Looking back at WHO’s work in the South-East Asia Region in the 60th anniversary of WHO’s existence, remarkable achievements in the area of disease control, family and community health, healthy environments and health system development are observed. These achievements could not have been made without close collaboration with Member countries and all partners in health at the country, regional and global levels.

This Report describes and analyses the outcomes of WHO’s work and its impact on countries’ capacity, and underscores key challenges and priorities for each area of work. In each area, it briefly describes the current health situation, and key strategy/policy changes that occurred during the review period and which address challenges in health.

The Report also serves as a useful information product, for our partners and others interested in health development, on WHO’s work and future priorities in the Region. Although the Report covers a period of one year, the principles of continuity, sustainability and follow-up of important outcomes have been emphasized.
Report of the Regional Director
1 July 2007 – 30 June 2008
The Work of WHO in the South-East Asia Region

Report of the Regional Director
1 July 2007– 30 June 2008
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Preface

This year’s report on the Work of WHO in the South-East Asia Region differs substantially from previous reports. While it keeps to the constitutional context as an accountability tool for the WHO Secretariat covering its work with Member countries during the period under review, the Report highlights WHO’s collaborative activities in relation to achievements in core health indicators in the context of current developments.

Each section (where appropriate) briefly describes the current health situation, and key strategy/policy changes that occurred during the review period and which address challenges in health. Instead of listing WHO collaborative activities, the Report describes and analyses the outcomes of WHO’s work and its impact on countries’ capacity. The Report also underscores key challenges and priorities for each area of work.

When we look back at our work in the Region in the 60th anniversary of WHO’s existence, remarkable achievements in the area of disease control, family and community health, healthy environments and health system development are observed. These achievements could not have been made without close collaboration with Member countries and all partners in health at the country, regional and global levels. This Report could also serve as a useful information product, for our partners and others interested in health development, on WHO’s work and future priorities in the Region. Although the Report covers a period of one year, the principles of continuity, sustainability and follow-up of important outcomes have been emphasized.

Samlee Plianbangchang, M.D., Dr.P.H.
Regional Director
Executive summary of key achievements
Executive summary of key achievements

Communicable diseases

1. Remarkable progress was achieved in the area of communicable diseases prevention and control in the South-East Asia (SEA) Region*. The global targets for tuberculosis case detection and treatment success were met in majority of Member countries. Leprosy prevalence declined remarkably, and, while detection of new cases continues, only two countries have yet to achieve the goal of elimination. Progress was made in interrupting the transmission of lymphatic filariasis, with mass drug administration covering 60% of the target populations. A remarkable decline in yaws was observed, and case management of kala-azar improved. However, the burden of communicable diseases still exists. Diarrhoeal and respiratory infections cause substantial mortality. Dengue continues to pose a major public health problem. Almost half of global avian influenza cases are reported from the Region. In terms of HIV infection, the Region is the second-most affected WHO region. Chikungunya fever is re-emerging and outbreaks of Nipah virus infections are reported. Drug-resistant malaria has spread. The following key achievements addressed these challenges.

Building up outbreak response

- International Health Regulations (IHR) core capacity assessments completed. High-level national task forces on avian influenza (AI) and coordinating bodies with ministries of health, livestock, home affairs and education established.
- Three-month field epidemiology training programme developed.
- Over 2000 health personnel trained in rapid response and containment of outbreaks.
- Laboratory capacity for detection and diagnosis of AI and other infectious diseases strengthened.

* Bangladesh, Bhutan, DPR Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste.
Controlling epidemics and scaling up HIV services

- A set of training modules for national AIDS programme management published; regional training of programme managers concluded.

Implementing the new Stop TB Strategy

- Interventions for managing multidrug-resistant TB established and TB-HIV scaled up; improved management of drug procurement and supply implemented.
- Member countries now have access to quality-assured affordable anti-TB drugs on a regular basis.

Implementing the revised Malaria Control Strategy

- Framework for implementing integrated vector management at district level formulated.
- National treatment guidelines revised and artemisinin-based combination therapy (ACT) adopted.

Improving access and implementation of the Global Fund grants

- Eight proposals worth about US$ 200 million accepted by GFATM in Round 7.
- Assessment of usefulness and impact of WHO support in relation to GFATM grants showed that in spite of a range of significant challenges, WHO’s efforts have had a positive impact and are appreciated.

Aiming to reverse the rising trend of dengue

- Strategic Plan for Dengue Control 2008–2015 drafted to guide Member countries in developing national operational plans.

Implementing strategy and policy in zoonoses

- Regional Framework defining strategy and policy for zoonoses control finalized.
- Review of the avian influenza situation conducted and actions required to prevent and control AI in the Region formulated.
Executive summary of key achievements

**Sustaining control activities in leprosy**
- Leprosy programme activities intensified and focused on priority countries.
- Leprosy post-elimination strategy adopted, revised and translated (as necessary).
- Guidelines for Global Surveillance of Drug Resistance for Leprosy developed.

**Eliminating lymphatic filariasis and controlling soil-transmitted helminth infections**
- The Regional Strategic Plan for Elimination of Lymphatic Filariasis revised.
- National focal points for soil-transmitted helminthiasis appointed and national deworming policies formulated.

**Building up to elimination of kala-azar**
- International mission determined the technical and operational challenges, reviewed progress in implementation and the epidemiological trends, and identified needs for improvement in kala-azar elimination activities.

**Eliminating and eradicating yaws**
- Proposal for the eradication of yaws in endemic countries developed and implementation initiated.

**Strengthening national and regional resources for blood safety and clinical technology**
- Laboratory capacities strengthened for diagnosis of TB and emerging viral infections, guidelines for accreditation of laboratories produced, and training on management of infectious material conducted.
- All aspects of blood safety related to policies, quality, management and access to safe blood addressed.

**Strengthening country capacity in tropical diseases research**
- Ten research proposals of the TDR small grants programme supported.
Noncommunicable diseases and mental health

2. Chronic noncommunicable diseases continued to be the major causes of death and morbidity in the Region. High levels of modifiable risk factors for noncommunicable diseases have been detected in the populations of South-East Asia, indicating potential for effective prevention. Tobacco use kills more than one million people in the Region annually. The treatment gap for neuropsychiatric conditions is large. One-third of the global burden of injuries is accounted for by the Region. These challenges are increasingly being addressed; key achievements are summarized below.

Developing comprehensive commitment for noncommunicable diseases

- Regional Framework for Prevention and Control of NCDs endorsed by the Sixtieth Session of the Regional Committee used to guide development of national policies, plans and programmes.
- Capacity strengthening workshops for NCD programme managers based on technical materials developed by the Regional Office for South-East Asia conducted, with WHO support.

Aiming for collective action in mental health

- Strategy for training village-based workers to identify the most common and disabling neuropsychiatric conditions implemented.
- Community-based surveys on patterns of alcohol use, and harm from alcohol use, conducted.

Nurturing a multisectoral approach in health promotion and education

- Regional profile on the social determinants of health compiled.
- Regional Strategy for Health Promotion for South-East Asia published.
- Data collection and analysis training conducted under the Global School Health Survey.

Expanding knowledge and awareness of the tobacco epidemic

- Various tobacco surveys conducted; regional strategy developed for utilization of tobacco surveillance data.
• Work on tobacco control implemented in conjunction with the TB programme.

Focusing on prevention of injuries, violence and disabilities
• National plans and implementing mechanisms for prevention of selected injuries formulated.
• A Situation Review and Update on Deafness, Hearing Loss and Intervention Programme published.

Family and community health
3. The majority of Member countries were on track towards achieving the MDG target in reducing under-five mortality, but there is no room for complacency as half of the countries need concerted efforts to reach the MDG target for improving maternal health. In reducing the prevalence of mild and moderate malnutrition, progress is slow. In the area of immunization, polio cases were reported from the Region. The work was focused on these challenges.

Moving towards Millennium Development Goal 4 in child health
• Implementation of the Integrated Management of Childhood Illness Strategy expanded to additional geographical areas.
• Regional initiative for improving quality of care for children in hospitals launched.

Increasing sensitivity to adolescents’ health needs
• Data on adolescent health from various sources analysed, and national profiles on adolescent health initiated.
• National standards to help countries measure the quality of services for adolescents developed.

Dealing with malnutrition through a life-course approach
• National action plans on nutrition and food safety drafted.
• Regional pool of master trainers on new WHO growth standards created.
Improving the quality of maternal and newborn health care

- Human resources for maternal and newborn health strengthened through midwifery training in Member countries with a low proportion of deliveries by skilled birth attendants.
- Essential newborn health care during child birth and post-natal period at primary health-care level implemented.
- Method for improving the quality of maternal and newborn health care including at first referral hospital introduced for country adaptation.

Confronting the challenges in reproductive health

- The Global Reproductive Health Strategy promoted for implementation within the regional context.
- Initiatives for preventing and managing unsafe abortion supported.
- WHO guidelines on preventing and managing reproductive tract infections adapted and pilot-tested.

Promoting gender equity

- Regional Strategic Directions formulated, enabling Member countries to develop national plans for gender analysis and actions.
- Framework for assessing gender and health drafted, focusing on a database management system and use of available tools.

Focusing on polio and new vaccines

- Massive efforts to stop polio in the Region undertaken.
- Regional laboratory networks (polio, measles, Japanese encephalitis) established, fully accredited and functioning; in polio surveillance, particular attention is paid to cross-border issues.
- New and under-utilized vaccines (hepatitis B, Japanese encephalitis, Haemophilus influenzae type b-Hib, and the pentavalent – DTP+Hep+Hib formulation) piloted and introduced; three vaccine manufacturers in the Region selected to develop seasonal influenza vaccine.
Sustainable development and healthy environments

4. Member countries made important strides towards increasing water supply coverage. Environmental factors including climate change and global warming pose a challenge for the Region, with possible long-term implications for health status. Nine hundred million people still lack access to improved sanitation. More than 70% of workers are not covered by occupational health provisions. In the area of health-care waste management, there is a major gap between the legal framework and its implementation. Public awareness of food hygiene related to food standards is limited, as is the food safety surveillance system. More than half the global number of deaths due to natural disasters occur in the Region. During the period under review, floods and cyclones killed tens of thousands and affected millions. In addressing these challenges, some important achievements of WHO’s work are described below.

Ensuring safety and adequacy of water supply and sanitation

- Water safety plans including water quality standards and the household treatment and safe storage approach pilot-tested.
- Ecological sanitation pilot-tested and found useful. Regional advocacy activities led to countries organizing subsequent activities.

Controlling workplace exposure in occupational health

- Adoption of the “occupation risk management toolbox” initiated in the Region.
- National profiles and action plans for protecting and promoting workers’ health developed.

Taking up the challenges in climate change and human health

- Regional framework for action to protect human health from the effects of climate change prepared.
- The SEA Region made significant contribution to selection of the topic “Protecting Health from Climate Change” as the World Health Day theme for 2008, and to the World Health Assembly resolution on climate change and health.
Supporting country activities on chemical safety

- Regional training curriculum for integrated vector management drafted and made available for Member countries to adapt.
- Assessment of water contamination, strengthening of sound management of hazardous chemicals, and exchange of information on mercury reduction supported.

Supporting national initiatives in health-care waste management

- National strategies and guidelines on management of health-care wastes developed.
- Training courses on strengthening the management (handling to disposal) of health-care wastes, including used syringes, developed and conducted.

Enabling the health sector in food safety

- National training activities on food safety and food standards, including implementing healthy food markets, supported.
- Studies on presence of pesticide residues in food products conducted and the need for total diet studies to improve food safety regulations and policy in the Region promoted.

Addressing the vulnerability of the SEA Region populations to natural disasters

- The SEA Region Benchmarks for Emergency Preparedness endorsed by the Health Ministers’ Meeting (through the Thimphu Declaration). As a follow-up, regional and national consultations on the safe hospitals initiative conducted.
- WHO acted as lead coordinating agency for the health cluster in emergencies.
- The South-East Asia Emergency Fund established to ensure easy accessibility of funds in an emergency. The Fund was activated in recent natural disasters.

Health systems development

5. Investing in the health system will, in the long term, save financial resources and make international and national health goals achievable. However, there are constraints in the health systems of the Region. These
mean that, while a significant proportion of the population does not have access to health services, of the patients that do have access, a substantial proportion still does not receive quality health care, leading to unnecessary morbidity and mortality, not only in remote areas and in vulnerable populations but also in hospitals. There is limited coverage by various health insurance schemes in many Member countries, resulting in high out-of-pocket expenditure. Efforts to produce the maximum benefit of medicines for health continues. Health data analysis and capacity of data management at the district level is a continuing issue in health information. The Region has an acute shortage of trained health workers, including community-based workforce, which can play an effective role in empowering the community. The capacity of some training institutions to train medical, nursing and other technical staff remains low. WHO’s work to confront these difficult challenges continued and the following outcomes were achieved.

**Focusing on management in health services delivery and policy**

- Regional Plan for Strengthening Health Services Management developed.
- Support from GAVI for health systems strengthening received for six Member countries.

**Improving quality and safety of health care**

- Declaration on “Patients for Patient Safety in the SEA Region countries” endorsed by the Regional Committee for South-East Asia.
- Roles and responsibilities for the medical councils in improving patient safety were elucidated.

**Improving equity in health financing**

- Support for establishing contributory mechanisms to supplement tax-based financing of health schemes that provide effective protection for the poor is ongoing.
- Countries are being assisted to improve efficiency in the use of resources, including public sector performance.

**Expanding activities in research policy and cooperation**

- Regional task forces established: (1) to address responsibility and priority areas for AI research, and (2) to address countries’ capacity in health research management.
• Modules on research management revised, consolidated and endorsed.
• Good clinical practice, research ethics, international standard operation procedure and pre-survey for recognition award training activities conducted.

The continuing journey in essential medicines
• Regional Strategic Framework for Promoting Rational Use of Medicines through Education drafted.
• Improvement in selecting medicines for national essential medicines lists, with incorporation of children’s medicines, expected as a result of a regional workshop.

Strengthening country health information systems
• Common standards of format, content and process for reporting of health statistics in Member countries formulated.
• Processes for better utilization of health information by decision-makers identified.

Promoting widespread access to health information
• Regional Institutional Repository of WHO information products made available online.
• Special “display corners” set up for WHO publications in five Member countries; support and training on upgraded WHO library and information systems provided.

Extending the health workforce
• Regional strategic directions for strengthening the community-based health workforce and community health volunteers developed.
• Issues such as medical ethics, quality assurance in medical education and accreditation of medical schools, continuing medical education for professional development and patients’ safety elaborated and followed up by the Regional Network of Medical Councils.
• Regional Strategic Plan for Health Workforce Development formulated.
Developing the health workforce in nursing and midwifery

- Guidelines on Quality Assurance and Accreditation of Nursing and Midwifery Educational Institutions drafted and adopted.
- A diploma programme in nursing, a quality system for nursing education and service, and a bridge programme in nursing developed.

Streamlining the process for education, training and support

- Several mechanisms are under review and development to help countries develop (i) better selection process, (ii) better utilization of the fellows, and (iii) timely implementation of the planned fellowship.
- The processes are also being developed to monitor the training of the fellows and their performance evaluation.

Policy, programme planning and partnership

6. The mobilization of resources for health programmes in the Region has been remarkable. The area of partnership requires continued effort to ensure that health is at the centre of stakeholders’ interests. Intellectual property rights and TRIPS standards would require increased attention in Member countries. The achievements of technical programmes broadly depend on political commitment at the national level and the resources available; governing body resolutions are the tools which can make these commitments realizable. Key achievements in these areas are listed below.

Governing bodies

- The Sixty-first World Health Assembly adopted 21 resolutions (i.e. on health impact from climate change; on tackling noncommunicable diseases; on eradicating polio; and preparing for influenza pandemic, etc.).
- The Sixtieth Regional Committee for South-East Asia adopted 10 resolutions, including: nutrition and food safety; prevention and control of noncommunicable diseases; implementation of the new Stop TB Strategy; the revised Malaria Control Strategy; and international migration of health personnel.
Important meetings

- The Twenty-fifth Meeting of Health Ministers adopted the Thimphu Declaration on International Health Security to work together for the implementation of international health security.

- Parliamentarians from Member countries pledged full support towards realizing a Call for Action regarding harm from alcohol and tobacco use.

- The Joint Meeting of Health Secretaries of Countries of the WHO SEA Region (HSM) and Consultative Committee for Programme Development and Management (CCPDM) reviewed thoroughly and provided recommendations on each of the agenda items of the Sixtieth Session of the Regional Committee and 25th Health Ministers’ Meeting. This ensured that RC and HMM were able to complete their agendas in a most efficient and effective manner.


- Regional Seminar on Strengthening International Health Coordination (IHC) at country level conducted. A regional action plan to strengthen IHC adopted.

Working towards global action in intellectual property, innovation and public health

- Several regional consultations on public health, innovation, essential health research and intellectual property rights organized and common understanding of Member countries on crucial issues achieved.

Consulting and supporting countries in programme planning and coordination


- Member countries fully involved at each stage of preparation of the Programme Budget workplan.

- Actions and follow-up to improve performance of WHO Representatives related to their roles and responsibilities formulated.
Executive summary of key achievements

• Country Cooperation Strategy reviews, to analyse WHO’s work and focus the agenda, undertaken.

Accessing voluntary and external resources
• WHO regional and country office efforts in resource mobilization intensified, and a total of US$ 344 million in voluntary contributions mobilized.
• 183 donor agreements with 45 donors and partners concluded.

Pooling resources in strategic alliance and partnership
• Regional consultation on UN reform concluded that interaction between ministers of health, foreign affairs, finance and planning would enable Member countries to benefit optimally from their membership of, and influence reform of, the international organizations.
• Memorandums of understanding (MoUs) were signed with UNEP to support the Regional Initiative on Environment and Health, and with UNODC to promote public awareness on the dangers of drugs.

Strengthening strategic communications for public relations and media
• SEARO communications network formed.

General management
7. Expectations from the new global management system (GSM) are high. Based on extensive preparatory work by the WHO administration during the period under review, some important developments in the areas of human resources, budget and finance, informatics, procurement, general support and field security were achieved.

Preparing for the new system in global management
• Plans to ensure regional readiness for GSM developed and work is under way on realigning the business framework and Organization’s structure, training staff, and getting information technology infrastructure and connectivity ready.
Strengthening WHO country capacity in human resources

- WHO’s presence at country level strengthened by establishing new professional posts.
- A gender balance in new appointments of professional staff maintained.

Budget and financial management

- Financial discipline strengthened through implementation of the delivery principle, which resulted in fewer carry-overs of unliquidated expenditures.
- Approximately 70% of expenditure funded by voluntary contributions.

Playing a role at all levels in informatics and infrastructure services

- A strong account management process, and customer-oriented services management through service-level agreements, further enhanced.
- ICT infrastructure review for all country offices carried out and activities to upgrade completed.

Procurement services

- All Regional Office procurement of goods, materials and services centralized under the Medical Supply unit.
- The overall supplies procured for Member countries and the Regional Office was approximately 59% higher than in the previous year.

General support and field security services

- Renewal of infrastructure, renovation of office environments, and enhanced management of stores and archives implemented.
- Number of new safety and security initiatives and training programmes introduced.
1

Communicable diseases
Communicable diseases surveillance: building up outbreak response

1. Environmental factors including climate change and global warming have serious implications for infectious diseases and are creating a challenge for all countries in the Region. Improving the response to outbreaks of communicable diseases is therefore an important focus of WHO South-East Asia Regional Office (SEARO) activities.

2. Increasing trends in Japanese encephalitis, dengue fever, chikungunya, and Nipah virus infections have been observed in the Region in the last few decades (see Box 1.1). This reinforced the need to build core capacities in Member countries to minimize morbidity, mortality and spread of disease, while emphasizing the importance of intersectoral collaboration.

Box 1.1 Current infectious diseases picture in the Region

- Dengue continues to pose a major public health problem; Member countries are reporting more than 200,000 cases per year, with more frequent reporting of outbreaks in the last five years.
- Chikungunya fever is re-emerging in many Member countries, causing concern due to rapid spreading and severity of the disease.
- Deadly outbreaks of Nipah virus infections were reported from Bangladesh in 2007.
- Avian influenza (H5N1 strain): as of 28 May 2008, a cumulative total of 160 of 383 global cases had been reported from the Region since 2003, comprising more than 40% of worldwide cases, and more than half the deaths (see Figure 1.1)
- Among communicable diseases, diarrhoeal and respiratory infections were leading causes of disease burden in the Region (see Box 1.2).
3. The International Health Regulations (IHR) of 2005, together with the need to be prepared for detecting, reporting and responding to potential global health threats, have compelled countries to establish more effective surveillance systems. With technical support from the Regional Office, Member countries assessed their existing national core capacities and resources for implementing

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**Box 1.2: Infectious diarrhoea and respiratory infections: integrating control**

Based on the increasing realization that the problem of acute diarrhoeal and respiratory diseases (ICDR) cannot remain neglected anymore, the Regional Office has planned a programme on their integrated control.

To boost this initiative, a Regional Technical Advisory Group for ICDR, consisting of experts in diarrhoeal diseases and respiratory infections and related fields, has been established to provide necessary guidance to the Regional Office and Member countries. The first meeting of this Group has been planned for the third quarter of 2008.

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*Western Pacific, Eastern Mediterranean, European, African
**As of 28 May 2008

Source: Member countries / WHO Geneva, 2008
IHR (see Figure 1.2) prior to developing action plans in 2008 and 2009 (see Box 1.3). High-level coordinating bodies consisting of ministries of health, livestock, home affairs and education have been formally established in all Member countries to coordinate planning and preparedness for an avian influenza pandemic in the context of IHR. As of 31 May 2008, WHO SEARO had responded to 352 events of potential public health emergencies of international concern since the new regulations came into effect in June 2007. These events involved seven Member countries.

**Figure 1.2: Core public health capacities for an effective response to emerging diseases**

Box 1.3: Thailand develops IHR action plan for 2008–2012

The Ministry of Public Health, Thailand, has formulated national action plans to develop public health infrastructure and human resources to meet the core capacity requirements as envisaged under the International Health Regulations (2005). The plan for 2008–2012 was approved by the Cabinet in December 2007.

The objectives of the plan focus on capacity building of all institutions involved in surveillance and public health emergencies, including laboratories and hospitals, and the 18 points of entry, and also on building of capacity to coordinate, among various related governmental and private institutions and the community, the integrated implementation of IHR (2005).
4. Epidemiological capacity is a key indicator for outbreak response. WHO supported:

- Development of a three-month field epidemiology training course, which was pilot tested in India with the participation of 21 public health experts from different levels of the health system of eight Member countries. This training programme will help countries conduct national and sub-national-level training in field epidemiology. It will have a direct impact on the number of trained epidemiologists and will indirectly impact on the quality and timeliness of outbreak response.

- Rapid response and containment training, using modules developed by WHO, in which more than two thousand trainees from six Member countries (Bangladesh, Bhutan, India, Indonesia, Maldives, Thailand) participated. Improvement in the timeliness of event verification and assessment has since been observed.

- Building or strengthening, in all Member countries, of laboratory capacity in polymerase chain reaction (PCR) techniques for the detection and diagnosis of avian influenza and other infectious diseases. For horizontal collaboration and networking, a network of influenza laboratories in Bangladesh, India, Indonesia, Myanmar and Thailand was established (see also page 32).

- Preparation of various guidelines and tools to assist countries in disease detection and control, including:
  - Guidelines on laboratory diagnosis of avian influenza¹
  - Guidelines on the case management of avian influenza²
  - EWAR – Early Warning and Response: a guide for countries to ensure early warning and response as an integral part of existing surveillance systems (in printing)
  - Guidelines on the healthy food market concept³

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- An interactive CD to help health-care workers at district level identify events that qualify as a public health emergency of international concern (PHEIC)\(^4\)
- A risk communication tool for crafting messages aimed at preventing human infections with avian influenza (under development)
- A report card (under development) to rate the safety of traditional wet (live animal) markets
- A document on the role of village health volunteers in avian influenza surveillance.\(^5\)
- The development of a strategic framework for the prevention and control of zoonotic diseases. Implementation of the Framework in countries of the Region will help: build public health capacity and intersectoral collaboration, strengthen surveillance response capacity for emerging zoonoses, and promote networking and capacity building (see also page 21).

**Challenges**

- The implementation of robust surveillance and early warning systems throughout the Region, ensuring that borders and points of entry have appropriate safeguards in place to protect public health.
- Introduction of a regional event management system to ensure uniformity in reporting events across the Region.
- Establishment of a regional outbreak alert and response network (ROARN) to draw upon regional expertise in the event of a pandemic.

**HIV/AIDS: controlling epidemics and scaling up services**

5. The work in this area is focused on halting and reversing HIV epidemics and scaling up HIV services. Emphasis was put on targeted prevention, increasing access to HIV services (counselling, testing and treatment), and using strategic information to improve programmes. See Box 1.4 and Figure 1.3 for current picture of HIV infections in the Region.

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\(^4\) Available from WHO India office

\(^5\) *Role of village health volunteers in avian influenza surveillance in Thailand.* New Delhi, WHO SEARO, 2007 (document SEA-CD-159) (available at: www.searo.who.int/LinkFiles/Publication_CD_-159-Role-VHV-AI-surveillance.pdf)
Box 1.4: Current picture of HIV infections in the Region

With an estimated 3.5 million HIV infections, South-East Asia is the second-most affected region in the world.

India, Myanmar and Thailand have advanced epidemics where HIV has penetrated significantly into the general population.

Bangladesh, Indonesia and Nepal currently have highly concentrated epidemics primarily affecting populations at high risk.6

Figure 1.3: HIV: projected trends in adult prevalence in six SEA Region countries with the highest burden

Controlling epidemics

Gaining control

6. Member countries were encouraged7 to focus on targeted prevention to reduce sexual and injection-related transmission of HIV. A new regional

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6 More than 5% prevalence in high-risk groups such as intravenous drug users in Indonesia and Nepal, and female commercial sex workers in Indonesia
7 At the 19th Meeting of National AIDS Programme Managers, October 2007, Bali, Indonesia (see: www.searo.who.int/LinkFiles/AIIDS_Conclusions.pdf)
strategy for 2007–2015\textsuperscript{8} focuses on preventing sexual transmission of HIV and other sexually transmitted infections (STIs) by reducing transmission in high-risk groups, improving STI services, and strengthening STI surveillance. Implementation in Member countries is supported by operational tools and capacity-building networks.

**Preventing drug-injection transmission**

7. WHO works with the UN Office for Drugs and Crime (UNODC) and AusAID to assist countries in scaling up harm-reduction interventions, including advocacy, programming, surveillance and capacity building, and to help them set up services, particularly for outreach prevention and drug-substitution therapy.

8. A training curriculum for clinicians on care for HIV-positive injecting drug users\textsuperscript{9} (IDUs) was developed in collaboration with the ASEAN Secretariat and Family Health International; training courses are planned for 2008 at country level.

**Addressing the issue of HIV transmission in prisons**

9. A review conducted in India, Indonesia, Nepal and Thailand and a subsequent document based on the results of this review\textsuperscript{10} shows that few interventions have been implemented in prisons despite demonstrated feasibility in preventing HIV transmission. Advocacy to address the issue of HIV transmission in prisons is now receiving priority attention.

**Increasing access to HIV services**

**Counselling and testing**

10. WHO is providing support to countries for scaling up counselling and testing, care and treatment. Support to India, for example, has helped to expand the number of voluntary counselling and testing (VCT) centres nine-

\textsuperscript{8} Regional strategy for the prevention and control of sexually transmitted infections 2007–2015: breaking the chain of transmission. New Delhi, WHO SEARO, 2007 (available at: www.searo.who.int/LinkFiles/Publications_WHO_Regional_Strategy_STI.pdf)

\textsuperscript{9} Treatment and care for HIV-positive injecting drug users (available at: www.searo.who.int/en/Section10/Section18/Section356_14247.htm

\textsuperscript{10} HIV prevention, care and treatment in prisons in the South-East Asia Region. New Delhi, WHO SEARO, 2007 (available at: www.searo.who.int/LinkFiles/Publications_TreatmentinPrisons.pdf)
fold over five years. With the release of the WHO/UNAIDS guidance on HIV testing and counselling, a Regional consultation was conducted in 2007 to support country implementation. Countries are encouraged to conduct training and expand their HIV testing and counselling services according to these guidelines in order to reach people who need to know their HIV status.

**Preventing mother-to-child transmission**

11. WHO also technically supported Member countries in scaling up prevention of mother-to-child transmission (PMTCT), particularly in setting up counselling and testing services for pregnant women and providing technical guidelines for treatment, breastfeeding and care for pregnant women and infants. In India, every district in the six high-HIV burden states and more than 90% of districts in the low-HIV burden states have at least one PMTCT centre. In Myanmar, the PMTCT programme currently covers 89 of 325 townships. Thailand has reached universal access targets for PMTCT and reports a decrease in number of paediatric AIDS cases. In other Member countries, services are being expanded according to the occurrence of HIV mother-to-child transmission.

**Rationalizing antiretroviral treatment**

12. Regional focus on rational antiretroviral therapy (ART) emphasizes high-quality first-line regimens, adherence support, close monitoring and attention to early warning indicators. Guidelines for the management of HIV infection and antiretroviral therapy in adults and adolescents were published, and *Management of common health problems of drug users* drafted. Other technical guidance covers the management of opportunistic infections and related HIV care issues, laboratory strengthening (see also page 32), and surveillance of HIV drug resistance. HIV-related services are increasingly being integrated into existing health-care facilities. By ensuring high-quality HIV care, support and treatment in the countries, the survival of HIV-infected persons will improve and the costs of treatment programmes can be contained.

**Using strategic information to improve programmes**

*Ensuring timely and reliable data*


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12 See: www.searo.who.int/LinkFiles/AIDS_ConclusionsNRecommendations.pdf

14. Outcomes included HIV drug resistance threshold surveys in India, Indonesia and Thailand; involvement of national staff in estimating HIV burden and national ownership of data; expansion of biological and behavioural surveillance among high-risk populations; and harmonization of monitoring and evaluation frameworks.

Building programme management skills

15. To strengthen coordinated national response in complex environments with multiple donors and implementing partners, skills in programme management are particularly important. A set of training modules was developed\textsuperscript{14} to build capacity in programme management. The regional training modules are now being adapted for country training.

Conducting programme reviews

16. Indonesia, Myanmar, Sri Lanka and Thailand were supported in external programme reviews, which resulted in recommendations for good strategic planning. The guidelines for conducting a review of the health sector response recently published by the Regional Office\textsuperscript{15} could help facilitate reviews in other countries.

Mobilizing resources

17. WHO is enhancing and intensifying resource mobilization. Extensive technical support has been provided to Member countries for proposal development. Since 2002, US$ 863 million have been mobilized from the Global Fund (to Fight AIDS, Tuberculosis and Malaria [GFATM]) for HIV in 10 Member countries. During the reporting period, two Global Fund proposals for HIV (for India and Nepal) were approved.

Challenges

18. Regional priorities for 2008 were set by AIDS programme managers (Bali 2007 commitment). These include:

- Strengthening targeted prevention to gain control of epidemics in line with the Millennium Development Goal (MDG) targets.
- Promotion of “rational ART” as countries continue efforts to scale up treatment access.
- Improvement of information systems.
- Strengthening of human resources capacity.

\textsuperscript{14} National AIDS programme management: a set of training modules. New Delhi, SEARO, 2007

\textsuperscript{15} Guidelines for conducting a review of health sector response to HIV/AIDS. New Delhi, SEARO, 2008 (available at: www.searo.who.int/LinkFiles/Publications_HealthSectorResponse-AIDS-2008.pdf)
19. Efforts to simultaneously address HIV epidemics and strengthen health systems could result in more effective interventions and more reliable information to guide programmes. Future challenges include:
   - Improving size estimates of high-risk populations.
   - Improving analysis, synthesis and use of data from multiple sources.
   - Developing HIV field epidemiology programmes.

Tuberculosis: implementing the new Stop TB Strategy

20. In 2007, the Regional Committee adopted a resolution on implementing the new Stop TB Strategy. Since then the emphasis of WHO’s work has been to support countries in addressing the various components of the Strategy, particularly the management of multidrug resistant tuberculosis (MDR-TB), TB/HIV co-infection; and strengthening of laboratory capacity, management of drug procurement and supply, and surveillance.

21. All Member countries have developed national plans in line with the Stop TB Strategy 2006–2015 (see Box 1.5) and begun to implement its components (See Box 1.6 for current picture of TB case detection and treatment in the Region).

22. Outcomes of WHO collaboration have led to the following achievements:
   - Scaling up of interventions for the management of multidrug-resistant TB and TB-HIV co-infection in India, Indonesia, Myanmar and Nepal.

Box 1.5: Key elements of the Stop TB Strategy 2006–2015

- Pursue high-quality DOTS expansion and enhancement
- Address TB/HIV, MDR-TB and other challenges
- Contribute to health system strengthening
- Engage all care providers
- Empower people with TB and communities
- Enable and promote research

16 Resolution SEA/RC60/8 on TB control: progress and plans for implementing the new Stop TB Strategy calls on Member countries to fully implement national plans for TB control, incorporating all elements of the new Stop TB Strategy, in order to achieve the TB targets set out under the Millennium Development Goals by 2015.
• Strengthened monitoring and evaluation, and performance of impact assessment, in seven countries (Bangladesh, Bhutan, DPR Korea, India, Indonesia, Myanmar and Nepal).

**Box 1.6: Current picture of TB case detection and treatment in the Region**

Countries in the South-East Asia Region have made considerable progress since the introduction of directly observed treatment short course (DOTS) for TB control in 1993. The entire population in the Region now lives within access of DOTS facilities. In the latest figures, the overall case detection rate (in 2006) was 68%, close to the global target of 70%, and the overall treatment success rate (in 2005) for the cohort of new smear-positive cases initiated on treatment was 87%. By the end of the current reporting period, seven countries of the Region had achieved/maintained both these global targets (for case detection and treatment success) (see Figures 1.4a and 1.4b).

**Figure 1.4a: Tuberculosis: case detection and treatment success rates in the SEA Region Member countries**

Source: annual reports on TB control, national TB programmes, SEAR Member countries, December 2007

BHU: Bhutan; BAN: Bangladesh; DPRK: Dem. People’s Rep. of Korea; IND: India; INO: Indonesia; MAV: Maldives; MMR: Myanmar; NEP: Nepal; SRL: Sri Lanka; THA: Thailand; SEAR: South-East Asia Region

Based on the total number of TB cases notified by Member countries by year (increasing gradually from 1997 [1 308 981] to 2006 [1 920 644]).
• TB control activities in which intersectoral collaboration and public–private partnership for delivery of services plays an important role are being established/scaled up in eight Member countries (Bangladesh, India, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste).

• Expansion in India and Myanmar of TB/HIV co-infection control activities (already widely available in Thailand). In Indonesia, which has a concentrated HIV epidemic, interventions are now implemented in three provinces with high HIV prevalence.

• Seven countries (Bangladesh, India, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand) have at least one national-level laboratory with facilities for mycobacterial culture and drug susceptibility testing for the detection of MDR-TB cases. Bangladesh and Nepal are in the process of having their national reference laboratories accredited.

• Treatment services for MDR-TB cases are being put in place by national programmes in seven Member countries (Bangladesh, Bhutan, India, Indonesia, Myanmar, Nepal, Timor-Leste).

17 See TB status paper at: www.searo.who.int/LinkFiles/Tuberculosis_Status_paper_TB-HIV-SEAR.pdf
18 More than 5% prevalence in high-risk groups such as intravenous drug users and female commercial sex workers
• The Regional Office assisted Bhutan, Indonesia and Myanmar in drafting their applications to the Green Light Committee of the Stop TB partnership for establishing treatment programmes for MDR-TB.

• Eight Member countries (Bangladesh, Bhutan, India, Indonesia, Nepal, Thailand, Sri Lanka, Timor-Leste) continue to benefit from funds mobilized from the Global Fund and all Member countries benefit from funds from other development partners and donor governments.

• All countries have access to quality-assured affordable anti-TB drugs on a regular basis through grants or direct procurement agreements with the WHO/Stop TB Global Drug Facility.

• National TB programme staff from all countries were trained (on an intercountry basis) in the management of TB laboratories, quality assurance, mycobacterium culture techniques, drug susceptibility testing, and management of MDR-TB (see also page 33).

• Training activities on control of TB/HIV for national TB programme staff conducted in India, Indonesia, Myanmar and Nepal; materials on data management and analysis for TB programme staff made available in Bangladesh, India and Myanmar; modules on leadership and strategic management, and guidelines on undertaking annual risk of tuberculosis infection (ARTI)\(^{19}\) assessments made available to all Member countries.

### Challenges

- Ensuring the necessary infrastructure and improving the quality and capacity of laboratory networks.

- More effectively addressing the needs of people with MDR-TB and HIV-TB co-infection.

- Promoting the analysis and use of routine programme data for programme improvement at the operational level of service delivery.

\(^{19}\) Currently the preferred epidemiological indicator of the TB situation
• Helping to address the impact of the multiple social and economic determinants on TB control.

**Malaria: implementing the revised control strategy**

23. A resolution on the Revised Malaria Control Strategy was adopted by the Regional Committee in 2007. Since then, SEARO attention has focused on providing technical support for strengthening the capacity of malaria control programmes, especially in relation to the issues of drug resistance and its monitoring, integrated vector management, and implementation of Global Fund projects in Member countries.

24. Key elements of the Revised Malaria Control Strategy are outlined in Box 1.7.

<table>
<thead>
<tr>
<th>Box 1.7: Key elements of the Revised Malaria Control Strategy for the Region</th>
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<td>• Reformation of malaria control programmes</td>
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<td>• Identification of vulnerable populations</td>
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<td>• A focus on <em>P. vivax</em></td>
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<td>• Balance of prevention and treatment</td>
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<td>• Integration of malaria into healthy public policies</td>
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<td>• Partnership and multisectoral approaches</td>
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<td>• Raising the visibility of malaria in the Region</td>
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**Reforming the control programmes**

25. To assist in the implementation of the Revised Malaria Control Strategy, *Guidelines for conducting reviews of national malaria control programmes* were drafted in collaboration with experts from Member countries. These will help malaria control programmes become more responsive and to use evidence-based interventions.

26. SEARO also provided technical support to strengthen national capacity in monitoring and evaluation of the malaria control programmes in

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20 Resolution SEA/RC60/R6: Revised Malaria Control Strategy: Focusing on a New Paradigm
Bangladesh, Bhutan, Nepal and Sri Lanka, and technical support for implementing the Global Fund projects in Bangladesh, Bhutan, India, Nepal and Timor-Leste.

**Monitoring of drug resistance**

27. Drug resistance in both *P. vivax* and *P. falciparum* malaria is monitored. As multidrug resistant *P. falciparum* has spread (see Figure 1.5) in some countries of the Region, almost all Member countries where *P. falciparum* is prevalent have, based on WHO recommendations, revised their national treatment guidelines and adopted artemisinin-based combination therapy (ACT).

28. India, Nepal, and Timor-Leste revised their national treatment policies and guidelines to ACT, and Sri Lanka is in the process of doing so; while Bhutan, Bangladesh, Indonesia, Myanmar, Thailand and Timor-Leste are at the stage of scaling up coverage with ACT; and Thailand made a minor revision in ACT dose following WHO recommendations.

29. Artemisinin-tolerant forms of *P. falciparum* present a global threat which requires close monitoring. WHO and USAID assisted Thailand and Cambodia
[from the WHO Western Pacific Region (WPR)] to develop a joint strategy for combating and eliminating these artemisinin-tolerant forms.

30. Drug resistance monitoring in sentinel sites, and networking continued to be strengthened in the countries covered by the Mekong Malaria Programme which includes Myanmar and Thailand – as part of bi-regional collaboration between the Western Pacific and South-East Asia Regions. Programme managers and experts from the Mekong countries were updated regarding available therapy and diagnostic tests, and drug efficacy study protocols.

**Implementing integrated vector management**

31. A document *Framework for implementing integrated vector management at district level in South-East Asia Region – A step-by-step approach* was drafted in collaboration with experts from Member countries. It addresses the appropriateness of intervention methods for an integrated programme. This Framework will guide countries in selectively applying the various vector control tools available, based on the epidemiological situation, vector biology, and socio-behavioural characteristics of the community.

**Collaborating and partnering**

32. In addition to collaborating with the Mekong countries on control of falciparum malaria, bi-regional collaboration also continued to address control of vivax malaria on the Korean Peninsula. With WHO’s technical support, DPR Korea successfully conducted one round of mass prophylaxis with primaquine in a population of five million. As a consequence, significant reduction of malaria incidence was observed in the border provinces of DPR Korea.

**Raising the visibility of malaria**

33. WHO provided technical support to Member countries in advocacy for malaria control at the political level. World Malaria Day was observed for the first time in Member countries on 25 April 2008, as recommended by the Regional Committee in 2007 through resolution SEA/RC60/R6.

**Challenges**

- Implementation of the integrated vector management strategy
- Implementation of efficient methods of diagnosis for malaria
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- Implementation of national malaria treatment policy, including effective drug treatment such as ACTs and making quality drugs available at affordable prices
- Strengthening the capacity of national malaria control programmes through human resources development.

Global Fund grants: improving access and implementation

34. Eight proposals from Member countries of the Region, worth about US$ 208 million, were approved in the Round 7 – Global Fund call for proposals. With this, a total of 55 grants, amounting to a total of about US$ 1.7 billion, have been approved for countries in the Region by the Global Fund since its inception in 2002. Since that time, WHO has been assisting Member countries in the various processes involved, including in proposal development, grant negotiation, implementation support and constituency matters. This substantial resource is enabling the countries to scale up their national responses to reduce the burden of HIV/AIDS, TB and malaria. It is also an excellent opportunity for Member countries to strengthen their overall health systems while improving the outcomes for the three diseases.

35. Member countries have been making concerted efforts to improve their capacities in accessing and implementing Global Fund resources. Their capacity needs, including technical support needs, are increasing substantially with the volume of resources becoming available. For Round 7 applications (2007), WHO helped six (Bhutan, India, Indonesia, Nepal, Thailand, Timor-Leste) countries to develop proposals. For Round 8 (2008), WHO assisted Bangladesh, DPR Korea, India, Indonesia, Sri Lanka and Thailand in submitting proposals.

36. The Regional Office facilitated two regional Global Fund constituency meetings. While general support for implementation of the HIV, TB and malaria programmes is provided through the Regional and country offices, specific support for implementation of Global Fund grants was provided to Bangladesh, Indonesia, Nepal and Timor-Leste through agreements signed with the principal recipients.

37. In assisting countries in relation to the Global Fund, the WHO focus has been to develop capacity in the countries. While WHO staff involved in assisting proposal development have, for instance, made efforts to train country counterparts, WHO has also held capacity-building workshops. With every call for proposals starting from 2006, WHO has held a proposal development
workshop; this year the workshop, in Jakarta, Indonesia, was attended by 70 participants. In February of this year also, a workshop on Grant negotiation and implementation was organized to develop capacity in efficient implementation and facilitate the early signing of approved Round 7 Global Fund grants.

38. A review and assessment of the usefulness and impact of WHO support in relation to Global Fund grants to countries was carried out. The results show that, although countries continue to face a range of significant challenges throughout the grant cycle (such as those due to the complex reporting procedures), WHO’s efforts have had a positive impact and are greatly appreciated by Member countries. Up to this point, the generation of financial resources for WHO support has been ad hoc and largely through WHO’s own budget. As the need for assistance continues to grow, there is a need to secure and manage resources adequate to keeping up the support to countries.

Dengue: aiming to reverse the rising trend

39. Work is focused on responding to the increasing threat from dengue, which is spreading to new geographical areas and causing high mortality during the early phase of outbreaks. See Box 1.8 for the current picture of dengue in the Region; trends in reported cases and case fatality rates are shown in Figure 1.6.

Box 1.8 Current dengue picture in the Region

In the WHO South-East Asia Region, 87% of the total population is at risk of dengue infection, and 10 countries are endemic for dengue.

Dengue fever has become one of the most important resurgent vector-borne diseases in the Region, with increased frequency of epidemics and circulation of multiple serotypes of virus in most countries.

Major outbreaks were reported from Indonesia, Myanmar and Thailand during the reporting period, while Nepal became a new dengue endemic country.

The reasons for the resurgence are complex, but the main factors are the unprecedented urbanization that is taking place, and the movement of populations within and outside the endemic countries.

Drafting a new strategic plan for 2008–2015

40. A draft Asia-Pacific Strategic Plan for Dengue Control for 2008–2015 was developed through collaboration with WPRO. It was reviewed by the
Regional Technical Advisory Group on Dengue\textsuperscript{21} and endorsed at a meeting of programme managers.\textsuperscript{22} The goal of the Strategic Plan is to reverse the rising trend of dengue in countries of the Asia-Pacific region. To be published later in 2008, the Plan will guide Member countries in developing national operational plans for dengue control, and will enhance country preparedness to promptly detect, characterize and contain outbreaks.

**Preparing for implementation of the strategic plan**

41. Available tools for the prevention, diagnosis and treatment of dengue, and studies on the burden and socioeconomic impact of the disease, were reviewed by the Regional Technical Advisory Group on Dengue.

42. At the programme managers’ meeting, SEARO initiated formation of the Asia-Pacific Dengue Partnerships (APDP), partnership being an important component of the Strategic Plan. A core group of APDP members was established to develop a strategic framework for mobilizing resources to support implementation of the bi-regional strategic plan.

\textsuperscript{21} First Meeting of Regional Technical Advisory Group on Dengue, Thailand, September 2007

\textsuperscript{22} Intercountry meeting of programme managers on dengue, Thailand, September 2007
43. SEARO promoted and supported the communication for behavioural impact (COMBI) approach in Member countries, and an international training course on COMBI was organized in collaboration with the Faculty of Tropical Medicine, Mahidol University, with participants from Indonesia, Maldives, Myanmar and Sri Lanka.

44. SEARO also supported Member countries to improve early detection and case management. An international course on clinical management of dengue was held in collaboration with the WHO Collaborating Centre on Clinical Management of Dengue, at the Queen Sirikit Institute of Child Health, Bangkok. More than 25 participants attended from Bhutan, Indonesia, Nepal and Thailand and other WHO Regions.

**Providing technical support**

45. Other outcomes included assessment of the dengue situation in Bhutan and Nepal, which SEARO technically supported. This will help these countries make their national dengue prevention and control plans more responsive. Technical support was also provided during outbreaks of dengue in Bhutan, Indonesia, Myanmar and Thailand.

46. *Dengue Bulletin*\(^{23}\) Volume 31 (2007), jointly published with WPRO, was widely distributed to programme officers, public health professionals and institutions in the SEA and other regions.

**Challenges**


- Acceleration of resource mobilization in collaboration with WPRO and partners through the APDP.

- Enhancing coordination among ministries of environment, education and tourism and local governments to ensure their engagement in implementation of the dengue control programme.

- Improving core capacity for surveillance (in terms of the timeliness, completeness and quality of data, and the sharing of information within and between countries and WHO) as per IHR (2005) (see also page 4).

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\(^{23}\) [www.searo.who.int/en/Section10/Section332_1097.htm](www.searo.who.int/en/Section10/Section332_1097.htm)
Zoonoses: implementing strategy and policy

47. A framework defining strategy and policy for zoonoses control in South-East Asia was finalized. It will be implemented in a phased manner through capacity building and development of a surveillance and response mechanism for endemic and emerging zoonoses.

48. The Framework will assist countries in selecting priority interventions for control of zoonotic diseases, and in strategic planning for priority zoonoses; it was developed in collaboration with experts from Member countries.

Building capacity

49. A project proposal on Strengthening of Surveillance and Response Capacity for Highly Pathogenic, Emerging and Re-Emerging Diseases in ASEAN and SAARC Countries under WHO Regional Offices for South-East Asia and Western Pacific, 2009–2012, under submission at the time of writing, is expected to receive support (Euro 4 million) from the European Commission.

50. A WHO Collaborating Centre for research and training on viral zoonoses was designated; and two research and training centres – for rabies and leptospirosis – were re-designated.

Surveying and responding

51. A zoonoses risk assessment tool for assessing the zoonoses situation and control activities was developed at country level and tested in Maldives. This tool will assist Member countries in developing consensus on national-level strategy and policy for zoonoses control. Operational guidelines for veterinary public health (VPH) services in the South-East Asia Region have been drafted to facilitate VPH activities in Member countries; they will be finalized later in 2008 after further discussion.

Rabies

52. WHO promoted September 8 as World Rabies Day, and advocacy and awareness meetings were held in Member countries on this day. WHO
is advocating national authorities, international communities and nongovernmental organizations to work together to eliminate human rabies as a public health problem from the Region.

53. WHO also supported: a mass rabies vaccination campaign in dogs, and a birth control programme for dogs (through chemical and surgical sterilization), which is to be launched by the Government of Bhutan; and production of a tissue-culture human rabies vaccine by the Government of Nepal.

**Avian influenza**

54. A review of the avian influenza (AI) situation, particularly in Indonesia, was conducted[^29] and actions required to prevent and control AI in the Region were formulated. These included: strengthening the AI surveillance and response system at all levels; developing community-based risk communication strategies; enhancing early recognition of suspected human AI cases; conducting data analysis of recorded human AI cases; and sharing best practices related to clinical case management.

**Leprosy: sustaining control activities in the Region**

55. Remarkable progress has been made in reducing the leprosy burden in the Region. The Regional Office has been working closely with Member countries to ensure technical support, especially with the priority countries — India, Indonesia, Nepal and Timor-Leste.

**Reaching the elimination goal**

56. Nepal and Timor-Leste have yet to achieve the goal of eliminating leprosy as a public health problem.

57. WHO assisted Timor-Leste in the strengthening of active case detection and treatment of leprosy cases. Rapid village surveys in one district showed that detection of leprosy cases had improved and that patients were receiving proper treatment. In order to strengthen the quality of leprosy case detection and case management in

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[^29]: National consultation on avian influenza, Jakarta, November 2007
districts with high leprosy prevalence, district leprosy officers from six districts were trained. WHO facilitated the provision of multidrug therapy (MDT) from Novartis Foundation to the Ministry of Health.

58. In Nepal, WHO supported several activities related to data quality, leprosy programme interventions, awareness, training and monitoring. A survey on disability load was conducted in one district; based on the results (of 582 cases, 101 had disabilities due to leprosy) training was conducted in self-care and necessary aids and appliances were disbursed. The experience from this survey could be replicated in other districts. WHO also promoted the active participation of medical colleges in leprosy programme activities which they could support or undertake, and supported the Ministry of Health in implementing activities related to community awareness, particularly through the mass media. The outcome of these activities was assessed and follow-up is being considered.

Post-elimination: reducing the burden further

59. Other countries of the Region — Bangladesh, India, Indonesia and Myanmar — have achieved the elimination goal but still have large caseloads. These countries have made significant progress in further reducing their disease burdens at sub-national levels. India, the country with the highest global leprosy burden, has achieved elimination in 29 (83%) of a total 35 states and union territories.

60. To implement the global strategy for further reducing the leprosy burden,30 Member countries were technically supported (by the Regional and country offices) to adapt and revise, as necessary, the post-elimination strategy; some countries have translated the Strategy into their national language(s) for wider distribution among leprosy and basic health workers.

Strengthening partnership, reducing stigma

61. To strengthen partnership, prominent officials of the International Federation of Anti-Leprosy Associations (ILEP), its member organizations and other partners, discussed country-specific issues with the Regional Office. The Regional Office also co-sponsored the 17th International Leprosy Congress (2008) in Hyderabad, India, which was attended by around 1600 participants from 60 countries as well as more than 100 persons affected by leprosy from 24 countries.

Ensuring treatment with multidrug therapy

62. The Regional Office is committed to ensuring free and uninterrupted supply of anti-leprosy drugs (MDT) to Member countries. The Regional Office encourages the use of an integrated approach to MDT drug procurement and supply, and use of a drug management system to provide feedback on utilization. During the programme reviews, and in collaboration with partners and national/sub-national programme managers, WHO shared technical information and developed a simplified monitoring sheet which is now part of each country’s leprosy modules.

63. Some Member countries with large numbers of patients on treatment have been concerned with minimizing and preventing operational problems in leprosy activities, for which WHO has provided technical support accordingly. A large-scale independent evaluation was initiated for the national leprosy programme of India; this evaluation was jointly organized by the Global Leprosy Programme and WHO Regional and country office in collaboration with the Government. The Regional Office is supporting, both technically and financially, the finalization of evaluation instruments.

Challenges

- Ensuring wider coverage of leprosy services, especially in remote rural areas, urban slums and migrant populations.
- Increasing and sustaining community awareness to promote voluntary case detection and decrease social stigma.
- Ensuring regular and adequate supply of free MDT drugs.
- Provision of support for conducting operational research on effectiveness of the MDT programme, monitoring the emergence of rifampicin resistance.
- Strengthening of integration of leprosy services into the general health system through capacity building and skill development.

64. Overcoming these challenges will ensure that quality leprosy services are sustained, including diagnosis and treatment at peripheral levels.

Global leprosy programme: reducing the number of cases

65. The WHO Global Leprosy Programme works under the leadership of the Regional Director, and covers 120 countries from five WHO Regions.
66. The WHO Global Strategy for Further Reducing the Leprosy Burden and Sustaining Leprosy Control Activities 2006–2010 continued to be implemented in all endemic countries with the support of various international and local NGOs. The Strategy, which has been adapted for use by each endemic country based on their health-care infrastructure and available resources, places emphasis on sustaining high-quality services that are easily accessible and equitably distributed, and on providing multidrug therapy (MDT) free of cost.

67. Globally the number of new cases of leprosy continues to fall (see Figure 1.7), although three countries (Brazil, Nepal and Timor-Leste) have yet to achieve the goal of elimination.31

Figure 1.7: Leprosy: trends in the detection of new cases by WHO Region, 2001–2006

![Graph showing trends in detection of new leprosy cases]

Source: WHO/SEARO Global Leprosy Programme, 2008

68. The Global Programme puts emphasis on:

- Strengthening capacity: in order to strengthen the capacity of national programmes, especially of low endemic countries, in their control and elimination activities, WHO, in close collaboration with its partners, developed a training module. This module was used in training activities conducted during the year in the African and American Regions. Further workshops are to be conducted in the South-East Asia and Western Pacific Regions during the latter part of 2008 and early 2009.

31 Prevalence of less than one case per 10,000 population
• Surveillance for drug resistance: *Guidelines for global surveillance of drug resistance in leprosy* were developed and will be finalized in 2008. It is anticipated that setting up a system to monitor drug resistance, particularly to rifampicin, in collaboration with reference laboratories, will enhance the quality of leprosy control in endemic countries.

• Rebuilding and strengthening of control programmes in countries where leprosy control has been weakened as a result of civil conflict: during the year under review, external training for national programme managers and local training for general health-care workers from Afghanistan, south Sudan and Somalia helped these countries to revitalize their programmes.

69. While leprosy control activities need to be maintained to ensure that the disease burden continues to decline, a bigger challenge lies ahead for national programmes. This is to sustain political commitment as well as maintain leprosy control services, especially at peripheral level, under relatively low endemic conditions. At this point in time, WHO cannot envisage an eradication strategy, as effective tools for disease prevention and early identification of at-risk and infected individuals are not yet available. In this context it is necessary to continue to vigorously apply the current morbidity control strategy using effective MDT, for which WHO will continue to provide technical and operational support.

**Eliminating lymphatic filariasis**

70. More than 63% of the global population at risk from lymphatic filariasis, and over 50% of the global number of lymphatic filariasis cases are in the SEA Region. The goal is to eliminate this disease as a public health problem by the year 2020. In this regard, significant progress has been achieved, particularly in the reduction of transmission in Sri Lanka and Thailand. Approximately 60% coverage by mass drug administration has been achieved in the nine endemic countries of the Region (Bhutan and DPR Korea are not endemic for this disease).

71. The Regional Strategic Plan for Elimination of Lymphatic Filariasis 2007–2010 was revised. Target dates were set up for progressive reduction and ultimate interruption of transmission of the disease, main and supportive strategies were formulated, and implementation activities including partnership and resource mobilization suggested (see Box 1.9).

72. Future attention will be focused on expanding mass drug administration and disability prevention and control. The challenge is to
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Communicable diseases

meet the requirements for diethylcarbamazine and albendazole in Member countries.

**Box 1.9: Elements of the revised strategy for elimination of lymphatic filariasis in the South-East Asia Region**

**Goal:** To eliminate lymphatic filariasis (LF) as a public health problem by the year 2020

**Objectives:**
- To progressively reduce and ultimately interrupt the transmission of lymphatic filariasis
- To prevent and reduce disability in affected persons through community based disability alleviation and appropriate management

**Specific objectives for 2007–2010:**
- To complete mapping of the distribution of LF
- To implement or sustain and scale up mass drug administration (MDA) with diethylcarbamazine and albendazole in all endemic countries
- To systematically assess the elimination status in each implementation area before stopping MDA after 5–6 rounds
- To implement activities for prevention and alleviation of disability in all endemic countries
- To conduct operational research on important elements of elimination activities

**Controlling soil-transmitted helminth infections**

73. In the South-East Asia Region about 500 million people are chronically infested with the various soil-transmitted helminthiases (STH), for which all Member countries are endemic.\(^\text{32}\) Infestation rates differ according to ecology, but in some areas in some countries are as high as 95% and polyparasitism is common. The highest rates of infestation are usually seen in children aged 5–14 years.\(^\text{33}\) The regional goal is to reduce morbidity and mortality caused by soil-transmitted helminths by 50%, and to achieve regular deworming of at least 75% of all school-aged children at risk, by 2010.

\(^{32}\) See: [www.searo.who.int/en/Section10/Section2289.htm](http://www.searo.who.int/en/Section10/Section2289.htm)

74. WHO technically assisted and supported most Member countries in scaling up of deworming, integrated school health programmes, and supplementary vitamin A campaigns. All Member countries in the Region have appointed a national focal point for STH and have national deworming policies.

75. The remaining challenges include:
   - Ensuring political commitment and priority in Member countries
   - Mobilizing adequate resources
   - Implementing interventions appropriately.

**Kala-azar: building up to elimination**

76. Efforts continued towards reducing the morbidity and mortality due to visceral leishmaniasis (kala-azar) in three endemic countries – Bangladesh, India and Nepal (see Box 1.10 and Figure 1.8).

### Box 1.10: Current kala-azar situation in the Region

The kala-azar situation is worsening due to the occurrence of asymptomatic cases, post-kala-azar dermal leishmaniasis (PKDL), undernutrition, and kala-azar/HIV co-infections. However, the mortality is stable because of improved case management. It has been estimated* that in 2007 there were 280,000 cases in 52 districts of India, 137,000 cases in 45 districts of Bangladesh, and 13,000 cases in 12 districts of Nepal. Factors responsible for the upsurge in visceral leishmaniasis include poor socioeconomic status, malnutrition, and insufficient spraying with insecticides in affected areas resulting in vector proliferation.

*estimations based on multicentric community-based studies in Bangladesh, India and Nepal, 2007

77. Based on the strategic framework for elimination of kala-azar, WHO supported the countries in a number of activities, as outlined below.

**Strengthening capacity**

78. A training package – *Kala-azar elimination in SEA Region: training module* – and standard operating procedures have been developed (document SEA-

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35 Target dates for elimination of kala-azar have been set for India (2010) and Bangladesh/Nepal (2015)
VBC-94), which Member countries are using for intensifying their training activities and implementing the elimination programme.

79. Participants from six countries of the Region were trained in Bihar, India, on technical and programmatic aspects of kala-azar elimination. This activity was followed by a national workshop in India with participants from 26 endemic districts. Both training activities were technically supported by the Regional Office.

80. Training was also provided for country coordinators, with the aim of enhancing the technical and managerial capacity of state and national coordinators in kala-azar elimination activities. This was supported jointly by WHO and the World Bank.

**Building partnerships**

81. A WHO mission consisting of national and international experts was organized to determine the technical and operational challenges, to review the progress of programme implementation, and the epidemiological trend of the disease in Bihar, India. The mission assisted local managers to identify improvements in kala-azar elimination activities as well as gaps to be addressed. Improvement was noted in relation to the introduction of the
new diagnostic test rk39 and the first-line drug miltefosine, and to methods of indoor residual spraying. Gaps identified included non-completion of treatment (due to its 28 days duration) and insufficient information, education and communication (IEC)/behavioural change communication (BCC) activities.

**Analysing and implementing research activities**

82. A meeting was held for analysis of the multicentre research studies on visceral leishmaniasis control and treatment strategies being conducted in Bangladesh, India and Nepal (in Nepal, May 2008). The analysis meeting was jointly supported by TDR, GTZ and the Regional Office. The wide gap between the number of reported and estimated cases is a constraint to the planning of elimination activities.

**Challenges**

- Availability of drugs: diagnosis and treatment have so far been limited to large hospitals, but poor people often seek treatment from some practitioners (or unqualified persons) who provide expensive, incomplete or inappropriate treatment favouring continued transmission of the disease.
- Completion of treatment: patients with only skin signs resulting from delayed or incomplete treatment are reservoirs of infection responsible for continued transmission; these patients are difficult to diagnose and treat.
- The increasing threat of HIV/AIDS and kala-azar co-infection.
- Issues related to unplanned poor-quality housing, unsatisfactory living conditions, undernutrition, migration, and resettlement.
- Organization of integrated vector management and behavioural change communication activities.
- Development of sustainable partnerships.

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36 UNICEF, UNDP, World Bank, WHO Special Programme for Research and Training in Tropical Diseases
37 Deutsche Gesellschaft für Technische Zusammenarbeit
Eliminating and eradicating yaws

83. Yaws occurs in three countries of the Region – India, Indonesia and Timor-Leste. It has been eliminated from India\(^38\) and the target date of 2010 was set for eradication of the disease from this country. India’s achievement in yaws elimination was lauded at the 11\(^{th}\) International Task Force on Disease Eradication meeting in Atlanta in October 2007. Yaws eradication is an achievable goal since there is a safe and cost-effective intervention: a single injection of long-acting benzathine penicillin.

84. In Indonesia, a few thousand cases of yaws are reported annually, and in Timor-Leste, a few hundred cases are estimated to occur each year. The target for elimination of yaws in these two countries has been set for 2012. WHO technically supported the development of a plan of action for eradication of yaws in Indonesia and Timor-Leste.

85. WHO’s work will be focused on commitment and capacity for yaws eradication in the endemic countries.

Blood safety and clinical technology: strengthening national and regional resources

86. Outcomes of WHO’s work and activities supported in this area are summarized below.

Laboratory services: strengthening the response to avian influenza and other emerging infections

- National influenza centres (NIC): two additional laboratories, in Bangladesh and Myanmar, were designated as NIC and included in the WHO Global Network of Influenza Surveillance (FLUNET). Seven Member countries of the Region\(^39\) now have NIC.

- Regional reference laboratory: the first Regional (and the tenth global-level) WHO reference laboratory for diagnosis of influenza A/H5 was designated.\(^40\) This laboratory will provide diagnostic referral services in support of surveillance, epidemiological tracing, vaccine development, and training.


\(^{39}\) Bangladesh, DPR Korea, India, Indonesia, Myanmar, Sri Lanka, Thailand

\(^{40}\) The National Institute of Virology, Pune, India
• Capacity in diagnosis: the skills of laboratory staff in diagnosis of avian influenza, and in the collection, storage and shipping of infectious material, were enhanced through intercountry activities held in Bangladesh, Hong Kong, Tokyo and India; and the network of Regional NICs was strengthened through information sharing. As critical reagents for establishing diagnosis of H5N1 virus are not available commercially, these were procured from the WHO A/H5 Reference Laboratory and distributed to national laboratories to facilitate timely diagnosis. Selected laboratories in Indonesia and Timor-Leste were assessed for their capacity to diagnose emerging infectious diseases, and were supported in terms of equipment, reagents and training to build their capacity.

Laboratory services: strengthening the quality of HIV laboratories

• Monitoring: there was overall improvement in the performance of laboratories carrying out enumeration of CD4 lymphocytes (for staging and monitoring of patients infected with HIV). While the external quality assessment scheme continued with the participation of 161 laboratories from the Region,41 improvement in the overall functioning became evident with a fall in coefficient of variation to 5% from 15% when the scheme was launched. Further improvements are expected with the continuation of this scheme.

• Emergence of resistance: the first Regional member of WHO ResNet42 was designated.43 This institute now contributes to the global database on emergence of resistance in HIV; data generated will be used by the national authorities for rational use of antiretroviral drugs.

• Opportunistic infections: a WHO Collaborating Centre is in the process of being designated44 to undertake research and provide referral services for opportunistic fungal infections (which are increasing with the escalation in number of immuno-compromised patients).

41 Including 120 laboratories from Thailand, 16 each from Indonesia and India, four each from Myanmar and Nepal, and one from Bhutan
42 A group of experts and organizations working together to develop and implement methods to contain HIV drug resistance
43 The National AIDS Research Institute (NARI), Pune, India
44 Department of Mycology, Postgraduate Institute of Medical Education and Research, Chandigarh, India
Laboratory services: strengthening tuberculosis and other laboratories and networks

- Tuberculosis capacity: the skills required to establish national TB laboratory networks for quality-assured smear microscopy, culture, and determination of TB drug susceptibility were taught to laboratory experts from all Member countries through a Regional workshop (Regional Workshop on Strengthening Laboratory Services for TB Control, Thailand, September 2007).

- Emerging viral infections: Regional guidelines on establishing virology laboratories were developed and disseminated as a response to the lack of diagnostic facilities in some Member countries in the face of emerging viral infections.

- Quality of laboratories: to improve the quality of health laboratories, guidelines on the accreditation of laboratories were published and disseminated to all countries. Beginning with national standards, the ultimate goal is to achieve an internationally acceptable accreditation system. As a follow-up, WHO technically assisted Maldives in accreditation activities, and supported training in accreditation for fellows from Nepal at the WHO Collaborating Centre on Quality Systems in Health Laboratories.

- Management of infectious material: training materials on the collection, storage and shipment of infectious material were shared with Member countries; support will be provided to implement the activities.

Blood safety: strengthening access to safe blood

In consonance with the World Health Assembly Resolution, World Blood Donor Day was celebrated across the Region on 14 June 2008. Activities supported were aimed at enhancing awareness about voluntary blood donation and recognizing the contribution that voluntary blood donors make to saving human life.

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46 WHO Collaborating Centre on Strengthening Quality System in Health Laboratory, Bureau of Laboratory Quality Standards, Dept. of Medical Sciences, Ministry of Public Health, Nonthaburi, Thailand
88. Other outcomes and aspects of blood safety technically supported by WHO included:

- **Policy:** Bhutan and Maldives developed their national blood policies enunciating the key elements of the WHO Strategy for Safe Blood. Myanmar drafted a national blood policy through national consensus.

- **Quality:** donor-funded projects on improving the quality and safety of blood were implemented in Bangladesh, DPR Korea, Sri Lanka and Timor-Leste. The Regional External Quality Assessment Scheme (EQAS) for blood grouping and screening for HIV antibody continued to function effectively in seven countries (Bhutan, India, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand).

- **Management:** a bi-regional workshop on strengthening the leadership and management skills of blood bank managers was organized (at the WHO Collaborating Centre on Safe Blood, Singapore). Seven Member countries attended this workshop. A national Quality Management Training course was held for officials from blood banks in DPR Korea.

- **Access to safe blood:** a Regional meeting on patient safety was held in Sri Lanka (see also page 102) to emphasize the importance of assuring access to safe blood and to discuss possible mechanisms for achieving this at district level. All Member countries will be provided with technical support by WHO to strengthen blood safety for patients at all levels of health-care services.

**Challenges**

- Enhancement of country capacity to generate quality results for emerging viral infections.
- Increasing the proportion of voluntary blood donations.

**Tropical diseases research: strengthening country capacity**

89. The Regional Office continued to provide technical support for developing research capacity and for “implementation research”\(^{48}\) in the priority areas identified by the UNICEF – UNDP – World Bank – WHO Special Programme for Research and Training in Tropical Diseases (TDR).\(^{49}\)

\(^{48}\) Research aimed at solving problems encountered in the implementation of a control tool, and at producing results with the potential for immediate application in policy or strategy  
\(^{49}\) [www.who.int/tdr/](http://www.who.int/tdr/)
Contributing to the formulation of national research priorities

90. The priorities for the TDR Small Grants Programme\textsuperscript{50} included malaria, kala-azar, dengue and leprosy. Various activities are involved in the administration of this Programme, including preparation of calls for application, review of proposals for funding, analysis of reports, dissemination of research findings, and promotion of the utilization of research results in the countries. A total of 58 proposals were received by the Regional Office from the Member countries. Of these, 10 were supported and the rest are being re-considered by the SEARO technical units for possible funding support. Outcomes of these research activities may also be utilized in formulation of national research priorities.

Contributing to national research capacity

91. The Regional Office participated and technically assisted in a training course on research methodology in Bhutan, the outcome of which was the formulation of five research proposals which were submitted to the Regional Office and were reviewed by the Regional Research Committee. These proposals address malaria, control of diarrhoeal diseases and the utilization of health research information. Three proposals were supported for fundings. This training contributed to strengthening the country’s capacity in research methodology.

Communicating research results

92. A research portfolio containing summaries of the final reports of TDR-supported research projects is being finalized and will be communicated to the countries for their information and possible follow up and utilization of the research results.

Challenges

- Improvement in the quality of proposals.
- Communication of research results to policy-makers.
- Research priority-setting.
- Financial resource constraints – the engagement of in-country partners such as GTZ, the World Bank, and the Gates Foundation, to be explored.

\textsuperscript{50} Altogether US$ 50 000 allocated annually for research proposals, preferably from young researchers
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Noncommunicable diseases and mental health
Noncommunicable diseases: developing comprehensive commitment

1. The challenges posed by chronic, noncommunicable diseases (NCDs) such as cardiovascular disease, cancer, chronic lung diseases and diabetes, are increasingly being addressed by Member countries. In 2007, the Regional Committee adopted a resolution\(^1\) endorsing the Regional Framework for Prevention and Control of NCDs\(^2\) and urging Member States to formulate and strengthen national policies, strategies and programmes for integrated prevention and control of NCDs.

Strengthening capacity

2. To support national efforts in formulating comprehensive NCD policies, plans and programmes, and to promote implementation of evidence-based and cost-effective interventions, the Regional Office initiated a project on Capacity Strengthening for Policy-Makers and NCD Programme Managers. Training materials developed under this project were pilot-tested in Nepal. Using this training package, and with WHO support, Bhutan, Maldives, Nepal, Sri Lanka and Thailand organized national capacity-strengthening workshops. Detailed guidelines for coordinators and resource persons conducting NCD capacity strengthening workshops at national and sub-national level were developed by the Regional Office.

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\(^1\) Resolution SEA/RC60/R4 on Scaling up Prevention and Control of Chronic Noncommunicable Diseases in the South-East Asia Region

\(^2\) see: www.searo.who.int/LinkFiles/Health_Promotion_&_Education_RegFrmonNCD.pdf
Formulating and implementing policy and strategy

3. With WHO technical support and guidance, significant progress in implementing existing national NCD policies, plans and programmes was noted in Bangladesh, India, Indonesia and Thailand. Other countries are in various stages of formulating new national NCD policy and strategy, including Bhutan (formulating its first ever national policy and strategy on NCD prevention and control), Nepal and Sri Lanka (in the process of formulating new national policies), and Maldives (completed formulation of a new strategic plan for 2008–2010). The ministries of health of Bangladesh, Indonesia and Sri Lanka made important structural changes within their ministries, strengthening technical units or departments at national level to coordinate integrated NCD programmes.

4. WHO provided technical support for the following:


- For chronic obstructive pulmonary disease and asthma: the establishment of a new WHO Collaborating Centre in Chandigarh, India, to conduct collaborative research and strengthen capacity for prevention and management of chronic obstructive pulmonary disease and asthma.

- For oral health: initiating the formulation of a Regional strategy on oral health, with the objectives of facilitating restructuring of the oral health system; encouraging Member countries to develop or strengthen their national oral health plans; facilitating oral health promotion and prevention programmes; and ensuring access to equitable, quality oral health care.

Surveying of risk factors

5. Since the introduction of the WHO STEPwise approach to surveillance of NCD risk factors in the Region in 2001, most Member countries have gathered standardized information on the levels of major risk factors in their populations. Further technical assistance was provided to Bhutan, India, Maldives, Nepal and Sri Lanka for planning, implementing and managing

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1. With the support of the governments, Regional Network for NCD Prevention and Control (SEANET-NCD), and the WHO Collaborating Centre for Promoting Community-based Oral Health, Chiang Mai, Thailand

2. See: www.who.int/chp/steps/en/index.html
data from the surveys. Results of the Regional surveys so far conducted, which were shared with the Regional Committee in 2007, will guide countries in further planning of health promotion and primary prevention of NCDs.

6. To facilitate risk factor surveillance activities, a new institution was designated as WHO Collaborating Centre for Noncommunicable Diseases Prevention and Control. This Centre will also sustain the Regional NCD Risk Factor InfoBase and support Regional networking including developing and hosting a website of the Regional NCD Network (SEANET-NCD).

Challenges

- Reducing the level of exposure of populations in the Region to NCD risk factors.
- Promoting multisectoral, multidisciplinary and multilevel partnerships.
- Strengthening the capacity of health systems to develop, implement, monitor and evaluate national plans and programmes for integrated prevention and control of NCDs.

Mental health: aiming for collective action

7. Mental health can be improved through the collective action of society. Improving it requires not only specific activities in the health field, but also coordinated policies and programmes of governments and business sectors. Priority attention was therefore given to four areas.

Promoting mental health

8. Owing to the many social and cultural determinants of mental well-being, strategies for mental health promotion have been formulated in terms of specific socio cultural context. The Regional Office earlier developed technical materials on mental health promotion. These were adapted and have been used in Bhutan, several states of India, Indonesia and Myanmar. To promote mental health, experts from Member countries agreed that traditional methods, such as yoga and meditation, played an important role.

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5 WHO Collaborating Centre for NCD Prevention and Control, Chennai, India
10. This strategy has also been successfully implemented in all atolls in Maldives. With the proper identification, referral and treatment of all patients with epilepsy, the Government of Maldives has now strengthened the community mental health system by training community health coordinators and developing a draft national mental health policy.

11. Similar training of community health workers has also been conducted in DPR Korea and Myanmar. Since the programmes were developed with the participation of Member countries, they are culturally appropriate and acceptable to the community, and hence sustainable.

Training in mental health related to disasters

12. The training manuals on psychological care of tsunami-affected populations,\textsuperscript{10,11} developed by the Regional Office after the tsunami disaster of 2004, were translated, adapted and used after cyclones Sidr in Bangladesh and Nargis in Myanmar. Extensive training of master trainers on implementation of psychological care has now been conducted in three

\textsuperscript{9} See: Development of strategies for community-based neuropsychiatric services. New Delhi, SEARO, 2002 (document SEA-MENT-128) (at: www.searo.who.int/LinkFiles/Meeting_reports_Development_of_Strategies_for_Community_Based_Neuropsychiatric_Services.pdf)


Reducing harm from alcohol use

13. Harm from alcohol use is a major concern in several Member countries of the Region. The Regional Office has conducted community-based surveys of patterns of alcohol use, and of harm from alcohol use, in India (Tamil Nadu), Myanmar and Sri Lanka. At this stage, the evidence is being compiled.

Challenges

- Consideration of culturally accepted traditional methods of mental health promotion, such as yoga and meditation.
- Implementing the strategy for training village-based workers as a national movement.
- Ensuring availability of appropriate drugs for treatment of neuropsychiatric conditions in the field.
- Strengthening the mental health and psychosocial aspects of disaster preparedness in Member countries.
- Developing culturally appropriate evidence-based strategies to reduce harm from alcohol use.

Health promotion and education: nurturing a multisectoral approach

14. The work in the area is guided by commitments related to the Bangkok Charter for Health Promotion (2005) and to resolutions of the Regional Committee\(^\text{12}\) and World Health Assembly.\(^\text{13}\) The overall strategy is to nurture and sustain a cross-sectoral approach focusing on disease-specific issues, and different population groups and settings. The *Regional Strategy for Health Promotion for South-East Asia*\(^\text{14}\) was published in 2008; it calls for multidisciplinary and multisectoral integration of health promotion into (i) disease or issue-specific interventions; (ii) population-based interventions; and (iii) settings-based interventions.

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\(^\text{13}\) WHA60.24 (2007) on Health Promotion in a Globalized World
\(^\text{14}\) (document SEA/HE/194)
15. Main activities supported by WHO included:

- Tobacco and alcohol: parliamentarians from countries of the Region endorsed a Call for Action\(^\text{15}\) making recommendations to WHO and Member countries related to the development of effective strategies for control of tobacco and alcohol. This Call promotes advocacy for health in national development and has helped bring about national consensus on important health issues, particularly legislative and policy actions for promoting health (see also page 121).

- Alternative financing: a five-country (India, Indonesia, Nepal, Sri Lanka, Thailand) study on innovative financing of health promotion\(^\text{16}\) was conducted in order to compile a Regional profile. The results of the study are being finalized and will offer local experts the opportunity to contribute towards health-financing policy and decision-making at the national level.

- Social determinants of health: in order to analyse health inequities and the impact of social determinants on health outcomes, a six-country (India, Indonesia, Maldives, Nepal, Sri Lanka, Thailand) health equity study was supported based on analysis of demographic and health survey data. A Regional profile was compiled following a Regional consultation;\(^\text{17}\) it will assist policymakers in addressing issues related to the social determinants of health.

- School health promotion: eight Member countries (Bhutan, India, Indonesia, DPR Korea, Maldives, Sri Lanka, Thailand, Timor-Leste) each conducted a case study on the implementation of school health promotion, highlighting the successes, challenges, and possible solutions; the case studies are being compiled as a SEARO publication. Additionally, nine Member countries (Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand) participated in data collection and analysis training under the Global School Health Survey (GSHS).\(^\text{18}\) This provided an opportunity for countries to generate data on behaviour among their school-age populations (13–15 years) for use during the development of school health programmes and policy.

\(^{15}\) Policy Options for Reducing Harm from Alcohol Use. Regional Conference of Parliamentarians on Legislative and Policy Actions for Promoting Health in the Countries of the WHO South-East Asia Region. Bali, Indonesia, October 2007 (www.searo.who.int/LinkFiles/Alcohol_and_Substance_abuse_PC_WorkingPaper.pdf)

\(^{16}\) Alternative Financing of Health Promotion: Policy Options and Management

\(^{17}\) Social determinants of health – report of a regional consultation, October 2007 (document SEA-HE-190)

\(^{18}\) Conducted by WHO and the US Centers for Disease Control
• Social and behavioural research: the Regional Office initiated social and behavioural research to collect evidence and explain human behaviour in complex settings. A study was conducted in Indonesia on the socio-cultural and behavioural factors associated with transmission of avian influenza from poultry to humans. A study in Sri Lanka was supported to identify the factors which contribute to malnutrition; the findings have been applied to the strengthening of interventions for behaviour change in the community. WHO provided technical support in the design and conduct of the studies.

• Urbanization: collaboration with the WHO Kobe Centre, Japan, on promoting healthy urbanization continues under the Bangalore Healthy Urbanization Project (BHUP). The purpose of the project is to determine the impact of social determinants of health on exposed populations in urban settings for 2006–2007. Technical support was provided to establish a coordination and management mechanism through a Public Health Promotion Board and a Health Promotion Policy, to assure multisectoral participation and assist in institutionalization of the project. A 20-minute video was produced to highlight implementation of the BHUP. WHO provided technical support in situation analysis, and in implementation of the interventions.

• Active and healthy ageing: great emphasis is placed on understanding demographic characteristics and trends, analysis of social and economic determinants, and policies and programme interventions using a life-course approach. In addition to the strategic directions agreed during a Regional consultation (see Box 2.1), WHO initiated 10 case studies on active and healthy ageing.

Box 2.1: Key strategic directions for implementing active and healthy ageing

• Health promotion based on a life-course approach across all sectors
• Strengthening of health systems in order to perform a stewardship role in active and healthy ageing
• Addressing the social and economic determinants of ageing.

20 Regional Consultation on Healthy Ageing, December 2007
focusing on health system strengthening, social and economic determinants, and health promotion to document the various factors that affect ageing.

Challenges
- Capacity building for health promotion infrastructure.
- Innovative financing mechanisms for health promotion.
- Gathering evidence on the impact of health promotion interventions.

Tobacco control: expanding knowledge and awareness of the epidemic

16. Tobacco use kills 1.2 million people annually in the Region, out of 5.4 million deaths globally. There are some unique characteristics of tobacco use in the Region, such as smokeless and indigenous tobacco products, which require unique responses. See Figure 2.1 for the current picture of use of tobacco products among the youth of the Region.

Figure 2.1: Current cigarette smoking and current use of tobacco products other than cigarettes among the youth* of selected Member countries, 2006–2007

*youth: 13–15-year-olds
Source: Global Youth Tobacco Survey (GYTS)
Strengthening national resources

17. WHO’s efforts to help countries build national capacity in tobacco control under the Bloomberg Global Initiative to Reduce Tobacco Use (BGI) have intensified.\(^{21}\) Four countries – Bangladesh, India, Indonesia, and Thailand – received direct support from BGI for staff and core activities. The staff support received at the Regional Office contributed to greater and intensified technical support to all Member countries. SEARO is also supporting the Member countries, as well as NGOs, to apply for grants through the Bloomberg Grant Mechanism. In addition to the US$ 3.1 million provided for staff and core activities in the four Bloomberg focus countries and the Regional Office, approximately US$ 15 million for the Region has also been received through the Bloomberg Grant Mechanism, most of which is for the four Bloomberg focus countries.

Strengthening tobacco surveillance

18. Tobacco surveillance is a key area of work, and the BGI provided a unique opportunity to implement the Global Adult Tobacco Survey (GATS), using the standard protocol. Three of the four BGI-supported countries have started field work for the GATS, which will be completed by the end of 2008. WHO technically supports this activity and analysis of the data. The results will help the countries strengthen tobacco surveillance, and will be useful for monitoring the tobacco epidemic to target interventions.

19. Bangladesh, India, Indonesia, Maldives, Myanmar, Nepal and Sri Lanka have also undertaken various surveys with WHO support, such as a youth tobacco survey, school personnel survey, and health-professional student survey.\(^{22}\)

20. As per the recommendations of a regional surveillance workshop (Regional Workshop on Tobacco Surveillance – Linking Data to Action, Nepal, February 2007), a regional strategy for utilization of tobacco surveillance data was developed to provide guidance on the use of data for developing and implementing evidence-based programmes and activities.

Advocating for tobacco control

21. Advocacy for tobacco control is a crucial area of work. A large-scale advocacy campaign based on the 2007 theme of World No Tobacco Day (WNTD) – Smoke-free Environments – was undertaken throughout the year. Member countries were also supported to intensify their advocacy campaigns

\(^{21}\) An initiative launched in 2006 by Mr Michael Bloomberg, Mayor of New York City, to strengthen capacity for tobacco control

\(^{22}\) see: www.searo.who.int/EN/Section1174/Section2469.htm
with the 2008 WNTD theme – Tobacco-free Youth. A number of documents\textsuperscript{23,24,25,26,27} were produced and disseminated among countries and stakeholders both as advocacy tools and to guide countries in revising and strengthening their tobacco control programmes. The mechanism for information exchange and sharing was also strengthened.

**Focusing on multisectoral collaboration**

22. Tobacco control being a cross-cutting area, countries of the Region have been focusing on multisectoral collaboration in their efforts to control tobacco in Member countries. In Bangladesh, India, Myanmar and Thailand, tobacco issues have been incorporated into the school curriculum in collaboration with the ministries of education.

23. The Region was the first WHO region to initiate close collaboration with the TB control programme. A pilot project on TB and tobacco was implemented in Nepal. By incorporating tobacco control measures and working together, the TB control programme will be strengthened, contributing to reduced morbidity and mortality.

**Enforcing legislation**

24. Issues such as the large number of smokeless tobacco products and the economic and employment aspects of tobacco are unique to the Region. Five countries (Bangladesh, India, Myanmar, Sri Lanka, Thailand) have comprehensive tobacco control legislation, and other countries are in the process of developing theirs.

25. However, enforcement of tobacco control measures and legislation needs to be strengthened in the Region to ensure effective tobacco control.

**Challenges**

- Development of appropriate tobacco control measures, including comprehensive national tobacco control legislation in line with the WHO Framework Convention on Tobacco Control (FCTC).
- Public education for sustained tobacco control, and multisectoral collaboration, with a particular focus on the raising of taxes on tobacco products.

\textsuperscript{23} Annual report on the progress of implementation of the BGI, 2007
\textsuperscript{24} Regional communication strategy for tobacco control, 2008
\textsuperscript{25} Regional tobacco surveillance report, 2007
\textsuperscript{26} BGI newsletter, Vol. 1, Issue 1, April 2008
\textsuperscript{27} Profile on tobacco and youth in the South-East Asia Region. New Delhi, SEARO, 2008
• Implementing the six-point MPOWER package (see Box 2.2) as advocated in the first WHO report on the tobacco epidemic.28

Box 2.2: MPOWER package

• Monitor tobacco use and prevention policies
• Protect people from tobacco smoke
• Offer help to quit tobacco use
• Warn about the dangers of tobacco
• Enforce bans on tobacco advertisements, promotions and sponsorships
• Raise taxes on tobacco

By developing and implementing the MPOWER package, deaths in the Region from tobacco use can be reduced.

Injuries, violence and disabilities: focusing on prevention

26. Available data substantiate the fact that up to one third of the global burden of injuries is accounted for by the Region.29 Road traffic injuries and violence are the leading causes of injury, and drowning is the leading cause of mortality in children less than 15 years of age in some Member countries. Motorcycle-related injuries account for a large proportion of road traffic injuries in the Region. This is due to the remarkably large percentage of motorcycles among all registered vehicles in Member countries (50%–75%) compared to developed countries (1%–4%).

Reviewing national programmes

27. Eight Member countries have formulated national plans and implementing mechanisms for preventing injuries. Most of these plans are based on the Regional Strategic Plan for Injury Prevention,30 which guides Member countries to collect information, formulate/implement policies for injury prevention, strengthen emergency care, mobilize resources, and include injury prevention in their public health agendas.

30 Strategic plan for injury prevention and control in South-East Asia. New Delhi, SEARO, 2002 (document SEA-Accident-8) (www.searo.who.int/en/Section1174/Section1461/Section1717_7365.htm)
28. The national programmes on violence and injury prevention and their linkages to disability prevention were reviewed in collaboration with all country programme managers. WHO and Member countries are working very closely to strengthen country capacity in implementing policies and strategies for injury prevention, establish centralized national responsibility for injury prevention, and report minimum essential data sets on injuries.

**Strengthening the generation of evidence**

29. Work to strengthen the capacities of Member countries in generating evidence and reporting injuries continued, based on the injury surveillance and information system. Technical support to establish this surveillance system was provided to Bhutan, DPR Korea, India, Indonesia, Nepal, and Sri Lanka; these countries are trying to find a way to incorporate injury reporting into their existing health information systems. Timor-Leste is being supported in a situation analysis on injuries. Thailand was supported to develop a data collection form and software for ensuring that data are useful for analysis.

**Training in injury prevention**

30. A Regional workshop on injury epidemiology, prevention and care was held for trainers, to adapt and use the TEACH-VIP modular training curriculum on injury prevention and control. A workshop on introducing injury prevention into the curriculum of medical and nursing schools in the Region is planned in July 2008.

**Collating national data on road safety**

31. As a follow-up to the World report on road traffic injury prevention launched in 2004, and the UN Road Safety Week Campaign of 2007, WHO has been

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31 Regional Meeting of National Managers of Injury Prevention and Care, September 2007, Thailand
32 Training education and advancing collaboration in health on violence and injury prevention, (TEACH-VIP) at: www.who.int/violence_injury_prevention/capacitybuilding
34 See: www.who.int/roadsafety/en/
collaborating with the Bloomberg Philanthropies in developing the *Global status report on road safety*\textsuperscript{35} to support Member countries of the Region in collating national data and advocating necessary actions for road safety.

### Identifying standards of care for hearing disability and for eliminating avoidable blindness

32. WHO provided the epidemiological framework and support for developing a situation review and update on deafness, hearing loss and intervention programmes,\textsuperscript{36} and drafted a Regional strategic framework, VISION 2020, for prevention of avoidable blindness.\textsuperscript{37} This framework includes targets and a timeline for implementation of VISION 2020 in Member countries.\textsuperscript{38}

### Challenges

- Improvement of the information system on injury and violence.
- Establishing units in ministries of health to implement and coordinate injury prevention and care.
- Measures to reduce the severity of, and deaths and disability due to, injuries.
- Prevention of disabilities and enhancement of community rehabilitation and services.

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\textsuperscript{35} See: www.who.int/violence_injury_prevention/road_traffic/global_status_report/en/
\textsuperscript{36} *Situation review and update on deafness, hearing loss and intervention programmes – proposed plans of hearing impairment in countries of the South-East Asia Region*. New Delhi, SEARO, 2007 (document SEA-Deafness-10)
\textsuperscript{38} See: www.searo.who.int/en/Section980/Section1162/Section1167/Section1171_4755.htm)
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Family and community health
Child health: moving towards Millennium Development Goal 4

1. Technical support to accelerate efforts for achieving the Millennium Development Goal number 4 – reduction of under-five mortality to two-thirds of 1990 levels by the year 2015 (see Figure 3.1) – was provided to Member countries during the year.

Figure 3.1: Reduction in under-five mortality in Member countries

Baseline data for 1990 for Timor-Leste is an estimate and 2015 is target set as Millennium Development Goal (MDG)
Reference year of data for 2005 vary from 2000 to 2005
Source: Country reports on MDG
2. The majority of SEA Region Member countries are on track towards achieving this MDG, and during the year progress advanced along several fronts, as outlined below and following the suggestions of national child health programme managers at their review meeting.

**Enhancing Integrated Management of Childhood Illness**

**Expanding coverage**

3. The Integrated Management of Childhood Illness (IMCI) strategy presents a platform for providing integrated child care services for the most common childhood afflictions. WHO Regional and country offices technically supported Member countries in expanding coverage with IMCI. As a result, significant additional geographical areas in Bangladesh, Bhutan, DPR Korea, India and Nepal are covered by the IMCI strategy.

**Institutionalizing IMCI**

4. Pre-service education of prospective doctors and nurses is a cost-effective and sustainable means of institutionalizing IMCI. Bangladesh, DPR Korea and India instituted medical and nursing pre-service IMCI training in medical and nursing schools using country adaptations of WHO training materials.1

**Reviewing programmes**

5. WHO provided support for IMCI programme reviews to improve efficiency and effectiveness of the programme. Myanmar was assisted in reviewing of its in-service IMCI initiative, and Indonesia was assisted in a review of its pre-service IMCI training programme. Also completed during the year was evaluation of the effectiveness and impact of IMCI in Bangladesh, as part of an ongoing multicountry evaluation.

**Improving quality of hospital care for children**

6. The Regional Office continued to provide technical support for improving the quality of hospital care for children. India and Indonesia have instituted a systematic process of improving child care services in small hospitals;2 a similar

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1 See: [www.searo.who.int/en/Section13/Section37/Section2017/Section2038_10199.htm](www.searo.who.int/en/Section13/Section37/Section2017/Section2038_10199.htm)

A systematic process of improving child care services in small hospitals is being instituted in Member countries.

process for improving quality of child care in hospitals was initiated in Bangladesh.

7. A Regional consultation on the subject led to the drafting of a Regional framework for improving the quality of hospital care for children. This framework will be finalized in 2008.

**Strengthening services for children with HIV/AIDS**

8. Responding to the needs of Member countries for strengthening services for children with HIV/AIDS, the Regional Office finalized guidelines for introducing and strengthening the paediatric component in national HIV/AIDS programmes. These guidelines\(^3\) were peer reviewed and published; they will help countries to rapidly scale up services for children with HIV/AIDS.

**Expanding neonatal and perinatal care**

9. The quality of data is being improved as a prerequisite for better programme planning and guiding the expansion of neonatal and perinatal care in Member countries. The South-East Asia Perinatal-Neonatal Database Network completed one year of work; perinatal and neonatal data from selected institutions in Bangladesh, India, Indonesia, Nepal, Sri Lanka and Thailand were compiled, analysed and reported.

**Establishing an expert group**

10. The South-East Asia Expert Group on Child Health and Development was established to guide the Regional Office and Member countries in preventing disease and promoting health of the child, focusing on the areas of delivery of effective interventions, quality of information, research, and demand for child health interventions.

\(^3\) *Paediatric HIV/AIDS in South-East Asia: strategic considerations for universal access to paediatric anti-retroviral therapy*
Adolescent health and development: increasing sensitivity to adolescents’ needs

11. Presently, about 300 million adolescents (10–19-year-olds) in Member countries of the Region are passing through this rapid phase of growth and development. To address their special needs, WHO provided technical assistance to Member countries to strengthen the health sector’s response and collaboration with other sectors. This work followed the four directions outlined below.

Gathering strategic information

12. To enable Member countries to prioritize adolescent health interventions, in particular to formulate national strategies for adolescent health, an epidemiological database is being developed. In this respect, activities supported by WHO included:

- Sub-set analysis of data from demographic and health surveys, behaviour surveys, HIV surveillance and other available youth surveys carried out in Bangladesh, India, Indonesia, Nepal and Sri Lanka, thus helping to fill a gap in age and sex disaggregated statistics.
- Preparation of national profiles on adolescent health in Bangladesh, Bhutan, Sri Lanka and Thailand.

Challenges

- Improving delivery of effective neonatal and child health interventions at high coverage.
- Addressing information gaps, and monitoring and evaluating child health programmes.
- Prioritizing child health research.
- Improving demand for child health interventions.
- Improving child health programme management capacity.
• Incorporation of age and sex disaggregated data for relevant indicators in planned national and district level surveys of selected countries (Bangladesh, India, Nepal and Sri Lanka).

Building a supportive policy environment

13. A WHO assessment tool for strengthening the laws, policies and standards of care related to the sexual and reproductive health of adolescents was developed and field tested in Sri Lanka. It will be shared with other Member countries to assist them in collating information on existing laws, policies and standards, and in improving the access of adolescents to reproductive health services.

14. Other activities supported included:

• Development of national strategy on adolescent health in Myanmar and Sri Lanka; finalization of a five-year strategic plan on adolescent health in Myanmar.
• Preparation of national policy on youth and national strategy on adolescent health and development (AHD) in Sri Lanka.
• Printing and dissemination of the national AHD strategies in Bangladesh, India and Nepal.
• Drafting of Regional strategic directions on AHD in collaboration with country programme managers; these will be finalized in 2008.

Developing services and supplies

15. Regarding the provision of Adolescent Friendly Health Services (AFHS), activities are centred around development of national standards on provision of quality AFHS to help countries measure the quality of services. Activities supported included:

• Development of national standards on provision of quality AFHS in Bangladesh, India and Sri Lanka; finalization of national standards in Indonesia and Nepal.
• Adaptation of training materials and guidelines on AFHS for health providers in Bangladesh, Bhutan, India and Sri Lanka.
• Sharing of experiences, during a programme managers’ meeting, from selected countries to plan the scaling up of implementation of AFHS.
• Creating a pool of trainers through training of trainers at the national level in Bangladesh, Bhutan, India, Indonesia and Sri Lanka.
16. To build countries’ capacity through alternative approaches to training in AFHS, technical assistance was provided to incorporate AHD in a distance learning course for medical officers.4

17. To improve the capacity of district-level programme managers in programming and planning for adolescent sexual and reproductive health and HIV/AIDS among young people, a management development course5 was finalized after the pilot phase. This course was developed by WHO in partnership with UNFPA,6 and the first Regional course was conducted.

18. For assessing the quality and costs of AFHS, draft tools and guidelines were field tested at three sites in India and Sri Lanka; the findings from India were reviewed in January 2008. The Population Council7 has been contracted to finalize the tools.

**Strengthening collaboration with other sectors**

19. During a meeting of national adolescent health programme managers,8 mechanisms for strengthening the linkages between ministries of health and education were discussed and regional strategic directions for improving adolescent health were drafted, to be finalized soon.

20. WHO has documented innovative approaches used in different Member countries for reaching out to young people with provision of health services on HIV/AIDS. These have been printed and widely disseminated.9

**Challenges**

- The inadequacy of information on key indicators of adolescent health and development.
- Empowerment of adolescents with correct information.
- Sensitization, including through the provision of information, of parents, teachers and service providers to adolescents’ needs.

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4 The Post Graduate Diploma in Maternal and Child Health at Indira Gandhi National Open University, India
5 Integrated HIV/AIDS and Reproductive Health Programming for Young People from South Asia
6 The United Nations Population Fund
7 An international, nonprofit, nongovernmental organization, seeking to improve the well-being and reproductive health of current and future generations
8 Meeting of National Adolescent Health Programme Managers in SEAR Countries, Bali, February 2008
9 Young people and HIV/AIDS. Responding to unmet needs through innovative approaches. New Delhi, SEARO, 2007 (document SEA/AHD/05) (see: www.searo.who.int/LinkFiles/Initiatives_Young_People_and_HIV-AIDS.pdf)
Family and community health

- Expansion of existing services and improvement in their quality and sensitivity to adolescents’ needs.
- Supportive policy environment.

**Nutrition: dealing with malnutrition through a life-course approach**

21. Progress in reducing the prevalence of mild and moderate malnutrition is slow in the majority of SEA Region Member countries. With the current trends, considering data between 1990 and 2005 (see Figure 3.2), in some countries it may be difficult to achieve the MDG target of halving by 2015 (from the 1990 baseline) the proportion of people who suffer from hunger.

22. The work of WHO in the area of nutrition followed on from the resolution of the Regional Committee in 2007.10

**Developing national policy and plans of action**

23. Support was provided to Member countries for developing national policy and plans of action in nutrition and food safety. Country programme

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10 SEA/RC60/R3 on Nutrition and Food Safety
managers in nutrition, and representatives of various sectors (e.g. planning, agriculture and public health, which have a direct bearing on implementation of food and nutrition plans and policies) drafted\textsuperscript{11} action plans to help the countries improve upon and implement their plans and policies.

Strengthening the regional research network

24. The South-East Asia Nutrition Research-cum-Action Network, which includes four WHO collaborating centres (CCs) in the Region,\textsuperscript{12} has played an important role in partnership and exchange of technical information on research, policy and programme initiatives pertaining to food and nutrition. During a joint meeting of the collaborating centres and the WHO and FAO regional secretariats, strategy to strengthen future plans and actions of the network was formulated.

Implementing the new WHO growth standards

25. Master trainers from six Member countries (Bangladesh, Bhutan, India, Indonesia, Maldives, Sri Lanka) were trained on the new WHO Child Growth Standards (see Box 3.1).\textsuperscript{13} The new standards demonstrate for the first time that children born in different regions of the world and given the optimum start in life have the potential to grow and develop within the same range of

\begin{boxed_text}
**Box 3.1 WHO growth standards for infants and children up to the age of five years**

Growth charts are an essential tool for assessing the growth and nutritional status of children. The new WHO growth standards make breastfeeding the biological “norm”, establish the breastfed infant as the normative growth model, and describe how children should grow when their needs are met.

Introduction of the new standards at national level requires careful planning and coordination with relevant national authorities, non-governmental organizations and international partners with regard to resource mobilization, awareness and advocacy.
\end{boxed_text}

\textsuperscript{11} At a joint WHO-FAO Intercountry Workshop on Food and Nutrition Policy and Plans of Action, India, December 2007. (document SEA-NUT-175)
\textsuperscript{12} • WHO Collaborating Centre for Prevention and Control of Micronutrient Malnutrition, Centre for Research and Development in Food and Nutrition, Indonesia
• WHO Collaborating Centre for Community Nutrition and Food Safety, Institute of Nutrition, Nakhon Pathom, Thailand
• WHO Collaborating Centre for Nutrition Science in Primary Health Care, National Institute of Nutrition, Hyderabad, India
• WHO Collaborating Centre for Research and Training in Promoting Nutrition in Health and Development, M.S. University of Baroda, Gujarat, India
\textsuperscript{13} www.who.int/nutrition/media_page/backgrounders_1_en.pdf
height and weight for age. This training of trainers has established a Regional pool of trainers to lead national training activities in the use and interpretation of the new growth standards. WHO technically supported national level training conducted in Indonesia and similar activities are planned for other Member countries in the near future.

**Integrating nutrition issues with response to HIV/AIDS**

26. Integration of nutrition as a fundamental part of the overall response to HIV/AIDS in the Region was addressed during a Regional consultation\(^\text{14}\) jointly organized by WHO, FAO, WFP, UNICEF\(^\text{15}\) and the US National Institute of Health. Action plans at the national and regional levels were elaborated, ensuring nutrition as a fundamental component of the comprehensive package of HIV/AIDS care, support and treatment programme, and including a research agenda with a Regional perspective to support evidence-based programming.

**Collecting data on vitamin A deficiency and iodine deficiency disorder**

27. The Regional Office and Member countries collaborated with WHO Headquarters, Geneva,\(^\text{16}\) in maintaining/updating the Vitamin and Mineral Nutrition Information System (VMNIS).\(^\text{17}\) Currently, the VMNIS includes three databases dealing with iodine deficiency, vitamin A deficiency, and anaemia.

**Transferring knowledge**

28. The Regional Office initiated the process of possible technology transfer for salt iodization with potassium iodate for the Ministry of Health, Government of Myanmar. Detailed modalities of the transfer are being worked out.

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\(^{14}\) Regional consultation on nutrition and HIV/AIDS: Evidence, lessons and recommendations for action in South-East Asia, Thailand, October 2007. (document SEA-NUT-172)

\(^{15}\) Food and Agriculture Organization (United Nations), World Food Programme (United Nations), United Nations Children’s Fund

\(^{16}\) The Micronutrient Unit, Department of Nutrition for Health and Development

\(^{17}\) [www.who.int/nutrition/database/micronutrients/en/](http://www.who.int/nutrition/database/micronutrients/en/)
Challenges

- The persistence of high levels of malnutrition in children and women.
- Two contrasting trends, leading to a “double burden” of nutrition (as a cause of both underweight and overweight), call for increased concerted and coordinated action between the health, nutrition, agriculture, trade and finance sectors.

Making pregnancy safer: improving the quality of care

29. Achieving Millennium Development Goal 5, on improving maternal health in the Region, remains a challenge; half of the countries in the Region will need concerted efforts if they are to reach this MDG target (see Figure 3.3). Activities during the year were oriented towards achieving better quality of service.

Figure 3.3: Trend of maternal mortality in Member countries

Promoting skilled care at every birth

30. The Regional Committee resolution on ‘Skilled care at every birth’ continued to be addressed. In WHO support special attention was given to

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18 SEA/RC58/R2, Skilled Care at Every Birth, 2005
countries in which the proportion of deliveries assisted by a skilled attendant is less than 50% (see Figure 3.4), where the maternal mortality ratio is usually high.

**Figure 3.4: Births attended by skilled health personnel in Member countries**

31. National movements for improving access to, and quality of, care by skilled attendants are ongoing in Bangladesh and Nepal, where the midwifery skills of existing maternal and newborn health (MNH) providers at the community level are being enhanced. With WHO support, Bangladesh, Bhutan and Timor-Leste reviewed and revised pre-service midwifery training. India carried out refresher midwifery training for staff nurses/auxiliary nurses-midwives and revised the pre-service midwifery curriculum, while Indonesia and Sri Lanka addressed provision of maternal and newborn care in remote and conflict areas respectively.

**Training of primary care trainers in essential newborn care**

32. Countries gave special attention to the health of newborns through promoting improvement of MNH primary care providers in essential newborn care skills. WHO organized a Regional training of master trainers, with the participation of up to 40 professionals from all Member countries. This was followed up by activities at national level, technically supported by WHO, such as national training of trainers (in Bangladesh, Myanmar, Nepal, Sri
Lanka), training of target groups (in Bangladesh, Bhutan, Maldives, Myanmar, Nepal, Sri Lanka), and adaptation of the training materials (in India, Indonesia, Sri Lanka, Timor-Leste).

33. At a Regional meeting\(^{19}\) to review progress in implementation of essential newborn care, technical support was given to countries for advancing the essential newborn care course. In Myanmar, WHO assisted in conducting an assessment of the training in some townships before expanding it to other townships.

**Promoting guidelines**

34. Evidence-based standards, practices, guidelines and tools for effective maternal and newborn care (especially guidelines in the Integrated Management of Pregnancy and Childbirth series\(^{20}\)) were promoted. Some of the countries (Bangladesh, DPR Korea, Indonesia, Myanmar, Nepal, Sri Lanka, Timor-Leste) translated and adapted various guidelines and tools; other countries (Bhutan, India, Maldives) used the materials as reference in developing national guidelines. Training on different aspects of maternal and newborn health care using these guidelines was carried out in these countries.

**Strengthening health facility capacity**

35. Health facility capacity in analysing the causes of maternal death was strengthened through a Regional workshop.\(^ {21}\) Facility-based maternal-death review continues to be implemented in Bangladesh, Bhutan, Indonesia, Maldives, Myanmar, Nepal and Sri Lanka. In DPR Korea, the WHO guidelines on maternal death review were translated.

36. A method for improving the quality of maternal and newborn health care at first referral hospital was introduced for country adaptation.\(^ {22}\)

**Strengthening care at community level**

37. Involving individuals, families and communities in maternal and newborn health care and actions is crucial for improving the health of the

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\(^{19}\) Regional Workshop on Essential Newborn Care, September 2007


\(^{21}\) *Regional workshop on strengthening capacity for facility-based maternal death reviews,* September 2007 (document no. SEA-MCH-244)

\(^{22}\) *Quality improvement of maternal and newborn health service at first referral hospital.* New Delhi, SEARO, 2008, draft guidelines
mother and newborn. Activities have been initiated in Bangladesh, Bhutan, Indonesia and Nepal. Educational materials on maternal and newborn care at the household level, for women, families and communities, were provided to countries for consideration for adaptation.\(^{23}\)

**Strengthening care at the district level**

38. The importance of strengthening MNH programme management and planning at the district level was acknowledged by all countries.\(^{24}\) Bangladesh, Indonesia and Timor-Leste have already completed analysis; districts with good programme management showed better performance according to MNH indicators, especially with respect to coverage by maternal and newborn health care. Bangladesh strengthened supervision of skilled attendants at the primary care level.

**Integrating with other programmes**

39. Integration of MNH services with other relevant programmes has been undertaken in the countries. For example, in Bangladesh, Bhutan, Nepal and Thailand, MNH services were integrated with midwifery education; in Bangladesh, MNH services were integrated with maternal nutrition; and in Indonesia, Sri Lanka and Thailand, MNH services were integrated with prevention and management of respiratory tract infections, sexually transmitted infections, and HIV.

**Mobilizing resources**

40. WHO assisted in resource mobilization and drafting of proposals for multi-year projects in the area of maternal and newborn health in Bangladesh (resources from DFID) and DPR Korea (resources from Republic of Korea).

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\(^{23}\) Resource material on maternal and newborn care for educating individuals, families and communities. New Delhi, SEARO, 2008

\(^{24}\) At the Regional Workshop on Strengthening Maternal and Newborn Health Programme, Indonesia, November 2007 (document SEA-MCH-245)
Challenges

- Ensuring skilled care for every birth through strengthening human resources for MNH.
- Improving quality of maternal and newborn care.
- Strengthening programme management, especially at district level and below.
- Involving women, families and communities in maternal and newborn care.

Reproductive health and research: confronting the challenges

41. Work supported by WHO related to the five core elements of the Global Reproductive Health Strategy (see Box 3.2). The adapted Framework for implementing the global reproductive health strategy was introduced in 2006 and is still being used to help countries identify and analyse their problems and, based on this, develop plans of action.

Box 3.2: The five core elements of reproductive health strategy

(i) Improving antenatal, delivery, postpartum and newborn care
(ii) Providing high-quality services for family planning
(iii) Eliminating unsafe abortion
(iv) Combating sexually transmitted infections, cervical cancer and other gynaecological morbidities
(v) Promoting sexual health.

Advocating for maternal and newborn care

42. The human rights tool for advocating maternal and newborn health, which was developed by WHO and the Harvard School of Public Health and pilot-tested in Indonesia (and Brazil and Mozambique) in 2005–2006, is now being refined with Regional Office technical support.


Providing services for family planning

43. Technical support was provided to countries for various elements of reproductive health, including family planning. DPR Korea, India, Maldives, Nepal, Thailand and Timor-Leste each adapted at least one of the family planning guidelines and tools.\(^{27,28,29}\) This work was mostly (except for India and DPR Korea) covered under the WHO–United Nations Population Fund (UNFPA) Strategic Partnership Programme.\(^{30}\) Indonesia completed provincial reproductive health profiles.

Preventing unsafe abortion

44. WHO supported the following initiatives towards preventing and managing unsafe abortion:

- In Bangladesh, the development of a proposal and implementation plan\(^{31}\) to strengthen the menstrual regulation programme for reducing maternal mortality.
- In DPR Korea, the training of health providers in menstrual regulation services.
- In India, work on improving services towards preventing and managing unsafe abortions.
- In Nepal, the conduct of a situation analysis on unsafe abortions.
- In Thailand, the provision of training and a workshop on advocacy.

Combatting gynaecological morbidities

45. For the prevention and management of reproductive tract infections (RTIs)/sexually transmitted infections (STIs), India, Indonesia and Nepal translated and adapted,\(^{32}\) with WHO technical and financial support, at least one of the WHO guidelines.\(^{33,34}\) Indonesia pilot-tested the integration of

\(^{27}\) Medical eligibility criteria for contraceptive use. Geneva, World Health Organization, 2004 (www.searo.who.int/LinkFiles/Publications_mec.pdf)

\(^{28}\) Decision-making tool for family planning clients and providers. Geneva, World Health Organization, 2005 (www.searo.who.int/en/Section13/Section36/Section129/

\(^{29}\) Section1920.htm)

\(^{31}\) Selected practice recommendations for contraceptive use. Geneva, World Health Organization, 2004 (www.who.int/reproductive-health/publications/spr/)


prevention and management of RTIs/STIs, including elimination of congenital syphilis, into maternal and newborn health (MNH)/family planning (FP) services, while Sri Lanka expanded such integration to its north-eastern provinces.

46. Support was provided for translating and adapting the WHO cervical cancer control guidelines35 in Indonesia to assist the country in preventing and managing this morbidity.

**Promoting sexual health**

47. WHO technically supported and guided six Regional WHO Collaborating Centres in their work in the area of reproductive health (in India, Indonesia and Thailand). After technical communications and suggestions by the Regional Office, the centres focused on the following key reproductive issues:

- a study on the knowledge, attitudes and practices of urban communities in seeking abortion services in North India
- compilation of information on research from 16 reproductive health centres in Indonesia
- development of materials to promote school-based adolescent reproductive health in Thailand.

48. Technical support was provided for operational research on key reproductive health issues in the areas of MNH, FP, RTIs/STIs carried out in Indonesia, Myanmar and Sri Lanka. Evidence was obtained in relation to the occurrence of STIs in pregnant women in some districts of Indonesia, which will help to prioritize work on reproductive health issues.

49. With WHO technical assistance, Sri Lanka completed an MNH programme review; similar reviews were carried out in Bangladesh, India and Nepal as part of collaboration among UN agencies in the Region36 and the World Bank. An analysis of the population situation and policies in the Region was carried out,37 from which a publication was produced which attempts to reflect the Regional situation by examining the views and policies of each country from 1975 to 2005; this will be a useful resource for addressing population and reproductive health issues at national and regional levels.

36 United Nations Children’s Fund Regional Office for South Asia (UNICEF-ROSA), UNFPA Country Technical Services Team (CST) - South and West Asia (SAWA), and WHO-SEARO
37 Population situation and policies in the South-East Asia Region. New Delhi, SEARO, 2007 (in press)
Challenges

- Integrating priority elements of reproductive health services into the primary health-care setting in order to allow one-stop services for the client.
- Providing effective services for MNH, FP, prevention and management of unsafe abortion, and RTIs/STIs.

Gender, women and health: promoting health equity

50. The internationally agreed development goals contained in the United Nations Millennium Declaration include the promotion of gender equality and the empowerment of women (Millennium Development Goal 3) as effective ways of combating poverty, hunger and disease, and of stimulating sustainable development.\(^{38}\)

Formulating regional strategic directions

50. Based on the 2007 World Health Assembly resolution,\(^{39}\) regional strategic directions were formulated during a regional consultation.\(^{40}\) These strategic directions will help countries develop national plans and integrate gender analysis and actions into their health policies and programmes.

Assessing gender and health

51. A conceptual framework for assessing gender and health was discussed\(^{41}\) and drafted in collaboration with Member countries. The Framework highlights the importance of a database management system and use of tools such as the Gender Analysis Matrix (GAM), Gender Analysis Pathway (GAP), and multicountry studies on domestic violence and women’s health.

Preventing gender-based violence

52. During a Regional workshop,\(^{42}\) Member countries initiated discussions on preventing gender-based violence (GBV), and identified six areas to take into further consideration in formulating policy briefs on GBV, as follows:

\(^{38}\) UN General Assembly Resolution 55/2, September 2000 (www.un.org/millennium/declaration/ares552e.pdf)


\(^{40}\) Development of Regional strategic direction to integrate gender into health policies and programmes in the SEA Region. New Delhi, SEARO, 2007 (document SEA-WHD-15)

\(^{41}\) At the Regional Workshop on Assessment Method in Gender and Health, Indonesia, July 2007

\(^{42}\) In July 2007, to review the document Review of tools in gender and health, New Delhi, SEARO, (document SEA-WHD-18)
• Development of tools for gender-sensitive assessment of evidence and prevention
• Harmonization of related laws
• Systematic collection of data on violence against women
• Improvement in coordination/networking among ministries/stakeholders
• Ensuring adequate funds to support activities on awareness, protection and prevention
• Achieving high-level political commitment.

53. The Regional Office provided technical support (resource person/speaker) to the organizing committee of the 4th Central Asia Regional Congress of the Medical Women’s International Association and the Thai Medical Women Association, June 2007. Various issues were discussed at the Congress, including the health and social situation of women in different societies, violence against women and children, and beliefs and cultural differences in gender perspectives. From the Region, Bhutan, India and Thailand participated in the Congress.

Training in gender analysis and actions

54. A Regional workshop for trainers (attended by Bangladesh, Bhutan, India, Indonesia, Maldives, Nepal, Thailand, Sri Lanka) on gender analysis and actions was held. Gender sensitivity, awareness, analysis and actions for certain gender disparities in health were addressed as well as the importance of appointing a gender focal point to support the capacity building process at country level.

Networking for a multisectoral approach

55. A Regional Gender, Women and Health Network (GWHN) was initiated during a regional consultation. This network will play an important role in exchange of information and collaboration between Member countries. A focus of the network’s activities will be on the mechanisms, partnership processes and actions that can be taken to reduce gender-based inequities in health. The knowledge management portal, conceptual framework of the GWHN in the Region, and country action plans were outlined. After

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43 Building capacity for integrating gender analysis and actions into the work of WHO, India, August 2007 (document SEA-WHD-17)
44 Regional Consultation on Multisectoral Approach for Gender, Women and Health, Sri Lanka, March 2008
finalization, the framework will assist countries in implementing a multisectoral approach in gender and health.

**Challenges**

- Preventing gender-based violence.
- Addressing gender perspective in health, especially in sexual and reproductive health.
- Implementation of a multisectoral approach within GWHN activities to reduce health inequity.
- Disaggregating data by gender.

**Immunization and vaccine development: focusing on polio and new vaccines**

56. While the priority focus has been on polio eradication, progress was also made in several other areas of immunization.

**Eradicating polio**

57. The Regional Office provided continuous support for tracking the quality of polio surveillance, with particular attention paid to border areas. Polio eradication activities are heavily dependent on high-quality acute flaccid paralysis (AFP) surveillance, and most countries have maintained this (see Box 3.3 for current picture of polio in the Region). The polio laboratory network consists of 13 accredited laboratories\(^45\) which are provided with laboratory supplies by WHO.

**Surveying for vaccine preventable diseases**

58. The Regional Office technically assisted three laboratory networks to support surveillance for vaccine preventable diseases in Member countries:

- A measles network consisting of 20 collaborating laboratories
- A Japanese encephalitis network consisting of 11 laboratories
- A polio network consisting of 13 laboratories.

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\(^{45}\) In Bangladesh, DPR Korea, India, Indonesia, Myanmar, Sri Lanka, Thailand
WHO provides reagents, test kits and other equipment to these laboratories and also ensures that they are fully accredited through regular accreditation visits.

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Box 3.3 Current picture of polio in the Region

**India:** Since India is one of the four remaining countries (along with Afghanistan, Pakistan, and Nigeria) where wild poliovirus has not yet been eradicated, the focus in 2007 was on reducing the number of poliomyelitis cases in India due to subtype P1, the most difficult poliovirus subtype to eradicate, which is virulent and spreading.

Multiple rounds of supplementary immunization with monovalent oral polio vaccine (mOPV1) reduced the number of P1 poliomyelitis cases reported from India by 88% – from 648 cases in 2006, to 76 cases in 2007. This reduction of P1 cases was most visible in western Uttar Pradesh (UP), where almost no circulation of P1 wild poliovirus was seen in 2007 despite circulation having been most entrenched in this state.

However, due to the selective use of mOPV1, there was a sudden upsurge of P3 poliomyelitis cases, raising the total reported cases of polio in India in 2007 to 860 as compared to 676 in 2006. Despite this, the India Expert Advisory Group (IEAG) decided the focus should remain elimination of the P1 subtype of poliovirus during the first half of 2008, the outbreak of P3 cases being a manageable risk, and two national immunization days have been conducted in the country so far, followed by a further two rounds of supplemental immunization activity (SIA) in Bihar, Uttar Pradesh and Delhi. The impact of supplementary immunization activities in Uttar Pradesh and Bihar is shown in Figure 3.5.

**Myanmar:** An outbreak of poliomyelitis cases (11 in total) occurred due to the importation of poliovirus type 1. The Government of Myanmar mounted an effective control response through multiple rounds of SIAs and a national immunization day in November and December 2007.

**Nepal:** December 2007/January 2008 saw several cases of polio reported from the terai belt. All cases were P3 subtype; multiple rounds of SIA were subsequently implemented to terminate circulation of the virus.
Immunizing against measles

60. The other important vaccine preventable disease with a global goal is measles (see Box 3.4).

Box 3.4: Picture of measles vaccination in the Region

By the end of 2007, all countries in the Region except India had successfully delivered a second opportunity for measles immunization, and more than 85 million children across the Region had received an additional dose of the vaccine.

In the latter half of 2007, the last phase of the measles campaign was completed in Indonesia, providing more than 6.2 million children aged between nine months and five years in this country with a second opportunity for measles immunization.

However, the Region as a whole has only reached about 26% of its projected target for measles mortality reduction as India has not initiated national measles control activities.
61. WHO continued its technical and financial support for combating measles outbreaks in DPR Korea, particularly in outbreak investigation, providing measles vaccine and injection equipment and in planning and monitoring of measles immunization campaign. About 5000 cases of measles occurred in 2006–2007, with a consequent mass immunization campaign; 16 million people (between the ages of 6 months and 44 years) were immunized and the outbreak was successfully contained. WHO also provided technical and financial support to sustain the accreditation status of the national measles laboratory.

**Introducing new vaccines**

62. Countries of the Region are progressing well with the introduction of new and under-utilized vaccines:

- Ten Member countries have introduced hepatitis B vaccine in their routine immunization programme nationwide. India continues with the pilot phase (introduced in 2001 in 33 districts and 15 metropolitan cities); by November 2007, hepatitis B vaccine had been successfully introduced in a further 11 states. All preparations are in place to reach nationwide coverage by 2009.
- Sri Lanka successfully launched the pentavalent DTP-HepB+Hib vaccine on 1 January 2008, with support from the GAVI Alliance; Bangladesh and Nepal both received an approval from GAVI Alliance for the pentavalent vaccine; Bhutan received a conditional approval.
- The GAVI Alliance approved US$ 350 million to support India with the introduction of new vaccines and strengthening of their health system, including the routine immunization programme.

**Developing a seasonal influenza vaccine**

63. An important development in the Region was the selection of three vaccine manufacturers – the Serum Institute of India, Government Pharmaceutical Organization of Thailand and BioFarma of Indonesia – to develop seasonal influenza vaccine, with the ultimate aim of enhancing the production base for a pandemic influenza vaccine. The manufacturers are working on research and development for the seasonal vaccine.

64. Each of these institutes received a WHO grant of US$ 2 million for this work. This was necessary because, despite the large-scale vaccine production capacity of the Region as a whole, no manufacturer produces influenza vaccine at present.
Improving quality and safety

65. The Region is an important vaccine manufacturing block, so ensuring the functioning of national regulatory authorities (NRA) is essential. WHO carried out an NRA assessment of India, and the Government subsequently took significant steps to improve the quality and safety of vaccines produced by public sector manufacturers. In collaboration with the Government, WHO put together a comprehensive package of support to strengthen India’s NRA. Assessment of the national regulatory authorities in Sri Lanka and Bangladesh will be conducted later in 2008.

66. WHO has been assisting in the investigation of adverse effects following immunization (AEFI) with the pentavalent vaccine in Sri Lanka; this investigation is ongoing. WHO provided technical support and coordinated investigation of the adverse events by providing information on the vaccine quality, safety and efficacy, and known background rates of AEFI for various antigens. In addition, WHO experts (from the Regional Office and headquarters) visited the Ministry of Health to help investigate the event.

Improving routine immunization coverage

67. WHO technically and financially supported planning, assessment and monitoring of routine immunization activities in Member countries. WHO national surveillance medical officers (SMOs) assisted the national immunization programmes in training and monitoring activities and key achievements were as follows:

- In Bangladesh, an immunization coverage survey confirmed an increase in routine immunization coverage, to more than 70% from about 60% in 2006.
- In Nepal, the coverage survey showed an increase in coverage and achievement of the target of 80%.
- In Myanmar, the main issues identified during review of the routine immunization programme included: transport of the vaccine, support for midwives’ travel to clinics, and availability of resources for immunization sessions and supervision.
- In India, apart from the SMO network which supports routine immunization, WHO hired local technical staff to work as immunization medical officers in four states, and eight medical officers in eight districts of western Uttar Pradesh. The WHO network supports microplanning, immunization sessions, monitoring and tracking of infants to define the denominators
better. WHO is also assisting the Ministry of Health to strengthen reporting by supporting the introduction of a routine immunization monitoring (RIM) tool at district level to enable timely data entry and their online availability.

- In Indonesia, WHO supported training of mid-level managers and health workers during the measles campaign.
- In Maldives, WHO supported the development of a draft comprehensive multi-year plan for immunization.

68. To strengthen country capacity and systems, WHO provided support for development of national immunization policies, training materials and supervisory tools, in addition to hiring local technical experts to assist in the immunization programmes. WHO has also developed and circulated guidelines for establishing national committees for immunization practices, and organized a workshop46 to strengthen immunization technical capacity at the country level. A meeting was also organized to develop the framework for the transitioning of oral polio vaccine to inactivated polio vaccine after the eradication of polio.47

Challenges

- Mobilization of the huge amount of resources needed to complete the task of polio eradication.
- Large numbers of children do not receive routine immunization.
- Reaching the goals for measles mortality reduction.
- Major financing challenges in the introduction of new vaccines.

46 Workshop on Strengthening the Capacity of National Committees for Immunization Practices – NCIP – for Pandemic Influenza Preparedness, Indonesia, March 2008
47 Meeting on Transition from Oral Polio Vaccine to Inactivated Polio Vaccine, Indonesia, April 2008
Sustainable development and healthy environments
Environment and Health: healthy settings and human rights-based approach

1. Ministers and high-level officials of environment and health endorsed the Bangkok Declaration on Environment and Health in August 2007\(^1\) in a collective effort\(^2\) to reduce the estimated 6.6 million deaths in Asia each year attributable to various environmental health risks. WHO was party to the coordination activities leading up to the hosting of the Regional Ministers’ Forum for Environment and Health for the countries in South-East and East Asia. It resulted in a Charter for Environment and Health in this Region, and a plan of action for an Environment and Health Initiative (EHI). Initially, Indonesia, Myanmar and Thailand were party to this Initiative. This process will now lead the review, re-formulation and implementation of national environmental health action plans (NEHAPs), a mandate given to WHO that dates back to the United Nations Conference on Environment and Development (UNCED) of 1992. WHO works with Member countries in a partnership with the Regional Office for Asia and the Pacific of the United Nations Environment Programme (UNEP)\(^3\).

2. The Regional Office continued to promote its Healthy Settings programme\(^3\) by preparing a set of modules for training Healthy Settings coordinators. The objective of these modules is to help develop a critical mass of healthy settings practitioners in Member countries. The first regional workshop using these modules was conducted\(^4\) with the participation of

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\(^1\) www.searo.who.int/en/Section23/Section1326_13471.htm
\(^2\) At a meeting jointly organized by:
- the United Nations Environment Programme Regional Office for Asia and the Pacific
- the WHO Regional Offices for South-East Asia and the Western Pacific and hosted by:
  - the Ministry of Natural Resources and Environment of the Government of Thailand
  - the Ministry of Public Health of the Government of Thailand
  - Chulabhorn Research Institute, Thailand
\(^3\) Which aims at establishing more effective work relations between the health sector and other sectors to create a healthier environment by solving health and related problems closer to their source
\(^4\) Intercountry Workshop for Healthy Setting Coordinators, Maldives, November 2007
objectives were discussed. The seminar was a first step towards integrating a human rights-based approach into public health policies and programmes in the South-East Asia Region.

Water supply and sanitation: ensuring safety and adequacy

4. Available data indicate that the majority of countries in the Region have made important strides towards increasing water supply coverage. However, 14% of the population in the Region (more than 200 million people) still lacks access to improved water supply, and up to 900 million people lack access to improved sanitation. Sustained investment and concerted political commitment of national health and development authorities are needed to improve the existing situation.

5. The outcomes of WHO’s support are outlined below.

Ensuring safety of drinking water

Strengthening monitoring and surveillance

6. Only a few Member countries in the Region have comprehensive water quality monitoring systems in place, so WHO continued to provide technical

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Regional Seminar: Human Rights-Based Approach to Health and Environment, Thailand, August 2007 (document SEA/HHR/01)
support for strengthening, monitoring and surveillance of national drinking water quality. This included the development of water quality standards, assessments of water quality, and provision of water-testing kits in Maldives and Myanmar.

7. Drinking water quality guidelines\(^6\) published in 2006 introduced Water Safety Plans (WSP)\(^7\) to ensure water safety through appropriate management practices. All Member countries have been introduced to the concept of WSPs.\(^8\) Pilot-testing of WSPs is ongoing in several rural water supply schemes in Bangladesh, Bhutan and Nepal, and in urban water supply systems in India and Myanmar. Collaboration with various agencies\(^9\) has been helpful in promoting WSPs in the Region.

**Promoting water management in the household**

8. In the Region, increasing urbanization threatens the safety of water supply for millions of people on low incomes, especially in mega cities. In order to improve the quality of water for these vulnerable populations, a Household Water Treatment and Safe Storage (HWTS)\(^10\) approach, including various low-cost water treatment options, was introduced to the countries. Pilot testing of one of the treatment options – chlorination and safe storage – has been carried out successfully in Bangladesh and Sri Lanka.

**Harvesting of rainwater**

9. WHO has provided support to Member countries, particularly Maldives, Nepal and Sri Lanka, for improving water quality through designing systems for the safe collection and storage of rainwater.

**Mitigating arsenic exposure**

10. Environmental arsenic exposure continued to receive attention. In the areas most affected by arsenic in drinking water (Bangladesh and nine districts in West Bengal, India), collaboration of the various agencies focusing on this problem was not adequate. During an intercountry workshop,\(^11\) a strategic mechanism and approaches for effective implementation of arsenic mitigation

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\(^7\) www.who.int/water_sanitation_health/dwq/practguidwspplans/en/

\(^8\) Regional Workshop on Water Safety Plans, December 2007, Nepal

\(^9\) Including United Nations Children’s Fund (UNICEF), International Water Association (IWA), AusAid, USAid, United States Environmental Protection Agency (USEPA), and the water and sanitation programme of the World Bank

\(^10\) See: www.who.int/household_water/en/

\(^11\) Intercountry Workshop on Institutional Collaboration for Arsenic Mitigation, Kolkata, September 2007
at the local level were formulated. It included the constitution of an Arsenic Task Force or Arsenic Steering Committee comprising experts in the fields of water, health, water resources, geology, irrigation, agriculture and environment, to deal with policy, planning, strategy of implementation, monitoring and evaluation of the mitigation. WHO gave technical support and facilitated collaboration of this multisectoral committee and agencies. Technical support was also provided to Bangladesh, India and Nepal, in carrying out arsenic mitigation activities, such as promotion of water treatment technologies and a few research activities.

**Ensuring adequate sanitation**

11. WHO supported country participation in two high-level conferences.\textsuperscript{12,13} Representatives from 10 Member countries participated in the conferences which were focused on taking necessary steps in the countries to meet the MDG target for sanitation.

12. WHO supported all countries in celebrating World Water Day 2008, on the theme “Sanitation matters” (2008 is the International Year of Sanitation), by providing advocacy guides (sharing the best practices in sanitation) for observing the day and organizing subsequent sanitation programmes.

13. The use of ecological sanitation as a sustainable sanitation option\textsuperscript{14} (recycling of biodegradable waste and its use as a resource) was pilot-tested in Nepal with WHO support and found to be useful. By using ecological sanitation, pollution of water will be avoided, access to sanitation will be improved, and agriculture will benefit from a fertilizing method. WHO supported training in ecological sanitation for 10 practitioners from Maldives at the Ecosan Services Foundation,\textsuperscript{15} India.

\textsuperscript{12} World Toilet Summit, India, 2007
\textsuperscript{13} East Asian Ministerial Conference on Sanitation, Beppu City, Japan, 2007
\textsuperscript{15} See: www.ecosanservices.org
Challenges

• Empowering communities to develop sustainable water supply systems.
• Monitoring of water supply and sanitation systems at both local and national levels.

Occupational health: controlling workplace exposure

14. The 2007 World Health Assembly resolution on Workers’ Health: Global Plan of Action\(^\text{16}\) provides a powerful political instrument and technical guidance for Member countries.

15. In following up the Global Plan of Action on Workers’ Health 2008–2017 and the 2005 Regional Strategy on Occupational Health,\(^\text{17}\) during a bi-regional workshop,\(^\text{18}\) WHO technically assisted Member countries to identify 12 specific actions to undertake in 2008–2009 with regional partners and collaborating institutions, including:

• formulation of national policy and plans of action with regard to improving the occupational health and safety of workers, particularly in informal sector industries;
• use of a multisectoral approach, and country-specific policy and plans of action, for elimination of asbestos-related diseases;
• improving coverage by basic occupation health services (BOHS) through linkage with primary health care.

Controlling exposure in small and medium-sized enterprises

16. In recent years, WHO collaboration with other international agencies and experts evolved a novel approach, called Occupational Risk Management Toolbox (ORMT),\(^\text{19}\) to help small- and medium-sized industries control workplace exposures without the onsite help of experts. SEARO was the first WHO Regional Office to organize a consultation for implementation of

\(^{16}\) Resolution WHA 60.26 (at: www.who.int/gb/ebwha/pdf_files/WHA60/A60_R26-en.pdf)
\(^{17}\) Regional Strategy on Occupational Health and Safety in SEAR Countries, 2005 (document SEA-Occ.Health-35)
\(^{19}\) See: www.who.int/occupational_health/publications/newsletter/gohnet7e.pdf
ORMT. Success factors and potential barriers in implementation of the toolkit were identified after reviewing experiences in implementation in countries, and future steps were identified by all partners for adoption of ORMT in the Region.

Addressing the scarcity of occupational health personnel

17. While the scarcity of qualified occupational health personnel is a major challenge, the role of occupational health nurses has been under-recognized in the Region. At the International Occupational Health Nursing Conference in 2007, the Regional Office facilitated technical sessions to help address the challenge.

18. A Training the Trainer manual on occupational health and safety was developed for the Region, and was used at an occupational health and safety training programme in Sri Lanka. The Ministry of Health will be using this manual for their training programmes after including additional relevant information. Similar collaboration is being worked out with other Member countries.

19. The Regional Office also provided technical support to Bangladesh, Bhutan and India for developing national profiles and action plans for the protection and promotion of workers’ health. These national profiles and plans will be finalized later in 2008 and the countries will then be able to systematically implement activities to tackle occupational health issues.

Challenges

- Policy development on elimination of asbestos-related diseases.
- Improvement in quality and coverage of occupational health services in the informal sector.

Climate change and human health: taking up the challenges

20. Discussions on international health security, and climate change and health, by the health ministers of the Region in 2007 resulted in the Thimphu Declaration which addresses the health impacts of global warming and climate change (see also page 120).

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20 Regional Consultation on Reducing Workplace Exposure through Risk Management Toolkit, November 2007, Chennai, India.
21 International Conference on Occupational Health Nursing (ICOHN), August 2007, Bangkok
22 Twenty-Fifth Meeting of Ministers of Health of Countries of the South-East Asia Region. See: www.searo.who.int/en/Section1430/Section1439/Section1640_11693.htm
Drafting regional and national action plans

21. As a follow-up to the Ministers’ meeting, WHO supported four national workshops (in Bangladesh, India, Indonesia and Nepal) and a regional workshop\(^{23}\) on human health and climate change. While the national workshops produced specific inputs for the national plans, the Regional workshop produced a Regional framework for action to protect human health from the effects of climate change.\(^{24}\)

Creating awareness

22. World Health Day 2008, which was commemorated in the Regional Office and in all Member countries, focused on the theme “Protecting health from climate change” and put health at the centre of the global dialogue about this urgent issue. The Regional Office produced an information kit\(^{25}\) containing materials to promote commitment and drive action for change among all sectors of society to work together and reduce the adverse impacts of climate change on human health. A special issue of the *Regional Health Forum* was published on *Protecting health from climate change*.\(^{26}\)

Addressing the health threats

23. WHO technically supported projects and worked closely with Member countries to address a wide range of health threats from climate change:

- In Bhutan, the support is aimed at preparing a proposal for a Global Environmental Facility to strengthen existing health programmes as per Bhutan’s National Adaptation Programme of Action.\(^{27}\)

- In Indonesia, the National Climate Change Intersectoral Committee\(^{28}\) is currently incorporating health concerns and actions related to health implications from climate change into the new Five-year National Development Plan. At provincial and district levels, these concerns are being streamlined into the Healthy Cities
programme. WHO supported a national workshop on climate change.

- In Sri Lanka, the Ministry of Environment has formulated a high-level committee, including members from the health sector, to study the situation and make recommendations for a series of activities to benefit human health in the long term.

- Thailand is taking action to reduce greenhouse gas emissions in absolute terms by the incorporation of state-of-the-art technologies and careful adoption of energy-efficiency measures. The Ministry of Natural Resources and Environment has developed a Strategic Plan on Climate Change for 2008–2012. WHO provided key technical inputs to a national meeting on the implications on health of haze and forest fires.

Challenges

- Capacity building for developing healthy public policies.

- Evidence-based assessments, norms and guidance on priority environmental health risks.

Chemical safety: supporting country activities

24. WHO continued to provide technical assistance to Member countries, particularly in the strengthening of country capacity, surveillance, regulatory mechanisms, and assessment of the effects of exposure to chemical hazards. The following initiatives were taken up by Member countries with technical support from WHO.

Supporting capacity development

25. The activities related to integrated vector management (IVM)\(^\text{29}\),\(^\text{30}\) served as the basis for further development of a regional curriculum on IVM. This regional training curriculum on integrated vector management is being developed, and will be useful to Member countries for conducting national training activities on IVM with community participation, including possible adaptation.

\(^\text{29}\) \textit{Regional framework for an integrated vector management strategy for the South-East Asia Region}, WHO SEARO, June 2005 (document SEA-VBC-86)

\(^\text{30}\) Regional Workshop to Implement Vector Management, Vector Control Research Centre, India, December 2006 (see: www.searo.who.int/LinkFiles/Publication_and_Documents_IPVM_Cover.pdf)
Supporting surveillance

26. Thailand has taken up various initiatives to strengthen its strategies on chemical safety. WHO supported the Ministry of Public Health with technical advice on assessment of heavy metal contamination in natural water; evaluation of the national silicosis elimination programme; strengthening of the surveillance system for health problems resulting from chemical substance or pesticide use among farmers; and assessment of chemical pollution and biological pathogens in the natural water of the Lower Mekong River.

Supporting regulation and assessment of chemical hazards

27. WHO participated in the exchange of information on mercury usage in the health sector at a workshop in India, and delivered a technical presentation highlighting the WHO Policy Paper on the health risks linked to mercury and the possibilities for mercury reduction and substitution. The need to support international action to ban/control the use of mercury, as pointed out in the WHO Policy Paper, was also stressed at the workshop.

Challenges

- Surveillance of health effects of chemical hazards.
- Availability of equipped poison control facilities and support for poison information centres.
- Reducing exposure to toxic chemicals in homes, schools and workplaces.

Health-care waste management: supporting national initiatives

28. The countries in the SEA Region produce an estimated total of 1000 tonnes of health-care wastes every day. Most of this huge volume of hazardous waste goes untreated into the general waste flow and thus represents a major public health threat.

29. To overcome this challenge, and recognizing the need for capacity building, WHO provides support to Member countries for strengthening

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31 National Workshop on Reducing Dependency on Mercury: Usage, Processes and Impacts in India, September 2007 (see: http://toxicslink.org)
32 At: www.who.int/water_sanitation_health/medicalwaste/mercurypolpap230506.pdf
their capacities in managing health care wastes. While some countries of the Region have developed national policies and legislation for the management of health care wastes, there is still a major gap between the legal frameworks and their implementation.

Supporting the development of guidelines on strategy, practices and capacity building

30. Five countries (Bhutan, India, Indonesia, Maldives, Nepal) were technically supported in developing national strategies and guidelines on health care waste management (HCWM). The national strategies are based on the recommendations of a joint WHO and FAO regional workshop held in 2006, and on the recommendations of a regional workshop (Building Capacity for Implementing Sound Health-Care Waste Management in the SEA Region, December 2007, India). In the latter workshop, a set of priority actions for improving capacity building for the sound management of health care wastes at the national level were formulated. In early 2008, Bangladesh, Bhutan, Indonesia and Maldives were moving towards establishing national study centres for the WHO-supported distance learning six-month certificate programme in Health care Waste Management conducted by Indira Gandhi National Open University. A national study centre was set up in Bangladesh, while the study centres in Bhutan, Indonesia and Maldives would be set up later in 2008.

Supporting the training of health care waste managers

31. The Global Alliance for Vaccines Initiative (GAVI) has given effective support for HCWM, particularly for initiatives on the safe handling and disposal of used syringes. This support has focused on training activities in Member countries. Over 300 professionals from Bangladesh, India and Nepal enrolled in the distance learning HCWM training course run together with Indira Gandhi National Open University. A set of priority actions for improving capacity building for the sound management of health care wastes at the national level were formulated at a Regional workshop.

Supporting the improvement of practices

32. “Integrated Health care Waste Management: mainstay toward patients’ safety” was a theme discussed at a conference by the Indian Society of Hospital

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33 Sound Management of Hazardous Wastes from Health Care and from Agriculture, June 2006, Indonesia (at: www.searo.who.int/en/Section23/Section1001/Section1110_12840.htm)
34 Building Capacity for Implementing Sound Health Care Waste Management in SEAR Countries, November 2007, Bangalore, India.
Waste Management. The Regional Office provided technical support for this conference. Practices for collection and segregation of, and safety measures related to, biomedical waste management were elaborated. India and other Member countries will use the experiences presented during this conference to improve their practices.

**Supporting implementation**

33. In Sri Lanka, WHO provided technical support for the implementation of waste management systems in major hospitals along with provision of training and supply of necessary equipment.

**Challenge**

- Ensuring safe management of potential infectious hospital sharp wastes.

**Food safety: enabling the health sector**

34. The Regional Office provides technical support for better integration of food safety policies through a number of initiatives including promoting the concept of and mechanisms for an intersectoral approach to issues in food safety. This support is based on a ten-point Regional Strategy for Food Safety in the South-East Asia Region.

**Networking**

35. All Member countries have joined and actively participate in the International Food Safety Authorities Network (INFOSAN). The Network promotes exchange of food safety information and improves collaboration among food safety authorities at national and international levels. WHO played a key role in advising countries on the need to have official INFOSAN focal points. As a result, almost all Member countries have now designated a focal point for food safety.

**Strengthening regulatory systems**

36. Sri Lanka has developed national rules and regulations to ensure food safety, and empowered the public health authorities to implement food safety standards, based on WHO assistance and guidelines.  

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35 www.medwasteind.org  
36 See: www.searo.who.int/EN/Section23/Section1001/Section1110/Section1454_5956.htm  
37 www.who.int/foodsafety/fs_management/infosan/en/  
38 See: www.searo.who.int/EN/Section314_4300.htm
Training and related activities

37. WHO provided technical support for a variety of activities related to training and capacity building, including:

- Training-of-trainers courses on food safety and food standards, and orientation workshops for local schoolteachers and religious leaders in Bangladesh and Maldives.
- Implementation of a World Bank-supported food-safety capacity-building programme in India and Thailand.
- Introduction of Total Diet Studies (TDS) to the Region, and establishment of a network of national counterparts for undertaking these projects.
- The training of a large number of health officials at different levels of the health services on food safety issues in Sri Lanka.
- Adaptation, translation and publication in the local language of a manual on how to prepare safer food in Timor-Leste.
- Training activities on the Healthy Food Market concept in Indonesia and Thailand, following the outbreaks of avian influenza. A specific training curriculum has been developed for this purpose, which can also be used in other countries. The WHO Healthy Food Market initiative has been expanded to three settings in Bhutan.

Challenges

- Orientation of all food safety work in Member countries towards the setting up of a single food safety authority for all countries.
- Promotion of public awareness about food hygiene and consumer rights in relation to food standards.
- Assessments of the health and economic burdens of diseases caused by unsafe food, and translation of these into advocacy materials.
- Strengthening of food safety surveillance systems.

Emergency and humanitarian action (EHA): addressing the vulnerability of the SEA Region populations

38. There has been a significant shift in emergency management capacity of the Member countries in the Region over the years. For example:

39 Regional Workshop on Total Diet Studies, Jakarta, December 2007
• There is enhanced awareness to improve the national disaster management capabilities; and
• Those countries frequently experiencing disaster situations have improved their emergency management capabilities through intersectoral collaboration (health, army and civil society organizations), decentralization of emergency response, and strengthening district-level management capabilities.

39. However, emergency management capacity among the countries is variable, disaster management remains response-oriented and supply-driven.

**Building the national emergency/disaster management capacity**

40. Endorsement\(^{40}\) by the Health Ministers to use the benchmarking, standards and indicators framework\(^{41}\) to build and strengthen the health sector national emergency/disaster management capacity has been the highlight during the reporting period. It provides an important tool for measuring the status of emergency preparedness in the countries, identifying gaps, and checking priorities within the multisectoral framework.

41. To provide a sound foundation to the Health Ministers’ Initiative, an exclusive workplan for the health sector emergency management has been outlined and a separate budget (assessed contribution) has been provided.

42. Additionally, a regional consultation was held\(^{42}\) to discuss the modalities on how to make the health facilities resistant to disasters. The Regional Office is supporting national consultations on keeping health facilities safe from disasters in Member countries.

**Establishing the EHA Regional Technical Advisory Group**

43. The Regional Office has established the EHA Regional Technical Advisory Group (RTAG) to provide a sound and scientific platform for the health sector emergency preparedness in the Region. The RTAG includes of Regional and global experts from various sectors and organizations. Among other things, RTAG is tasked to:

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\(^{40}\) At the SEAR Health Ministers Meeting, September 2007, through the Thimphu Declaration on International Health Security in the South-East Asia Region

\(^{41}\) Benchmarking, Standards and Indicators for Emergency Preparedness and Response, draft VI, July 2007 (see: www.searo.who.int/LinkFiles/EHA_Benchmarks_Standards11_July_07.pdf)

\(^{42}\) Regional Consultation on Keeping Health Facilities Safe from Disasters, New Delhi, April 2008.
• Provide independent opinion on the strategic, scientific and technical aspects of WHO’s Emergency and Humanitarian Action (EHA) area of work;
• Review progress and challenges in the implementation of areas identified in the EHA Regional Strategy;
• Provide technical advice and guidance on a regular basis, including identifying gaps and proposing appropriate solutions; and
• Contribute to the identification of new strategies/approaches, including research priorities, their implementation and management.

Establishing the South-East Asia Regional Health Emergency Fund

44. Experience gained during the previous emergencies, particularly the tsunami of 2004, clearly indicated the need for an exclusive fund after an event which could be easily accessible during the crucial hours, i.e. within the first 72 hours to meet the urgent needs of the affected people. With this intention, the South-East Asia Regional Health Emergency Fund (SEARHEF) amounting to US$ 2.25 million was established during 2008 through a Regional Committee resolution\(^43\), of which the member countries have donated 1% of their Regular Budget (approximately US$ 1 000 000) to form the core of the fund. Additionally, the Royal Government of Thailand contributed an additional US$ 100 000. Efforts are being made to mobilize additional resources from voluntary donor contribution.

45. A working group composed of representatives from Member countries has been made responsible to refine and oversee the management of the Fund. The benefits of the SEARHEF became evident during the recent devastating cyclone (Nargis) specially affecting delta areas of Myanmar in May 2008 and during the floods in Sri Lanka in June 2008. Within 24 hours following Cyclone Nargis and the floods, US$ 350 000 were released to Myanmar and US$ 23 000 to Sri Lanka.

Responding to recent emergencies

46. Major disasters in the Region included:

• **Bangladesh** – one-third of the country faced floods in August 2007 and a major cyclone (Sidr) in November 2007.

\(^{43}\) Resolution SEA/RC60/R7 (2007) on the South-East Asia Regional Health Emergency Fund
47. Conscious of the Region’s susceptibility to natural disasters and their impact on the health of affected populations, the Organization works closely with Member countries to set up practical measures to minimize mortality and morbidity in the wake of such events. The common management features noted were:

(1) Facilitating rapid assessment and rapid response
- Quick redeployment of WHO national and international experts from the non-affected areas in the countries to the affected areas for rapid health needs assessment and provide immediate help to the local health authorities under the MOH to meet the immediate health needs.
- Pre-positioning of supplies and needs in close association with the ministries of health prior to the yearly monsoon.
- Provision of operational and financial support for the deployment of rapid response teams and mobile medical teams from the Ministry of Health to the affected areas.

(2) Establishing an early warning system to prevent potential disease outbreak in the affected community
- Strengthening the early warning, alert and response system (EWARS) through informal and formal mechanisms for disease surveillance and outbreak forecast.
- Procurement and pre-positioning of medical supplies, bleaching powder and water purification tablets for possible outbreaks of cholera and other water-borne diseases, as well as other supplies such as drugs and insecticide-treated bed nets for treatment and prevention of vector-borne diseases.
- Provision of technical support through guidelines and international expertise to the Ministry of Health and health partners.

(3) Facilitating health sector coordination
- Supporting the district health officials to take the lead in coordination at the district level.
- Establishment of effective coordination amongst the health partners comprising UN agencies, international and national...
NGOs working together under the health cluster led by WHO (as laid down in the new UN humanitarian reform).

(4) **Facilitating common health emergency response plan**
- Developing and implementing the joint health sector intervention plan in close consultation with the ministries of health.
- Supporting the national emergency response plan of the Ministry of Health of the affected countries.

(5) **Facilitating disaster response to development**
- WHO plays a catalytic role to interlink the common health sector emergency response plan with early recovery plan within the health sector and dovetailing these plans with the post-disaster national development plans.
- Assistance in the revitalization of health services.
- Leading the health cluster agencies in the development of a joint action plan for health operations for six months during the relief, recovery and rehabilitation period.

(6) **Facilitating fund mobilization through UN and other donors**
- Mobilization of SEARHEF, CERF (Central Emergency Relief Fund), Flash Appeal and CAP (consolidated action plan).
- Funding and material support from donors.

**Impact of WHO’s work**

48. WHO has supported the affected countries to:
- Develop national emergency response plans and improve its management capacity and capability.
- Facilitate in addressing the post-disaster immediate public health needs of the affected population.
- Prevent avoidable mortality and morbidity.
Challenges

- The building of country capacity to respond to emergencies, particularly through in-country learning activities and training of health professionals.
- Systematic application of benchmarks and indicators.
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Health systems development
Health services delivery and policy: focusing on management

1. The emphasis of WHO’s work has been to support countries in: strengthening health system and services management, promoting/revitalizing the primary health care (PHC) approach, working with the Global Alliance for Vaccines and Immunization in Member countries on health systems strengthening, and enhancing Public Health Initiative networking, as outlined below.

Formulating a regional strategy for health systems strengthening

2. A regional six-point strategy for health systems strengthening\(^1\) was formulated in collaboration with Member countries. It provides an insight into current health systems challenges in the Region and PHC-based strategies for strengthening health systems. Important country experiences were drawn upon while drafting the strategy, including the upgrading of health infrastructure in rural areas (Nepal, Sri Lanka and Thailand) and community participation for procurement of medical equipment for hospitals and improved drug accessibility and affordability in Indonesia, Myanmar, Nepal and Thailand.

Developing a regional plan for strengthening health services management

3. A plan for the South-East Asia Region\(^2\) was developed through the joint efforts of Member countries and the Regional Office. Six strategic areas of action were identified (see Box 5.1).

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\(^1\) The Regional six-point strategy for health systems strengthening based on the primary health care approach. New Delhi, SEARO, 2007 (document SEA/HSD/305)

\(^2\) Regional strategic plan for strengthening health services management in the South-East Asia Region. New Delhi, SEARO, 2007 (document SEA/HSD/301)
4. WHO’s role in strengthening health services management in Member countries focuses on capacity strengthening, bridging the managerial competency gaps, disseminating good practices in health management, developing tools and guidelines, and defining service standards. Mobilizing resources through existing networks and partnerships, and monitoring and reporting progress on management strengthening initiatives in Member countries are also covered.

5. The plan is intended to assist Member countries and WHO in developing comprehensive interventions to strengthen the management of health systems in a coherent and systematic manner.

**Developing technical modules on strengthening health services management**

6. Technical modules on strengthening health services management were developed in a joint effort with the WHO Collaborating Centre for District Health System based on primary health care. The modules are targeted at district health managers to help them become more efficient, and to improve their competencies, the availability of functional support and a favourable working environment. The modules have been field-tested and are in the final stages of production. During a regional workshop, guidelines based on the modules were finalized and are being prepared for dissemination.

**Involving GAVI in health systems strengthening**

7. WHO provided technical assistance to countries in drafting proposals on health systems strengthening for submission to the Global Alliance for

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3 At the Indian Institute for Health Management Research, Jaipur, India
4 Regional Workshop for Trainers on Sub-National/District Health Management Development, Indonesia, 22–25 April 2008
Vaccines and Immunization (GAVI). Of the 10 proposals submitted, six were accepted (Bhutan, DPRK, Indonesia, Myanmar, Nepal, Sri Lanka).

**Formulating a SEAPHEIN role in influencing public health policy and action**

8. During the third annual meeting of the South-East Asia Public Health Education Institutions Network (SEAPHEIN) — supported by WHO and organized by the Indian Institute of Health Management Research — methods for improving and harmonizing the standards of public health education across the Region to contribute to better policy interventions were elaborated.

9. WHO technically supported SEAPHEIN in:

- Estimation of public health (PH) workforce availability;
- Advocacy for change in existing policies on admission to PH courses;
- Assessment of essential PH functions in five countries;
- Initiating of appropriate national and regional accreditation systems to recognize PH degrees;
- Initiating steps to build up a system for benchmarking the quality of PH education institutions;
- Support to Bhutan and Myanmar to establish PH programmes and schools of public health.

10. A website has been developed in SEARO and currently houses a virtual resource centre with freely accessible learning materials drawn from the past six years of experience in the FETP (www.searo.who.int/en/section2394/preview.asp).

**Challenges**

- Addressing shortage of district health managers.
- Improving competency of district health managers.
- Enhancing the functional support system.
- Improving organization and management of health services delivery systems.
- Strengthening human resources management.
- Improving the working environment at district health management level.

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3 At the Indian Institute for Health Management Research, Jaipur, India
Improving quality and safety in health care

11. The safety of health care for the patient received particular attention, following the formulation of a Regional Committee resolution.5

Calling for dialogue

12. One focus of activities was on promotion of partnership and dialogue, and on reduction of malpractice in health institutions. The Jakarta Declaration on Patients for Patient Safety in Countries of the South-East Asia Region calls for open and honest communication between patients and health-care professionals, and for partnership to build a health-care system in which no patient should suffer preventable harm.6

Improving surgical care at first referral level

13. A second focus was on improving the quality and safety of emergency and essential surgical care at first referral level. Consensus on several issues – procedures, equipment and materials, resource planning and management, availability and rational and safe use of blood and blood products – was achieved among senior policy-makers, surgeons, anaesthesiologists, and operating-room nurses from Member countries.7

Integrating patient safety concepts into medical education and training

14. A third focus of activities was on strengthening the pre-registration training of house officers, and on integrating patient safety concepts and practices into medical education, training and induction schemes. For this, WHO partnered with the Regional Network of Medical Councils in the drafting of a document on the Roles and

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5 Resolution SEA/RC59/R3 on Promoting Patient Safety in Health Care recommends that Member countries develop/strengthen programmes on patient safety through intra- and inter-sectoral collaboration, including the private sector, with support/facilitation by the WHO Regional Office.

6 Regional Patient Safety Workshop on Patients for Patients Safety, Indonesia, July 2007 (document: SEA-HSD-310)

7 Regional Patient Safety Workshop on the Integrated Management of Emergency Essential Surgical Care, Sri Lanka, January 2008
The Work of WHO in the South-East Asia Region

Responsibilities of medical councils in ensuring patient safety in the Region. This document is in the final stages before adoption by members of the Network (see also page 112).

Accrediting health institutions

15. A fourth focus was on the usefulness and feasibility of external oversight mechanisms such as accreditation in introducing quality and patient safety goals into health care in the Region. This issue was discussed by experts from India, Indonesia, Sri Lanka and Thailand (Expert Group Making an Accreditation and External Quality Assessment System for Health Care, Thailand, February, 2008), who agreed that a hospital accreditation process based on uniform standards should be phased in over the next decade according to the needs and resources of individual Member countries.

Improving compliance with hand hygiene

16. WHO supported field testing of the implementation strategy and toolkit of the advanced draft of the WHO Guidelines on Hand Hygiene in Health Care in the South-East Asia Region, which is being conducted in the Chittagong Medical College Hospital in Bangladesh. The results would contribute to improvement of hand hygiene as a crucial pillar of the prevention of health care-associated infections in Member countries.

Challenges

- Promoting best preventive practices, such as hand hygiene, to improve patient safety.
- Ensuring that the voices of patients are heard at the core of patient safety efforts.
- Developing and introducing a medical student curriculum on patient safety.
- Strengthening capacity for research on patient safety.

Health financing: improving equity

17. Household out-of-pocket expenditure to access health care is the cause of one third of all new annual poverty in the Region, and so a particular focus was on reducing such expenditures, especially among the poor. To address this issue, the Regional Office focused on strengthening capacity in Member countries to institutionalize equitable and sustainable financial protection mechanisms. In addition, it also supported the use of economic principles to guide health policy and planning more broadly.
18. The main achievements included:

- With technical support from the Regional Office, in Bangladesh, implementation of a voucher scheme for maternal health. Findings from a rapid assessment were disseminated in a workshop for more general application of demand-side financing in the Region.

- In Maldives, the design (ongoing) of a new social insurance scheme to supplement the current tax-based financing system. Horizontal support from Thailand is being supplemented by assistance from the Regional Office, particularly for Ministry of Health’s preparedness for the roll out of the scheme.

- In Myanmar, WHO supported a health financing study and its dissemination under the aegis of the ESCAP project on *Promoting Sustainable Social Protection Strategies to Improve Access to Health Care in the Greater Mekong Subregion*.

- In Nepal, SEARO developed a framework for a health financing and expenditure review to explore the potential for replacing user-fee with a contributory system of health financing in the context of *Health in New Nepal*. The framework also incorporated a possible platform for advancing aid effectiveness to implement the International Health Partnership (IHP) initiative (see also page 129).

- A course on *Economic principles for health policy and planning in low-income countries* was developed with the first training to be administered by international faculty and in collaboration with the Chulalongkorn University, Bangkok, in November 2008.

- Work on a health financing observatory has been initiated with India in a dynamic process to promote common understanding of concepts in health economics and financing as well as to exchange and disseminate country experiences.
Health systems development

- SEARO participated in finalizing a WHO Guide on the Economic impact of diseases and injuries. A series of desk reviews on the economic impact of specific diseases and interventions was also initiated.
- SEARO along with Indonesia (WHO Country Office) and Maldives (MoH) participated in a HQ exploratory consultation on the strategic use of contracting to improve performance in the public sector and in public-private partnerships. Based on this consultation, a training course for application in the SEA context was subsequently developed for a training in December 2008.

19 Other capacity-building efforts included work on national health accounts (NHA). The NHA of all countries were updated, and national training workshops were conducted in Indonesia and Maldives. Through horizontal collaboration, Thailand provided NHA training in Bangladesh. Also in Bangladesh, WHO participated in preparation of the third round of NHA.

Challenges

- Reducing the persistently large and impoverishing out-of-pocket health household expenditure on health.
- Including the poor in the informal sector in social protection mechanisms, including scaling up of successful community-based and demand-side initiatives.
- Better financial management, including garnering the large, unregulated private sector into public health efforts.

Research policy and cooperation: expanding activities

Establishing research task forces

20. Following recommendations of the Thirtieth session of the Advisory Committee on Health Research (ACHR),\(^8\) two regional task forces were established:

- Regional Task Force on Avian Influenza (AI). The policy, strategy and priority areas framework on Avian Influenza research were formulated; and the linkages between national influenza centres, institutions and WHO collaborating centres for AI reference laboratories were established.

\(^8\) The Thirtieth session of WHO South-East Asia Advisory Committee on Health Research: report to the Regional Director, Jakarta, Indonesia, March 2007 (at: www.searo.who.int/LinkFiles/RPC_30-ACHR_report.pdf)
• Regional Task force on Health Research Management and Capacity Building. The 10 health research management training modules were reviewed, consolidated, improved by this task force in March 2008 and endorsed by participants from ten countries at the intercountry workshop in June 2008. The modules will be further developed in the form of a self-learning package. Small grants are provided to Member countries for applications of those modules to each country’s own needs.

**Updating country profiles on health research**

21. Profiles depicting the overall current scenario of health research systems in the SEA Region Member countries are being reviewed and updated; they will be published in the SEARO RPC webpage. Providing information on the current research activities and research priorities in the different countries, the profiles will help in information sharing between countries and in horizontal collaboration.

**Cooperating in research**

**Small grants**

22. SEARO Regional Research Review Committee (RRC) reviewed 25 research proposals of the total 58 received from Member States, of which 10 were supported under the Small Grants scheme of TDR. These proposals addressed tropical diseases control (see also page 35).

**Accelerating on research ethics review worldwide standard**

23. The Regional Office promoted research ethics standards according to the 30th SEA-ACHR recommendation in collaboration with the Forum for Ethical Review Committees in Asia and the Pacific (FERCAP). WHO advocated, supported and facilitated enhancing of the research ethics review and ethics review committee (ERC) capacity of the Member countries, through three short training courses: (1) the Principle of Good Clinical Practice (GCP) and Research Ethics, (2) the Standard Operating Procedures (SOPs) and (3) the International course on Surveying and Evaluating Ethics Committees. The Strategic Initiative for Developing Capacity in Ethical Review

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9 The First meeting of the Task Force on Health Research Management and Capacity Building, New Delhi, India, March 2008
10 The Inter-country Workshop on Research Management, Bali, Indonesia, June 2008
11 UNICEF, UNDP, World Bank, WHO Special Programme for Research and Training in Tropical Diseases
(SIDCER)\textsuperscript{12} recognition programme for meeting ethical review worldwide standards which was supported by WHO TDR has been initiated in Member countries.

24. WHO provided financial support and facilitated countries’ capacity building in training GCP/SOPs for ERCs in Bangladesh, Bhutan, India, Indonesia, Nepal and Thailand.

### WHO collaborating centres

25. As of 30 June 2008, there were a total of 87 WHO collaborating centres (WHO CCs) in the Region (see Table); the number has increased from 78 in 2004. This represents 9\% of WHO CCs globally (as at 30 June 2008). Two new centres were designated as WHO CCs and 17 centres were re-designated; in addition, six new centres are in the process of being designated. No WHO CC has yet been designated in Bhutan, Maldives and Timor-Leste. The Regional Office was promoting and reviewing the work of WHO CCs in their respective areas of responsibility.

<table>
<thead>
<tr>
<th>Area of Work</th>
<th>Bangladesh</th>
<th>Bhutan</th>
<th>DPR Korea</th>
<th>India</th>
<th>Indonesia</th>
<th>Maldives</th>
<th>Myanmar</th>
<th>Nepal</th>
<th>Sri Lanka</th>
<th>Thailand</th>
<th>Timor-Leste</th>
<th>Total</th>
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<tbody>
<tr>
<td>Communicable Disease and Surveillance</td>
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<td>0</td>
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<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>11</td>
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<td>26</td>
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<tr>
<td>Sustainable Development and Healthy Environments</td>
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<td>2</td>
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<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>19</td>
<td></td>
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<tr>
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<td>1</td>
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<td>–</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>0</td>
<td>14</td>
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<tr>
<td>Noncommunicable Diseases and Mental Health</td>
<td>1</td>
<td>0</td>
<td>1</td>
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<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
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<td><strong>2</strong></td>
<td><strong>33</strong></td>
<td><strong>0</strong></td>
<td><strong>87</strong></td>
<td><strong>87</strong></td>
<td></td>
</tr>
</tbody>
</table>

As of 31 May 2008

26. WHO financial support was provided to the Network for National WHO CCs and National Centres of Expertise (NEW-CCET) in Thailand. This Network facilitates collaboration between CCs in research, and keeps an up-to-date database of experts. It is a good model for working together and building

\textsuperscript{12} See: www.sidcer.org; www.who.int/sidcer/en/; www.fercap-sidcer.org/
capacity, and becoming an international hub of scientific knowledge and technology.

**WHO expert advisory panels**

27. WHO has always worked closely with scientific communities in Member countries to identify experts for selection and appointment as Expert Advisory Panel (EAP)/Expert Advisory Committee (EAC) members. Of 781 EAP members globally, 75 experts are from SEA Region countries (an increase by three experts compared to 2007) and represent 47 areas of expertise (as of 30 June 2008).

**Challenges**

- Supporting country research capacity building.
- Strengthening health research management and governance.
- Enhancing research ethical review.
- Supporting research infrastructure for enhancing quality of health research.
- Strengthening health research networking and partnership.

**Essential medicines: the continuing journey**

28. The 30-year journey (see Box 5.3) to provide access to safe essential medicines of adequate quality to the people of the Region continued during the year with activities in the traditional areas and the initiation of new activities as countries face new challenges.

**Box 5.3: Thirty years of implementation**

The 30th anniversary of the WHO Model Essential Medicines List was commemorated in Sri Lanka during an intercountry workshop attended by all Member countries of the Region. All Member countries have a national essential medicines list in some form, and have used it in their health care systems. An outcome of the workshop was the realization that it is important to have joint activities for countries with similar needs; a workshop for Bhutan, Timor-Leste and Maldives will be held in 2008.
Implementing rational use

29. Implementation of the essential medicines concept and list has to be accompanied by appropriate and rational use of medicines. A regional meeting13 focused on the increasing consumer awareness of the issues involved in rational use and brought out areas requiring a different approach. The increased awareness and enthusiasm generated at the meeting is now being harnessed into projects and activities which involve civil society and are focused on the consumer.

Strengthening country offices

30. As the medicines situation in countries becomes more complex, there is a constant demand for technical advice. The policy of strengthening country offices through the appointment of WHO National Professional Officers or equivalent has been initiated; at present India, Indonesia, Myanmar and Sri Lanka have such officers in place, while Bangladesh is in the process of recruitment. This will provide a continuous link from headquarters through the Regional Office and the country office to the ministry of health.

Improving quality, safety and efficacy

31. Countries in the Region have continued to promote production of essential medicines in their pharmaceutical industries. DPR Korea now produces essential medicines in a pharmaceutical factory developed with WHO assistance. Bangladesh has been provided with WHO assistance to enable it to reach the standards required by the UN prequalification system (and hence for supplying UN agencies); it is likely that a final inspection will be carried out in late 2008.

32. Detection and management of adverse reactions to medicines, using medicines safely (pharmacovigilance) is an important part of the functions of the ministry of health. Nepal, Sri Lanka and Thailand have vigorous activities (which have been supported by the Regional Office) that have contributed to the global database on pharmacovigilance. The Regional Office has also assisted Bhutan to initiate these activities and the country will soon begin to contribute to the global system. India has a system in place but is yet to implement it completely.

33. Concerning the regulation of medicines, countries continue to face major challenges. Counterfeit medicines are one issue where there were many activities during the year. Countries are yet to clearly define in their

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13 on The Role of Education in the Rational Use of Medicines, Thailand, December 2007
legislation what a counterfeit medicine is; such a definition aids in detecting counterfeits as well as in comparing the situation across countries. The International Medical Products Anti-Counterfeiting Taskforce (IMPACT), coordinated by WHO, is now actively involved in the Region, and activities in the area will increase.

34. After establishing its drug regulatory authority, Bhutan moved ahead with developing detailed regulations such as the list of over-the-counter (OTC) medicines and the information to be provided with these medicines; this was supported by the Regional Office through a workshop and technical resources. This will improve access and rational use of medicines.

Increasing access

35. Medicines for children is an area that has been neglected. There is an increasing realization that more work is needed in the area of children’s medicines, and that products appropriate for this group need to be specifically developed.\(^{14}\) Baseline information on the situation is lacking and surveys have been initiated, with WHO support, in Bhutan, India, Sri Lanka and Thailand to assess the situation. Results of these surveys will be available later in 2008.

36. Good Pharmacy Practice (GPP) is the universal professional standard of service developed as a professional tool for pharmacists. The principles of GPP were developed by the International Pharmaceutical Federation along with WHO. The regional implementation has been done by the South-East Asia Pharmaceutical Forum (SEARPharm) in collaboration with the Regional Office.

37. Countries in the Region have taken GPP and modified it according to their requirements, and implemented it with varying degree of success. Thailand has been the most successful, and has been able to demonstrate that pharmacies with GPP were better patronized and commercially more successful than those which did not practice GPP.

Traditional medicine

38. Traditional medicine is widely used in all Member countries. To initiate and promote information exchange and inter-institutional cooperation, the Regional Office compiled a list of traditional medicine departments, and teaching, health-care service and research institutions in Member countries.\(^{15}\)

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\(^{15}\) List of Potential Herbal/Traditional Medicine Institutions for Networking in South-East Asia Region
Further steps being taken by the Regional Office include selection of core institutes for networking and preparation of a Regional forum.

39. To maximize the potential of traditional medicine in Member countries, a regional plan of action\textsuperscript{16} was drafted for further development in collaboration with experts from Member countries. Objectives of this plan of action include promoting the safety, efficacy and quality of herbal medicines; developing/strengthening the cultivation, collection and preservation of herbs; promoting rational use of traditional medicines; and exchanging information between countries.

**Challenges**

- Addressing access, regulation, production and use of medicines in context of globalization.
- Ensuring the maximum benefit for health in medicines through National Medicinal Drug Policies.

**Evidence for health policy: strengthening country health information systems**

40. In 2007 the Regional Committee urged Member Countries to institute evidence-based health information for formulating policies and initiating effective interventions, particularly based on disaggregated data at the sub-national level;\textsuperscript{17} to assess country health information systems and track progress towards the Millennium Development Goals. The outcomes and achievements are summarized below.

**Improving the quality of data**

41. WHO is supporting implementation of the International Classification of Diseases (ICD) as part of its regional strategy to strengthen health information at the country level. The existing ICD training modules were reviewed during the regional training-of-trainers workshop\textsuperscript{18} with the participation of 10 Member countries.

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\textsuperscript{16} Regional Plan of Action on Herbal Medicine 2007-2010
\textsuperscript{17} See: www.searo.who.int/en/Section1243/Section1382_12648.htm
Upgrading the standards of reporting and utilization of health statistics

42. Reliable and timely health information is basic to the efficient performance of the health system, and to public health programming and decision-making. At a workshop19 in which all Member countries participated, the Regional Office helped and facilitated the countries to: review their existing annual health statistics reports; elaborate a consultative process of data validation between WHO, Member countries and other development partners. The common standards of format, content and process for reporting of health statistics was agreed upon. Employing such standards at the country level will enhance the use of data for decision-making and resource allocation, and will enable Member countries to better analyse data and utilize them at the subnational level too.

Transforming health information into decisions

43. Discussions on how to transform data and statistics from health information into decisions took place as a follow-up to the above two courses of action at the Regional Consultation on Utilization of Health Information for Decision-Making, Sri Lanka, June 2008. It is expected the discussions will impact the supply and demand for quality health information and better utilization of health information by policy-makers and programme managers at the country and subnational levels.

Sharing of information

44. To enhance the sharing of knowledge and information among SEA Region countries, health system profiles of all 11 Member countries were updated and posted on the Regional Office website.20 Each country health profile provides information on health policy, socioeconomic status, health and environment, health resources, health system, health services, and trends in health outcome as indicated by health status indicators; and includes links to related websites of relevant and respective governments, technical departments of WHO, and development partners. The profiles also provide the status of progress towards the MDGs by target and indicator.

45. The online SEARO Integrated Data Analysis System (SIDAS) was launched on the Regional Office website.21 It will provide a valuable tool for Member countries to generate tables and graphs of health data and health-related indicators.

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20 At: www.searo.who.int/en/Section315.htm
21 At: www.searo.who.int/EN/querybuilder.htm
46. *Health situation in the South-East Asia Region 2001–2007* has been prepared (to be published). It describes the progress of health development in the Region. In illustrating the socioeconomic inequalities, demographic changes and epidemiological shifts that have taken place in the Region, it provides a perspective on disease control priorities and will provide a valuable source of information for policy-makers and health planners.

**Challenges**

- Streamlining collection of country-level data.
- Promoting disaggregation of data.
- Capacity strengthening in data management at the subnational level.
- Measuring progress towards achievement of MDGs.

**Information management and dissemination: promoting widespread access to health information**

47. Activities to increase access to health information took a number of directions, as outlined below.

**Revising the WHO publications policy**

48. WHO is undergoing an Organization-wide revision of its publications policy, aimed at improving the quality of, and access to, the Organization’s information products. In 2007, a working group on Publishing Policy and Procedures was formed at the Regional Office. This group is revising the publications policy of the Regional Office and country offices so that it is appropriate for the Region and in line with WHO Global Publishing Policy.

**Archiving of WHO information**

49. An effective mechanism for archiving and promoting widespread access to WHO information products is the development of WHO institutional repositories, in accord with the Executive Board resolution of May 2007. The Regional Institutional Repository started to become available online in

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22 121* and 122nd WHO Executive Board meetings in 2007 (see: EB121/6, EB122.R9, EB122/20 at: www.who.int/gb/)

23 121* WHO Executive Board meeting, May 2007 (see: EB121/6 and EB122.R9 at: www.who.int/gb/)

24 At: http://repository.searo.who.int
2007;\textsuperscript{24} it will be a component of the WHO Global Institutional Repository which will serve as a unified source for open and easy access to all WHO information products. The practice of institutional repository was also introduced to Member countries (Bhutan, Indonesia, Sri Lanka, Thailand) so that knowledge assets in the Region will become more visible and easily accessible to the public worldwide. Technical assistance and training courses for building institutional repositories have so far been provided to these Member countries.

### Distributing WHO information

50. A Regional Publications Distribution System has been developed and was incorporated into the SEARO website in 2007.\textsuperscript{25} The system allows the public to view both priced and free SEARO publications and to download them or to submit requests/orders for information products directly to the Regional Office. Special “display corners” have also been set up for WHO publications at selected libraries in Bhutan, DPR Korea, India, Myanmar and Sri Lanka, to maximize access to WHO information products.

### Sharing and integrating information

51. Another focus of work was to upgrade existing library and information systems in the Member countries in order to facilitate sharing and integration of information resources among institutions. Support and training in information management were provided to Bangladesh, Bhutan, Indonesia, Myanmar and Nepal. The updated systems will allow adoption of international standard character codes for national languages and facilitate effective resource sharing and integration of information resources. The updated systems are search-engine optimized, allowing greater visibility of national information assets through global search engines. A documents repository, including a SEA Region institutional repository on meeting reports and assignments reports, is under development and will be finalized in 2008.

### Accessing commercial information

52. Six Member countries (Bangladesh, Bhutan, Maldives, Myanmar, Nepal, Timor-Leste) are eligible (based on GNP per capita) for access to global commercial biomedical information services through the Health InterNetwork Access to Research Initiative (HINARI). During 2007–2008, HINARI training courses were conducted in all these HINARI-eligible Member countries. At

\textsuperscript{25} At: http://203.90.70.117/pds/
the same time, the Regional Office continues to function as a focal point for provision of full-text documents not available through HINARI, and to Member countries not eligible for HINARI, following existing copyright laws.

**Helping to develop libraries**

53. Within the framework of the Public Health Initiative launched in 2004, aimed at increasing the Region’s capacity in public health education, the Regional Office is developing core lists of standard textbooks in public health, epidemiology and statistics, and providing support for the development of library collections (by providing public health books) at nine schools of public health in Member countries (Bangladesh, DPR Korea, India, Indonesia, Maldives, Myanmar, Nepal, Thailand, Timor-Leste).

**Challenges**

- Commitments from policy-makers, programme managers and administrators related to Health Literature and Library Information Services (HELLIS).
- Maximizing the use of HINARI resources.

**Human resources for health: extending the health workforce**

54. Work in this area has focused mainly on supporting Member countries to develop adequate and quality assured health workforce at different levels.

**Boosting the community level health workforce**

55. Concerning the primary health care (PHC) workforce, many Member countries are facing a shortage of PHC workers for ensuring essential health interventions, which is acting as a constraint to revitalizing the PHC approach.

56. To enhance the capacity to address the high burden of preventable diseases at community level and to facilitate Member countries to develop and maintain a workforce of community-based health workers (CBHWs) and community health volunteers (CHVs), the regional strategic directions were developed\(^\text{26}\) during a regional meeting.\(^\text{27}\) This advocacy meeting created

\(^{26}\) Strategic directions for strengthening community-based health workers and community health volunteers in the South-East Asia Region, March 2008 (document SEA-HSD-311)

\(^{27}\) Revisiting community-based health workers and community health volunteers, October 2007 (document SEA-HSD-309)
awareness among Member countries on the contribution of CBHW and CHV to health promotion and disease prevention particularly for the poor, underserved and underprivileged. Nine strategic directions were proposed under three pillars: (1) renew political commitment and recognize the importance of CBHWs and CHVs; (2) strengthen the CBHWs and CHVs system; and (3) ensure a supportive environment for effective functioning of CBHWs and CHVs.

Networking the medical professional workforce

57. The first meeting of the regional network enabled representatives of medical councils of Member countries to identify several key components that need further emphasis. Based on these discussions, a set of activities for future WHO work was identified by the participants. Particular attention was paid to developing a teaching module on ethics for undergraduate medical courses, developing medical accreditation guidelines, and identifying the roles and responsibilities of medical councils in ensuring patients’ safety.

Planning for the health workforce

- Member countries are at different levels of developing strategic plans for health workers. Complying with country requests, SEARO and respective country offices have been providing specific technical and financial support to Bhutan and Sri Lanka to initiate the development of medium-term strategic plans for human resources for health (HRH) development. In addition, Bhutan has been provided with technical and financial support to develop the Royal Institute of Health Sciences, the main HRH development centre in the country, into a degree-awarding institution.

- A peer review meeting for finalization of “Regional Strategic Directions for Strengthening CBHWs and CHVs in SEA Region countries” was organized in the Regional Office in January 2008.

- A draft Regional Guidelines for Development of Health Workforce Strategic Plan in SEA Region countries was developed. SEARO is in the process of assisting Member countries to develop health workforce strategic plans.

- A Regional Health Workforce database is being developed and would be harmonized with the country health workforce surveys to support evidence-based HRH planning.

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28 First Meeting of the Regional Network of Medical Councils in SEA Region countries, Sri Lanka, December 2007
Collaborating with regional HRH networks

- The Regional Office collaborated with the Asia-Pacific Action Alliance on Human Resources for Health,\(^{29}\) participated and made a presentation at the AAAH Training Workshop on Regional Guidelines for Country Strategic Planning of HRH, Manila, May 2008, and supported participation of representatives from Bangladesh, Myanmar, Nepal and Sri Lanka at the same workshop.

Challenges

- Strengthening the community-based health workforce.
- Developing national health workforce profiles.
- Developing a regional observatory for human resources.
- Addressing migration of the health workforce.
- Strengthening medical and health councils in Member countries.

Nursing and midwifery: developing the health workforce

58. Several crucial issues are being taken up in the area of nursing and midwifery. A particular focus was to address the quality of education and service, and the shortage of staff and qualified teachers.

59. To enhance quality of education and competencies of new graduates, WHO developed the Guidelines on quality assurance and accreditation of nursing and midwifery educational institutions for the educational institutions to use or adapt. Technical support and advice was provided to nursing and midwifery councils on their roles in accreditation of an educational institution, as a means to ensure standard curricula, qualified and competent teachers and an effective teaching and learning environment.

56. With WHO technical and financial support, significant achievements included:

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\(^{29}\) www.aaahrh.org/aaah.php
• In Bangladesh, the revised diploma programme in nursing and midwifery was implemented in all nursing institutes in 2008; the teachers were trained on the teaching of the revised nursing curriculum; the model ward was developed to enhance quality of nursing care; and quality assurance guidelines for nursing and midwifery education institutes were developed in collaboration with the Bangladesh Nursing Council.

• In DPR Korea, equipment for skilled nursing and midwifery laboratories was provided, core textbooks were translated in local languages and guidance provided for the development of a quality system for nursing education and service.

• In Sri Lanka, a bridge programme in nursing for upgradation of nurses’ qualification was launched and an evaluation of national maternal and child health programme conducted.

• In Bhutan, with WHO support, 45 nurses with a Bachelor’s Degree in nursing graduated from the Royal Institute for Health Sciences in collaboration with the school of nursing, La Trobe University, Australia.

61. WHO provided financial support to the WHO Collaborating Centres for Nursing and Midwifery Development in Bangladesh, India and Thailand, addressing the quality of nursing and midwifery education and service. In addition to providing short training courses in specialized nursing and midwifery areas under fellowships, the outcomes of their work included:

• The development of three educational modules on midwifery teaching, community nursing and nursing management of patients with severe respiratory syndrome;

• The organization of five training courses in the area of HIV/AIDS, malaria, community-oriented nursing curriculum, midwifery teaching and community nursing;

• Development of the website of the South-East Asia Nursing and Midwifery Educational Institutions Network; and

• With partial support from WHO, two international conferences were organized to discuss future directions of the nursing and midwifery in primary health care and its contribution towards the Millennium Development Goals.

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30 On: New Frontiers in Primary Health Care: Role of Nurses and Other Professionals and on Healthy People for a Healthy World
62. Thus, in order to scale up nursing and midwifery services, as recommended by two recent Regional Committee resolutions, the main focus is on developing the health workforce through national strategy and planning, strengthening the capacity and quality of training institutions, and revitalizing the role of community-based health workers.

Challenges

- Migration of nursing staff and international movement (ethical recruitment).
- Scaling up nursing and midwifery services.

Education, training and support: streamlining the process

63. A well-performing health workforce is vital to the effective management of the health system and provision of quality care. Performance of the workforce can be improved through proper needs-based education and training, and WHO supports this by providing the best available training opportunities through its fellowships mechanism.

Awarding of fellowships

64. Of 286 applications received during the reporting period, 233 fellowships were awarded. Box 5.4 outlines the main features of the fellowships programme for the period under review.

> Box 5.4: Salient features of the fellowships programme for the period July 2007 to June 2008

A total of 233 fellowships were awarded

72% of the fellowships are in the area for strengthening public health

87% of fellowships were conducted in institutes of the Region, the (bulk in Thailand and India, with 1% to 2% each in Bangladesh, Indonesia and Sri Lanka), 11% in the WHO Western Pacific Region, 1% in the European Region and 1% in the Americas Region.

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31 SEA/RC59/R6; SEA/RC60/R9
Selecting candidates

65. Selecting the right candidates and providing them needs-based training in the right training institute is vital for the development of quality health workforce in Member countries. The Regional Office initiated reviewing the selection process by collecting details of existing selection and nomination practices in countries.

Reviewing, monitoring and evaluating impact

66. Several mechanisms are being reviewed in the Regional Office:

- A process for rapidly reviewing fellowships training under the Country Cooperation Strategy (CCS); this will help countries develop better policy for correctly selecting, placing and utilizing fellows, and thereby strengthening the health systems.

- Monitoring of fellowships and workplans, a system to supplement the current proposal-tracking system to enable better follow-up in countries and timely implementation of planned activities.

- A post-training performance evaluation mechanism development initiative has been taken. This will help to see the training impact using standard tools and indicators and will contribute in improving the programme and the process.

Making the directory of training institutions more useful

67. To help maximize use of the web-based WHO Regional Directory of Training Institutions (RDTI),\(^\text{32}\) and to make the tool more meaningful for ministries, WHO country and regional offices, potential fellows and other stakeholders, the RDTI is updated regularly, including the institution profiles, faculty and training programmes (a CD is available from SEARO).

\(^{32}\) At: www.searo.who.int/en/section13/Section1054/Section1059.htm
Processing of fellowships

68. The recently revised e-document management system and proposal-tracking system have improved the processing of fellowships – of placements and follow-up – while dramatically reducing the processing time in SEARO by approximately 50% to about 60 days of average lag time.

Group educational activities

69. A total of 77 meetings/group educational activities were held in the Region, of which six were policy meetings, four were advisory meetings and 67 were intercountry technical meetings.

Challenges

- Effective monitoring of training of fellows (quality assurance of training).
- Formulation of a post-training performance evaluation mechanism to measure the impact of training using standard tools and indicators.

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33 See: www.searo.who.int/en/Section1243/Section1374/Section1427_5960.htm
Policy, programme planning and partnership
Governing bodies and policy dialogue

World Health Assembly

1. The Sixty-first World Health Assembly was held in Geneva from 19 to 24 May 2008. The Assembly had two guest speakers, Her Royal Highness Princess Muna Al-Hussein of Jordan, WHO Patron for Nursing and Midwifery in the Eastern Mediterranean Region; and Bishop Desmond Tutu, Archbishop Emeritus, Cape Town and Nobel Laureate. Both drew attention to the current health challenges and approaches to meet them, particularly focusing on human resources, better health and education services, and empowering women to save the lives of children and prevent maternal deaths. Tribute was paid to the human spirit and capacity of all people to do good, and the essentiality of spiritual health to human well-being was emphasized.

2. The SEA Region Member States made consolidated statements in the Health Assembly on behalf of the Region on seven agenda items. The Health Assembly adopted 21 resolutions and one decision.

Executive Board

3. The 122nd and 123rd sessions of the Executive Board were held in Geneva from 21 to 26 January 2008 and 26 to 27 May 2008 respectively. The Report of the 122nd session of the Executive Board was submitted at the Sixty-first session of the Health Assembly in May 2008. At the 123rd session of the Executive Board, the outcome of the Sixty-first Health Assembly and the Report of the Eighth meeting of the Programme, Budget and Administration Committee (PBAC) of the Executive Board were submitted for noting.
Regional Committee

4. The Sixtieth session of the Regional Committee for South-East Asia was held in Thimphu, Bhutan, from 31 August to 4 September 2007. Besides representatives of all Member countries of the Region, the Director-General of WHO and representatives of other UN agencies, NGOs having official relations with WHO and observers also attended the session.

5. The Committee reviewed the Report of the Regional Director on the Work of WHO in the South-East Asia Region covering the period 1 July 2006 to 30 June 2007. The Committee adopted 10 resolutions and four decisions. (see Annex 1)

6. The Committee also established a Sub-committee on Policy and Programme Development and Management (SPPDM) composed of representatives from each Member country of the Region to replace the Consultative Committee on Programme Development and Management (CCPDM).

7. The Committee requested the Regional Director to support those Member countries who were Members of the Executive Board in building their capacity to effectively participate and represent the interests of the Region in the deliberations of the governing bodies of WHO.

Important meetings

Health ministers’ meeting

International health security

8. Keeping in view the health threats that transcend international borders, the Ministers unanimously adopted the Thimphu Declaration on International Health Security in the South-East Asia Region, wherein it was agreed that WHO and Member countries would work together for the implementation of international health security.

Climate change and health

9. The Ministers agreed that climate change is a major threat to health security in the South-East Asia Region and needs to be addressed, and were resolute that WHO collaborate with other UN organizations and development agencies to ensure that health impact assessments and environmental impact

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assessments are carried out prior to any development efforts. To sensitize the people of the Region to these issues, the Ministers desired that “Human Health and Climate Change” be the theme for World Health Day in 2008 or soon after.

Parliamentarians’ Conference on Legislative and Policy Actions for Promoting Health

10. The Regional Conference of Parliamentarians on Legislative and Policy Actions for Promoting Health was held in Indonesia.2 The objective was to advocate for health in national development and to bring about national consensus on important health issues, particularly legislative and policy actions for promoting health.

11. The Parliamentarians unanimously agreed to:

- Strengthen information for community-based assessment and monitoring of alcohol and tobacco consumption, including information on social and cultural determinants of alcohol and tobacco use.
- Develop comprehensive intersectoral, inter ministerial legislative and policy action to reduce harm from alcohol and tobacco use.
- Increase their national budget allocation for health promotion both within the health sector allocation and within other sectors.

Intellectual property, innovation and public health: working towards global action

12. The most important development in the area of intellectual property, innovation and public health is undoubtedly the development of a global strategy and plan of action that “aims at securing an enhanced and sustainable basis for needs-driven, essential health research and development relevant to diseases that disproportionately affect developing countries”.3 This is the task of the Intergovernmental Working Group (IGWG) on Public Health, Innovation and Intellectual Property set up by the World Health Assembly in 2006. The IGWG completed its work in May 2008 with the adoption of a resolution (WHA61.21).

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2 Regional Conference of Parliamentarians on Legislative and Policy Actions for Promoting Health, Indonesia, October 2007. (www.searo.who.int/en/Section1257/Section2181/Section2211/Section2357_13800.htm)
13. The SEA Region Member countries are well aware of the importance of issues related to intellectual property rights (IPR) and innovation, and of their relevance to the Region. While several Member countries have the capacity to innovate and/or to produce pharmaceuticals, others are interested in developing such capacity. All the SEA Region countries are home to one or more of the diseases for which research and development incentives have been insufficient; thus all Member countries can benefit from increasing research efforts for the “neglected” diseases.

14. In line with the Regional Committee resolution 4 and Member countries’ requests, SEARO has organized several Regional consultations. These highly interactive consultations have contributed to a common understanding among Member countries on many of the issues being discussed in the IGWG. For instance, Member countries of the Region agree on the importance of the Trade-Related Aspects of Intellectual Property Rights (TRIPS) flexibilities, and reject demands for the protection of IPR that surpasses the TRIPS standards. Countries also agree that it is important to explore additional mechanisms that can provide incentives for research and development. In addition, several Member countries have organized national inter-sectoral consultations to think through the issues and prepare informed positions.

15. Thus, while the work carried out by the IGWG is undoubtedly a global undertaking, countries of the Region have actively and constructively contributed to the global discussions. This has been recognized by the fact that both IGWG drafting groups were chaired by a delegate from the Region (India and Thailand).

Challenge

- Implementation of the global plan of action on public health innovation and intellectual property (WHA61.21).

Programme planning and coordination: consulting and supporting countries

Programme management


16. Programme Budget Performance Assessment (PBPA) for the 2006–2007 biennium was conducted in all countries and the Regional Office in the last

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4 SEA/RC59/R7 on Public health, innovation, essential health research and intellectual property rights, 2006. See: www.searo.who.int/en/Section1430/Section1439/Section1638/Section2234/Section2272_12133.htm
two months of 2007. As well as assessing key achievements, the PBPA encompassed review of success factors, impediments, lessons learnt and actions required for improving performance, and provided an analysis of financial implementation of the Programme Budget for each area of work. The PBPA 2006–2007 guide all levels of the organization in better quality implementation for the 2008–2009 biennium and in planning for the 2010–2011 biennium.

**Implementing the Programme Budget for 2008–2009**

17. Following the advice of the Consultative Committee for Programme Development and Management (CCPDM) and the Regional Committee, the 2008–2009 workplans for the Regional Office and countries were finalized and approved by the Regional Director before the end of 2007 in order to ensure that implementation would start at the beginning of 2008. Subsequently, monitoring of the implementation of the workplans was intensified with the objectives of mobilizing adequate resources for planned work and ensuring that implementation was undertaken without delay.

**Preparing the Programme Budget for 2010–2011**

18. The process of programme budget formulation in the SEA Region is “bottom-up” approach. Inputs from the country level on priorities identified in the country cooperation strategies were technically reviewed and synthesized at the Regional Office by the respective technical units in formulating the regional PB estimates for inclusion in the first draft of the Organization-wide PB for 2010–2011.

**Country support**

**Developing strategies**

19. Efforts continued in support of developing new Country Cooperation Strategies (CCSs) for the countries in the Region. New CCSs were finalized for Bangladesh, Indonesia, Maldives, Myanmar and Thailand. Several of these countries held official CCS launchings to ensure wider distribution of the documents, which outline priorities for WHO support to each country over a period of five to six years.

**Strengthening international health**

20. A regional seminar on strengthening International Health Coordination (IHC) at country level was held (Indonesia, February 2008). Heads of international health divisions from 10 Member countries of the Region
attended this meeting to discuss how to strengthen the coordination of international health in their countries. At the seminar, countries shared experiences in IHC and outlined specific plans for improving International Health Coordination, including specific support required from WHO.

Planning and implementing multicountry activities

21. During the 2006–2007 biennium, work started on the planning and implementing of multicountry activities (MCAs). Assessment of this work showed that there were still constraints preventing the most effective use of MCAs to support country work. In March 2008, the Regional Office Executive Management met with all WHO Representatives in the Region to discuss the MCAs for the 2008–2009 biennium. In close consultation with ministries of health, WHO country offices were delegated to work together to formulate activities benefiting the countries of the Region. Proposed MCAs were reviewed and selected for further consideration. The decision to participate in MCAs can be made primarily by the participating countries. The Regional Office will provide support to facilitate MCA implementation at the request of the countries involved.

Resource mobilization, external cooperation and partnerships: accessing voluntary and external resources

22. In view of the growing requirements for voluntary contributions in the WHO Programme Budget and the need for more active resource mobilization, the Regional Committee in 2007 requested the Sub-committee on Policy and Programme Development and Management (SPPDM), through resolution SEA/RC60/R2, to provide its views and recommendations to the Regional Committee on resource mobilization efforts and status of funding of the Regional Programme Budget.

Achieving the Voluntary Contribution target of the Programme Budget

23. It was a crucial time for the WHO Regional and country offices to mobilize sufficient resources to meet the Voluntary Contribution target for the 2006–2007 Programme Budget and to begin implementing the 2008–2009 workplan. Regional and country offices intensified their efforts in resource mobilization. These efforts contributed to the successful negotiations and conclusions of 183 donor agreements with 45 donors and partners during the biennium and the mobilization of US$ 344 million of Voluntary
Box 6.1: Resource mobilization during the period under review

Regional and country offices intensified their efforts in resource mobilization and concluded a number of donor agreements with development partners and donors including:

- An agreement with the European Community on avian influenza for Indonesia (US$ 17.3 million).
- An umbrella grant with the United States Agency For International Development (USAID) for the Region (US$ 9.6 million) on various technical programmes.
- A grant agreement with USAID for polio eradication in the Region (US$ 6.6 million).
- Seven agreements with the United Nations Office for Project Services (UNOPS) on the Three-Diseases Fund for Myanmar (US$ 7.3 million).
- A grant agreement with the US Centers for Disease Control (CDC) for polio and measles in the Region (US$ 4 million).
- An agreement with the Netherlands for reduction of maternal mortality and morbidity in Bangladesh (US$ 3.9 million).
- An agreement with Australia for the Asia-Pacific Strategy on Emerging Infectious Diseases (US$ 3.4 million).
- A grant agreement with CDC for avian influenza in the Region (US$ 1.5 million).
- An agreement with Italy for emergency and humanitarian action (EHA) activities in DPR Korea (US$ 1.3 million).

Contributions by the end of December 2007 – a 33.3% increase over the Voluntary Contribution target in the approved Programme Budget for 2006–2007 (US$ 257.9 million – see Figure 6.1).

24. The Regional Office has improved its role as the coordinating and supporting centre for WHO offices in the Region, providing, among other things, regular updates on: donor information; policy and technical guidelines and tools; donor relations; project negotiations and agreements; and coordination with WHO headquarters. To improve and strengthen technical capacity for resource mobilization, SEARO organized a country training workshop in Maldives, contributing to the country’s capacity to write short fundable project proposals and communicate effectively with donors.

25. WHO took several actions, including:
- More proactive follow-up to decentralized and corporate approaches;
• developing and strengthening strategic partnerships with development agencies and funding sources; and
• applying a more systematic approach, including development and implementation of plans of action for resource mobilization in the Regional Office and country offices.

Challenges

• The absence of any donor country in the Region.
• Ensuring alignment between activities planned and resources mobilized in view of donor’s priority.

Strategic alliance and partnership: pooling resources

Collaborating with United Nations organizations

Collaboration was ongoing in a number of spheres as outlined below.

Environment and health

26. SEARO and WPRO signed a memorandum of understanding (MoU) with the UNEP\(^5\) Regional Office for Asia and the Pacific to support the

\(^5\) United Nations Environment Programme
Regional Initiative on Environment and Health. This cooperation is valid for three years (2008–2010); resources will be pooled to provide a joint secretariat to support the Initiative and to organize an Advisory Board and Ministerial Regional Forum. Accordingly, the First Ministerial Regional Forum on Environment and Health was held in Thailand in August 2007. This forum endorsed the Bangkok Declaration, aimed to strengthen cooperation between ministries responsible for environment and health within countries and across the Region.

**Drugs and crime**

27. SEARO and WPRO renewed, for a further five years, the MoU which was signed with UNODC\(^6\) in August 2003 on promoting public awareness in East Asia on the dangers of drugs. Under the umbrella of this agreement WHO provided strategic advice through the Project Advisory Committee (PAC) and technical support in the light of their successful experience in anti-tobacco smoking campaign to a three-year joint project: “Promotion of Public Awareness on the Dangers of Drugs in East Asia”. The project addresses the public advocacy and awareness-building challenges and possibilities in the Region, focusing on preventive education against illicit drugs in generating increased public awareness and understanding on the damaging impact of drug abuse on the individual, family and community. The project produced and distributed awareness building materials; developed model campaigns; supported innovative community-based special events, and reviewed and adjusted public advocacy initiatives as necessary. Indonesia, Myanmar and Thailand were participating in this project from the South-East Asia Region. The end of project evaluation in April 2008 indicated that the project was successfully implemented in accordance with its project design and intent.

**UN Regional Coordination Mechanism**

28. SEARO has strengthened its relations with UNESCAP\(^7\) and is actively participating in the UN Regional Coordination Mechanism (UNRCM\(^8\)) for Asia and the Pacific. While the Regional Director continued to be represented at UNRCM meetings, the Health Thematic Working Group continued to be co-chaired by WHO and UNFPA.\(^9\) This Working Group published a review of existing information on inequities in access to health care in the Asia-

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\(^6\) United Nations Office on Drugs and Crime  
\(^7\) United Nations Economic and Social Commission for Asia and the Pacific  
\(^8\) Constituted of all the regional heads of UN entities, the Asian Development Bank, and the International Migration Organization  
\(^9\) United Nations Population Fund
Pacific Region, and is now compiling a review of work undertaken in the area of reducing inequity in health; it is also exploring synergy among UN organizations.

**Synergy between sectors**

29. In 2007, the Regional Committee discussed UN reform and its impact at the country level, and endorsed the proposal for a Regional consultation on UN reform, health and development, engaging the ministries of both health and foreign affairs. The Regional consultation was held in Colombo, Sri Lanka, in December 2007. Areas of synergy between the work of these ministries were explored in an effort to influence policy for better health and development outcomes.

**Aid effectiveness**

30. As requested by the World Health Assembly in 2005 (resolution WHA 58.25), countries in the Region are fully participating in the CCA/UNDAF process to harmonize operational development activities at the country level. To increase the capacity of WHO country offices to serve Member countries, a pilot training workshop on the 2005 Paris Declaration on Aid Effectiveness was conducted in Nepal. Based on the lessons learnt from the Nepal training, the training toolkit was finalized. An adapted version of the toolkit is being developed for use by Member countries and partners.

**Collaborating with regional intergovernmental organizations**

31. The WHO collaboration with ASEAN, which commenced in the 1980s, has continued to do well. In 2008, the joint plan of work for 2006–2007 was reviewed. The review indicated areas where this collaboration had led to progress, including: emerging infectious diseases; stockpiling of oseltamivir (Tamiflu) and personal protection equipment; intellectual property rights, counterfeit drugs; traditional medicine; HIV/AIDS; food safety; and healthy lifestyle. The MoU is currently under review before being extended until the end of 2013.

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12 Common Country Assessment and United Nations Development Assistance Framework

13 See: www.who.int/hdp/publications/1a_paris_declaration.pdf

14 Association of Southeast Asian Nations
32. The collaboration with SAARC,\textsuperscript{15} formalized with the signing of a MoU in 2000, is also expected to continue in 2008–2009. Significant progress was seen in the areas of TB, malaria, HIV/AIDS, Tobacco Free Initiative, and in joint SAARC–WHO publishing activities.

Collaborating with nongovernmental organizations

33. The Regional Office continues to collaborate with international and national NGOs including those in official relations with WHO. NGOs have continued to participate in activities and meetings of the Regional Office. The special relationship WHO enjoys with IFRC\textsuperscript{16} is bearing fruit in the areas of disaster management and emergency preparedness through joint training and information exchange, HIV/AIDS through joint advocacy, blood banking through jointly organizing blood donation and promotion of voluntary blood donation, adolescent health, and health promotion.

Participating in and benefiting from global health partnerships

34. Nepal is one of eight developing countries participating in the International Health Partnership, launched in September 2007 to accelerate action to scale up coverage and use of health services, and deliver improved outcomes against the health-related Millenium Development Goals and universal access commitments. The Regional Office mobilized resources for this partnership in Nepal and supported the health sector in coordination, project development and technical support. The Region is also actively ensuring that its Member countries benefit optimally from global health partnerships such as GAVI;\textsuperscript{17} GFATM;\textsuperscript{18} the STOP TB Partnership; the Partnership for Maternal, Newborn and Child Health; the Roll Back Malaria partnership; etc.

Public relations and media: strengthening strategic communication

Networking

35. SEARO formed a network of communication officers/media focal points from the country offices – the SEA Region Communication Network (SCN).

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\textsuperscript{15} South Asian Association for Regional Cooperation
\textsuperscript{16} International Federation of Red Cross and Red Crescent Societies
\textsuperscript{17} Global Alliance for Vaccines and Immunization
\textsuperscript{18} Global Fund to Fight AIDS, Tuberculosis and Malaria
The broad objective of SCN is to help strengthen internal and external communications between the Regional Office and Member countries and to strengthen the capacity of the Regional Office and countries in public relations and media collaboration. The SEA Region Communication Network now communicates regularly through a user group and monthly teleconferences.

**Building awareness**

36. The Regional Office continued to publish regular press releases. These focused on health and climate change, World TB Day, awareness related to the rational use of medicines, and tackling the HIV epidemic. In a special edition of *Window on SEAR*, international health security, strengthening and working together on this crucial first-line defence against the threats caused by disease outbreaks and the large number of natural and man-made disasters was elaborated.

**Challenges**

- Strengthening capacity at the country level, training professional staff and communication officers in communication skills.
- Updating SEARO communications strategy to be more responsive to the need of the Member countries.

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19 [www.searo.who.int/EN/Section316/Section503.htm](http://www.searo.who.int/EN/Section316/Section503.htm)
20 [www.searo.who.int/EN/Section864.htm](http://www.searo.who.int/EN/Section864.htm)
7 General Management
Global management: preparing for the new system

1. WHO is nearing Organization-wide implementation of a Global Management System (GSM). This new system, combining modern technology with improved ways of working, will boost the Organization’s contribution to global health by allowing less time to be spent on administrative issues and more time on technical aspects of health programmes.

2. Work to ensure Regional readiness for the GSM consisted of the two components outlined below.

Managing the changeover

3. To realign the business framework, a Regional operational model is being developed. Preparations included producing standard operating procedures (SOPs) based on GSM processes, creating the Regional approval matrix, and development of service-level agreements (SLAs), etc. A Regional Organization structure review is underway to ensure optimal functioning of the GSM in SEA Region.

4. Building staff competency in their new roles within the GSM environment is critical for a successful rollout, and a comprehensive training strategy and plan for the Region was developed. Workshops for both Regional and country office staff began in April 2008 and will be followed by specific skills training before the system is launched in the Region early next year.
Getting information technology infrastructure and connectivity ready

5. The information technology infrastructure and implementation of the connectivity readiness plan for the GSM is progressing well. An information and communication technology (ICT) infrastructure review had been carried out for all country offices, and procurement of required equipment was underway.

Human resources: strengthening WHO country capacity

6. The main focus was to strengthen WHO country capacity, ensure that staff members are better equipped to fulfil the Organization’s mandate, and enhance equity among staff.

### Human resources in WHO Secretariat in SEA Region – Regional and Country Offices

<table>
<thead>
<tr>
<th>Category of staff</th>
<th>Regional Office</th>
<th>Bangladesh</th>
<th>Bhutan</th>
<th>DPR Korea</th>
<th>India</th>
<th>Indonesia</th>
<th>Maldives</th>
<th>Myanmar</th>
<th>Nepal</th>
<th>Sri Lanka</th>
<th>Thailand</th>
<th>Timor-Leste</th>
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<td>Professional Staff</td>
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<td>8</td>
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<td>10</td>
<td>1</td>
<td>6</td>
<td>8</td>
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<td>4</td>
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<td>9</td>
<td>1</td>
<td>1</td>
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<tr>
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<td><strong>47</strong></td>
<td><strong>9</strong></td>
<td><strong>5</strong></td>
<td><strong>46</strong></td>
<td><strong>60</strong></td>
<td><strong>14</strong></td>
<td><strong>62</strong></td>
<td><strong>62</strong></td>
<td><strong>25</strong></td>
<td><strong>31</strong></td>
<td><strong>11</strong></td>
<td><strong>748</strong></td>
</tr>
</tbody>
</table>

As of 31 May 2008

Strengthening country capacity

7. To increase technical capacity and strengthen WHO presence at country level, nine new professional posts (including National Professional Officer [NPO] posts) were established. As of 31 May 2008, the total staff strength (with fixed or long-term contracts) in the Region was 493 (similar to the last three years), comprising 127 international professional staff, 35 NPOs, and 331 general service staff. In addition, the services of 255 temporary staff

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2 The Organizational chart of the WHO Secretariat in the South-East Asia Region is in Annex 2.
Human resources (HR) support was also provided to national projects such as polio eradication, tuberculosis and HIV/AIDS through special service agreements (SSAs). As of 15 June 2008, a total of 1678 SSA contracts had been issued to nationals of Member countries for professional and support-type duties.

**Staff development at country level**

9. The WHO Regional Office and country offices were provided with support for staff development and learning (SDL) activities for all staff. A large number of SDL activities were held for staff, both in technical areas and especially in managerial and administrative areas; these included specific training in HR contractual reform and information technology-related areas for country office staff.

**Towards gender and nationality balance**

10. Efforts are underway to attain the gender balance stipulated by the World Health Assembly and to achieve appropriate representation of Member countries in WHO according to the Organization’s geographical distribution criteria.

11. The percentage of female professional staff in the Region increased from 30% to 34%. Nineteen new professional staff members were appointed/reassigned to the Region.

12. The Region continues to have a diverse professional workforce of 58 nationalities. Seventy-two professional staff are from the Member countries. According to the WHO geographical distribution criteria, four Member countries remain overrepresented (India, Myanmar, Sri Lanka and Thailand).

**Revising staff orientation**

13. The orientation programme was revised for all new employees, including staff from country offices who often join these programmes through video conferencing. It now includes a personal message for new groups of staff by the Regional Director. This introduction sessions in the Regional Office has proved to be catalytic in empowering new staff members with essential information and insight into the objectives, processes and procedures towards achieving WHO’s objectives, and into the administrative functioning of the Organization.
Budget and financial management

Implementation and expenditures

14. In the 2006–2007 biennium, the Region’s implementation of the budget surpassed that of the previous biennium by about 8%. Further, the Region strengthened its financial discipline through successful implementation of the delivery principle, resulting in fewer carry-overs of unliquidated expenditures, and hence reduced risk of surrender in the following biennium. At the close of the 2006–2007 biennium, the Region had fully committed its Assessed Contribution (AC) allocation of US$ 97.46 million and had expended US$ 220.27 million of Voluntary Contributions (VC) received from donors. Expenditures for 2006–2007 are shown by country and the Regional Office and by programmatic areas of work in Annexes 3 and 4.

Voluntary versus assessed contribution(s)

15. Some 70% of the expenditure in the Region was funded by voluntary contributions, more than double that funded by ACs, in continuation of the trend previously seen in the Region and experienced across the Organization as a whole. Immunization and vaccine development (including polio eradication) remained the largest VC-funded programme, accounting for 44% of all voluntary contributions. This was followed by emergency preparedness and response (11%), tuberculosis (10%) and HIV/AIDS (7%).

16. For 2008–2009, the Region’s AC was increased by 4% to nearly US$ 103.9 million, further strengthening regional financial resources by building on the increase received in the 2006–2007 biennium. Additional AC funds were allocated after consultations with Member countries. As in previous bienniums, the Region continues to allocate more of its AC to countries than any other Region. Figure 7.1 shows the trends in Regional expenditure over the last few bienniums. Annexes 5 and 6 provide the distribution of resources based on approved workplans.

Challenges

- Implementation of the new Global Management System
- Close monitoring and management of workplans, budget and resources.

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2 Formerly known as Regular Budget
Informatics and infrastructure services: playing a role at all levels

17. Information and communications technology (ICT) has great potential for improving health services and systems, enabling WHO to deliver more effectively in all areas of work including technical support to Member countries. The work of ICT was guided by the Regional ICT Strategy (2008-2013). The Strategy incorporates a strong account management process and customer-oriented services management.

Extending eHealth applications

18. WHO’s eHealth initiatives continue: eHealth and ICT readiness survey was conducted in DPR Korea in November 2007 prior to establishing an eHealth project in the country. On the basis of this, the required equipment was procured and further work on this eHealth project would follow.

Disseminating information

19. Dissemination of electronic information in the Region was strengthened through continuous updating of the SEARO website in all areas of work, and through regular support for country office websites. Web Site Builder Tool (WBT) was enhanced to incorporate multilingual support for the websites,
and a country workshop on the use of WBT was conducted in December 2007. Search functionality and other web management functionalities were improved using state-of-the-art technology.

Providing services

20. Examples of the key services provided by the Regional Office are given in Box 7.1; other services provided are outlined below.

Box 7.1: Selected key services provided by the SEARO ICT unit

- Outsourcing of Regional Office Helpdesk services and implementation of the Information Technology Infrastructure Library (ITIL).
- Development of a service level agreement-based outsourcing contract template for country offices.
- Establishment of a new data centre and migration of the SEARO server to this.
- Establishment of a new server in the WHO Myanmar Office.
- Provision of backup Internet links at the Regional Office and in eight country offices.
- Enhancement of the SEARO teleconferencing facility.
- Extension of ICT infrastructure and connectivity support to communicable diseases surveillance and response.

21. Services related to the application of geographical information systems (GIS) and service availability mapping (SAM) were continued for Member countries. In Maldives, where the web-based SEARO Integrated Data Analysis System (SIDAS) is fully utilized to develop epidemiological reports for the Ministry of Health, further training was conducted in 2008 for the Department of Public Health and atoll-level officials, with WHO technical support. The system was strengthened to incorporate user requirements. Fortnightly surveillance reports are generated for communicable diseases at the Ministry of Health; and all atolls use the system to maintain daily surveillance data.

22. To automate processes, deliver cost-effective ICT solutions, and enhance the analytical and reporting capabilities of users, revision of administrative and technical systems is ongoing at the Regional and country offices, and
for Member countries. Support was provided to WHO/HQ during development of the WHO Global Management System. Also, technical contributions were provided for the development of WHO global web policy.

**Procurement services**

23. The Regional Office procurement services continued to facilitate timely and effective supply and logistic support for various activities in connection with avian influenza, poliomyelitis, the DOTS programme, malaria, HIV/AIDS, and various other technical/health programmes in the Region. Effective from January 2008, and following internal audit recommendations, all Regional Office procurement of goods, materials and services was centralized under the Medical Supply Unit (MSU) in order to strengthen internal controls.

**Procurement of drugs/vaccines and laboratory/hospital equipment**

24. Figure 7.2 shows procurement percentages for major categories of supplies in the Region.

*Figure 7.2: Procurement for major categories of supplies in the SEA Region*
Procurements for emergencies

25. Emergency supplies were arranged on a priority basis during natural disasters in Bangladesh, DPR Korea, Myanmar and Sri Lanka. Avian influenza items (drugs and equipment) were urgently procured and transported to the affected areas of West Bengal, India, and Indonesia. Antiretroviral drugs were procured for Member countries at a competitive rate from the global market.

Procurements for preparedness

26. In line with emergency preparedness related to avian influenza, the Regional Office made procurements of AI drugs. A stockpile has been operationalized, with plans to increase this in case of an AI pandemic. SEARO has also procured these items for other UN agencies as part of the avian influenza pandemic preparedness and response efforts. Large amounts of personal protective equipment (PPE) and specimen collection kits were also procured for the pandemic preparedness stockpile at the Communicable Diseases Surveillance and Response sub-unit in Thailand for rapid outbreak response to avian influenza.

Funding of procurements

27. During the reporting period, the overall supplies procured for Member countries and the Regional Office amounted to US$ 39.2 million, which is approximately 59% higher than the last year. Of this, US$ 2.7 million were spent using Assessed Contribution funds, and US$ 36.5 million using other sources of funds. Procurements under other sources saw a marked increase from the previous year’s figure of US$ 21.93 million.

Reimbursable procurements

28. Of the procurement from other sources, purchases made for individual countries on a reimbursable basis amounted to US$ 0.32 million, a decrease from the previous period of US$ 1.74 million. Requests were received for the procurement of drugs, vaccines, diagnostic test kits, water purifying chemicals and other items under reimbursable mechanisms. Bangladesh, Bhutan, India, Indonesia, Maldives, Nepal, Sri Lanka and Thailand were supported for procurement under the reimbursable procurement mechanism.
Annex 1

RC 60 Resolutions and Decisions

Resolutions

SEA/RC60/R1: Resolution of thanks
SEA/RC60/R2: Matters relating to programme development and management
SEA/RC60/R3: Nutrition and food safety in the South-East Asia Region
SEA/RC60/R4: Scaling up prevention and control of chronic noncommunicable diseases in the South-East Asia Region
SEA/RC60/R5: The New Stop TB Strategy and its implementation
SEA/RC60/R6: Revised Malaria Control Strategy: Focusing on a new paradigm
SEA/RC60/R7: South-East Asia Regional Health Emergency Fund
SEA/RC60/R8: Challenges in polio eradication
SEA/RC60/R9: International migration of health personnel: A challenge for health systems in developing countries
SEA/RC60/R10: Equitable geographical distribution of the membership of the Executive Board

Decisions

SEA/RC60(1): Technical Discussions: Selection of a subject for the Technical Discussions to be held prior to the Sixty-first Session of the Regional Committee

The Committee decided on “Revitalizing Primary Health Care” as the subject for Technical Discussions to be held prior to the Sixty-first Session of the Regional Committee in 2008.

SEA/RC60(2): Nomination of a Member State to the Joint Coordinating Board (JCB) of the Special Programme for Research and Training in Tropical Diseases

The Committee nominated Bhutan as a member of the JCB for a period of three years effective 1 January 2008 and requested the Regional Director to inform WHO headquarters accordingly.

SEA/RC60(3): Nomination of a Member State to the Policy and Coordination Committee (PCC) of the WHO Special Programme for Research, Development and Research Training in Human Reproduction

The Committee nominated Indonesia as a member of the PCC for a period of three years effective 1 January 2008 and requested the Regional Director to inform WHO headquarters accordingly.

SEA/RC60(4): Time and place of future Sessions of the Regional Committee

The Committee decided to hold its Sixty-first Session in the Regional Office, New Delhi during the week beginning 8 September 2008. The specific timing within that week will be confirmed later.
## Annex 3

### Budgetary implementation, 2006-2007 by country/intercountry/Regional Office

**All sources of funds**

(as of 31 December 2007)

*Expressed in US $*

<table>
<thead>
<tr>
<th>Member State</th>
<th>Assessed Contributions (AC)</th>
<th>Voluntary Contributions (VC)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>10 076 700</td>
<td>18 715 534</td>
<td>28 792 234</td>
</tr>
<tr>
<td>Bhutan</td>
<td>2 911 700</td>
<td>189 796</td>
<td>3 101 496</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>4 442 400</td>
<td>15 816 399</td>
<td>20 258 799</td>
</tr>
<tr>
<td>India</td>
<td>12 606 300</td>
<td>58 584 731</td>
<td>71 191 031</td>
</tr>
<tr>
<td>Indonesia</td>
<td>8 591 900</td>
<td>38 577 519</td>
<td>47 169 419</td>
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<tr>
<td>Maldives</td>
<td>2 477 900</td>
<td>613 459</td>
<td>3 091 359</td>
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<tr>
<td>Myanmar</td>
<td>7 015 500</td>
<td>13 112 878</td>
<td>20 128 378</td>
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<tr>
<td>Nepal</td>
<td>8 801 100</td>
<td>8 768 612</td>
<td>17 569 712</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>4 762 500</td>
<td>3 502 254</td>
<td>8 264 754</td>
</tr>
<tr>
<td>Thailand</td>
<td>5 631 400</td>
<td>2 185 977</td>
<td>7 817 377</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>2 058 600</td>
<td>1 025 143</td>
<td>3 083 743</td>
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<tr>
<td><strong>Country total</strong></td>
<td><strong>69 376 000</strong></td>
<td><strong>161 092 302</strong></td>
<td><strong>230 468 302</strong></td>
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<tr>
<td><strong>Intercountry/Regional Office</strong></td>
<td><strong>28 083 000</strong></td>
<td><strong>59 178 600</strong></td>
<td><strong>87 261 600</strong></td>
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<tr>
<td><strong>SEA Region total</strong></td>
<td><strong>97 459 000</strong></td>
<td><strong>220 270 902</strong></td>
<td><strong>317 729 902</strong></td>
</tr>
</tbody>
</table>

AC expenditure of US$ 97 459 000 on allocation of US$ 97 459 000, implementation 100%
VC expenditure of US$ 220 270 902 on allocation of US$ 316 402 362, implementation 70%
## Annex 4

### Budgetary implementation, 2006-2007 by Area of Work (in descending order)

*All sources of funds*

(as of 31 December 2007)

Expressed in US $

### Area of Work

<table>
<thead>
<tr>
<th>Area of Work</th>
<th>Expenditure</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
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<td>Voluntary Contributions (VC)</td>
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<td>99 274 995</td>
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<td>Emergency preparedness and response</td>
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<td>24 731 137</td>
<td>27 093 141</td>
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<td>Tuberculosis</td>
<td>2 680 430</td>
<td>22 057 366</td>
<td>24 737 796</td>
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<td>WHO’s core presence in countries</td>
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<td>21 921 064</td>
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<td>HIV/AIDS</td>
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<tr>
<td>Communicable disease prevention and control</td>
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<td>9 925 658</td>
<td>11 815 570</td>
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</tr>
<tr>
<td>Infrastructure and logistics</td>
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<td>6 771 947</td>
<td>9 197 910</td>
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</tr>
<tr>
<td>Malaria</td>
<td>2 204 649</td>
<td>6 358 225</td>
<td>8 562 874</td>
<td></td>
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<tr>
<td>Knowledge management and information technology</td>
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<td>4 352 473</td>
<td>7 902 022</td>
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<tr>
<td>Health system policies and service delivery</td>
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<td>656 422</td>
<td>7 630 035</td>
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<td>Human resource for health</td>
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<td>7 525 692</td>
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<td>Surveillance prevention and management of chronic noncommunicable diseases</td>
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<td>Making pregnancy safer</td>
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<td>Direction</td>
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<td>1 649 360</td>
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<td>Nutrition</td>
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<td>External relations</td>
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<td>Planning Resource Coordination and Oversight</td>
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<td>Gender equity, women and health</td>
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<td>106 010</td>
<td>577 337</td>
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</table>

**SEA Region total**

| 97 459 000 | 220 270 902 | 317 729 902 |

AC expenditure of US$ 97 459 000 on allocation of US$ 97 459 000, implementation 100%

VC expenditure of US$ 220 270 902 on allocation of US$ 316 402 362, implementation 70%
### Annex 5

**Budgetary implementation, 2008-2009**

**by budget centre**

*All sources of funds*

(as of 10 June 2008)

Expressed in US $

<table>
<thead>
<tr>
<th>Budget Centre</th>
<th>Planned AC</th>
<th>Planned VC</th>
<th>Available resources AC</th>
<th>Available resources VC</th>
<th>Funding gap AC</th>
<th>Funding gap VC</th>
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<td>Bhutan</td>
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<td>3 922 802</td>
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<tr>
<td>DPR Korea</td>
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<td>–</td>
<td>22 629 623</td>
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<td>India</td>
<td>13 712 000</td>
<td>88 976 000</td>
<td>13 712 000</td>
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<td>Indonesia</td>
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<td>–</td>
<td>35 172 792</td>
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<td>Maldives</td>
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<td>3 662 000</td>
<td>2 539 000</td>
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<td>Sri Lanka</td>
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<td>1 452 231</td>
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<td>7 197 012</td>
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<td>Timor-Leste</td>
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<td>5 993 000</td>
<td>2 127 000</td>
<td>1 271 935</td>
<td>–</td>
<td>4 721 065</td>
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<td><strong>Country total</strong></td>
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<td><strong>317 886 000</strong></td>
<td><strong>73 255 600</strong></td>
<td><strong>123 894 693</strong></td>
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<td><strong>193 991 307</strong></td>
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<td>29 207 000</td>
<td>3 843 000</td>
<td>20 363 423</td>
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<td>Administration and Finance</td>
<td>4 128 000</td>
<td>15 956 000</td>
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<td>Office of Director, Programme Management</td>
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<td>1 741 000</td>
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<td>1 259 994</td>
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<tr>
<td>Office of Deputy Regional Director</td>
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<td>3 643 607</td>
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<td>2 773 393</td>
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<tr>
<td>Emergency and Humanitarian Action</td>
<td>1 176 400</td>
<td>5 966 000</td>
<td>1 176 400</td>
<td>3 052 447</td>
<td>–</td>
<td>2 913 553</td>
</tr>
<tr>
<td>Family and Community Health</td>
<td>2 401 000</td>
<td>12 702 000</td>
<td>2 401 000</td>
<td>3 292 149</td>
<td>–</td>
<td>9 409 851</td>
</tr>
<tr>
<td>Health Systems Development</td>
<td>4 812 000</td>
<td>10 389 000</td>
<td>4 812 000</td>
<td>4 870 151</td>
<td>–</td>
<td>5 518 849</td>
</tr>
<tr>
<td>Immunization and Vaccine Development</td>
<td>632 000</td>
<td>19 567 000</td>
<td>632 000</td>
<td>9 602 771</td>
<td>–</td>
<td>9 964 229</td>
</tr>
<tr>
<td>Noncommunicable Diseases and Mental Health</td>
<td>2 562 000</td>
<td>6 434 000</td>
<td>2 562 000</td>
<td>4 235 881</td>
<td>–</td>
<td>2 198 119</td>
</tr>
<tr>
<td>Office of Regional Director</td>
<td>1 666 000</td>
<td>975 000</td>
<td>1 666 000</td>
<td>351 250</td>
<td>–</td>
<td>623 750</td>
</tr>
<tr>
<td>Sustainable Development and Healthy Environments</td>
<td>1 894 000</td>
<td>3 093 000</td>
<td>1 894 000</td>
<td>1 748 124</td>
<td>–</td>
<td>1 344 876</td>
</tr>
<tr>
<td><strong>Regional Office total</strong></td>
<td><strong>25 734 400</strong></td>
<td><strong>112 447 000</strong></td>
<td><strong>25 734 400</strong></td>
<td><strong>57 825 047</strong></td>
<td>–</td>
<td><strong>54 621 953</strong></td>
</tr>
<tr>
<td><strong>SEA Region total</strong></td>
<td><strong>98 990 000</strong></td>
<td><strong>430 333 000</strong></td>
<td><strong>98 990 000</strong></td>
<td><strong>181 719 740</strong></td>
<td>–</td>
<td><strong>248 613 260</strong></td>
</tr>
</tbody>
</table>
## Annex 6

### Budgetary implementation, 2008-2009 by Strategic Objective

*All sources of funds*

(as of 10 June 2008)

Expressed in US $

<table>
<thead>
<tr>
<th>Strategic Objective</th>
<th>Planned AC</th>
<th>Planned VC</th>
<th>Available resources AC</th>
<th>Available resources VC</th>
<th>Funding gap AC</th>
<th>Funding gap VC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To reduce the health, social and economic burden of communicable diseases</td>
<td>8 883 000</td>
<td>157 395 000</td>
<td>8 883 000</td>
<td>79 416 461</td>
<td>–</td>
<td>77 978 539</td>
</tr>
<tr>
<td>2. To combat HIV/AIDS, tuberculosis and malaria</td>
<td>7 127 000</td>
<td>81 315 000</td>
<td>7 127 000</td>
<td>41 704 567</td>
<td>–</td>
<td>39 610 433</td>
</tr>
<tr>
<td>3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries</td>
<td>6 634 000</td>
<td>8 801 000</td>
<td>6 634 000</td>
<td>2 560 163</td>
<td>–</td>
<td>6 240 837</td>
</tr>
<tr>
<td>4. To reduce morbidity and mortality and improve health during key stages of life including pregnancy, childbirth and neonatal period, childhood and adolescence and improve sexual and reproductive health and promote active and healthy ageing for all</td>
<td>7 352 000</td>
<td>31 546 000</td>
<td>7 352 000</td>
<td>5 360 629</td>
<td>–</td>
<td>26 185 371</td>
</tr>
<tr>
<td>5. To reduce the health consequences of emergencies, disasters, crises in conflicts, and minimize their social and economic impact</td>
<td>3 825 000</td>
<td>54 108 000</td>
<td>3 825 000</td>
<td>23 546 548</td>
<td>–</td>
<td>30 561 452</td>
</tr>
<tr>
<td>6. To promote health and development, and prevent or reduced risk factors for health conditions associated with the use of tobacco, alcohol, drug and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex</td>
<td>3 894 000</td>
<td>10 879 000</td>
<td>3 894 000</td>
<td>4 340 384</td>
<td>–</td>
<td>6 538 616</td>
</tr>
<tr>
<td>7. To address the underlying social and economic determinants of health policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches</td>
<td>966 000</td>
<td>3 560 000</td>
<td>966 000</td>
<td>1 872 144</td>
<td>–</td>
<td>1 687 856</td>
</tr>
<tr>
<td>8. To promote a healthier environment, intensified primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health</td>
<td>5 650 000</td>
<td>6 761 000</td>
<td>5 650 000</td>
<td>2 490 634</td>
<td>–</td>
<td>4 270 366</td>
</tr>
<tr>
<td>9. To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development</td>
<td>2 241 000</td>
<td>7 403 000</td>
<td>2 241 000</td>
<td>1 161 434</td>
<td>–</td>
<td>6 241 566</td>
</tr>
<tr>
<td>10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research</td>
<td>24 651 000</td>
<td>28 149 000</td>
<td>24 651 000</td>
<td>6 331 057</td>
<td>–</td>
<td>21 817 943</td>
</tr>
<tr>
<td>11. To ensure improved access, quality and use of medical products and technologies</td>
<td>3 516 000</td>
<td>9 900 000</td>
<td>3 516 000</td>
<td>1 335 618</td>
<td>–</td>
<td>8 564 382</td>
</tr>
<tr>
<td>12. To provide leadership, strengthen governance and foster partnership in collaboration with countries in order to fulfill the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work</td>
<td>8 529 000</td>
<td>6 433 000</td>
<td>8 529 000</td>
<td>3 165 776</td>
<td>–</td>
<td>3 267 224</td>
</tr>
<tr>
<td>13. To develop and sustain WHO is a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively</td>
<td>15 722 000</td>
<td>24 083 000</td>
<td>15 722 000</td>
<td>8 434 325</td>
<td>–</td>
<td>15 648 675</td>
</tr>
</tbody>
</table>

| Total                           | 98 990 000       | 430 333 000      | 98 990 000                 | 181 719 740            | –                 | 248 613 260       |
Looking back at WHO's work in the South-East Asia Region in the 60th anniversary of WHO's existence, remarkable achievements in the area of disease control, family and community health, healthy environments and health system development are observed. These achievements could not have been made without close collaboration with Member countries and all partners in health at the country, regional and global levels.

This Report describes and analyses the outcomes of WHO's work and its impact on countries' capacity, and underscores key challenges and priorities for each area of work. In each area, it briefly describes the current health situation, and key strategy/policy changes that occurred during the review period and which address challenges in health.

The Report also serves as a useful information product, for our partners and others interested in health development, on WHO's work and future priorities in the Region. Although the Report covers a period of one year, the principles of continuity, sustainability and follow-up of important outcomes have been emphasized.