Progress reports on selected Regional Committee resolutions

This document includes the progress reports on the following selected Regional Committee resolutions:

1. Measles and rubella elimination by 2023 (SEA/RC72/R3);
2. Challenges in polio eradication (SEA/RC60/R8);
3. Delhi Declaration on improving access to essential medical products in the Region and beyond (SEA/RC71/R2);
4. Covering every birth and death: improving civil registration and vital statistics (SEA/RC67/R2);
5. (a) South-East Asia Regional Health Emergency Fund (SEA/RC60/R7); and
   (b) Expanding the scope of the South-East Asia Regional Health Emergency Fund (SEARHEF) (SEA/RC69/R6);
6. Patient safety contributing to sustainable universal health coverage (SEA/RC68/R4);
7. Delhi Declaration on Emergency Preparedness in the South-East Asia Region (SEA/RC72/R1); and
8. Colombo Declaration on strengthening health systems to accelerate delivery of NCD services at the primary health care level (SEA/RC69/R1).

The High-Level Preparatory Meeting for the Seventy-fourth Session of the WHO Regional Committee for South-East Asia held virtually on 19–21 July 2021 reviewed each progress report and made recommendations, which have been consolidated as Addendum 1 (SEA/RC74/12 Add. 1) to this Working Paper, for consideration by the Seventy-fourth Session of the WHO Regional Committee for South-East Asia.

The related Regional Committee resolutions covered in this Agenda item are appended to this Working Paper as Addendum 2 (SEA/RC74/12 Add. 2).
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1. **Measles and rubella elimination by 2023 (SEA/RC72/R3)**

**Background**

1. The Seventy-second session of the WHO Regional Committee for South-East Asia in September 2019 endorsed resolution SEA/RC72/R3, in which the 11 Member States of the South-East Asia Region adopted the goal of “measles and rubella elimination by 2023”.

2. Measles and rubella elimination by 2023 is one of the Flagship Priority Programmes of the South-East Asia Region. To ensure adequate technical guidance to accelerate progress towards the measles and rubella elimination goal, the Strategic Plan for Measles and Rubella Elimination in the WHO South-East Asia Region 2020–2024 (henceforth referred to as the Strategic Plan) has been developed.

3. The WHO South-East Asia Regional Verification Commission (SEA-RVC) for measles and rubella elimination annually reviews the progress made by Member States towards measles and rubella elimination by 2023.

**Progress made in the WHO South-East Asia Region**

4. Significant progress has been made in the South-East Asia Region towards measles and rubella elimination since 2014. Maldives and Sri Lanka were verified as having eliminated endemic rubella in 2020. Five countries – Bhutan, the Democratic People’s Republic (DPR) of Korea, Maldives, Sri Lanka and Timor-Leste – sustained their measles elimination status in 2020 while rubella control was sustained in four countries – Bangladesh, Bhutan, Nepal and Timor-Leste. A National Strategic Plan for Measles and Rubella Elimination 2020–2024 or its equivalent has been developed in 10 Member States and is in draft stage in one.

5. It is estimated that there has been 80% reduction in mortality due to measles in the Region by 2019 compared with 2000. Nearly 35 million additional children have been vaccinated with measles and rubella vaccine through mass vaccination campaigns in the Region in 2020–2021 despite the COVID-19 pandemic being prevalent.

6. As of end-2020, all Member States in the Region are administering two doses of measles-containing vaccine (MCV) as well as at least one dose of rubella-containing vaccine (RCV) through their routine immunization programmes.

7. In 2020, the WHO–UNICEF Joint Immunization Coverage estimates for the first dose of measles-containing vaccine (MCV1) was pegged at more than 95% in four Member States (Bangladesh, DPR Korea, Maldives and Sri Lanka). The estimated coverage was between 80% and 94% in five Member States (Bhutan, India, Myanmar, Nepal and Thailand) and less than 80% in two Member States (Indonesia and Timor-Leste).

8. Laboratory-supported case-based surveillance for measles and rubella has been initiated in all Member States using acute fever and maculopapular rash as the definition for suspected cases of measles and/or rubella.

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9. All Member States in the Region have at least one proficient national laboratory to support measles and rubella case-based surveillance. The measles–rubella laboratory network has expanded from 23 laboratories in 2013 to 49 in 2020, with 41 laboratories accredited as being “proficient” in measles and rubella testing.

**Challenges being faced**

10. The COVID-19 pandemic had a considerable negative impact on measles and rubella elimination activities. Routine immunization sessions stopped or were severely affected for varying durations, either nationally or subnationally, in most Member countries. The decline in coverage of measles vaccination is likely to result in increased mortality and morbidity due to measles. Similarly, surveillance for vaccine-preventable diseases was affected by the pandemic due to various reasons, such as “repurposing” of health workers for the COVID-19 response, absence of health workers from work due to COVID-19 infection, lockdown measures and fear of infection among communities.

11. Nearly 37,800 fewer cases of suspected measles were reported and investigated in 2020, compared with 2019, leading to a decline in the sensitivity of surveillance for measles and rubella. The pandemic also delayed the implementation of mass vaccination campaigns for measles and rubella as well as various monitoring and evaluation activities.

12. Significant challenges to achieving measles and rubella elimination in the Region remain, irrespective of the pandemic, the greatest of which is to improve routine immunization programmes to reach 95% or more coverage with two doses of a measles–rubella-containing vaccine in all districts of all countries. A significant number of children in the Region do not receive the first dose of a measles-containing vaccine through the routine immunization programme annually. The sensitivity of surveillance for measles and rubella remains suboptimal in endemic countries, resulting in underreporting of cases and underestimation of the disease burden.

13. Laboratory network support, especially for diagnostic kit procurement services, is becoming a challenge. Most Member States are still dependent on the Global Measles and Rubella Laboratory Network supported by WHO and the Centers for Disease Control and Prevention, Atlanta, United States of America (US-CDC), for procurement of laboratory diagnostic kits for measles and rubella. There are also challenges around getting a green-light approval for Customs clearance of these kits in some Member States.

14. In addition to the current funding level, an additional funding requirement of US$ 0.19 per capita per year will have to be committed jointly by national governments and partners to optimally implement strategies to achieve the measles and rubella elimination goal by 2023.

15. Ensuring optimal implementation of key elimination strategies at an accelerated pace remains a huge challenge, more so now with the COVID-19 pandemic as well as post-COVID-19 recovery, which are likely to last for a couple of years.

**The way forward**

16. Post-COVID-19 pandemic mitigation phase: countries in the South-East Asia Region are in the process of developing and refining strategic, operational and policy guidelines for reviving immunization and surveillance activities post-COVID-19 pandemic. It is critical to identify gaps in performance at national and subnational levels following the outbreak and to develop tailored strategies to plug these gaps so that progress towards measles and rubella elimination can be accelerated.

17. High-level political and programmatic commitment to implement the Strategic Plan to eliminate measles and rubella from the Region will have to continue to drive the agenda in the Region towards accelerated implementation of the strategic plans at optimal levels.
18. In order to make the laboratory network self-sustaining, Member States that are still dependent on WHO for procurement of laboratory diagnostic kits for measles and rubella will have to gradually plan to transit and initiate procurement through their national programmes via dedicated line-items in their Budgets in a planned and phased manner.

19. Full and timely implementation of the recommendations made by the Eleventh Meeting of the WHO South-East Asia Regional Immunization Technical Advisory Group in 2020 and the Fifth Meeting of the WHO South-East Asia Regional Verification Commission for measles and rubella elimination in 2020 will be required to ensure that progress towards measles and rubella elimination by 2023 are on track. WHO and partners will have to ensure adequate technical support to the countries for quality implementation of the activities.

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2. **Challenges in polio eradication (SEA/RC60/R8)**

**Background**

20. Globally, 140 cases of wild poliovirus type 1 (WPV1) were reported in 2020, limited to two countries: Afghanistan (56 cases) and Pakistan (84 cases). In 2021, WPV1 continues to be detected in parts of Afghanistan and Pakistan with one case each (as on 21 July 2021). WPV has also been detected in 2020 and 2021 in environmental samples in these two countries. But for these two countries, the world remains polio-free.

21. Other key milestones achieved are as follows:
   
   a. on 25 August 2020, the WHO African Region was certified as free of WPVs; and
   
   b. WPV type 2 and WPV type 3 have been certified as having been eradicated globally in 2015 and 2019, respectively.

22. Outbreaks due to circulating vaccine-derived polioviruses (cVDPVs), in particular, type 2 (cVDPV2), continue to affect countries of the African, Eastern Mediterranean, European and Western Pacific regions.

23. The Seventy-fourth World Health Assembly noted the Polio Eradication Strategy 2022–2026, developed by the Global Polio Eradication Initiative (GPEI), which will guide the programme until global polio-free certification is achieved. The two goals of the new GPEI strategy are:

   a. Goal One: to permanently interrupt poliovirus transmission in the final WPV-endemic countries of Afghanistan and Pakistan,

   b. Goal Two: to stop cVDPV transmission and prevent outbreaks in non-endemic countries.

24. The new GPEI emphasizes on cutting down response times, increasing vaccine demand, transforming the effectiveness of campaigns, working systematically through integration, transitioning towards government ownership, and improving decision-making and accountability.

25. The GPEI developed a strategy for the response to type 2 cVDPV 2020–2021 that includes the use of novel oral polio vaccine type 2 (nOPV2). In its Decision EB146(11) of 2020 on polio eradication, the WHO Executive Board took note of this strategy and urged Member States to mobilize domestic financial resources to contribute to outbreak response efforts.

26. Polio transition is an integral part of the polio progress report that was noted by the Regional Committee for South-East Asia at its Seventy-third session, which called upon Member States for continued commitment in implementing their transition plans, emphasizing the need to mobilize domestic resources or alternative sources of funding for long-term sustainability.

27. The Strategic Action Plan on polio transition (2018–2023) was noted by the Seventy-first World Health Assembly and has three key objectives:

   a. sustaining a polio-free world after eradication of poliovirus;

   b. strengthening immunization systems, including surveillance for vaccine-preventable diseases, to achieve the goals of WHO’s Global Vaccine Action Plan; and

   c. strengthening emergency preparedness, detection and response capacity in countries to fully implement the International Health Regulations (2005).

28. The Transition Independent Monitoring Board (TIMB) reviewed the progress in polio transition, as well as the impact of the COVID-19 pandemic on polio transition and implementation. It has recognized the role played by polio assets globally in the COVID-19 response.
Progress made in the WHO South-East Asia Region

29. The SEA Region of WHO was certified polio-free on 27 March 2014 and has since remained free of all WPVs. The Regional Certification Commission for Polio Eradication (RCCPCE) continues its oversight.

30. BioFarma, Indonesia, has obtained emergency use listing (EUL) for nOPV2, vital for cVDPV2 outbreaks. It is the first ever EUL for a vaccine.

31. The COVID-19 pandemic has affected polio eradication activities such as laboratory-supported surveillance, routine immunization coverage of bivalent oral polio vaccine (bOPV) and inactivated polio vaccine (IPV), and containment activities as per the WHO Global Action Plan (GAP III). All Member States have taken several actions to revive and resume immunization and surveillance activities.

32. All 16 polio laboratories in the Region maintained timeliness of reporting laboratory results above the global target of 80% despite providing support to COVID-19 testing.

33. There are five polio priority countries in the Region – Bangladesh, India, Indonesia, Myanmar and Nepal. Each of the five countries has developed its national transition plan adopting a country-centric approach. The pace of implementation of these plans is guided by country readiness (technical, financial and managerial capacity), available financing as well as operational modalities.

   a. The Government of Bangladesh endorsed the national transition plan in 2018 and implementation in three phases is mostly on track and as planned.

   b. The Government of India endorsed the national transition plan and domestic resources continue to be transferred to cover the gaps. A mid-term assessment of transition was conducted in 2020, which concluded that overall, significant progress has been made in the transition from polio to public health.

   c. The Government of Indonesia has initiated actions to self-fund a large proportion of the surveillance, laboratory and immunization costs, previously funded by GPEI.

   d. The Government of the Union of Myanmar has developed a draft roadmap (2020–2024) to transfer all duties and responsibilities of the Regional Surveillance Officers Network to the Ministry of Health and Sports; however, delays are anticipated in the implementation of the plan.

   e. The implementation of the transition plan of Nepal was slow due to an overhaul of the administrative structures and processes, as a part of the ongoing federalization in the country, and this has been further delayed due to recent COVID-19 pandemic.

34. The TIMB has recognized that the SEA Region is the most advanced among the regions in polio transition planning and has recognized the strong commitment to polio transition both from the highest levels of WHO and the ministries of health. The main concern of the Board is financial sustainability and that the plans do not yet have a long-term horizon. The current approach for polio transitioning being followed in the South-East Asia Region is aligned with the TIMB recommendations.

35. In the Region, polio infrastructure and programmes have been fully integrated with the other immunization services and these also provide support in responding to health emergencies. The Region has demonstrated the ability to pool personnel as well as financial resources to provide support as one integrated public health team during the COVID-19 response.

36. WHO’s surveillance networks in all priority countries of the SEA Region have provided substantive support to the response to COVID-19, with almost 2600 personnel deployed for full or partial support to the COVID-19 response.
Challenges being faced

37. The Region continues to be at risk of importation of WPV from countries that have current infection and of cVDPV emergence and/or importation from neighbouring regions.

38. While immunization coverage and surveillance performance have shown signs of recovery, overall coverage, reporting of cases of acute flaccid paralysis, and collection of environmental surveillance samples remains below pre-COVID-19 levels in several countries.

39. Sustaining high routine immunization coverage, sensitive surveillance, strong outbreak response capacity and containment of polioviruses in facilities during the post-certification period remain key challenges.

40. While countries are making commendable efforts towards polio transition, advocacy with donors and partners for continued commitment remains critical to ensure that integrated surveillance and immunization infrastructure and capacities continue to support essential polio functions and strengthen health systems.

The way forward

41. All Member States of the Region must fully implement the Polio Eradication Strategy 2022–2026, including collective coordination for an emergency response, reaching zero-dose children and gender parity in leadership roles.

42. To minimize the risks and consequences of potential VDPVs, Member States should ensure high routine immunization coverage, conduct surveillance for timely detection of the emergence of cVDPV, maintain strong outbreak response capacity and ensure uninterrupted functioning of polio laboratories where they are present.

43. Continue to maintain and strengthen polio eradication activities keeping in mind the risk of COVID-19 transmission among frontline workers and communities, and ensure that the benefits of carrying out the activity outweigh the risks.

44. In accordance with World Health Assembly resolution WHA68.3 (2015) on poliomyelitis, countries need to continue to intensify activities for the containment of type 2 polioviruses. In addition, with the certification of global eradication of wild poliovirus type 3 (WPV3), samples containing WPV3 should now be handled in containment conditions or destroyed.

45. To mitigate any potential risk of slowdown in implementing the national transition plans amid the COVID-19 pandemic, continued commitment of Member States and partners will remain critical to maintain essential polio functions and contribute to strengthening immunization systems, and help achieve coverage and equity goals.

46. TIMB recommendations need to be implemented, including an urgent post-COVID-19 review of all national polio transition plans, expansion of integrated public health teams, country-wise staff capacity-building plan, and subnational capacity and capability mapping.
3. **Delhi Declaration on improving access to essential medical products in the Region and beyond (SEA/RC71/R2)**

**Background**

47. Equitable access to essential medical products is a global priority, and the accessibility, availability, acceptability and affordability of essential medical products of assured quality need to be addressed in order to achieve universal health coverage and other Sustainable Development Goal targets.

48. Every disease management strategy requires access to essential medical products for prevention, diagnosis, treatment, palliative care and rehabilitation. Primary health care services rely on access to essential medical products that include medicines, vaccines, medical devices, diagnostics, protective equipment and assistive devices. These products must be of assured safety, efficacy, performance and quality, as well as appropriate, available and affordable.

49. However, despite improvements in the access to essential medical products in the Region, availability of essential medicines and other essential medical products remains a challenge. The high level of out-of-pocket (OOP) spending on health care in many SEA Region countries is well known, and is pushing around 65 million into poverty every year. This is mainly on account of spending on medical products, particularly medicines that account for the major share of OOP payment, in most countries of the Region.

50. The current COVID-19 pandemic has further highlighted the importance of timely access to quality medical products. Accordingly, all SEA Region Member States have supported World Health Assembly resolution WHA 73.1 of 2020 for access to medical products. Member States recognized “the need for all countries to have unhindered, timely access to quality, safe, efficacious and affordable diagnostics, therapeutics, medicines and vaccines, and essential health technologies, and their components, as well as equipment”.

51. At the Seventy-first session of the WHO Regional Committee in September 2018, intercountry technical consultations following the Decision (SEA/RC70(3)) adopted by the Seventieth session of the Regional Committee led to the adoption of the South-East Asia Ministerial Delhi Declaration on Improving Access to Essential Medical Products in the Region and Beyond. The Delhi Declaration was significant as it included a commitment for access to the entire range of medical products (medicines, vaccines, diagnostics and medical devices) for achieving universal health coverage and the 2030 Agenda for Sustainable Development.⁶

52. In addition, SEA Region Member States actively participated in global consultations that led to the adoption of significant World Health Assembly resolutions on this subject. In resolution WHA72.8 of 2019 on “Improving the transparency of markets for medicines, vaccines and other health products”, the World Health Assembly expanded the scope of “health products” to include “medicines, vaccines, medical devices, diagnostics, assistive products, cell- and gene-based therapies, and other health technologies”.

53. This report is an opportunity to take stock of the progress made to improve access in the Region and beyond. The report builds on the previous report presented to the Seventy-first session of the Regional Committee in 2018. The publication titled *Access to medical products in the South-East Asia Region: 2021 report* with more details will be released during the Seventy-fourth Regional Committee Session.

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Progress made in the WHO South-East Asia Region

54. The availability and affordability of medicines, as per the standard method for reporting the SDG 3.b.3. indicator for availability of medicines, is not yet regularly monitored globally or in the South-East Asia Region. The lack of robust information on availability, access to and affordability of medical products means that it is difficult for policy-makers to know how well their policies are working. MedMon is a new smartphone application developed by WHO [https://www.who.int/news/item/18-02-2018-medmon-mobile-application] that can facilitate the rapid collection of data on availability and price of medical products. It is now being used in the field by several South-East Asia Region countries.7

55. The recent national surveys in four countries of the Region showed that the availability of a defined basket of essential medicines was better in private facilities compared with public facilities. Since the availability of medicines in the public sector is often low, there is no choice for individuals but to purchase medicines in the private sector. Even more disconcerting is the fact that many households may forgo the expenses of buying needed medicines and face adverse health outcomes as a consequence. This inequity has long-term social and economic consequences for the country.7

56. Several countries in the Region where prepaid, public and/or private financing of medicines is very low, access to essential medicines for the population is affected. This impedes their progress towards universal health coverage (UHC). In about one third of the WHO SEA Region countries, a large proportion of households face catastrophic expenditures due to unaffordable prices of medicines in the private sector.

57. Pricing policies play a key role in keeping the prices of medicines affordable. WHO conducted an analysis and organized an expert consultation virtually in February 2021 to discuss pricing policies adopted in the Region and their implications. Results show that policies commonly used in all countries are promotion of generic medicines, tendering, and making available free essential medicines in the public sector. All of these policies are recommended by the WHO pricing guideline.8 Some pricing policies such as value-based pricing and price negotiation or special price agreements are used in only a few countries as these policies require technical capacity and continuous investment. There is, however, limited evidence on the effectiveness of these policies in many countries of the Region. Countries are encouraged to invest in studying the impact of their pricing policies.

58. WHO conducted an analysis on policies and practices for the management of conflicts of interest in the pharmaceutical sector in the Region. The results show that only few policies explicitly addressed conflicts of interest, many discussed committee governance, ethics, integrity and underlying values more generally. Processes for preventing or managing conflicts of interest are much less well developed, overall, except for a few key public procurement processes. To strengthen good governance, there is a need for capacity-building in Member States around management of conflicts of interest; this must include defining and identifying types of conflicts, developing selection criteria for independent committee members with requisite expertise, and creating effective redressal mechanisms.

59. The Initiative for Coordinated Antidotes Procurement in the South-East Asia Region (iCAPS) was launched in early 2018 to support collaborative procurement of essential antidotes for a number of common causes of poisoning. This systematic approach towards antidote procurement is expected to improve procurement efficiency by aggregating demand, reducing costs and coordinating quality assurance. A high-level regional meeting was conducted virtually in October 2020. It was attended by representatives from all Member States and persons involved in high-level health policy, poison management and procurement agencies.

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60. This high-level meeting led to the publication of the *iCAPS Manual* and a promotional video [https://www.youtube.com/watch?v=qMQsg0BCtLw](https://www.youtube.com/watch?v=qMQsg0BCtLw) to highlight how countries can benefit from the initiative. The manual was based on the inputs provided by representatives of Member States of the WHO SEA Region, the iCAPS Thai Working Group from Thailand, regional experts on poisoning and medicine procurement, and WHO. This provides clear guidance on the steps to be followed to ensure the effective coordination and timely provision of antidotes in response to poisoning emergencies. There has been significant interest in accessing essential antidotes from Thailand using the initiative even from countries outside the Region. Key partners from Thai National Antidote Project (NAP) including Ramathibodi Poison Center (RPC), National Health Security Office (NHSO) and the Government Pharmaceutical Organization (GPO) form the Thai Working Group.

61. Effective antimicrobial stewardship is important; WHO has developed a systematic surveillance system to monitor the trends on antimicrobial consumption and use for consumers and health professionals. A pool of regional experts was trained in 2020 to support national antimicrobial consumption surveillance and stewardship programmes in Member States. Antimicrobial consumption monitoring has been conducted in Bangladesh, Maldives and Nepal.

**Challenges being faced**

62. Inadequate financing of health products, high prices of new health products, and ineffective policy interventions and processes to manage expenditure, such as the ineffective use of policies for generic and biosimilar medicines, contribute to the challenges facing the health system in achieving UHC.

63. Weak governance of the pharmaceutical sector is one of the factors that contribute to poor access and inappropriate use of essential health products, inflated prices, and wastage of scarce health system resources. Pharmaceutical systems are technically complex and involve extensive interactions between the private sector and the public sector. Private sector interests can influence what products are selected for reimbursement or procurement, the prices of health products, and how health products are used. Without adequate regulation, public trust and confidence in policy-makers, the policy process and its outcomes can be undermined.

64. The COVID-19 pandemic resulted in human and economic costs related to shortages of critical medical supplies, including personal protective equipment (PPE), essential medicines, diagnostics, vaccines and medical devices. The pandemic also exposed vulnerabilities that impact the global supply chain such as lockdowns, travel bans and suspended transport services and flights, all of which reduced production, disrupted distribution and increased the cost of not only emergency medical supplies but also other critical medicines required for essential health-care services. WHO, through the South-East Asia Regulatory Network (SEARN), provided support to Member States to strengthen regulatory capacity and engage in promoting local production and technology transfer for enhanced resilience.

**The way forward**

65. Member States can allocate resources more effectively through evidence-based decisions to ensure that essential health products, as per a country’s disease burden, are included in a country’s essential medicines list, essential diagnostics list or reimbursement list, and through more efficient procurement and supply processes, and rational use of medicines. Support for fair pricing and policy implementation to reduce OOP expenditure will be important.

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66. The need for good governance is increasingly recognized as a key step on the road to achieving UHC. Weak governance complicates access to health products by fuelling inefficiency, distorting competitive mechanisms, and leaving the system vulnerable to undue influence and abuse. The relationship between governments and the private sector, such as pharmaceutical companies and medical device companies, requires attention. A question of growing importance is how to support governments to collaborate effectively with the private sector and develop public policies while avoiding the risks of undue influence and maximizing public benefits.

67. To make accurate and useful decisions to improve access to essential medical products, there is the need for timely and accurate data and information on access to medicines in the country. This may cover the gamut of national expenditures on health products; the procurement of health products, supply chain and distribution; pharmacovigilance and post-marketing surveillance; health insurance coverage; prescription prices of health products; and the availability of medicines, vaccines and other health products in health facilities.

68. Monitoring access to health products is a complex endeavour that requires gathering information from multiple sources and ensuring the interoperability of various data collection systems. More complete and timely data on access to medicines will better enable countries to identify access disparities between population groups and understand the effects of interventions across their medicine supply and distribution chains.

69. Ensuring appropriate use of medicines is part of ensuring access. Medicines, diagnostics and devices need to be used correctly and rationally to be effective and efficient. Clinical guidelines and essential lists for medicines and for different medical products can help. It is encouraging to see the increasing development of national essential diagnostics lists. However, adherence to guidelines by health professionals is still irregular, and an area worthy of more attention.

70. There is further need for effective implementation of the Initiative for Coordinated Antidotes Procurement in the South-East Asia Region and robust collaboration between key stakeholders and participating countries. The systematic approach to procuring and managing the supply and distribution of quality-assured antidotes, and assuring their appropriate use can be used to build further procurement collaboration of essential medical products.

71. To build resilient supply chains, especially during a global pandemic, efforts are needed to reduce risks and ensure supply security by reducing dependency, increasing domestic production, diversifying the supply base, and financing and securing adequate safety stockpiles. Health systems need to establish mechanisms to define shortages and monitor and trace stocks, and anticipate any surge in demand and potential shortages early. Partnership with the private sector and regulatory system strengthening are needed for technology transfer and consequent enhanced local production of high-priority medical products.

72. Initiatives such as the COVID-19 Technology Access Pool (C-TAP) can be very useful. Such initiatives aim to provide a global one-stop shop for developers of COVID-19 therapeutics, diagnostics, vaccines and other health products to share their intellectual property, knowledge and data, with quality-assured manufacturers.
4. **Covering every birth and death: improving civil registration and vital statistics (SEA/RC67/R2)**

**Background**

73. Civil registration and vital statistics (CRVS) systems are the optimal source of data on births, deaths and causes of death for health policy and epidemiological research. These data are also essential to monitor cause-specific mortality for targets listed under the United Nations’ Sustainable Development Goals as well as under the results monitoring framework of the WHO Thirteenth General Programme of Work 13 (GPW13). The targets cover a range of communicable and noncommunicable diseases, as well as injuries and health conditions that arise from environmental exposures such as unsafe water and air pollution. However, there is a critical deficiency of such data for many developing countries in the world, including in the SEA Region.

74. About three in 10 children worldwide under the age of 1 year (about 40 million) have not had their births registered. The proportion of deaths that go unregistered is higher than that of unregistered births. WHO estimates that, in 2015, only 48% of all deaths were registered and the causes of most of these deaths were unknown.

75. The WHO South-East Asia Regional Strategy for strengthening the role of the health sector for improving civil registration and vital statistics 2015–2024 was adopted at the Sixty-seventh session of the WHO Regional Committee in Dhaka, Bangladesh, in September 2014 (SEA/RC67/R2). It focuses on health sector initiatives at the regional, national and local levels to support notification and universal civil registration of births and deaths, and improve the generation of accurate, complete and timely vital statistics. Resolution SEA/RC67/R2 included a request for periodic progress updates to the Seventy-first, Seventy-fourth and Seventy-eighth sessions of the Regional Committee in 2018, 2021 and 2025, respectively.

76. The SEA Region CRVS Strategy, goals and indicators are aligned with the Regional Action Framework for CRVS in Asia and the Pacific developed through the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP), which includes all countries in the WHO SEA Region. The Regional Office for South-East Asia, along with other UN agencies and development partners, had collaborated on the development of the UNESCAP CRVS Regional Action Framework. Several UN agencies, including UNICEF, UNESCAP, UNDP and UNHCR, are also focused on improving civil registration. WHO is leading the support from development partners in the Region to strengthen the generation and use of reliable mortality statistics.

77. At the global level, WHO has developed a CRVS Strategic Implementation Plan 2021–2025 designed to empower Member States to more effectively mobilize the health sector to contribute to efforts at strengthening CRVS systems. The Implementation Plan calls for strong leadership in the health sector and draws on the normative function of WHO, focusing on empowering the health sector in Member States with the needed tools, knowledge and training.

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78. The aims of the Implementation Plan are to improve coverage of the notification of births and deaths; improve certification practices of causes of death; more effectively exploit research and information technology advances to improve the diagnosis of home deaths; and build capacity to more effectively analyse and use mortality and cause-of-death data to support policy and monitor progress against national and international development goals.

**Progress made in the WHO South-East Asia Region**

79. CRVS systems function to some extent in all countries of the SEA Region and many of them have in recent years conducted assessments of CRVS functioning, developed improvement plans and established CRVS multisectoral coordination committees. However, there are persistent systemic weaknesses almost everywhere that result in the non-registration of vital events. A data availability assessment conducted by WHO in 2015 identified that no country in the SEA Region had sufficient local data on mortality and causes of death that could be directly used to measure national burden of disease.\(^{14}\)

80. Birth registration coverage is more than 75% in six countries (Bhutan, India, Indonesia, Maldives, Sri Lanka and Thailand). Indonesia, on the other hand, reports birth registration completeness over 100%, which is indicative of either inaccurate counting of registered births (for example, double counting or inclusion of delayed registrations), underestimation of total expected births, or a combination of both. The figures are less than 75% in the remaining countries of the Region.

81. Death registration coverage lags birth registration coverage across the SEA Region. Relatively high levels of completeness (70% and over) were reported in Bhutan, India, Maldives, Nepal, Sri Lanka and Thailand. Death registration completeness is 50% or lower in Bangladesh, Myanmar and Timor-Leste. No completeness estimates on death registration are available for Indonesia (see Fig. 1). There are a number of gaps in relation to the registration of deaths and the determination of causes of death using international standards. Reporting of death registration completeness is ad hoc and based on calculation methods that are not always clear.

**Fig. 1. Percentage of death registration in countries of the South-East Asia Region**

![Chart showing death registration percentages in countries of the South-East Asia Region](chart.png)

*Source:* UNESCAP CRVS regional action framework mid-term report 2020 (forthcoming); Indonesia – No data available

82. Ministries of health of the SEA Region have been actively engaged in global, regional and national activities to strengthen CRVS systems. Following the 2014 Ministerial CRVS Declaration, the launch of the SEA Regional CRVS Strategy and the UNESCAP CRVS Regional Action Framework, there has been an increase in political commitment to health sector initiatives for CRVS development, support for CRVS development plans, coordination by stakeholders and partners, expansion of knowledge-sharing, and use of tools and techniques for improving CRVS performance.

83. To accelerate improvement in CRVS through health sector interventions, in collaboration with global, regional and national development partners, WHO initiated a new intensified CRVS improvement initiative in seven countries of the SEA Region, namely, Bangladesh, Bhutan, India, Indonesia, Myanmar, Nepal and Timor-Leste. WHO has supported government CRVS-strengthening efforts to review progress, form and/or revitalize multisectoral coordination, build capacity, develop key performance indicators, generate CRVS process maps, undertake further assessments, better utilize the latest version of the International Classification of Diseases (ICD-11), and integrate cause-of-death data collection into existing systems.

Challenges being faced

84. Major challenges include coordination among multiple stakeholders, lack of sufficient capacity and adequately trained staff for timely data collection and analysis, incomplete coverage of death registration, and poor availability and quality of cause-of-death information to generate mortality statistics. In addition, there are current difficulties in prioritizing CRVS strengthening due to the urgent need for relevant staff within the health, registration and statistics sectors to manage and monitor the impact of the COVID-19 pandemic in countries.

85. In general, there is an overall need to ensure that sound and sustainable mechanisms are in place for overall CRVS management, coordination and for the technical aspects. In particular, country partners need time to become familiar with the tools used, such as business process mapping (BPM) and the CRVS System Analysis and Redesign (CRVS-SAR) tool.

The way forward

86. The approach and priorities of the SEA Regional Strategy 2015–2024, designed to guide and support the improvement of CRVS systems in the Region, remain pertinent today, in particular, the strong focus on strengthening the role of the health sector to improve CRVS systems. Lessons learned from past CRVS assessments coupled with the ongoing SEA Regional CRVS improvement initiative highlight the importance of adopting country-specific strategies characterized by a high degree of intersectoral and cross-programme collaboration. To achieve this, countries should establish the following structures and arrangements:

a. Revised business processes:

i. stakeholder involvement in the review and revision of business processes to enhance the flow of records and information between health and civil registration systems, as well as the individuals/offices involved in the civil registration process;

ii. designation by the legal and regulatory framework of health institutions and agents as legally recognized informants of the occurrence of births and deaths to the civil registrar, as recommended by the United Nations;

iii. allocation of civil registration staff to health facilities to provide on-the-spot registration and certification services. Where CRVS regulations permit, designation of health institutions or agents as registrars who will provide registration services directly to the population would be desirable.

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[https://getinthepicture.org/sites/default/files/resources/Ministerial_Declaration_English_final_0_0.pdf](https://getinthepicture.org/sites/default/files/resources/Ministerial_Declaration_English_final_0_0.pdf) - accessed 26 June 2021.
b. Information sharing:

i. agreements, such as memoranda of understanding (MoUs) between health and CRVS agencies that provide for the exchange of information on individual live birth, stillbirth, death and cause-of-death records.

c. Interoperability and standardization of data collection protocols:

i. use of common definitions, classifications, forms and software instruments across all health programmes to help avoid parallel data “silos”; 

ii. standard templates for the notification of live and still births and deaths that are compatible across the health, CRVS agencies for both paper-based and electronic systems, and that will enable the civil registration of the events; 

iii. decentralization and digitization of the civil registration system, preferably using open-source software based on published standards; 

iv. consensus on interoperable databases for birth, death and fetal death data.
5. (a) South-East Asia Regional Health Emergency Fund (SEARHEF) (SEA/RC60/R7); and
(b) Expanding the scope of the South-East Asia Regional Health Emergency Fund (SEARHEF) (SEA/RC69/R6)

(a) South-East Asia Regional Health Emergency Fund (SEARHEF) (SEA/RC60/R7)

Background

87. The South-East Asia Regional Health Emergency Fund (SEARHEF) is an operational fund of the SEA Region and is earmarked for providing support to the health sector response of Member States during emergencies. The Fund was established in 2008 by Regional Committee resolution SEA/RC60/R7 by pooling a budget of US$ 1 million for each biennium from Assessed Contributions.

88. The Fund is designed to provide financial support for the first three months following a disaster that occurs in an affected country to meet immediate and urgent health needs, support emergency field operations, and fill in critical gaps. It also has a window to receive funds from donors. A total amount of US$ 350 000 can be released in two tranches. The funds can be released within 24 hours of receiving a request from a Member State.

89. The SEARHEF has set a record as “the emergency fund that is released fastest among all UN agencies”. The SEARHEF is overseen by a Working Group comprising representatives from all 11 Member States. The Working Group has met nine times since 2008. The Royal Thai Government donated US$ 100 000 in 2008, while the Government of the Democratic Republic of Timor-Leste donated US$ 10 000 in 2009. In 2015, Timor-Leste made a second Voluntary Contribution of US$ 100 000 to the Fund at the Sixty-eighth session of the Regional Committee. Progress made by the Regional Health Emergency Fund in the WHO SEA Region include the following:

a. Since its inception in 2008, the Fund has allowed for an immediate and flexible response to 43 emergency events occurring in 10 Member States of the Region.

b. In the current biennium (2020–2021), SEARHEF has supported four emergency events in Bhutan, Maldives and Thailand for COVID-19 response operations, and in Timor-Leste to cover immediate health needs following a natural disaster (flash floods and landslides).

c. Till date, SEARHEF has disbursed a total of US$ 6.77 million since its inception.

d. In the previous biennium (2018–2019), there was an unutilized balance of US$ 300 000. With the consent of the Working Group, these funds were used to procure essential emergency medical supplies and equipment for the regional stockpile, such as interagency emergency health kits, laboratory and sample collection kits, cholera kits, personal deployment kits, equipment for health emergency operations centres (HEOCs).

e. Nine meetings have been held, till date, of the Working Group of the Fund, the last being in August 2020 via videoconference. Due to the ongoing COVID-19 pandemic, the Tenth Meeting of the Working Group will be held virtually on 11 August 2021.

f. Balance available: The SEARHEF balance from Assessed Contributions as of June 2021 is US$ 400 000 for the current biennium of 2020–2021, while US$ 100 000 is available from Voluntary Contribution funds.
Progress made in the WHO South-East Asia Region

90. Upon the recommendation of the Sixth Meeting of the Working Group for governance of the SEARHEF (6–7 June 2017), an evaluation of the utilization and impact of the Fund was undertaken upon completion of 10 years of its existence, through an independent external evaluation agency. The evaluation criteria included relevance, effectiveness, efficiency, sustainability and impact. The key findings of the evaluations were shared with the Member States and Working Group members of the Fund.

91. Table 1 gives a list of health emergencies that were supported by SEARHEF since its inception till April 2021, and the countries in which they occurred (table at the end of the report).

Challenges being faced

92. One of the key gaps in the management of the Fund appears to be the lack of output and outcome data for the use of SEARHEF. The evaluation findings suggest that while efforts towards standardization have been made in the form of templates for proposal requisition or utilization reporting, more specifically, there were several concerns with regard to utilization reporting, in the form of incomplete information and inconsistencies in interpreting the template requirements that resulted in non-availability of comparable information.

93. Response to the ongoing COVID-19 pandemic has delayed an exclusive monitoring and evaluation (M&E) framework for SEARHEF-related emergency support. However, there is a good M&E framework for the COVID-19 response itself and that is being implemented. Since the recent use of SEARHEF has been in the context of COVID-19 only, there is significant overlap already. This will be reviewed later in 2021 for necessary actions to strengthen SEARHEF.

94. To respond effectively to the emerging needs of the Region, the need for increasing the corpus amount of SEARHEF was raised during various Working Group meetings. Inadequate contribution towards the total corpus of the SEARHEF and specifically for the “Preparedness Stream” has been a long-standing challenge, despite the high level of political commitment for strengthening emergency preparedness and operational readiness. The focus of Member States is yet to be shifted from “responding to emergencies in crisis mode” to “proactively identifying and reducing health emergency risks”. All these factors point towards the need to make dedicated efforts to increase the corpus.

The way forward

95. The COVID-19 pandemic is considered as one of the world’s worst public health emergencies in history. Its unprecedented and unexpected surge has further accentuated the already vulnerable economies of the SEA Region. Prone to natural disasters and calamities, the Region has been consistently investing in emergency preparedness and response. Even before the state of pandemic emergency was declared in early 2020, Member countries had adopted a resolution at the Regional Committee on 4 September 2019 to strengthen emergency preparedness capacities by scaling up risk assessment, increasing investments and enhancing implementation of multisectoral plans.

96. The lessons being learnt through the course of this ongoing pandemic augment the importance of a sturdier SEARHEF:

(1) Need for strategic efforts to increase the SEARHEF corpus: the Secretariat holds regular SEARHEF Working Group meetings annually, and the need for increasing the corpus for SEARHEF has been also recognized by all Member States. The Regional Office has engaged with various international financial institutions such as Asian Development Bank (ADB) and the World Bank and other donors to discuss possible contributions to SEARHEF. At the 9th SEARHEF Working Group Meeting held virtually on 18 August 2020, during the roundtable deliberations, Working Group members provided updates on discussions being undertaken with the respective ministries of finance and planning of Member States on contributing to SEARHEF. In particular, delegates from Bangladesh, Bhutan, Nepal and India mentioned the ongoing discussions within their countries on potential Voluntary Contributions to SEARHEF.
(2) Effective utilization of standardized templates and improved internal communication: the evaluation findings suggest that while efforts towards standardization in the form of templates already existed for proposal requisition or utilization reporting, the usage of these templates varied from country to country. Specifically, with regard to utilization reporting, there were several concerns in the form of incomplete information and inconsistencies in interpreting the template requirements that led to non-availability of comparable information. For these reasons, the format of the utilization report has been revisited and a new template is suggested to overcome the issues mentioned above.

(3) Improvement in monitoring, reporting and evaluation: the basis for M&E activities of any development programme is the evaluation framework of the programme. For this reason, it is important to develop an M&E framework for each emergency that was supported through SEARHEF, including the development of a key set of indicators to measure outcomes. Although the current M&E framework of Strategic Preparedness and Response Plan (SPRP) serves the purpose of the use of SEARHEF in the context of COVID-19, the Secretariat intends to develop a dedicated M&E mechanism for the Fund.

(4) The need to enhance multisectoral collaboration has been highlighted by different global committees and recommendations for financing of pandemic preparedness and response. The Secretariat and Member States need to explore opportunities and synergies in the near future, as deliberations on a possible global pandemic treaty are ongoing.
<table>
<thead>
<tr>
<th>No.</th>
<th>Emergency</th>
<th>Period</th>
<th>SEARHEF allocation in US$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Cyclone Nargis in Myanmar</td>
<td>May 2008</td>
<td>350 000</td>
</tr>
<tr>
<td>2</td>
<td>Flash floods in Sri Lanka</td>
<td>June 2008</td>
<td>23 299</td>
</tr>
<tr>
<td>3</td>
<td>Kosi river floods (in two tranches) in Nepal</td>
<td>September 2008</td>
<td>325 000</td>
</tr>
<tr>
<td>4</td>
<td>Emergency health interventions for internally displaced populations (IDPs) in conflict-affected areas in northern Sri Lanka (in two tranches)</td>
<td>September 2008</td>
<td>350 000</td>
</tr>
<tr>
<td>5</td>
<td>Earthquake in North Sumatra province, Indonesia (in two tranches)</td>
<td>October 2009</td>
<td>300 000</td>
</tr>
<tr>
<td>6</td>
<td>Emergency health interventions for relocated IDPs affected by conflict in Sri Lanka</td>
<td>January 2010</td>
<td>175 000</td>
</tr>
<tr>
<td>7</td>
<td>Fire in Dhaka, Bangladesh</td>
<td>June 2010</td>
<td>175 000</td>
</tr>
<tr>
<td>8</td>
<td>Mt Merapi volcanic eruption in East Java province, Indonesia</td>
<td>November 2010</td>
<td>139 000</td>
</tr>
<tr>
<td>9</td>
<td>Critical health-care services to the resettled population affected by conflict in Sri Lanka</td>
<td>February 2011</td>
<td>175 000</td>
</tr>
<tr>
<td>10</td>
<td>Floods in Thailand (in two tranches)</td>
<td>July 2011</td>
<td>350 000</td>
</tr>
<tr>
<td>11</td>
<td>Torrential rains in DPR Korea (in two tranches)</td>
<td>August 2011</td>
<td>310 000</td>
</tr>
<tr>
<td>12</td>
<td>Fire outbreak/explosion in Yangon, Myanmar</td>
<td>January 2012</td>
<td>25 000</td>
</tr>
<tr>
<td>13</td>
<td>Provision of emergency health care in Rakhine State, Myanmar</td>
<td>June 2012</td>
<td>12 300</td>
</tr>
<tr>
<td>14</td>
<td>Flash floods in DPR Korea</td>
<td>July 2012</td>
<td>134 130</td>
</tr>
<tr>
<td>15</td>
<td>Support to population affected by storm in Maldives</td>
<td>November 2012</td>
<td>47 717</td>
</tr>
<tr>
<td>16</td>
<td>Support to Myanmar for procuring emergency medical supplies (fire outbreak and earthquake)</td>
<td>November 2012</td>
<td>30 778</td>
</tr>
<tr>
<td>17</td>
<td>Support to Myanmar for establishing health-care services for townships affected by communal conflict in Rakhine State</td>
<td>April 2013</td>
<td>175 000</td>
</tr>
<tr>
<td>18</td>
<td>Support for relief during emergency caused by flash floods in South Phyongan, North Phyongan, Kangwon and South Hamgyong provinces of DPR Korea</td>
<td>July 2013</td>
<td>175 000</td>
</tr>
<tr>
<td>19</td>
<td>Support to emergency response activities for the crisis situation emerging due to Mt Sinabung eruption in North Sumatra province, Indonesia</td>
<td>February 2014</td>
<td>144 068</td>
</tr>
<tr>
<td>20</td>
<td>Establish sustainable health-care services for townships affected by communal conflict in Rakhine State, Myanmar</td>
<td>May 2014</td>
<td>175 000</td>
</tr>
<tr>
<td>No.</td>
<td>Emergency</td>
<td>Period</td>
<td>SEARHEF allocation in US$</td>
</tr>
<tr>
<td>-----</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------</td>
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</tr>
<tr>
<td>21</td>
<td>Complement the response and recovery activities conducted by MoH, Sri Lanka to support short- to medium-term needs of the health sector</td>
<td>November 2014</td>
<td>35 500</td>
</tr>
<tr>
<td>22</td>
<td>Complement the response and recovery activities conducted by MoH, Sri Lanka to support response and recovery activities from heavy floods and landslides in 22 (out of 25) administrative districts in Sri Lanka</td>
<td>December 2014</td>
<td>30 000</td>
</tr>
<tr>
<td>23</td>
<td>Support for rehabilitation efforts after the Nepal earthquake</td>
<td>April 2015</td>
<td>175 000</td>
</tr>
<tr>
<td>24</td>
<td>Support for strengthening the capacity of health institutions to meet the immediate needs of the population in drought-affected areas (88 counties and 20 cities in South and North Hwanghae, South and North Pyongang provinces) of DPR Korea</td>
<td>July 2015</td>
<td>137 160</td>
</tr>
<tr>
<td>25</td>
<td>Support MoHS to help provide operational costs for post-disaster management of floods following heavy rain that affected health facilities in the Sagaing and Magwe regions and Rakhine State of Myanmar</td>
<td>August 2015</td>
<td>26 000</td>
</tr>
<tr>
<td>26</td>
<td>Support to MoHS for emergency medical interventions for flood-affected populations in Rakhine and Chin states, and Sagaing and Magway regions of Myanmar</td>
<td>August 2015</td>
<td>149 000</td>
</tr>
<tr>
<td>27</td>
<td>Support for emergency medical supplies and essential drugs for flood-affected populations in Rason City, North Hamgyong province, DPR Korea</td>
<td>September 2015</td>
<td>161 887</td>
</tr>
<tr>
<td>28</td>
<td>Support to MoH, Sri Lanka for response and recovery activities for flood victims</td>
<td>May 2016</td>
<td>100 000</td>
</tr>
<tr>
<td>29</td>
<td>Support to MoH, Bhutan to provide health sector assistance to flood-affected populations</td>
<td>July 2016</td>
<td>161 624</td>
</tr>
<tr>
<td>30</td>
<td>Support to MoHS of Myanmar for provision of emergency health care to flood-affected populations</td>
<td>August 2016</td>
<td>175 000</td>
</tr>
<tr>
<td>31</td>
<td>Support for provision of emergency health care to populations affected by torrential rains and flood in the northern regions of DPR Korea</td>
<td>September 2016</td>
<td>175 000</td>
</tr>
<tr>
<td>32</td>
<td>Support to Sri Lanka after floods and landslides</td>
<td>May 2017</td>
<td>175 000</td>
</tr>
<tr>
<td>33</td>
<td>Support to MoH&amp;FW, Bangladesh after Cyclone Mora</td>
<td>June 2017</td>
<td>170 000</td>
</tr>
<tr>
<td>34</td>
<td>Support to MoH&amp;FW, Bangladesh for activities for population affected by Rakhine crisis</td>
<td>September 2017</td>
<td>175 000</td>
</tr>
<tr>
<td>35</td>
<td>Support to MoH, Maldives for response activities by Health Protection Agency/MoH for victims of tropical storm Ockhi</td>
<td>December 2017</td>
<td>13 000</td>
</tr>
<tr>
<td>36</td>
<td>Support to MoHS for providing essential health services to the conflict-affected population in Rakhine State, Myanmar</td>
<td>February 2018</td>
<td>156 490</td>
</tr>
<tr>
<td>No.</td>
<td>Emergency</td>
<td>Period</td>
<td>SEARHEF allocation in US$</td>
</tr>
<tr>
<td>-----</td>
<td>--------------------------------------------------------------------------</td>
<td>-----------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>37</td>
<td>Support to address the immediate health needs of the displaced Rohingya population at Cox's Bazar (Grade 3 Emergency), <strong>Bangladesh</strong></td>
<td>February 2018</td>
<td>137,842</td>
</tr>
<tr>
<td>38</td>
<td>Support operations for flood-affected areas in North and South Hwanghae provinces, <strong>DPR Korea</strong></td>
<td>September 2018</td>
<td>171,975</td>
</tr>
<tr>
<td>39</td>
<td>Provision of life-saving health-care services to flood-affected populations, <strong>Myanmar</strong></td>
<td>August 2019</td>
<td>160,000</td>
</tr>
<tr>
<td>40</td>
<td>Support for COVID-19 preparedness and response, <strong>Thailand</strong></td>
<td>January 2020</td>
<td>175,000</td>
</tr>
<tr>
<td>41</td>
<td>Support for COVID-19 preparedness and response, <strong>Bhutan</strong></td>
<td>March 2020</td>
<td>175,000</td>
</tr>
<tr>
<td>42</td>
<td>Support for COVID-19 preparedness and response, <strong>Maldives</strong></td>
<td>March 2020</td>
<td>175,000</td>
</tr>
<tr>
<td>43</td>
<td>Support to cover immediate health needs due to flash floods and landslides, <strong>Timor-Leste</strong></td>
<td>April 2021</td>
<td>175,000</td>
</tr>
</tbody>
</table>

**Grand total**  
6,776,770
(b) Expanding the scope of the South-East Asia Regional Health Emergency Fund (SEARHEF) (SEA/RC69/R6)

Background

97. The Sixty-ninth session of the WHO Regional Committee for South-East Asia endorsed resolution SEA/RC69/R6 on “Expanding the scope of SEARHEF” to include a “preparedness stream” that would strengthen key aspects such as disease surveillance, health emergency workforce and health emergency teams. There was also an expressed need for increasing the amount in the tranches for emergency funding from SEARHEF. It was anticipated that support for basic preparedness activities may cost US$ 200 000 per country per biennium. Thus, the minimum corpus per biennium was set at US$ 2.2 million. The target date for implementation of the SEARHEF preparedness funding stream was decided to be 1 January 2018. As of June 2021, Thailand and India had contributed an amount of US$ 200 000 each towards the SEARHEF preparedness stream as Voluntary Contributions.

98. The purpose of the Fund for preparedness is to complement, not replace, development programmes under the biennium workplans. Activities under SEARHEF funding aim to provide short-term, bridging funds to kickstart, add value to, and/or support larger preparedness projects. Furthermore, the SEARHEF preparedness stream does not affect the functioning of the response Fund. The criteria for allocations for preparedness from the Fund are as follows:

a. Address a priority gap as found in the International Health Regulations (IHR; 2005) capacity assessments and/or SEA Region benchmark assessments.

b. Address gaps in core skills such as risk assessments or information management.

c. Strengthen public health emergency operations centres (PHEOCs).

99. The types of activities for emergency health preparedness that will be considered under the new preparedness stream of SEARHEF, as endorsed by Regional Committee resolution SEA/RC69/R6, are as follows:

i. development and strengthening of policies and capacities;

ii. development and implementation of training courses;

iii. systems for disease surveillance, information and knowledge exchange across countries for risk assessments and risk communications;

iv. strengthening PHEOCs;

v. health emergency supply chain management system;

vi. strengthening of emergency medical teams and their coordination;

vii. assessment of health facilities for disaster risk reduction; and

viii. strengthening the health emergency workforce through the establishment of systems that include efficient recruitment and deployment.

Progress made in the WHO South-East Asia Region

100. From the total of US$ 400 000 in Voluntary Contributions made by Thailand and India, US$ 125 000 has been disbursed to Bhutan (US$ 50 000), Maldives (US$ 50 000) and Sri Lanka (US$ 25 000), for strengthening HEOCs and rapid response teams or for surveillance, etc.

101. The HEOCs in all three countries of Bhutan, Maldives and Sri Lanka have been operationalized as part of the incident management system for the COVID-19 pandemic response.
102. The balance available, as of June 2021, is US$ 275 000, excluding the Programme Support Cost (PSC) charges, which are charged at the rate of 13% for the Voluntary Contributions.

103. Management of the preparedness stream of SEARHEF is overseen by the same Working Group comprising representatives from all 11 Member States that manages the response stream. The Working Group has met nine times since 2008. The Ninth Meeting of the Working Group was held virtually in August 2020.

**Challenges being faced**

104. Major challenges being faced by SEARHEF have been well articulated in the recommendations made by the Working Group during the meetings. These include:

i. challenges in mobilizing domestic resources for preparedness activities;

ii. global and regional donor environment for funding not being conducive; and

iii. need for further strengthening of timely reporting on utilization of SEARHEF, as we expand to this new preparedness stream.

**The way forward**

105. During the roundtable deliberations at the Ninth Meeting of the Working Group, the members provided updates on discussions being undertaken with countries’ respective ministries of finance and planning on contributing to SEARHEF. In particular, delegates from Bangladesh, Bhutan, India and Nepal mentioned the ongoing discussions at the country level on potential Voluntary Contributions to SEARHEF.

106. The COVID-19 pandemic has brought to light the importance of emergency preparedness and both Member States and the Secretariat need to leverage this situation to mobilize additional resources for this preparedness fund. Member States of the Region are highly encouraged to fund the preparedness stream of SEARHEF as a very good and highly rewarding investment.
6. Patient safety contributing to sustainable universal health coverage (SEA/RC68/R4)

Background

107. Patient safety is critical to the delivery of health care in all settings. This aims to achieve the maximum possible reduction in avoidable harm due to unsafe health care. Patient safety has been recognized as a public health problem for many years in the SEA Region. Several resolutions on this topic have been adopted in various sessions of the Regional Committee and World Health Assembly. The COVID-19 pandemic has further highlighted the need to focus on patient safety.

108. In 2006, the Fifty-ninth session of the WHO Regional Committee for South-East Asia endorsed a resolution SEA/RC59/R3, titled “Promoting patient safety in health care”.

109. In 2015, the Sixty-eighth session of the Regional Committee for South-East Asia, vide its resolution SEA/RC68/R4 titled “Patient safety contributing to sustained universal health coverage”, endorsed the “Regional Strategy for Patient Safety 2016–2025”. This urged Member States to translate six strategic objectives into action; engage with all relevant stakeholders in creating and sustaining a culture of patient safety at all levels of health care; create awareness and engage patients and communities in the process of improved patient safety; and allocate adequate resources to implement the country action plan.

110. The Regional Director was also requested, inter alia, to provide technical support in implementing the Regional Strategy and to report progress, achievements and challenges in implementing this resolution to the Regional Committee in 2017, 2019, and facilitate assessment of the patient safety scenario in Member States of the Region upon request, as well as report to the Regional Committee in 2021.

111. Preliminary baseline assessment conducted using the tool developed by the Regional Office (as reported to the Seventieth session of the Regional Committee in 2017 vide document SEA/RC70/13), showed that adverse events in most health-care facilities (HCFs) are not reported except for immunization and maternal deaths. Many countries either did not have quality assurance mechanisms or their compliance with existing quality assurance standards was low. The report presented to the Seventy-second session of the Regional Committee in 2019 (document SEA/RC72/13) did show progress in patient safety in Member States of the SEA Region as compared with the previous round of reporting in 2017.

112. The Seventy-second World Health Assembly in 2019 adopted resolution WHA72.6 on Global Action on Patient Safety. The Health Assembly also requested the Director-General to formulate a Global Patient Safety Action Plan (GPSAP) in consultation with Member States and all relevant stakeholders, for submission to the Seventy-fourth World Health Assembly in 2021.

113. The WHO Secretariat developed a draft Global Patient Safety Action Plan (GPSAP) that was supported by consultations with relevant technical experts globally and shared with Member States for their inputs. In 2020, the Seventy-third session of the Regional Committee for South-East Asia vide Decision SEA/RC73(2) requested the Regional Director to convene a Regional Consultation with Member States and other relevant stakeholders to consider the draft GPSAP with a view to prioritizing regional patient safety actions aligned with the draft Global Action Plan and the Regional Patient Safety Strategy.

114. Accordingly, a Regional Consultation on Patient Safety was organized virtually on 31 March 2021 to review the Regional Strategy 2016–2025 at its mid-term; and the Global Patient Safety Action Plan 2021–2030 with respect to the country priorities and needs in the SEA Region.
115. The Global Patient Safety Action Plan 2021–2030 has been adopted by the Seventy-fourth World Health Assembly in May 2021. The Health Assembly, inter alia, requested the Director-General of WHO to report back on progress in the implementation of the Action Plan to the Seventy-sixth World Health Assembly in 2023 and thereafter every two years until 2031.

**Progress made in the WHO South-East Asia Region**

116. The regional consultation held on 31 March 2021 revealed that in the SEA Region, most Member States have national patient safety/quality strategies in place. Almost all Member States are also actively commemorating World Patient Safety Day on 17 September every year. Several Member States also have in place robust administrative structures with a mandate for health-care quality and safety. Mindful of the cross-cutting nature of this work area, Member States have incorporated patient safety in various health programmes, e.g. maternal and child health, medication safety, blood safety, sepsis and surgical site infections, and antimicrobial resistance (AMR), among others.

117. Patient safety assessments have been conducted in many Member States of the SEA Region in previous years to understand the gaps. No recent assessments on gaps in patient safety, however, have been reported from Member States and neither has any Member State requested WHO to undertake any such assessment. This could be on account of health staff being preoccupied with the COVID-19 pandemic response.

118. To support the initiative of patient safety and evidence-based implementation of GPSAP, WHO has initiated a situational analysis of patient safety in Member States. This situational analysis will help in identifying gaps and prioritizing next steps in the country context.

119. Infection prevention and control and water, sanitation and hygiene (WASH) have taken on special significance and urgency due to COVID-19. Most countries have updated their infection prevention and control (IPC) guidelines and conducted extensive capacity-building for IPC and WASH during this past year.

120. During the regional consultation, Member States made the following recommendations with respect to aligning the Regional Strategy and GPSAP to address country needs:

   a. The Regional Strategy may further emphasize the role of patients and families in patient safety under the current Strategic Objective 1.

   b. Strategic Objective 3 of the Regional Strategy may be revised to include health worker safety as a key to patient safety.

   c. A monitoring framework can be included in the Regional Strategy for systematic tracking of progress in the remaining period. It was agreed that the monitoring framework of the GPSAP be used as relevant for individual country contexts.

121. The Seventy-fourth World Health Assembly endorsed the GPSAP. India, Indonesia, Sri Lanka and Thailand from the SEA Region made interventions in support of the GPSAP during the deliberations on this subject.

122. Member States will be reporting back on progress in the implementation of the Global Patient Safety Action Plan 2021–2030 to the Seventy-sixth World Health Assembly in 2023 and thereafter every two years until 2031.
Challenges being faced

123. The COVID-19 pandemic has exposed the gaps and highlighted the need to focus on patient safety. Since this is a multidisciplinary area, it is important to simultaneously focus on IPC, hand hygiene, WASH, AMR, among others, for sustained improvements. Member States have witnessed a large volume of infections among health-care workers as well as hospital-acquired infections during COVID-19. There is a need to improve the quality and safety of frontline services, and their links to higher levels of care. Most of these challenges cannot be addressed at the facility level alone and require national and subnational engagement and action. Political commitment is required to ensure sustainability of the programmes and efforts in this direction. Managing change in countries is both a technical and political challenge.

The way forward

124. The COVID-19 pandemic has highlighted the importance of patient safety, helped in identifying priority actions and created an opportunity to strengthen the implementation of national patient safety action plans. The release of GPSAP is very timely and will further strengthen and accelerate global and national action on patient safety. The Regional Strategy with proposed revisions is well aligned with the GPSAP. Monitoring and reporting are important to evaluate the progress made by the Member States. A monitoring framework and indicators will be adapted from the GPSAP as per country contexts and priorities. WHO will continue extending technical support to Member States to establish sustainable and robust patient safety systems. WHO will also foster global/regional patient safety networks to facilitate intercountry and intracountry learning.

125. Patient safety has explicitly demonstrated its immense importance to mitigate the debilitating effects of COVID-19. GPSAP received commendable support from Member States during its adoption by the Seventy-fourth World Health Assembly. So, it is expected that there will be enhanced country commitment, which should help in improving the implementation of the Regional Strategy on Patient Safety and the GPSAP in Member countries, with technical support from WHO.
7. Delhi Declaration on Emergency Preparedness in the South-East Asia Region (SEA/RC72/R1)

Background

126. The WHO South-East Asia Region continues to face threats from public health emergencies and disasters on an increasing scale and of increasing complexity. Strengthening health emergency preparedness has been considered as one of the highest health priorities in our Region, resulting in emergency risk management being included as a Regional Flagship Priority Programme of the WHO SEA Region since 2014.

127. The Delhi Declaration on Emergency Preparedness in the South-East Asia Region was endorsed as a ministerial-level political commitment by the Seventy-second session of the WHO Regional Committee for South-East Asia in 2019. The Delhi Declaration calls for joint efforts towards a safer and more secure Region through investing in people and systems for emergency risk management and forging stronger partnerships.

128. Along with the Delhi Declaration, the Five-year Regional Strategic Plan to strengthen public health preparedness and response 2019–2023 and the Risk Communication Strategy for public health emergencies in the WHO South-East Asia Region 2019–2023 were launched at the same session. In addition, the Region’s efforts to strengthen health security systems have also been guided by the Bi-regional Strategic Framework, the Asia-Pacific Strategy for Emerging Diseases and Public Health Emergencies (APSED III): Advancing implementation of the IHR (2005), of which the original iteration was launched in 2005.

Progress made in the WHO South-East Asia Region

129. Member States of the Region have made considerable progress in advancing implementation of the International Health Regulations (IHR) (2005) for health security. According to the State Party Self-Assessment Annual Reporting (SPAR) submitted by Member States, the average total score of IHR capacities has gradually increased from 56 in 2018 to 61 in 2019 and 63 in 2020.

130. Eight Member States have conducted the voluntary joint external evaluation (JEE) of the implementation of IHR (2005) since 2016, based on which six Member States – Bhutan, Indonesia, Maldives, Myanmar, Sri Lanka, Thailand and Timor-Leste – have developed and implemented their multiyear national action plans for health security (NAPHS) to further strengthen core capacities, as guided by the Regional Strategic Framework. Bangladesh also developed its draft national action plan, which is now awaiting approval. Most Member States have also developed and implemented national action plans for disaster risk management in line with the Sendai Framework for Disaster Risk Reduction 2015–2030.

131. These capacities have been tested by the unprecedented COVID-19 pandemic. Member States fully utilized the capacities and systems developed in the past decades in managing the pandemic. Moreover, all Member States developed and implemented national preparedness and response plans for COVID-19, mobilizing all available resources as well as health and non-health sector stakeholders to implement whole-of-government and whole-of-society responses.

132. In this process, all the aspects of health security systems were strengthened, from national incidence command and coordination structure and health emergency operation centres (HEOCs) to surveillance, national laboratory network, clinical management, infection prevention and control, risk communication and community engagement, as well as operations support and logistics management. WHO has provided technical and financial support for the national pandemic response to all Member States, mobilizing resources from the three levels of the Organization.
133. Some Member States, such as Bangladesh, Bhutan, India (state of Gujarat), Indonesia and Thailand, conducted intra-action reviews of their COVID-19 response, engaging stakeholders from all relevant sectors, aiming to identify strengths, challenges, lessons learnt and priority actions to further improve the ongoing pandemic response. The findings and recommendations also had important implications for health security system strengthening.

134. The regional platform to connect national IHR focal points (IHR NFPs) was strengthened as follows:

- The Regional Office organized several virtual meetings with IHR NFPs in the context of COVID-19, which contributed to exchanging information and sharing lessons learnt among IHR NFPs, and between Member States and the WHO Secretariat.
- The Regional Knowledge Network of NFPs was also used to provide online learning resources and a “Regional Knowledge Repository” among its 196 users.

**Challenges being faced**

135. Despite the major progress in strengthening public health emergency preparedness among Member States in the Region, the COVID-19 pandemic has exposed the fact that the current levels of preparedness are not sufficient to effectively manage severe health emergencies such as this pandemic, and to prevent the outbreak from becoming a protracted global health emergency.

136. Core capacities required by the IHR (2005) need further improvement for more effective health emergency preparedness and response. This will necessitate the highest level of political leadership, as well as sustainable and predictable financing to support long-term planning and investment.

137. IHR NFPs have played critical roles in the national pandemic response. However, IHR NFPs were not always granted adequate authority to engage other sectors or agencies in emergency planning processes.

138. Surveillance that enables early detection and alerts, as well as risk assessment that supports timely decisions on response measures, must be strengthened further. Rapid scale-up of coordinated laboratory networks for diagnostic testing and genetic sequencing was also a major challenge for many Member States.

139. Challenges were also found in health systems and their resilience. Preparedness of health-care services, including surge capacities, triage and appropriate care pathways, adequate infection prevention and control, combined with effective supply management systems, require improvements.

140. Risk communication and community engagement have been central to the pandemic response; however, investment in this area has been limited. Effective infodemic management, including management of misinformation, is essential.

141. COVID-19 vaccines were developed at an unprecedented speed, yet the global distribution in the first half of 2021 at the time of preparing this report has been suboptimal and inequitable.
The way forward

142. While the battle against COVID-19 continues, Member States, WHO and other partners must work together to identify priority actions to further strengthen health emergency preparedness and response capacities to more effectively respond to the ongoing pandemic and to prepare for future pandemics, emergencies and disasters.

143. It is critical that lessons from the ongoing pandemic response be used to inform further efforts to strengthen health security systems in our Region.

144. Global review committees and bodies, such as the Review Committee on the functioning of IHR (2005) during the COVID-19 response and the Independent Panel on Pandemic Preparedness and Response, have also issued their recommendations. These recommendations are expected to guide the efforts by Member States and WHO to strengthen health security systems, while at the same time the regional and country contexts must also be taken into account.

145. Member States are encouraged to contribute collectively to transform the global health security architecture. This includes contribution to the deliberations at the Member States’ Working Group on Strengthening WHO Preparedness and Response to Health Emergencies (as per resolution WHA74.7 of the Seventy-fourth World Health Assembly in May 2021), and development of the Universal Health and Preparedness Review as a Member State-led, voluntary peer-to-peer review mechanism.

146. Building regional and national health security systems, linked to resilient health systems and through multisectoral arrangement, requires long-term vision and perspective, robust political leadership and sustainable financing. Both the whole-of-society approach as well as the “One Health” approach will need to be strengthened further.

147. Member States and WHO should work together to further synthesize the lessons gained from the COVID-19 pandemic response and examine and interpret the implications of recommendations made by global committees and bodies in the regional context. Based on such deliberations, Member States and WHO should develop a regional roadmap to propose strategic actions that will transform the levels of preparedness in the Region for future health emergencies. This roadmap should aim to accelerate the implementation of the Delhi Declaration and inform the development of a future health security framework in the Region.
8. Colombo Declaration on strengthening health systems to accelerate delivery of NCD services at the primary health care level (SEA/RC69/R1)

Background

148. The Colombo Declaration on strengthening health systems to accelerate delivery of NCD services at the primary health care level was endorsed by the Sixty-ninth session of the WHO Regional Committee for South-East Asia on 9 September in 2016 in Colombo, Sri Lanka (SEA/RC69/R1). The Declaration highlights renewed commitment by Member States to accelerate NCD service delivery through a people-centred primary health care approach to realize the Global and Regional Voluntary Targets for noncommunicable disease (NCD) prevention and control, which includes achieving 80% availability of essential NCD medicines and technologies in health facilities and ensuring that 50% of high-risk populations receive drug and counselling therapies to prevent heart attack and stroke by 2025.

149. The resolution entrusted the Secretariat to submit an interim report in 2019 and a full progress report in 2021. In 2019, interim progress was reported to the Seventy-second session of the Regional Committee for South-East Asia. A Side-event on “Moving NCD services from specialists to generalists, closer to the people through primary health care” was organized during the Seventy-second session of the Regional Committee to highlight the need to sustain the commitments to improve access to NCD services at the primary health care level.

Progress made in the WHO South-East Asia Region

150. While there has been notable progress in mainstreaming NCD services in the primary health care system in the SEA Region, the ongoing COVID-19 pandemic has tested the resilience of primary health care systems, including for NCD services, all over the world and has adversely impacted the progress, mainly due to disruption in essential health services. With the focus on continuity of essential services within the Strategic Preparedness and Response Plans to COVID-19 at the country level, there are signs of improvement in NCD services, as reported in the WHO Pulse surveys.

Visible policy initiatives to strengthen NCD early diagnosis and management

151. There is steady progress in integrating essential NCD services within health systems in the Region to accelerate integration of NCD services into primary health care systems. Some of the health policy initiatives with a direct bearing on NCD services adopted by Member States include: India – the National Health Policy 2017, which focuses on a range of NCD interventions; Indonesia – enactment of the “minimum service standard regulations for health” in November 2016, which includes screening for NCD risk factors for people aged 15–59 years (Minister’s regulation no. 43 for 2016 on minimum service standards for health) and services for diabetes and hypertension as an integral performance indicator for local governments; Thailand – health policy to strengthen early detection and management of NCDs as part of its primary health care service package; Bangladesh – endorsement of NCD services in the Essential Services Package in 2016; Nepal – enactment of the Basic Health Service Act in 2018 and Basic Health Service Regulation in 2020; and Sri Lanka – launch of the Policy on Healthcare Delivery for Universal Health Coverage in April 2018 and the Sri Lanka Essential Service Package with a focus on NCDs in 2019.
Early detection and screening of NCDs are expanding at the frontline

152. The Package of Essential Noncommunicable Diseases (PEN) and Healthy Lifestyle Intervention training modules for primary health care workers was developed and released at the Seventy-first session of the Regional Committee in 2018. All countries of the Region were oriented on the regional PEN training package at a three-day meeting in October 2018 in Dhaka. In 2020, the WHO Regional Office for South-East Asia developed an online course on the delivery of people-centred NCD services to enable capacity-building during the COVID-19 pandemic. Ninety-eight participants from Bangladesh, Bhutan, Nepal and Sri Lanka completed the course. The second online course is planned in 2021 for participants from the remaining Member States.

153. Salient country-level progress achieved thus far include the following:

a. **Bangladesh**: WHO PEN-HEARTS has been scaled up to 66 sub-districts so far and interventions are being scaled up to 34 more sub-districts, taking the total to 100 out of 492 sub-districts. Capacity-building, use of protocol-based management, supply of medicine and equipment, monitoring and supervision, and telehealth innovations are being implemented. Implementation of the model has been expanded to the camps hosting displaced population groups.

b. **Bhutan**: Bhutan adopted WHO PEN and scaled up interventions across the country. The updated version of the PEN is being scaled up in 2021 and branded as “Service with Care and Compassion” in nine out of 20 districts to improve care delivery focusing on team-based care, clinical mentoring of primary health care teams, patient recalls and follow up, and prescription refills at primary health care facilities.

c. **DPR Korea**: adapted the PEN training modules for management of hypertension and diabetes at the primary health care level, with plans to scale up training soon.

d. **India**: population-based screening has been expanded to more than 600 districts covering 50 481 subcentres and 21 072 primary health centres (PHCs); more than 110 million individuals have been screened as of 21 June 2021. Nearly 75 550 health and wellness centres have initiated point-of-care diagnostics with mid-level care providers, screening services for NCDs and free drugs supply. As of December 2020, 31 million NCD clinic visits have been recorded through the National Programme for the Prevention and Control of Cancer, Diabetes, Cardiovascular Disease and Stroke (NPCDCS Programme). The India hypertension control initiative has been rolled out to 17 states covering 80 districts and enrolled 1.4 million patients since the start of the programme in 2018.

e. **Indonesia**: PANDU PTM guideline (algorithm for cardiovascular (CV) risk assessment using the latest chart was updated and disseminated to all the PHCs in the western and central regions of Indonesia in 2021 with evaluation planned after six months of implementation. The Ministry of Health (MoH) has targeted 250 cities/districts for implementation of PANDU PTM by the end of 2021, of which 101 cities/districts had started PANDU PTM by May 2021. The MoH also plans to conduct a survey to evaluate implementation of PANDU PTM by PHCs during the COVID-19 pandemic.

f. **Maldives**: since the launch of the first trainings in Male’ and Addu Atoll in 2017, PEN training has been now been conducted in nine out of the country’s 20 atolls. A mobile app, mPEN, was launched in 2019 to facilitate the use of PEN specifically at atoll and island levels.
g. **Myanmar**: the PEN programme was expanded from 20 townships in 2017 to 177 in 2018 and 232 townships in 2019. This translates into 5058 health facilities in 2018 and 9518 health facilities in 2019 resulting in 429 400 and 205 945 patients diagnosed with hypertension and diabetes, respectively. A total of 462 193 individuals with a 10-year cardiovascular disease (CVD) risk score of >10% were assessed through NCD clinics held every Wednesday.

h. **Nepal**: since the pilot implementation of the PEN in two districts of Kailali and Ilam in 2017, the programme has been scaled up to 51 districts, and the Ministry of Health and Population, plans to cover all 77 districts by 2022. Additionally, six districts have been identified in 2021 for the rollout of a comprehensive chronic care model in the country.

i. **Sri Lanka**: the number of healthy lifestyle clinics has now expanded to 1200, up from the 800 clinics registered in 2016. Sri Lanka embarked on reorganizing primary health care to implement a shared care model in which primary care institutes are linked to an apex tertiary care hospital through referral and counter referral system in 2019; identified Kandy district in 2021 to implement a care pathway model for NCDs in the country.

j. **Thailand**: hypertension management has been prioritized. A National Strategic Technical Advisory Group on Hypertension meets quarterly and provides oversight and policy directions to the programme. The CVD track has been integrated into the Field Epidemiology Training Programme (FETP). Surveillance and research undertaken by FETP trainees provide feedback for programme improvement. A rapid health facility assessment survey was undertaken to identify best practices and gaps. In 2019, Thai hypertension guidelines were launched, and a public awareness campaign was carried out on social media to create awareness about blood pressure monitoring and treatment.

k. **Timor-Leste**: PEN services have been expanded to 37 community health centres in six municipalities (Dili, Ermera, Baucau, Manatuto, Liquiça and Bobonaro) after the programme was first launched in six such centres in Dili Municipality in 2017. NCD services are also being delivered to the community through domiciliary visits (under the umbrella of the pioneering nationwide Saude na família initiative), mobile clinics, Servisu Integrado Sude Comunita (SISCA) – integrated health service programme in the community and the School Health Services.

154. While the progress across all Member States is encouraging, there is a need to improve coverage of screening and effective treatment services. For example, the hypertension control coverage rates in most countries is below 10%. This indicates that NCD services need both a scale up of services as well as bolstered quality of care.

**From screening and early diagnosis to chronic care**

155. **Refocus on palliative care services**: WHO assessment has shown that during the COVID-19 pandemic, palliative care and rehabilitative care were the most disrupted and least prioritized of health-care services. Bhutan, India and Maldives have initiated palliative policy and capacity development in 2020. A two-day regional online workshop on palliative care conducted by the Healthier Population and Noncommunicable Diseases (HPN) Department of the WHO Regional Office for South-East Asia in April 2021 called for countries to strengthen national policies and programme administration, fast-track integration of palliative care in the primary health care system, ensure the availability of opioids, and reinvigorate the delivery of community- and home-based care.
156. **Stroke care improvement initiative**: stroke services are generally provided as a routine health service in hospital settings. However, a systemic approach to care driven by quality performance measures is not widely practised in the Region. A regional forum on stroke care improvement organized virtually by the WHO Regional Office for South-East Asia during World Stroke Day on 29 October 2020 recommended that countries take concrete steps in stroke care improvement. In 2020, Bhutan, Maldives, Myanmar and Timor-Leste initiated stroke care improvement in selected hospitals. In 2021, Nepal and Sri Lanka have started the appraisal dialogues for stroke care improvement. In India, telestroke care programme has been implemented in Himachal Pradesh while states such as Assam, Kerala and Uttar Pradesh have initiated stroke care improvement programmes.

157. **Strengthening national cancer control programmes**: review of cancer control through imPACT missions in Indonesia, Myanmar and Sri Lanka have set the pace for improving national policies and strategies on cancer control. In 2020–2021, Nepal conducted the imPACT mission, which will feed into the development of the National Cancer Control Plan. A regional workshop on cancer control conducted in 2019 adopted an acceleration framework for cancer control, following which Bhutan, Indonesia and Maldives drafted their national cancer control plans.

158. **Childhood cancer**: through the Global Initiative for Childhood Cancer (GICC), three countries — Myanmar, Nepal and Sri Lanka — have been identified as GICC focus countries in 2019. Kanti Children’s Hospital (Nepal), Yangon Children’s Hospital (Myanmar) and the National Cancer Institute in Colombo (Sri Lanka) are implementing the initiative. Fifteen institutions in 10 countries of the Region joined the SEA Region Childhood Cancer Initiative (SEAR CCN) in 2021 to promote a “community of practice” among institutions. A virtual tumour board of clinicians has been initiated at the Tata Memorial Hospital in Mumbai, India, for case management discussions.

159. **Cervical cancer**: the Seventy-second session of the Regional Committee for South-East Asia noted the elimination threshold for cervical cancer for the century and endorsed the interim targets “90-70-90” [90% of girls fully vaccinated with HPV vaccine by the age of 15; 70% of women screened with a high-performance test by 35 years of age and again by 45 years of age; and 90% women identified with cervical disease receive treatment] for 2030. The Regional Implementation Framework for the elimination of cervical cancer as a public health problem was developed in 2021 to provide guidance to Member States.

**Operational levers for NCD response at the primary health care level**

160. **Making the health workforce NCD-ready at the primary health care level**: several actions have been implemented in all Member States to strengthen primary health care, including task-sharing by non-physician health workers to manage NCDs. Key examples include prescription rights of health assistants to treat common NCDs in Bhutan, creation of a cadre of public health nursing officers for NCDs in Sri Lanka, appointment of staff nurses at the PHC level and integrating professionals from alternative systems of medicine (AYUSH) to provide services in NCD clinics in India.

161. **Updated essential drugs and diagnostics at health facilities**: after the Colombo Declaration, Bangladesh, Bhutan, Nepal, Sri Lanka, Thailand and Timor-Leste updated their essential drugs lists (EDL) with NCD medicines. Medicines and diagnostics have been included in the Essential Services Package (ESP) in Bangladesh, and Basic Health Service Package in Nepal.

162. **NCD-related registries are expanding**: after 2016, population-based cancer registry (PBCR) sites in countries have increased. Nine countries (all except DPR Korea and Maldives) have a PBCR. Bhutan and Nepal published their first PBCR reports in 2020. India and Thailand have well-established multiple PBCRs that generate reliable population data on cancer. Indonesia has expanded its population-based cancer registry to 14 provinces in the country. The National Stroke Registry and Registry of Youth Onset Diabetes are implemented in India. Sri Lanka also has a stroke registry. Stroke surveillance and stroke care can be improved with stroke registries. Similarly, rheumatic heart disease registries are an important part of the NCD registry system but have been dismantled in most countries and will require renewal.
163. **Financial protection and universal health coverage**: NCDs contribute to a high proportion of out-of-pocket (OOP) expenditure in the Region. Several measures have been initiated to reduce OOP payments and inequities. These include adoption of a National Health Policy 2017 (NHP, 2017) in India to help reduce the number of households facing catastrophic health expenditure by 25% by 2025, progressive increase in enrolment in a health insurance scheme in Nepal to 3.3 million by 2020, and Indonesia’s commitment to cover health-care costs for all NCDs through the National Health Insurance. Various government schemes and subsidies have been rolled out to improve access to medicines, such as provision of free cancer treatment in many states and Union Government institutions in India, and financial support of Nepalese Rupee 100 000 for eight identified conditions, including heart disease, cancers and kidney disease in Nepal.

**Challenges being faced**

164. **COVID-19 and disruption of NCD essential services**: the COVID-19 pandemic has adversely affected the NCD burden and worsened access. Most of the essential NCD services have suffered heavy disruptions due to shifting strategies and priorities, repurposing of the health workforce for COVID-19 pandemic activities, and disruption of supply chains for medicines and diagnostics. This has resulted in a reduction in patient visits for medicine refills, cancellation of surgeries, including for cancer, and fewer follow up of scheduled visits in all Member States of the Region. The impact of disrupted care has been seen in patient health outcomes such as reduction in control rates of hypertension and diabetes. The threat of continuing disruptions persists, as countries are forced to strike a delicate balance between tackling the pandemic and ensuring essential services including for NCDs. Some of the key ongoing challenges include:

a. weak chronic care models for NCDs within existing health systems frameworks;

b. inadequate organizational structure for programme management of NCDs in ministries of health; and

c. low investment and inadequate gatekeeping in PHCs.

**The way forward**

165. The Astana Declaration on Primary Health Care of 2018 has reiterated that investment in primary health care systems is essential for improving access to the management of NCDs. Achieving the UHC-related SDG Target 3.8 by 2030 depends on countries’ abilities to adequately respond to the NCD epidemic. Addressing the NCD burden requires a PHC-oriented health system that delivers people-centric, integrated, equitable and responsive care.

166. It is essential to build on the lessons learnt in the past five years. Engagement of political leaders is critical in setting the national NCD agenda; nurturing champions and leveraging academia is also critical for sustained advocacy, capacity-building and expanding networks of communities of practice. Primary health care workers are equal partners of clinical specialists in the quest to achieve universal health. Knowledge-sharing and horizontal collaboration across countries is key to promoting learning and leveraging experiences to leapfrog implementation for results. Use of digital innovation for capacity-building in NCD prevention and control has become a game-changing experience in the wake of the COVID-19 pandemic, and this experience must be harnessed beyond the pandemic response. Empowered and engaged communities responsive to the voices and experiences of people living with NCDs are necessary to co-design and co-deliver the NCD agenda – this is no longer a matter of choice but is imperative.
167. NCD programme management and stewardship must be strengthened to accelerate NCD services at the PHC level. Ministries of health need to prioritize strengthening of the capacities of national NCD programmes by realigning the structures to the evolving mandates and commitments of governments to deliver on NCD prevention and control. Appropriate structures and human resources should be in place to enhance the steering role of the ministries of health for strategic management of cross-sectoral policy partnerships and addressing disease-specific programmes.

168. It is essential to build an NCD-ready primary health care workforce. It is imperative to reorient primary health care systems for capacity-building and task-sharing to optimize the use of the primary health care workforce, and build additional cadres as necessary to respond to the increased scope and expectations of people-centred NCD services. Ministries of health need to improve the policy and legal environment to promote task-sharing and delegation for managing NCDs at the primary health care level; and harness the power of partnerships with training institutions to strengthen both pre- and in-service education in line with evolving chronic care needs.

169. To contextualize the models of care with PHC as the centre, it is necessary to invest in building models of care that promote high-quality, people-centred primary care through the life-course, and across the continuum of home, community and facility, with a special focus on the needs of vulnerable and hard-to-reach populations. An organizational culture that supports monitoring and evaluation through knowledge-sharing, feedback and use of data for decision-making must be promoted.

170. To better finance primary health care to strengthen NCD services at the PHC level, fiscal allocation for primary health care NCD services from domestic resources must be increased. This must include innovative financing mechanisms linked to social protection for the poor that will reduce out-of-pocket expenditure to realize UHC. Mechanisms for financial tracking will ensure accountability and better returns on investment.

171. Through country partnerships, WHO will continue its role of providing support for evidence-based policy generation, advocacy, capacity-building, systems strengthening, partnerships and knowledge management to improve NCD services at the primary health are even after the sunsetting of the Colombo Declaration in 2021 in order to achieve SDG Target 3.4.