance and support provided to Member States for the preparation and implementation of multisectoral, population-wide programmes to promote mental health, and to prevent mental and behavioural disorders, violence and injuries, together with hearing and visual impairment, including blindness.

3.6 Guidance and support provided to Member States to improve the ability of their health and social systems to prevent and manage chronic noncommunicable diseases, mental and behavioural disorders, violence, injuries and disabilities together with visual impairment, including blindness.

Strategic objective 4

To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals

4.1 Support provided to Member States to formulate a comprehensive policy, plan and strategy for scaling up towards universal access to effective interventions in collaboration with other programmes, paying attention to reducing gender inequality and health inequities, providing a continuum of care throughout the life course, integrating service delivery across different levels of the health system and strengthening coordination with civil society and the private sector.

4.2 National research capacity strengthened as necessary and new evidence, products, technologies, interventions and delivery approaches of global and/or national relevance available to improve maternal, newborn, child and adolescent health, to promote active and healthy ageing, and to improve sexual and reproductive health.

4.3 Guidelines, approaches and tools for improving maternal care applied at the country level, including technical support provided to Member States for intensified action to ensure skilled care for every pregnant woman and every newborn, through childbirth and the postpartum and postnatal periods, particularly for poor and disadvantaged populations, with progress monitored.

4.4 Guidelines, approaches and tools for improving neonatal survival and health applied at country level, with technical support provided to Member States for intensified action towards universal coverage, effective interventions and monitoring of progress.

4.5 Guidelines, approaches and tools for improving child health and development applied at the country level, with technical support provided to Member States for intensified action towards universal coverage of the population with effective interventions and for monitoring progress, taking into consideration international and human-rights norms and standards, notably those stipulated in the Convention on the Rights of the Child.

4.6 Technical support provided to Member States for the implementation of evidence-based policies and strategies on adolescent health and development, and for the scaling up of a package of prevention, treatment and care interventions in accordance with established standards.

4.7 Guidelines, approaches and tools made available, with provision of technical support to Member States for accelerated action towards implementing the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health, with particular emphasis on ensuring equitable access to good-quality sexual and reproductive health services, particularly in areas of unmet need, and with respect for human rights as they relate to sexual and reproductive health.

4.8 Guidelines, approaches, tools, and technical assistance provided to Member States for increased advocacy for consideration of ageing as a public health issue, for the development and implementation of policies and programmes aiming at maintaining maximum functional
capacity throughout the life course and for the training of health-care providers in approaches that ensure healthy ageing.

**Strategic objective 5**

**To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact**

5.1 Norms and standards developed, capacity built and technical support provided to Member States for the development and strengthening of national emergency preparedness plans and programmes.

5.2 Norms and standards developed and capacity built to enable Member States to provide timely response to disasters associated with natural hazards and conflict-related crises.

5.3 Norms and standards developed and capacity built to enable Member States to assess needs and for planning interventions during the transition and recovery phases of conflicts and disasters.

5.4 Coordinated technical support provided to Member States for communicable disease control in natural disaster and conflict situations.

5.5 Support provided to Member States for strengthening national preparedness and for establishing alert and response mechanisms for food-safety and environmental health emergencies.

5.6 Effective communications issued, partnerships formed and coordination developed with other organizations in the United Nations system, governments, local and international nongovernmental organizations, academic institutions and professional associations at the country, regional and global levels.

5.7 Acute, ongoing and recovery operations implemented in a timely and effective manner.

**Strategic objective 6**

**To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex**

6.1 Advice and support provided to Member States to build their capacity for health promotion across all relevant programmes, and to establish effective multisectoral and multidisciplinary collaborations for promoting health and preventing or reducing major risk factors.

6.2 Guidance and support provided in order to strengthen national systems for surveillance of major risk factors through development and validation of frameworks, tools and operating procedures and their dissemination to Member States where a high or increasing burden of death and disability is attributable to these risk factors.

6.3 Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease and death associated with tobacco use, enabling them to strengthen institutions in order to tackle or prevent the public health problems concerned; support also provided to the Conference of the Parties to the WHO Framework Convention on Tobacco Control for implementation of the provisions of the Convention and development and implementation of protocols and guidelines.

6.4 Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease or death associated with alcohol, drugs and other psychoactive substance use, enabling them to strengthen institutions in order to combat or prevent the public health problems concerned.
6.5 Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed and technical support provided to Member States with a high or increasing burden of disease or death associated with unhealthy diets and physical inactivity, enabling them to strengthen institutions in order to combat or prevent the public health problems concerned.

6.6 Evidence-based and ethical policies, strategies, interventions, recommendations, standards and guidelines developed and technical support provided to Member States to promote safer sex and strengthen institutions in order to tackle and manage the social and individual consequences of unsafe sex.

### Strategic objective 7

**To address the underlying social and economic determinants of health through policies and programmes that enhances health equity and integrates pro-poor, gender responsive, and human rights-based approaches**

7.1 Significance of social and economic determinants of health recognized throughout the Organization and incorporated into normative work and technical collaboration with Member States and other partners.

7.2 Initiative taken by WHO in providing opportunities and means for intersectoral collaboration at national and international levels to address social and economic determinants of health, including understanding and acting upon the public health implications of trade and trade agreements, and to encourage poverty-reduction and sustainable development.

7.3 Social and economic data relevant to health collected, collated and analysed on a disaggregated basis (by sex, age, ethnicity, income, and health conditions, such as disease or disability).

7.4 Ethics- and human rights-based approaches to health promoted within WHO and at national and global levels.

7.5 Gender analysis and responsive actions incorporated into WHO’s normative work and support provided to Member States for formulation of gender responsive policies and programmes.

### Strategic objective 8

**To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health**

8.1 Evidence-based assessments made, and norms and standards formulated and updated on major environmental hazards to health (e.g., poor air quality, chemical substances, electromagnetic fields, radon, poor-quality drinking-water and waste-water reuse).

8.2 Technical support and guidance provided to Member States for the implementation of primary prevention interventions that reduce environmental hazards to health, enhance safety and promote public health, including in specific settings (e.g. workplaces, homes or urban settings) and among vulnerable population groups (e.g. children).
8.3 Technical assistance and support provided to Member States for strengthening national occupational and environmental health risk management systems, functions and services.

8.4 Guidance, tools and initiatives created in order to support the health sector in influencing policies in other sectors to allow policies that improve health, the environment and safety to be identified and adopted.

8.5 Health-sector leadership enhanced for creating a healthier environment and changing policies in all sectors so as to tackle the root causes of environmental threats to health, through means such as responding to emerging and reemerging consequences of development on environmental health and altered patterns of consumption and production and to the damaging effect of evolving technologies.

8.6 Evidence-based policies, strategies and recommendations developed, and technical support provided to Member States for identifying, preventing and tackling public health problems resulting from climate change.

**Strategic objective 9**

**To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development**

9.1 Partnerships and alliances formed, leadership built and coordination and networking developed with all stakeholders at country, regional and global levels, in order to promote advocacy and communication, stimulate intersectoral actions, increase investment in nutrition, food-safety and food-security interventions, and develop and support a research agenda.

9.2 Norms, including references, requirements, research priorities, guidelines, training manuals and standards, produced and disseminated to Member States in order to increase their capacity to assess and respond to all forms of malnutrition, and zoonotic and non-zoonotic foodborne diseases, and to promote healthy dietary practices.

9.3 Monitoring and surveillance of needs and assessment and evaluation of responses in the area of nutrition and diet-related chronic diseases strengthened, and ability to identify best policy options improved, in stable and emergency situations.

9.4 Capacity built and support provided to target Member States for the development, strengthening and implementation of nutrition plans, policies and programmes aimed at improving nutrition throughout the life-course, in stable and emergency situations.

9.5 Systems for surveillance, prevention and control of zoonotic and non-zoonotic foodborne diseases strengthened; food-hazard monitoring and evaluation programmes established and integrated into existing national surveillance systems, and results disseminated to all key players.

9.6 Capacity built and support provided to Member States, including their participation in international standard-setting in order to increase their ability to assess risk in the areas of zoonotic and non-zoonotic foodborne diseases and food safety, and to develop and implement national food control systems, with links to international emergency systems.

**Strategic objective 10**

**To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research**

10.1 Management and organization of integrated, population-based health-service delivery through public and non public providers and networks improved, reflecting the primary health care strategy, scaling up coverage, equity, quality and safety of personal and population-based health services, and enhancing health outcomes.
10.2 National capacities for governance and leadership improved through evidence-based policy dialogue, institutional capacity building for policy analysis and development, strategy-based health system performance assessment, greater transparency and accountability for performance, and more effective intersectoral collaboration.

10.3 Coordination of the various mechanisms (including donor assistance) that provide support to Member States in their efforts to achieve national targets for health system development and global health goals improved.

10.4 Country health-information systems that provide and use high-quality and timely information for health planning and for monitoring progress towards national and major international goals strengthened.

10.5 Better knowledge and evidence for health decision making assured through consolidation and publication of existing evidence, facilitation of knowledge generation in priority areas, and global leadership in health research policy and coordination, including with regard to ethical conduct.

10.6 National health research for development of health systems strengthened in the context of regional and international research and engagement of civil society.

10.7 Knowledge management and eHealth policies and strategies developed and implemented in order to strengthen health systems.

10.8 Health workforce information and knowledge base strengthened, and country capacities for policy analysis, planning, implementation, information sharing and research built up.

10.9 Technical support provided to Member States, with a focus on those facing severe health-workforce difficulties in order to improve the production, distribution, skill mix and retention of the health workforce.

10.10 Evidence-based policy and technical support provided to Member States in order to improve health-system financing in terms of the availability of funds, social and financial-risk protection, equity, access to services and efficiency of resource use.

10.11 Norms, standards and measurement tools developed for tracking resources, estimating the economic consequences of illness, and the costs and effects of interventions, financial catastrophe, impoverishment, and social exclusion, and their use supported and monitored.

10.12 Steps taken to advocate additional funds for health where necessary; to build capacity in framing of health-financing policy and interpretation and use of financial information; and to stimulate the generation and translation of knowledge to support policy development.

10.13 Evidence-based norms, standards and measurement tools developed to support Member States to quantify and decrease the level of unsafe health care provided.

Strategic objective 11

To ensure improved access, quality and use of medical products and technologies

11.1 Formulation and monitoring of comprehensive national policies on access, quality and use of essential medical products and technologies advocated and supported.

11.2 International norms, standards and guidelines for the quality, safety, efficacy and cost-effective use of medical products and technologies developed and their national and/or regional implementation advocated and supported.

11.3 Evidence-based policy guidance on promoting scientifically sound and cost-effective use of medical products and technologies by health workers and consumers developed and supported within the Secretariat and regional and national programmes.
Strategic objective 12

To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work

12.1 Effective leadership and direction of the Organization exercised through enhancement of governance, and the coherence, accountability and synergy of WHO’s work.

12.2 Effective WHO country presence established to implement WHO country cooperation strategies that are aligned with Member States’ health and development agendas, and harmonized with the United Nations country team and other development partners.

12.3 Global health and development mechanisms established to provide more sustained and predictable technical and financial resources for health on the basis of a common health agenda which responds to the health needs and priorities of Member States.

12.4 Essential multilingual health knowledge and advocacy material made accessible to Member States, health partners and other stakeholders through the effective exchange and sharing of knowledge.

Strategic objective 13

To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively

13.1 Work of the Organization guided by strategic and operational plans that build on lessons learnt, reflect country needs, are elaborated across the Organization, and used to monitor performance and evaluate results.

13.2 Sound financial practices and efficient management of financial resources achieved through continuous monitoring and mobilization of resources to ensure the alignment of resources with the programme budgets.

13.3 Human resource policies and practices in place to attract and retain top talent, promote learning and professional development, manage performance, and foster ethical behaviour.

13.4 Management strategies, policies and practices in place for information systems, that ensure reliable, secure and cost-effective solutions while meeting the changing needs of the Organization.

13.5 Managerial and administrative support services necessary for the efficient functioning of the Organization provided in accordance with service-level agreements that emphasize quality and responsiveness.

13.6 Working environment conducive to the well-being and safety of staff in all locations.
### ANNEX 2

**Budget implementation by strategic objective (as on 31 December 2010)**

<table>
<thead>
<tr>
<th>Strategic Objective</th>
<th>Budget</th>
<th>Approved budget</th>
<th>Funds available</th>
<th>Utilization (Expenditure plus Encumbrances)</th>
<th>Utilization (% of approved budget)</th>
<th>Utilization (% of funds available)</th>
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</thead>
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<td>VC</td>
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<td>Grand Total</td>
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<td>404 045 000</td>
<td>502 247 000</td>
<td>355 834 063</td>
<td>71</td>
<td>186 386 416</td>
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</tbody>
</table>
## ANNEX 3

### Budget implementation by budget centre
(as on 31 December 2010)

<table>
<thead>
<tr>
<th>Budget Centre</th>
<th>AC</th>
<th>VC</th>
<th>Approved budget</th>
<th>Funds available</th>
<th>Funds available (% of approved budget)</th>
<th>Utilization (Expenditure plus Encumbrances)</th>
<th>Utilization (% of approved budget)</th>
<th>Utilization (% of funds available)</th>
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<td><strong>Bangladesh</strong></td>
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<td>12 793 025</td>
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<td>35 072 000</td>
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<td><strong>Grand Total</strong></td>
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<td>502 247 000</td>
<td>355 834 063</td>
<td>71</td>
<td>186 386 416</td>
<td>37</td>
<td>52</td>
</tr>
</tbody>
</table>
In its collaborative efforts spanning over six decades, WHO has always focused on the priority health needs of its Member States in the South-East Asia Region. The prime objectives have been to strengthen health systems, to achieve improved health outcomes and to ensure fair and equitable access to health care by all.

The Report of the Regional Director on the Work of WHO the South-East Asia Region, covering the period 1 January – 31 December 2010, clearly highlights the progress made in health development and in achieving the Organization's strategic objectives. The Report which identifies various challenges and the measures adopted to address them will be found most useful by those following health developments in the South-East Asia Region.