



REGIONAL COMMITTEE

Provisional Agenda item 9

*Sixty-eighth Session
Dili, Timor-Leste
7–11 September 2015*

SEA/RC68/16

20 July 2015

Progress reports on selected Regional Committee resolutions

Progress reports on the following selected Regional Committee resolutions are covered in this document:

- (1) Measles elimination and rubella/CRS control in SEAR by 2020 (SEA/RC66/R5)
- (2) Challenges in polio eradication (SEA/RC60/R8)
- (3) Health intervention and technology assessment in support of universal health coverage (SEA/RC66/R4)
- (4) South-East Asia Regional Health Emergency Fund (SEARHEF) (SEA/RC60/R7)
- (5) Effective management of medicines (SEA/RC66/R7)
- (6) Regional strategy on health information system (SEA/RC63/R7)

The High-Level Preparatory (HLP) Meeting held in the WHO Regional Office in New Delhi from 29 June to 2 July 2015 reviewed each of the above-mentioned progress reports and made recommendations which have been consolidated as an addendum (SEA/RC68/16 Add.1) to this working paper for consideration by the Sixty-eighth Session of the Regional Committee.

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1. Measles elimination and rubella/CRS control in SEAR by 2020 (SEA/RC66/R5)

Background

- All 11 Member States have had well-functioning national immunization programmes that have included a measles containing vaccine (MCV) in the routine immunization schedule for many years. From 2003 to 2013, coverage with MCV1 increased from 67–78%; an estimated 286 million children (95% of the target) were vaccinated in supplemental immunization activities (SIA); and estimated measles deaths decreased by 63%. In September 2013, the Sixty-sixth Session of the Regional Committee resolved to adopt the goal of measles elimination and rubella/congenital rubella syndrome (CRS) control in the South-East Asia Region by 2020, the final WHO Region to adopt a measles elimination goal.
- The key strategies are to: (1) achieve and maintain at least 95% population immunity with two doses against measles and rubella (MR) within every district through routine and/or supplementary immunization; (2) develop and sustain a sensitive and timely CRS and integrated MR case-based surveillance system in each country that fulfils recommended surveillance performance indicators; (3) develop and maintain an accredited MR laboratory network that supports every country; and (4) strengthen support and linkages to achieve the above three strategic objectives.

Progress made in the South-East Asia Region

- Nine countries have conducted national wide age-range measles SIA; Thailand has not and India covered the poorer performing areas. Bhutan, Democratic People's Republic of Korea, Maldives, Sri Lanka and Thailand have national MCV1 coverage >95%; Bangladesh has >90%; while Indonesia and Timor-Leste have below 80%.
- The national measles laboratories, except in Timor-Leste, have achieved "WHO Proficient Laboratory" status. Case-based surveillance with regular reporting to the Regional Office is conducted in all countries except India, Indonesia, Myanmar and Timor-Leste.

Challenges being faced

- Despite the great progress to date, significant challenges remain including: ensuring high immunization coverage, verifying measles elimination at the national and regional levels, standardizing laboratory-supported surveillance and achieving vaccine security.
- The current global supply of MR and measles, mumps and rubella (MMR) vaccines is not sufficient. Significant vaccine manufacturing capacity exists in the Region and can be expanded to meet the increased demand.

Way forward

- Recommended concrete steps to meeting the current challenges include: (1) establishment of national verification commissions to assess and assist countries to achieve and maintain measles elimination; (2) establishment of a regional verification committee to assess and assist the Region to achieve and maintain measles elimination; (3) finalization of plans for national wide age-range MR campaigns in the Democratic People's Republic of Korea, India and Indonesia; (4) institution of a two-dose MCV routine immunization schedule at the appropriate ages in all countries; (5) implementation of verification-quality laboratory-supported case-based surveillance in all countries; (6) organization of training programmes in all countries on a regular basis to produce population immunity profiles against measles by age and location, and standardized risk assessment for the spread of measles; and (7) advocacy to governments to commit to manufacturers for sustainable purchasing of measles vaccines at required levels.

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

Background

- WHO South-East Asia Region reported the last polio case due to wild poliovirus on 13 January 2011 and was certified polio-free on 27 March 2014. Despite being polio-free, all Member States in the Region continue to face the risk of importation of wild poliovirus from the currently infected countries and subsequent spread of the virus within the Region.
- The Global Polio Eradication Initiative's Polio Endgame Strategy involves a phased, risk-free withdrawal of oral polio vaccine (OPV), starting with the withdrawal of type 2 OPV, through a switch from trivalent OPV (tOPV) to bivalent OPV (bOPV), currently scheduled for April 2016. The switch from tOPV to bOPV is being undertaken to eliminate the risks of paralysis associated with the use of type 2 OPV and must be preceded by the introduction of inactivated polio vaccine (IPV).

Progress made in the South-East Asia Region

- Appropriate actions to mitigate the risk of spread of wild poliovirus following an importation are being taken by all Member States in the Region. WHO South-East Asia Region has remained polio-free for over four years.
- Member States in the Region are introducing inactivated polio vaccine (IPV) and gearing up for a coordinated withdrawal of type 2 OPV by switching from tOPV to bOPV in April 2016. Bangladesh, Democratic People's Republic of Korea, Maldives and Nepal have already introduced IPV, while preparations are underway for IPV introduction in the remaining Member States.

Challenges being faced

- A number of preparatory activities will have to be completed prior to the tOPV–bOPV switch by all Member States. These include the introduction of IPV in the routine immunization schedule; ensuring availability of licensed bOPV in adequate quantities; an effective management of tOPV stocks; plans for containment of all type 2 polioviruses as per Global Action Plan III; verification of elimination of wild poliovirus type 2; and surveillance for poliovirus detection and outbreak response plans to manage any type 2 poliovirus outbreaks.

Way forward

- All Member States must continue to strengthen actions required to maintain polio-free status of the Region until global polio-free certification is achieved.
- All Member States must introduce IPV prior to the switch from tOPV to bOPV.
- Detailed ‘national switch plans’ must be finalized by all Member States by September 2015 in preparation of the globally coordinated tOPV to bOPV switch scheduled for April 2016.

3. Health intervention and technology assessment in support of universal health coverage (SEA/RC66/R4)

Background

- Resolution SEA/RC66/R4 on Health intervention and technology assessment in support of universal health coverage (UHC) adopted at the Sixty-sixth Session of the Regional Committee urged Member States to build national capacity on using health intervention and technology assessment (HITA) for evidence-based health policy. The resolution urged WHO to provide necessary support in strengthening capacity and exchange of information. This report informs on the progress achieved in HITA activities in the Region, discussed at the regional seminar on HITA in support of UHC, 4–6 June 2015, held at the WHO Regional Office for South-East Asia, New Delhi, India.
- HITA is part of a range of activities to support implementation of the Regional strategy for UHC, endorsed by Member States in 2012. The Regional strategy called for strengthening of capacity for evidence-informed policy development for UHC, especially for the effective use of limited resources for the highest health impact (SEA/RC65/R6). Policy decisions always need to balance technical, social and political considerations. HITA as a source of evidence has not been widely used by countries of the Region to inform UHC policy and this was flagged for particular attention through resolution SEA/RC66/R4.
- The Regional strategy for UHC emphasizes equity and efficiency in service delivery. *World Health Report 2010 on Health systems financing: the path to universal*

coverage estimates that 20–40% of all health spending is currently wasted through inefficiency, and points to medicines and the selection of interventions as key areas where better policies and practices could increase – sometimes dramatically – the impact of expenditures.

- HITA is a systematic, multidisciplinary approach for reviewing evidence on health interventions or technologies. The approach can be used to generate evidence on equity and efficiency. By emphasizing systematic, participatory and transparent development of evidence-for-policy, HITA can be used for strengthening both the technical and process aspects of delivering UHC policy.

Progress made in the South-East Asia Region

- The following policy questions have been addressed recently using the HITA approach:
 - *Indonesia*: The Health Technology Assessment Committee undertook an economic evaluation of renal dialysis and treatment of pulmonary artery hypertension to inform coverage decision under Indonesia's Health Insurance National Security System. In addition, HITA has been used to undertake a cost-effectiveness analysis of current policy on population-based screening of diabetes and hypertension, as part of the package for essential noncommunicable disease (PEN) interventions.
 - *Nepal*: Nepal has had an essential drug list since 1986, with a systematic mechanism for update. Recently, 70 medicines from the Free Drugs List are being provided free-of-cost at the primary health care level. It has been proposed to use HITA for the review and update of the Free Drugs List, taking into account cost-effectiveness, alignment of drugs with the burden of disease and ensuring transparent, participatory, and evidence-informed coverage decisions of the government-funded drug scheme.
 - *Sri Lanka*: HITA has been used to conduct an evaluation of the social costs and health impacts of alcohol and tobacco consumption in order to inform the government's health promotion and disease prevention policy. Preliminary results suggest the costs of alcohol and tobacco consumption far outweigh the revenues they generate via excise tax to the government.

Institutional arrangements for HITA in countries:

- Thailand established a Health Intervention and Technology Assessment Programme (HITAP) in 2007 and institutionalized the use of HITA to inform UHC policy. Since its inception, HITAP has considered 120 topics suggested by stakeholders for prioritization and 20 new interventions were included in the benefit package, based on value for money, budget impact, feasibility and impact on equity.

- The Essential Medicines and Technology Division, Department of Medical Services, Bhutan, was established in 2009 and is responsible for assessing the introduction of new health technologies and their rational use.
- Indonesia established a Health Technology Assessment Committee, by a Ministry of Health Decree in 2014, and is in the process of developing a plan of action and working mechanism.

Progress at regional level

- WHO convened a regional seminar on HITA in support of UHC, on 4–6 June 2015 in New Delhi, in which 10 Member States and HITA experts participated. The purpose was to share experiences, understand the use of HITA in different contexts and recommend the way forward to support UHC.
- Member States agreed that HITA is a powerful approach to support evidence-based actions for UHC – making policy choices between available technologies, negotiating prices, and assessing the health, social and economic impact of disease or programmes. The significance of explicitly including 'interventions' in health technology assessments in the regional context was appreciated by Member States – broadening the scope to include assessment of programmes and interventions, beyond informing on efficient choices regarding health technologies alone.
- The meeting noted that the use of systematic assessment for decision-making is not new, and studies that could be categorized as HITA have been undertaken in countries of the Region for some time. However, with the advances in health interventions and technologies, decision-makers are presented with choices that are more complex and numerous than ever before, making systematic evaluations such as HITA to inform policy decisions all the more relevant.
- It was reiterated that HITA itself is only one approach available for economic evaluations and impact assessments. Policy decisions on UHC need to use HITA in conjunction with other approaches, especially those that provide more detailed information on all aspects of (in)equity. It was also noted that while being very valuable, HITA alone cannot secure the effective implementation of policy decisions. Other aspects of regulation and management of health systems also need to be strengthened.
- There was much discussion on how to institutionalize HITA, and what sorts of capacity are needed. Two types of capacities were identified. In all countries, it is important that decision-makers know what HITA can offer them; identify the relevant policy questions that it can address, and interpret the findings of the assessments. Second, technical skills/institutional capacity to conduct HITA is needed, but how this is handled will vary by country context. In some countries, units already exist, in which the requisite skills for HITA could be developed, rather than setting up a separate body. In very small countries, it may be more appropriate to bring in the required technical skills as needed from neighbouring countries or regional institutions.

- In addition to capacity, discussions stressed that the processes of doing HITA are critical for the quality and effectiveness of the technical studies. Ways to handle conflict of interest were extensively discussed. Predictable funding, which may often be from government sources, along with autonomous functioning of the HITA agency can aid in avoiding conflicts of interest.
- Data – both availability and quality – are key for HITA. This has been identified as a major challenge in the Region, part of the wider issue of strengthening health information systems.
- The meeting was informed about the range of resources available to support national HITA efforts – from online courses to networks that share experience as well as assist with practical 'troubleshooting'.

Challenges being faced

- *Capacity challenges:* Human capacity remains a crucial factor for conducting HITA. Training of researchers and technical advisers as well as providing capacity development to policy-makers are key for effective institutionalization of HITA.
- *Academic and technical challenges:* Research and policy decisions at national and subnational levels need sound understanding of the place of evidence in the broader health and development context. HITA needs a multidisciplinary approach to ensure policy-relevant information. Technical challenges are more context-specific and refer to the issues around data collection and quality assurance, varied health system constructs and other aspects of research implementation.
- *Managing conflicts of interest:* HITA needs multi-stakeholder engagement across sectors. These stakeholders may have conflicting interests; HITA could then be at risk of being influenced towards a particular recommendation, thereby providing inaccurate information for policy. Establishing a formal system to manage conflicts of interest early on in the process is extremely important.
- *Political challenges:* Benefits package or coverage decisions regarding introducing new interventions and expanding population coverage are political decisions and it is important to understand the policy-making process to enable effective advocacy, so that evidence-informed decisions are made.

Way forward

For Member States

- Continuance of support for systematic use and institutionalization of HITA to address particular policy questions related with advancing UHC, using the range of available resources.

- Development and adequate funding of institutions and capacities for HITA as relevant for individual country needs to advance UHC at the same time.
- Continuance with the broader effort to strengthen the research agenda and health information systems for effective decision-making on advancing UHC.

For WHO

- Provision of support for raising understanding and awareness of policy-makers on what HITA can offer for policy decisions; how to frame questions to be addressed and how to interpret the findings of the assessment.
- Continuance of technical assistance on HITA for UHC with policy-related case studies, including identification of priority research topics and dissemination of findings.
- Provision of assistance with identifying the appropriate national structures for HITA and support to capacity strengthening.
- Facilitation of identification and updating of available resources to provide continuous technical and financial support to national HITA efforts.
- Continuance with support for broader research and health information systems for UHC in the Region.

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

Background

- SEARHEF is an operational fund of WHO's South-East Asia Region (SEAR), earmarked for providing support to health sectors of Member countries during emergencies. The experience of the Region with the earthquake and tsunami of December 2004 taught valuable lessons on the need for creating a fund that could be immediately made available during an emergency to support relief operations. As a result, SEARHEF was established in 2008 by Regional Committee resolution SEA/RC60/R7 by pooling a budget of US\$ 1 million for each biennium from assessed contributions (AC). Till date, SEARHEF has supported nine out of 11 Member States for 23 emergency operations, costing US\$ 3.5 million. Each Member State can request the Regional Office through the respective WHO Country Office for SEARHEF funding support in two tranches totalling US\$ 350 000. The first tranche of US\$ 175 000 is requested during the first month of emergency operations and the second tranche for the same amount may be requested for further response activities. Funds are released within 24 hours of receiving a request and the fastest release made so far was during the April 2015 earthquake in Nepal, when funds were transferred to the WHO Country Office in Nepal within six hours on the day of the disaster. SEARHEF is overseen by a working group comprising 11 representatives from Member States which has met three times since 2008.

Progress made in the South-East Asia Region

- During the current biennium, the SEARHEF working group had its third meeting through videoconference and recommended the following key points for consideration:
 - use of SEARHEF for preparedness and recovery phases of disaster or crisis;
 - increase the corpus of the Fund through other contributions such as those received from Thailand for US\$ 100 000 in 2007 and Timor-Leste for US\$ 10 000 in 2009; and
 - SEARHEF balances, if any, at the end of the biennium to be utilized for regional capacity-building activities and repositioning supplies.
- The table below shows interventions and expenditure supported by SEARHEF for the biennium 2014–2015. Four Member States – Indonesia, Myanmar, Nepal and Sri Lanka – have been supported.

No	Date	Country	SEARHEF for 2014–2015 biennium	US\$ 1 000 000
1	Feb–2014	Indonesia	To support emergency response activities for crises situation created due to Mt Sinabung eruption at Indonesia's North Sumatera Province;	144 068
2	May–2014	Myanmar	To establish sustainable health-care services for communal conflict affected townships in Rakhine state, Myanmar;	175 000
3	Nov–2014	Sri Lanka	To support response and recovery activities in Badulla due to Meeriyabadda landslide disaster;	35 500
4	Dec–2014	Sri Lanka	To support response and recovery activities from heavy floods and landslides in 22 (out of 25) administrative districts of Sri Lanka;	30 000
5	Apr–2015	Nepal	To support response and recovery activities pursuant to Himalayan earthquake of 7.9 magnitude resulting in heavy loss of life and property.	175 000
			Balance available	440 432

Challenges being faced

- The major challenge for SEARHEF as mentioned by the working group in the third meeting in August 2014 is additional funds for SEARHEF.

- The way forward is to advocate for increased contribution to SEARHEF. Mechanisms also need to be identified that will support use of additional funds for: 1) increased tranches allocated for emergency response; and 2) capacity-building initiatives for preparedness and readiness.

5. Effective management of medicines (SEA/RC66/R7)

Background

- The Regional Committee adopted Resolution SEA/RC66/R7¹ on Effective management of medicines urging Member States to invest in all areas of medicines management and implement, as appropriate, the recommendations with regard to medicines regulation, policy and coordination, supply, selection and use as agreed at the Regional Consultation on Effective Management of Medicines 23–26 April 2013 in Bangkok. Countries were also urged to speed up implementation of recommendations in Resolution SEA/RC64/R5² on National Essential Drug Policy and the rational use of medicines, and to undertake a situational analysis of medicines in health-care delivery for monitoring and planning purposes at least every four years and to publish such reports.
- The Regional Director was requested to: (1) continue to collect, share and analyse reports on use of medicines and policy implementation to use for advocacy and to monitor progress; (2) develop a tool for country use from the protocol used by the Regional Office for situational analyses and to support countries to undertake such analyses at least every four years for monitoring and planning purposes; (3) convene a regional meeting at least every four years to share information on progress and plan the way forward; (4) appoint sufficient dedicated personnel and allocate adequate resources for the management of medicines at regional and/or country level to ensure meaningful technical collaboration and ensure better coordinated support from partners; and (5) provide technical support and explore options of assisting small countries with procurement of medicines to achieve economies of scale and quality assurance.

Progress made in the South-East Asia Region

- The WHO database on medicines use in primary care in developing and transitional countries was updated with data from surveys published during 2010–2013 and is currently being updated with surveys published in 2014. Analysis of data shows continuing irrational use of medicines in countries of the region as well as globally. Previous analysis of data on medicines use (from the database) and pharmaceutical

¹ World Health Organization Regional Office for South-East Asia. *Effective management of medicines*, Resolution SEA/RC66/R7. WHO/SEARO. New Delhi, 2013.

² World Health Organization Regional Office for South-East Asia. *National Essential Drug Policy including the rational use of medicines*, Resolution SEA/RC64/R5. WHO/SEARO. New Delhi, 2011.

policy (from country pharmaceutical profiles, based on questionnaires sent every four years to ministries of health) showed that those countries reporting implementation of policies designed to promote better medicines use did indeed have better use as compared to countries that did not report implementation. This analysis was validated and published internationally³ and formed part of the progress report for the Sixtieth World Health Assembly.

- During 2014–April 2015, situational analyses of medicines in health-care delivery were done in all five countries (Bangladesh, Maldives, Myanmar, Nepal and Sri Lanka) that had undertaken the previous situational analysis four years previously (i.e. during 2010–2011). During July– December 2015, it is planned to undertake a situational analysis in another four countries (Bhutan, Indonesia, Thailand and Timor-Leste). In each country, the situational analysis was done by a multidisciplinary team of about six staff using a tool developed by the Regional Office. The tool is in the form of a workbook that can be filled in manually and electronically and forms the template of the final report, plus a set of survey forms for data collection and health facility, warehouse and private pharmacy. A one-day national workshop, well attended in all cases, was held at the end of each analysis during which the findings were validated and recommendations made and in each case the whole process was facilitated by the Regional Office. The final reports are published on the Regional Office website. The situational analysis approach was mentioned in the report on progress in the rational use of medicines (A68/36).⁴ It is planned to hold a regional consultation in 2017, after all countries have completed a second situational analysis, to share progress and discuss the way forward.
- The situational analyses of medicines in health-care delivery have provided at minimal cost baseline data on drug availability, prescribing in the public and private sectors, drug consumption and implementation of policies and regulations. Such information is often unavailable elsewhere and is useful to understand the real situation, identify priority problems and find feasible, pragmatic and acceptable solutions. The data also allow monitoring of progress and provide institutional memory. Findings show very impressive achievements in many countries, considering the low investment in drug management. Nevertheless, in many countries supply and regulatory systems are weak, policies are often poorly implemented and irrational use of medicines is widespread. Recommendations common to many countries include the development of electronic logistic management information systems to better manage drug supplies, greater investment in national drug regulatory authorities, and establishment of units in the ministries of health dedicated to monitoring the use of medicines and implementing policies to promote better use of medicines.

³ Holloway K.A. and Henry D. WHO Essential Medicines Policies and Use in Developing and Transitional Countries: an analysis of reported policy implementation and medicines use surveys. *PLOS Medicine*, Sept 2014; 11(9): e1001724.

⁴ Progress reports by the Secretariat to the Sixty-eighth World Health Assembly: Progress in the rational use of medicines (WHA60.16), page 29, http://apps.who.int/gb/e/e_wha68.html

- Core resources for the management of medicines in countries and in WHO as a whole remain limited. In the Regional Office, two of the Regional Director's flagship priorities – universal health coverage and antimicrobial resistance – are putting renewed attention on effective medicines management and have helped to mobilize resources for the situational analyses supported by WHO. These provide relevant information on health system inefficiencies, with potential solutions, concerning medicines management – relevant to universal health coverage, and provision of data on antibiotic use and implementation of policies to improve use, relevant to containing antimicrobial resistance. There are plans to recruit additional medicines management expertise in the Regional Office and in selected country offices in 2016–2017.
- A regional workshop on Strengthening Quantification and Procurement of Essential Medicines was held in New Delhi, India, on 10–12 June 2014.⁵ Information was shared on all aspects of drug quantification and procurement, including pooled procurement mechanisms from around the world. It was concluded that all countries need to establish unified electronic drug management information systems, from centre to periphery, to monitor medicines availability and to better quantify and manage medicines. Standard operating procedures should be followed for all aspects of drug management and mechanisms need to be established to share information that could ease drug procurement such as drug prices, supplier performance, product quality problems and registration status of pharmaceutical products.
- Specific technical support was provided to Member States upon request. This in the Region included provision of training on drug regulation, drug supply, updating of Essential Medicines and Clinical Guidelines, and promoting rational use of medicines. Most countries of the South-East Asia Region participated in the 16th International Conference for Drug Regulatory Authorities in Brazil, from 24– 29 August 2014.

Challenges being faced

- The situational analyses show that there is some progress, but medicines management remains weak in many countries. The required actions to improve the situation are now clearer. However, without greater investment by countries and by WHO, further progress will be limited.

Way forward

- The Regional Office will continue to facilitate country situational analyses every four years in order to monitor progress, develop recommendations to inform future planning and provide country-specific technical support. A second regional consultation on effective management of medicines, where all countries will report

⁵ Regional workshop on Strengthening quantification and procurement of essential medicines, New Delhi, India, 10–12 June 2014, http://www.searo.who.int/entity/medicines/documents/sea_drugs_165/en/

progress after having undertaken a second situational analysis, is planned for 2017. Monitoring of progress with regard to medicines use and policy implementation will continue through regular maintenance of the WHO medicines use database and a further country pharmaceutical profile questionnaire to ministries of health in 2015. Continued efforts will be made to increase resources for technical support for medicines management.

6. Regional strategy on health information system (SEA/RC63/R7)

Background

- Resolution SEA/RC63/R7 in 2010 noted the need to continuously improve national health information including vital statistics, to serve national, regional and global requirements for monitoring health system progress. It included monitoring of the health MDG. It noted that implementation of the 10-point Regional strategy for strengthening information systems required investment, capacity-building and information system strengthening.
- This 2015 report comes in the final year of reporting on the MDG, and as negotiations on indicators and targets for the proposed Sustainable Development Goal (SDG) for health are underway. It comes in the context of Member State commitments to universal health coverage (UHC), and work on practical ways to monitor progress towards UHC.

Progress made in SEAR and challenges being faced

- MDG monitoring has boosted attention on national health information systems, and strategies and actions to strengthen the quality, completeness and use of data.
- In the last five years, most countries of the Region have developed or updated their frameworks for reviewing progress in implementing their national health priorities and strategies. Many have reviewed the strengths and weaknesses of their health data and health information systems, using a tool developed by WHO and adopted by the UN Commission on Information and Accountability for Women's and Children's Health (COIA). WHO has supported workshops for Member States in the Region to build capacity to analyse their health information systems and areas for improvement, and identify actions needed over the short to medium term. Some Member States have developed investment plans, to encourage more harmonized/collective investment in their national information platforms.

- Civil registration and vital statistics (CRVS) has received considerable attention in the South-East Asia Region in the last five years. Birth registration is high in many countries of the Region, but in some, it remains under 50%. There has been a growing recognition of the urgent need to improve cause of death reporting, because of the need for better data on noncommunicable diseases. This has led to a major effort to improve CRVS systems. The Regional Office has actively supported efforts to clearly define the role of the health sector in CRVS. It has facilitated discussions between the multiple actors involved in CRVS, and co-organized a ministerial conference on CRVS in the Asia-Pacific in late 2014, under the theme 'Get everyone in the picture'. In a related development, WHO has recently released a simplified version of ICD10 that may be more practical for regular cause of death reporting in many countries of the Region.
- DHIS II and Open HMIS are being rolled out in Member States of the Region, to strengthen subnational information systems, with active support from WHO.
- Reporting on health system inputs such as national health expenditures has improved. WHO has been actively supporting the institutionalization of national health accounts. Health workforce data are also receiving more attention, but much remains to be done to generate more complete and timely data.
- The use of modern information and communication technologies, such as mhealth and ehealth, to support improved quality and use of data, has grown in the last five years. The Regional Office has supported development of national ehealth strategies when requested. Electronic cause of death reporting is being tested in several Member States. The Regional Office has also supported intercountry cooperation and knowledge sharing through the Asia e-Health Information Network (AeHIN). This now has almost 400 members from 25 countries in South and South-East Asia, and has become a useful source of support and advice between experts in Member States.
- More resources have become available in the Region for information system strengthening, to enable improvements in the quality, completeness, timeliness and transparency of health information. International resources come from initiatives such as COIA; international development banks; bilateral agencies; and foundations such as Bloomberg, which is focusing on strengthening CRVS. There remains a real need to ensure these funds complement national resources and do not lead to fragmentation or duplication of investment and action.
- WHO and the World Bank have led an important effort recently to reduce the burden of reporting from international health development agencies on Member States. In 2014, the heads of these agencies agreed to a revised and reduced list of 100 core health indicators (down from 800).
- There remains little documentation and research on experience with improving health information systems in the Region. This is an important gap.

Way forward

- There has been progress towards improved national health information systems in the Region over the last five years. The increased global attention and action on this agenda has reinforced regional and national strategies and actions.
- Further progress would be beneficial. Looking forward, negotiations on the post-2015 SDG health goal and associated targets and indicators are underway. There will be more emphasis on disaggregated data. Use of national data is seen as central to the SDG monitoring approach. Both these developments are positive and need to be encouraged.
- Global attention on health information system development is likely to continue. Multiple national data sources and institutions will be involved. There are concerns about the burden of reporting implied by the SDG.
- There is a real risk of duplication and fragmentation of health information systems, unless deliberate efforts are made to develop unified national 'information and accountability platforms'. Member States are encouraged to actively think on how to manage these risks.
- A global summit on measurement and accountability for health results was held in June 2015 in Washington DC. A roadmap for improving monitoring over the next 15 years, including monitoring of progress on health SDG targets was affixed. Member States of the Region are actively involved. Regular updates will be provided.