The Work of WHO in the South-East Asia Region

Report of the Regional Director
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1. Delivery of Health Care. 2. Disaster planning. 3. Disease Elimination.


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Acronyms

3MDG Three Millennium Development Goal
AAAHH Asia-Pacific Action Alliance on Human Resources for Health
AFP acute flaccid paralysis
AMR antimicrobial resistance
ART anti-retroviral therapy
ASEAN Association of Southeast Asian Nations
BAFRA Bhutan Agriculture and Food Regulatory Authority
BMGF Bill and Melinda Gates Foundation
BNCA Bhutan Narcotic Control Agency
CCHF Crimean-Congo haemorrhagic fever
CCS country cooperation strategy
CES coverage evaluation survey
CHC centre for health crisis
CIDA Canadian International Development Agency
CKDue chronic kidney diseases of uncertain etiology
CRVS civil registration and vital statistics
CVD cardiovascular disease
DALYs disability-adjusted life years
DFAT department of foreign affairs and trade
DOTS directly observed treatment, short-course
DRA drug regulatory authority
EB Executive Board
EVD Ebola virus disease
FAO Food and Agriculture Organization of the United Nations
FCTC WHO Framework Convention on Tobacco Control
FETP field epidemiology training programme
GAP global action plan
GAVI Global Alliance for Vaccines and Immunization
GDP gross domestic product
GNH gross national happiness
GPW General Programme of Work (of WHO)
GYTS Global Youth Tobacco Survey
HITAP health intervention and technology assessment
HIV human immunodeficiency virus
HMM Health Ministers’ Meeting
HMP health master plan
HRH human resources for health
IFRC International Federation of Red Cross and Red Crescent Societies
ILO International Labour Organization
IOM International Organization for Migration
IPV inactivated polio vaccine
IU implementation unit
ITC-DRR International Training Consortium - Disaster Risk Reduction
KNCV Koninklijke Nederlandse Chemische Vereniging
KP Kaiser Permanente
LECreD Low Emissions and Climate Resilient Development
LF lymphatic filariasis
MCV measles-containing vaccine
MDA mass drug administration
MDG Millennium Development Goal
MERS-CoV Middle East respiratory syndrome coronavirus
MIC middle-income country
MNCH maternal, newborn and child health
MSD musculoskeletal disorders
MTSP medium-term strategic plan
NCD noncommunicable disease
NEC New England Council
NHAM National Health Assurance Mission
NMCP national malaria control programme
NSET national society for earthquake technology
NTDs neglected tropical diseases
OCHA United Nations Office for the Coordination of Humanitarian Affairs
OIE World Organisation for Animal Health
PCV pneumococcal conjugate vaccine
PKDL post-kala-azar dermal leishmaniasis
RC Regional Committee
RCV rubella-containing vaccine
RI Rhode Island
RMCAH reproductive, maternal, child and adolescent health
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<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>R-TAG</td>
<td>Regional Technical Advisory Group</td>
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<tr>
<td>SAM</td>
<td>Senior Advisers’ Meeting</td>
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<tr>
<td>SARA</td>
<td>service availability and readiness assessment</td>
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<td>SIA</td>
<td>supplemental immunization activity</td>
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<td>SOP</td>
<td>standard operating procedure</td>
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<tr>
<td>STH</td>
<td>soil-transmitted helminths</td>
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<td>STI</td>
<td>sexually transmitted infection</td>
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<tr>
<td>SUFA</td>
<td>strategic use of antiretroviral for treatment and prevention of HIV infections</td>
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<td>TAS</td>
<td>transmission assessment surveys</td>
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<td>TB</td>
<td>tuberculosis</td>
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<td>UCS</td>
<td>universal coverage scheme</td>
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<td>universal health coverage</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNCT</td>
<td>UN country team</td>
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<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>UNIDO</td>
<td>United Nations Industrial Development Organization</td>
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<td>UNOPS</td>
<td>United Nations Office for Project Services</td>
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<td>UNSF</td>
<td>United Nations Strategic Framework</td>
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<tr>
<td>VL</td>
<td>visceral leishmaniasis</td>
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<tr>
<td>VPDs</td>
<td>vaccine-preventable diseases</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WCO</td>
<td>WHO country office</td>
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<td>WHA</td>
<td>World Health Assembly</td>
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<td>WPRO</td>
<td>WHO Office for the Western Pacific</td>
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<td>WSP</td>
<td>water safety plan</td>
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The Work of WHO in the South-East Asia Region

Dr Poonam Khetrapal Singh
Regional Director

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Preface

It gives me great pleasure to present the first edition of a new-look Regional Director’s report. This year’s report is new in several important ways.

First, reports from WHO must be up to date. Ideally, our reports should cover the period between Regional Committees. Realistically, however, to allow time for data collection and production, the reporting period is closer to the calendar year. This report therefore covers 2014; however, it also includes some important events that occurred in the first half of 2015. It will be followed next year, and in subsequent years, by annual reports, avoiding the repetition that comes with biennial reports.

Second, our reports must be relevant to policy-makers. Breaking with tradition, this report does not seek to present an exhaustive catalogue of events and activities. Rather, it highlights important achievements and ongoing challenges. My comments in the opening chapter look to future challenges as well as reporting on the present.

Third, WHO is an organization of Member States. I therefore have focused the report on what happens in each country – reflecting the diversity of experience in our Region and illustrating ways in which WHO makes a difference. Chapter 2 contains concise briefings from all 11 Member States prepared by their respective WHO Country Offices.

Fourth, the report needs to show that WHO is changing as a result of reform. The Regional Office must add value to our work at the country level. Chapter 3 looks at how this is happening: through more integrated technical work; through new approaches to defining deliverables, linking resources to the achievement of results; through developing the tools and instruments for addressing cross-border and other common challenges; and through increasing the efficiency and effectiveness of our management systems.

Like any new venture, we may not bring about all the changes we want at a first attempt. I therefore look to our Member States for feedback that will help make the Regional Director’s report more useful and relevant.

Dr Poonam Khetrapal Singh
Regional Director
1. Introduction

A. Health in the South-East Asia Region

Making health a national priority

1. Our Region is home to more than one fourth of the world’s population but accounts for a disproportionate percentage of the global burden of disease. This in itself is a cause for concern. However, taking all the countries of the Region together, we find that total health expenditure as a percentage of GDP is lower than in any other WHO Region. Moreover, if we look at individual countries in the Region we find several in which government health spending as a proportion of GDP is close to the bottom of the global scale, and out-of-pocket expenditure as a proportion of total health expenditure is close to the top (Annex 1).

2. This suggests that there is a disconnect between the many statements we hear that good health is an essential element of poverty reduction and national development, and the level of resources that governments are prepared to commit to making better health a reality.

3. At the same time, looking at the achievements of individual countries and of the Region as a whole, the results are truly impressive. Last year we celebrated the Region’s polio-free status. Leprosy has been eliminated at the national level in all Member States. We have seen significant declines in deaths from AIDS, TB and malaria across the Region. At the Regional Committee (RC) last year we applauded the achievements of our hosts in Bangladesh in reducing child and maternal mortality. The country briefs in Chapter 2 show that several other countries have now made similar strides, often in the face of considerable challenges.

4. The key point therefore is that despite relatively low levels of spending on health, much has been achieved. However, we should not just accept the status quo. This is particularly so when much of the financial burden is still placed on individuals and families through out-of-pocket expenditure.

5. Matching financial commitments with real resources becomes ever more urgent in the face of the growing challenge of noncommunicable diseases (NCDs). This is an area in which statements of positive intent still run far ahead of resource allocation. Were our Region to move only 1 or 2 percentage points towards the global average of total health expenditure against GDP, or towards levels achieved by other Regions, there is so much more that we could achieve (Annex 2).

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1 Figures from the WHO Global Health Observatory show that Total Health Expenditure (THE) as a percentage of GDP is 3.7% in SEAR against a global average of 9.1% and 6.2% in AFR.
Strengthening governance for health

6. In my address to the Regional Committee last year, I spoke about some of the key lessons we have learnt in recent years. Perhaps the most important is that many of the major health problems we face – the challenge of NCDs, antimicrobial resistance (AMR), the impact of conflict and instability on the spread of disease and access to safe and affordable health care – are not amenable to technical solutions alone. They are, above all else, problems of governance and require coordinated efforts across government and, indeed, across our societies.

7. In this regard, I am heartened by several of the country reports included in the next chapter. Increasingly we are seeing health leadership coming from the highest levels of government – in many countries, heads of state and government have spoken out on the need for action to tackle the major risk factors for NCDs. So far the focus has been mainly on tobacco. This is laudable, especially in examples of broader initiatives that promote more active lifestyles and recognize the links between nutrition, food security and climate change.

8. Better governance for health is primarily a national issue – ensuring that policies in all sectors have a positive impact on health outcomes. But in our interconnected and globalized world, it is an issue for the Region as a whole. One of my key strategic directions has been to ensure that the Region has a stronger voice in global affairs. Our discussions at the Regional Committee and our preparatory work for the Executive Board and World Health Assembly (WHA) suggest to me that we are increasingly able to influence key policy debates on issues such as the next generation of development goals; WHO reform and the role of non-State actors; access to medical products and health technology assessment; and development of policy and practice for universal health coverage (UHC).

Focusing on preparedness for emergencies

9. The global health community has learnt some hard lessons over the last year as a result of the Ebola outbreak in West Africa. The most obvious, of course, is the need for a rapid and comprehensive response in the face of any outbreak that threatens to impact public health. As we have heard several times: outbreaks are inevitable, epidemics are not. An effective public health response – which depends on robust
The Work of WHO in the South-East Asia Region

health systems – is absolutely essential. Only two countries in the Region continue to have the core competencies required by the International Health Regulations 2005 (IHR). It is encouraging though that several of the country reports highlight IHR implementation as a priority.

10. The Ebola outbreak has also taught us several lessons – for instance the importance of understanding how cultural practices impact on health and health-seeking behaviour. The reaction of communities in West Africa remind us that we cannot always assume that those affected by disease will always welcome or even understand our good intentions. Critically, in a globalized world, we have to recognize that an outbreak that affects several thousand people can have a devastating impact on the economy of a country and the livelihood of millions. Beyond the direct economic impact of an outbreak, we have also seen the effects that fear of infection can cause – even in countries where the chances of spread are relatively low.

11. The tragic events of the 2004 tsunami and its aftermath have had a positive impact on the preparedness of countries in this Region. I am encouraged by the number of country reports this year that highlight work on national multihazard preparedness and response contingency plans. This is an area where the health sector cannot act in isolation but must be part of a joint response that draws on the assets of many other sectors. I would also stress that plans alone are not enough; they have to be tested against well-planned simulation activities. Natural disasters, such as the massive earthquake in Nepal in April 2015, have underscored the need for multisectoral preparedness and response contingency plans.

**Looking to the future: ageing populations**

12. My fourth general message in this report focuses on an issue that receives surprisingly little attention in the country reports: the ageing of our populations. In part this results from lower mortality in childhood, but, as in many high-income countries, it is increased by greater longevity in older age groups.

13. In our Region, a key concern is the rapid pace of demographic change. In Japan, the proportion of the population aged more than 60 had already exceeded the proportion aged less than 14 by 1990. The crossover point, where the elderly start to
outnumber the young, will be reached in China in the next five years and in Sri Lanka in the next 15. Moreover, while most high-income countries have had time to adapt to these changes, countries in our Region will have to move much faster. In France, for example, it took over 150 years for the proportion of over 65-year-olds to move from 10% to 20% of the population. Forthcoming data from WHO will show that in India and Thailand, the same change will take place in just over 20 years.

14. If people are experiencing extra years of good health, then their ability to do things that matter will vary slightly from that of a younger person. By contrast, if these added years are dominated by declines in physical and mental function, the implications for older people and for society may be much more negative. While the evidence is still limited, research suggests that the majority of these extra years are currently being experienced in poor health. To change this, we need to act sooner rather than later.

15. WHO will be launching a global report on ageing and health later in 2015. This will be followed by the development of a global strategy and plan of action. Countries in this Region have already documented their experience for the report, but I am keen that we make a serious contribution to the strategy and follow through at the country level.

Ageing populations must be supported to ensure good health for a meaningful life.
16. We need to start thinking now about the implications for health systems strengthening, recognizing that older people suffer from multiple pathologies that cannot be tackled disease by disease. We have to start thinking about outcomes in terms of the effective functioning and independence of the individual in whatever environment they live in – not just in terms of specific clinical outcomes. To do this will require reorienting service delivery to make it more integrated and people-centred as well as changing medical education. As our population structures change and extended families cease to be the norm, we will need new approaches to link medical and social care. Much can be done at all stages of life to ensure healthy ageing, but in each of our countries we need a solid public health approach that is tailored to the specific needs of different communities.

B. The technical work of WHO

Setting priorities

17. One of the most frequent criticisms that led to the current process of reform is that WHO tries to do too much and does not have clear priorities. This criticism applied to WHO globally and, indeed, to our Region. When elected as Regional Director therefore it was my first priority to ensure clear strategic direction for our work. The first step was to match what I had heard as priorities in my consultation with Member States with the leadership priorities defined in the 12th General Programme of Work. This led to the definition of four strategic directions: addressing persistent and emerging epidemiological challenges; strengthening emergency risk management for sustainable development; advancing universal health coverage and robust health systems; and articulating a strong regional voice in the global health agenda.

Flagship Programmes

- Measles elimination and rubella control in the SEA Region by 2020
- Prevention of noncommunicable diseases through multisectoral policies and plans with focus on “best buys”
- The unfinished MDG agenda: Ending preventable maternal, newborn and child deaths with focus on neonatal deaths
- Scaling up capacity development in emergency risk management
- Universal health coverage with a focus on human resources for health and essential medicines
- Building national capacity for preventing and combating antimicrobial resistance
- Finishing the task of eliminating diseases on the verge of elimination (kala-azar, leprosy, lymphatic filariasis, schistosomiasis, yaws).
18. While these four themes continue to provide the overarching vision for our work, they are necessarily broad. I therefore went a step further to define, within each area, a number of more specific initiatives, or flagship programmes. The flagship programmes serve as a means to give further focus to our work and to provide a framework for accountability. As we will see in Chapter 3, they are being used as a means of driving a more integrated approach to work across the Regional Office and within Country Offices, as well as being a basic framework to inform and guide operational planning for the next biennium. In short, they represent the areas in which WHO seeks to make a real difference.

19. The flagship programmes are mixed in nature. UHC, NCDs and emergency risk management, for example, are deliberately broad, retaining in some cases the language of the strategic direction, while also suggesting specific areas of focus. In this regard, the focus areas are not meant to be prescriptive or exclusive, as country needs will vary.

20. The flagship on antimicrobial resistance (AMR) fulfils a different purpose: it represents an area of global and regional significance that has been relatively neglected and requires urgent action across governments. It is encouraging to see that cross-sectoral bodies to address the threat of AMR feature in several country reports. I believe that one of the key roles of WHO is to bring issues to the attention of Member States that might otherwise receive little attention and that are still not on the agenda of most external development partners.

21. The flagships provide focus by adding specific targets in relation to selected neglected tropical diseases. The diseases selected are chosen in part because the targets can be achieved in the timeframe specified. Similarly, measles and rubella have been selected to provide a clear demonstration that, given the right level of political and financial support, we can eliminate major public health problems in our Region. If we succeed, as I am convinced we shall, this kind of achievement gives confidence to decision-makers at higher levels of government that an investment in health pays real and tangible dividends. Confidence gained through the achievement of shorter-term results provides a persuasive platform for longer-term investment.

22. The flagship on the MDGs reminds us that we still have work to do in achieving goals that all countries are committed to. However, there is an important rider to this programme – the focus on neonatal mortality. Country reports in Chapter 2 and the Regional synthesis in Chapter 3 show that real progress is being made in relation to
child mortality. However, as Figures 17 and 18 in Chapter 3 show, further declines will depend on reducing the significant proportion of deaths that occur in the neonatal period. This in turn will require – as recent research in the Region shows – that more attention be paid to the quality of care provided at health facilities.

23. Lastly, it is important to stress that flagship priority areas, while limited in number and designed as a mechanism for defining clear priorities, are not set in stone. While the current seven areas will remain relevant for the next biennium, other issues – such as health and ageing – may emerge and be added to the list.

Universal health coverage and health systems strengthening

24. More detailed comments on each of the flagship programmes are found in the country reports and in Chapter 3. I will therefore confine my comments in this year’s report to universal health coverage and health systems strengthening.

25. **UHC is a means to the achievement of other objectives**: It is clear from the country reports that UHC is a concept that resonates with all SEAR Member States. As a priority for the Region and indeed for WHO as a whole, UHC stands out from the other strategic directions and flagship programmes. It does so for a number of reasons, but primarily because UHC and strengthening health systems represent the means through which the other flagship priorities will be achieved.

26. Without a robust and equitable health system, we will not be able to eliminate rubella and measles; nor will we be able to make further inroads on childhood and neonatal mortality; nor tackle neglected tropical diseases (NTDs). The Ebola outbreak has now brought home to a much wider political audience something that those of us directly involved in public health have known for a long time – health security will be fatally compromised, and in effect becomes a meaningless concept in the absence of a functioning health system.

27. Increasing access to needed health care services and protecting people from the adverse financial consequences of illness is thus central to our work. But if UHC is to become a real force for progress, it needs also to address the determinants of health – the risk factors that drive NCDs; the political, economic and social constraints that limit access to health care; the global and regional forces that affect the availability
of medicines, vaccines and other health technologies; and the institutional interests that sustain the threat of AMR.

28. As our work on UHC progresses, I look forward to seeing signs of national programmes starting to recognize the utility of UHC for addressing broader health issues beyond the provision and financing of personal services.

29. **UHC is a desirable goal in its own right:** A second reason why UHC stands out is that, as well as being a means to the achievement of other health goals, it is an important and desirable end in and of itself. It is a desirable state of affairs in any country for people to have access to the services they need and to be protected financially when they use them. It is a means for making health equity more of a reality than is currently the case in most countries. Governments in our Region widely support these goals but, equally, they recognize the difficulty of achieving them. They also realize that, while they come at the goal from different starting points, progress is always possible.

30. Progress, however, as we see in the country reports, raises difficult and often politically contentious issues. How should universality be defined when the status of citizenship is in dispute or the country is host to a large number of migrants? How should benefit packages be defined so that they are both financially sustainable and politically convincing? How do we strike a balance between public demands for financing high-quality hospital care and under-resourced preventive services? And how do we harness the assets of the private sector in ways that advance public health goals and do not undermine equity?

31. **The importance of policy dialogue for UHC:** A careful reading of the country reports will show that the above are all “live” issues in the countries of our Region. The key message for WHO is that if we are to support governments effectively, it will require new skill sets and new ways of working. No longer can WHO at the country level just be concerned with managing specific projects and programmes. Rather, UHC requires that Country Office staff become more involved in policy dialogue with government colleagues and with other development partners. Over the last year, I have seen several instances of WHO country and regional staff helping government colleagues reach consensus in contested areas, such as health financing. Using WHO’s convening power, presenting and synthesizing the best evidence, facilitating dialogue in the face of conflicting advice from different development partners – is a role of growing importance in the Region.

32. Policy dialogue does not preclude WHO fulfilling some of its more traditional roles. At the moment, however, I am concerned that effective engagement tends to be the exception rather than the rule. It is therefore an area in which staff development (through health diplomacy and other forms of training) will be an important priority.

33. **Flagship priorities for UHC:** Equitable financing policies are central to UHC. However, it is important that countries do not focus on health financing and neglect the factors that influence access to services. To give a greater degree of focus to our
work in helping countries advance the goal of universal coverage, I have requested that plans for the coming biennium focus on two areas: human resources for health and access to safe, affordable and effective medicines. From our analyses (see for example Figure 9 in Chapter 3), it is clear that, with only one or two exceptions, all countries in the Region face challenges in workforce distribution, retention and performance. Equally, the way medicines are used is one of the major causes of waste and inefficiency identified in the 2010 World Health Report. In addition, the governance issues around public health, trade, intellectual property and medicines are areas in which countries in our Region have a major role to play on the global stage.

34. As I noted above, these flagship areas within the broad strategic direction of UHC are not set in stone. In some countries, for example, work on medicine logistics and supply-chain management may be getting support from other partners, allowing WHO to use resources more effectively in other areas that are equally important but not receiving adequate support. The flagship priorities are therefore designed to signal areas of general importance for most countries, but they must be used following a review of priorities by governments and other development partners in the context of our country cooperation strategies (CCS).
C. A more responsive WHO in the South-East Asia Region

35. As Regional Director my prime concern is to ensure that WHO serves the needs of Member States as effectively as possible. In practice this means focusing on three things: programmes and priorities; governance; and management – in other words, the three areas of WHO Reform. In this report I have commented above on priority setting. Chapter 3 will look in more detail at the work of the Regional Office itself. I will use this section to outline some of the principles we are following as we seek to improve the management and governance of WHO in our Region.

Transparency and accountability for resources

36. WHO’s resources are tiny compared to the Region’s needs. In this regard, setting technical priorities is a necessary step, but alone it is insufficient. We need to be clear not just about what we do, but how we do it. WHO is not a major donor and must therefore use its financial resources to facilitate and stimulate action on the part of others and to leverage resources from different partners.

37. At the same time, we have to make sure that we use efficiently the resources available to us. The Region has a history of slow implementation. I am very happy that this is now changing. But as I said at the Regional Committee last year, it is not just a question of spending fast – we must also spend wisely.

38. We must also remain responsive to Member States as we plan for the future. Priorities and focus are important, but this cannot preclude the need to address some of the specific needs of individual countries. Given the diversity of our Region – not everything that is important to Bhutan will be relevant to Maldives – one size cannot ever fit all.

39. Increasingly I want to see country plans and budgets that focus on agreed priorities; that allow space for addressing specific national needs; that use WHO resources strategically and tactically; that are transparent and easily accessible; and that define results for which WHO can be held accountable. When working with other partners, defining results can be a challenge – particularly as we increase our role in policy dialogue. This should not, however, preclude our seeking to do so.
Management systems to support more efficient, effective work

40. WHO has a reputation for being slow and bureaucratic when it comes to management. We are working hard to change this perception. Our management systems need to support the way we want to work rather than dictating, and too often slowing down the way we actually have to work. This does not mean sacrificing due process, care and attention or organizational integrity. It does though mean avoiding duplicative systems and unnecessary levels of approval. It does mean injecting a sense of urgency even into routine transactions. It does mean working towards a system in which trust is balanced by clear lines of accountability. Changing practice and culture in an organization is a challenge. But it is a challenge I am determined to show that we can meet.

Recruitment based on experience and merit

41. As an international organization, WHO is committed to recruiting the best talent in public health. As our priorities evolve, we will also need to widen the skill base of staff, increasing the number of senior personnel in the Regional Office and at country level with experience in policy dialogue and with governance processes in other sectors that impact on health. Understanding national context in this regard is critical and we need more staff that combine international experience with deep local knowledge.

A clear role for the Regional Office

42. The Regional Office should neither duplicate the role of WHO headquarters nor of WHO Country Offices. Rather, it must add value to both. The WHO Reform programme has been helpful in defining common and differentiated responsibilities for each level of the Organization. My concern is that we now put theory into practice. Chapter 3 speaks of the progress we have made in this regard: through more integrated technical work; through new approaches to defining deliverables that link resources to results; and through developing the tools and instruments for addressing cross-border and other common challenges. All these activities are of benefit to all Member States. They are in this sense regional public goods. However, it is important to stress that Regional Office staff will not
relinquish their active support role in countries. Similarly, when it comes to emergencies, the Region will not only provide guidance, it will be the centre of active support to those on the ground.

**Streamlining and strengthening regional governance**

43. Over the last year, I have been keen to streamline the series of governing body meetings leading up to the Regional Committee in September. As proposed to RC67 and agreed, the number of governing body meetings would be reduced from five to three. There will be (i) a High Level Preparatory Meeting (HLP), (ii) a Subcommittee on Policy and Programme Development and Management (SPPDM) and (iii) the Regional Committee, which will amalgamate the Senior Advisers’ Meeting (SAM), Health Minister's Meeting (HMM) and the Regional Committee meeting itself. I have also taken steps to ensure that Member States are better briefed and better prepared prior to the World Health Assembly and Executive Board. In this way the Region’s voice will carry greater weight in global debates.
Widening engagement with other partners

44. WHO works with a variety of other development partners in each country. These include other UN agencies, the Global Fund and GAVI and a range of bilateral agencies active in the health sector. Increasingly, I also hope to see greater engagement with civil society given their important role as both implementers and advocates for health. The Region has been active in the negotiations on the WHO framework for engagement with non-State actors and, once this has been agreed by all Member States, it will become the basis for our future work in this area.

45. As a trend worldwide, the influence of regional integration organizations is increasing. While no regional body is coterminous with WHO’s South-East Asia Region, it is nevertheless important that we engage with those bodies that do include our Member States. It is one of the key functions of the Regional Office to lead WHO’s interactions with other regional organizations with an interest in health and development. I am therefore happy to report on the Memorandum of Understanding (MoU) between ASEAN, SEARO and WHO’s Western Pacific Regional Office on strategic areas for cooperation.

46. WHO is one actor among many in global health. As I mentioned at the Regional Committee last year, we are working in a very crowded space. New donors such as major philanthropies and global funds and partnerships have brought much needed additional finance. They have been a source of innovation in both delivery and governance. But they have also brought challenges, particularly with regard to the technical capacity of countries to donors’ expectations.
2. WHO at the country level – producing results

Introduction

1. Before we begin to focus on the reporting of individual countries and to avoid repetition in the country reports, let us look at a summary table and two important graphs showing individual countries’ achievements towards MDG health-related targets. There is remarkable progress towards achieving the MDG targets, with an average of about 80% of MDG targets already achieved by SEAR countries (Table 1).

Table 1: Status on achievements towards health-related MDGs in countries of the WHO South-East Asia Region within the regional and global perspective. (Latest available data as of June 2015)

<table>
<thead>
<tr>
<th>MDG indicator number and name</th>
<th>BAN</th>
<th>BHU</th>
<th>DPRK*</th>
<th>IND</th>
<th>INO</th>
<th>MAV</th>
<th>MMR</th>
<th>NEP</th>
<th>SRL</th>
<th>THA</th>
<th>TLS</th>
<th>SEAR</th>
<th>Global</th>
</tr>
</thead>
<tbody>
<tr>
<td>G1. T1C. I1.8 Prevalence of underweight children under-5 years of age (%)</td>
<td>35.1</td>
<td>12.8</td>
<td>15.2</td>
<td>–</td>
<td>19.9</td>
<td>17.8</td>
<td>22.6</td>
<td>29.1</td>
<td>26.3</td>
<td>9.2</td>
<td>45.3</td>
<td>26.6</td>
<td>15.1</td>
</tr>
<tr>
<td>G4. T4A. I4.1 Under-5 mortality rate (per 1000)</td>
<td>41</td>
<td>36</td>
<td>27</td>
<td>53</td>
<td>29</td>
<td>10</td>
<td>51</td>
<td>40</td>
<td>10</td>
<td>13</td>
<td>55</td>
<td>50</td>
<td>48</td>
</tr>
<tr>
<td>G4. T4A. I4.2 Infant mortality rate (per 1000)</td>
<td>33</td>
<td>30</td>
<td>22</td>
<td>41</td>
<td>25</td>
<td>8</td>
<td>40</td>
<td>32</td>
<td>8</td>
<td>11</td>
<td>46</td>
<td>39</td>
<td>53</td>
</tr>
<tr>
<td>G4. T4A. I4.3 Proportion of 1-year-old children immunized against measles (%)</td>
<td>93</td>
<td>94</td>
<td>99</td>
<td>74</td>
<td>84</td>
<td>99</td>
<td>86</td>
<td>88</td>
<td>99</td>
<td>99</td>
<td>70</td>
<td>78</td>
<td>84</td>
</tr>
<tr>
<td>G5. T5A. I5.1 Maternal mortality ratio (per 100 000 live births)</td>
<td>170</td>
<td>120</td>
<td>87</td>
<td>190</td>
<td>190</td>
<td>31</td>
<td>200</td>
<td>190</td>
<td>29</td>
<td>26</td>
<td>270</td>
<td></td>
<td>190</td>
</tr>
<tr>
<td>G5. T5A. I5.2 Proportion of births attended by skilled health personnel (%)</td>
<td>44</td>
<td>58</td>
<td>100</td>
<td>67</td>
<td>83</td>
<td>99</td>
<td>78</td>
<td>36</td>
<td>99</td>
<td>100</td>
<td>21</td>
<td>67</td>
<td>21</td>
</tr>
<tr>
<td>G5. T5B. I5.5 Antenatal care coverage (at least one visit/ at least four visits)</td>
<td>59/25</td>
<td>74/77</td>
<td>100/94</td>
<td>75/72</td>
<td>96/88</td>
<td>99/85</td>
<td>83/43</td>
<td>58/50</td>
<td>99/93</td>
<td>98/93</td>
<td>84/55</td>
<td></td>
<td>76/54</td>
</tr>
<tr>
<td>G6. T6A. I6.1 HIV prevalence in adults (15–49 years) (%)</td>
<td>&lt;0.1</td>
<td>0.1</td>
<td>–</td>
<td>0.3</td>
<td>0.5</td>
<td>&lt;0.1</td>
<td>0.6</td>
<td>0.2</td>
<td>&lt;0.1</td>
<td>1.1</td>
<td>–</td>
<td>0.3</td>
<td>0.8</td>
</tr>
<tr>
<td>G6. T6B. I6.5 Proportion of population with HIV infection with access to antiretroviral drugs (%)</td>
<td>11</td>
<td>23</td>
<td>–</td>
<td>36</td>
<td>6</td>
<td>19</td>
<td>35</td>
<td>23</td>
<td>18</td>
<td>57</td>
<td>–</td>
<td>33</td>
<td>36</td>
</tr>
<tr>
<td>G6. T6C. I6.6 Malaria incidence rate per 100 000</td>
<td>394</td>
<td>20</td>
<td>383</td>
<td>1536</td>
<td>2268</td>
<td>40</td>
<td>373</td>
<td>156</td>
<td>66</td>
<td>119</td>
<td>498</td>
<td></td>
<td>87.0</td>
</tr>
<tr>
<td>Malaria deaths per 100 000</td>
<td>0.9</td>
<td>0.0</td>
<td>0.0</td>
<td>2.3</td>
<td>3.8</td>
<td>0</td>
<td>5.5</td>
<td>&lt;0.1</td>
<td>0</td>
<td>0.3</td>
<td>0</td>
<td>0.04</td>
<td>3</td>
</tr>
<tr>
<td>Tuberculosis prevalence per 100 000</td>
<td>402</td>
<td>196</td>
<td>536</td>
<td>211</td>
<td>272</td>
<td>57</td>
<td>473</td>
<td>211</td>
<td>103</td>
<td>149</td>
<td>802</td>
<td></td>
<td>244</td>
</tr>
<tr>
<td>Tuberculosis deaths per 100 000</td>
<td>51</td>
<td>12</td>
<td>27</td>
<td>19</td>
<td>25</td>
<td>2.0</td>
<td>49</td>
<td>17</td>
<td>1.3</td>
<td>12</td>
<td>87</td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>Tuberculosis case notification rate per 100 000</td>
<td>119</td>
<td>143</td>
<td>392</td>
<td>99</td>
<td>130</td>
<td>33</td>
<td>253</td>
<td>122</td>
<td>44</td>
<td>95</td>
<td>332</td>
<td></td>
<td>113</td>
</tr>
<tr>
<td>Tuberculosis treatment success rate (%)</td>
<td>92</td>
<td>92</td>
<td>92</td>
<td>88</td>
<td>86</td>
<td>79</td>
<td>89</td>
<td>91</td>
<td>86</td>
<td>81</td>
<td>89</td>
<td>88</td>
<td>86</td>
</tr>
<tr>
<td>G7. T7C. I7.7 Proportion of population using an improved drinking water source</td>
<td>85</td>
<td>98</td>
<td>98</td>
<td>93</td>
<td>85</td>
<td>99</td>
<td>86</td>
<td>88</td>
<td>94</td>
<td>96</td>
<td>70</td>
<td>91</td>
<td>90</td>
</tr>
<tr>
<td>G7. T7C. I7.8 Proportion of population using an improved sanitation facility</td>
<td>57</td>
<td>47</td>
<td>82</td>
<td>36</td>
<td>59</td>
<td>99</td>
<td>77</td>
<td>37</td>
<td>92</td>
<td>93</td>
<td>39</td>
<td>45</td>
<td>64</td>
</tr>
<tr>
<td>Number of targets (out of above 17) already achieved or are on track</td>
<td>13</td>
<td>14</td>
<td>12</td>
<td>11</td>
<td>12</td>
<td>15</td>
<td>14</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Democratic People’s Republic of Korea

* Global/Regional and country estimates are from global and other reports of WHO technical programmes (as of June 2015).

2. However, during the post-MDG era, our work with countries in achieving all the targets and maintaining the achievements in MDG health indicators with a focus on further reducing child and maternal mortality (Figures 1 and 2) will continue. We see the MDGs and post-MDG achievements as milestones on the road towards “Health for All.”

Figure 1: Trends in maternal mortality in the SEA Region, by country, 1990–2012

*Democratic People’s Republic of Korea

Source: Latest MDG reports and further data update of SEAR countries.

Note: 1. MDG-2015 targets being one fourth of 1990 baseline level differ for each country.
Figure 2: Trends in under-five mortality in the SEA Region, by country, 1990–2012

*Democratic People’s Republic of Korea

Source: Latest MDG reports and further data update of SEAR countries.

Note: 1. MDG-2015 targets being one third of 1990 baseline level differ for each country.
Bangladesh

**Achieving the Millennium Development Goals**

4. Bangladesh has made remarkable progress especially in some of the outcomes and health impact indicators. The under-five mortality rate in the last two decades decreased from 133/1000 live births to 41/1000 live births (a 70% reduction). At the same time, the maternal mortality ratio dropped by 66% (from 574/100,000 live births to 194/100,000 live births). Immunization coverage is high (>90% for all antigens at the national level) and contributed to the reduction in the childhood and maternal morbidity and mortality.

5. According to the Coverage Evaluation Survey (CES) 2013, Pentavalent 3 (DTP+ HepB+Hib) coverage was 92.35%, and measles vaccination coverage at nine months was 88.7%. With regard to measles vaccination coverage, 72 out of 75 districts and city corporations achieved over 80% coverage.

6. A Transmission Assessment Survey in 2014 showed the microfilaria prevalence rate of <1.0% in 18 high-endemic districts out of 34 lymphatic filariasis (LF) endemic districts. The government has set 2017 as the target for LF elimination in Bangladesh.

7. WHO Package for Essential NCD interventions has been initiated at the subdistrict level. To facilitate this intervention, manuals on hypertension and diabetes for prevention and case management for the primary health care level have been published.

8. Existing laws and policies on NCD prevention and control have been reviewed and a report published to strengthen the involvement and participation of relevant stakeholders.

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ministries. Piloting of a national survey on prevalence of musculoskeletal disorders (MSD) in 2014 made by the Department of Rheumatology, Bangabandhu Sheikh Mujib Medical University, showed a high prevalence (around 35%) in adults (>18 years of age). Among them, 17% had a moderate to severe degree of functional difficulty.

9. Documents related to health systems, such as the draft National Health Protection Act and a Framework for UHC Monitoring, have been approved, and several conferences on UHC have been conducted with multisectoral participation. A joint forum on UHC is being planned for 2015.

10. Slower progress has been observed in the areas of stewardship (regulatory) functions, in an effective implementation of the Emergency Response Framework, in the health financing area – out-of-pocket private expenditure on health by households, in improving nutritional status of children (Figure 3) and in the area of health workforce – its shortage and retention.

11. However, many challenges in health remain, which the country, in close collaboration with WHO and other development partners, is addressing. The following sections highlight some key areas of focus of current efforts to strengthen health systems and services in the country.

**Addressing inequities**

12. Major health challenges have been faced in the area of UHC. With only US$ 27 per capita of total health expenditure, of which over 60% is out-of-pocket expenditure (National Health Accounts – 2012), it is difficult to provide a comprehensive range of health services. To address this challenge, Bangladesh initiated provision of people-centred integrated service delivery through the approximately 13 000 community clinics spread across the country. Shortage of nurses and midwives and retention of the health
The Work of WHO in the South-East Asia Region

13. Neonatal deaths constitute 60% of all under-five deaths, compared with an average of up to 45% globally.\(^5\) The low rate of deliveries by skilled birth attendants (31%)\(^6\) and the slower pace of raising the proportion of institutional deliveries are among the main causes, together with a high rate of early marriages and early pregnancies, diversification and discontinuation of family planning services. Expanding access to and quality of maternal, newborn and child health (MNCH) services is a priority in addressing this challenge.

14. Other major challenges that need to be addressed include the marked rise in NCDs and risk factors (consumption of tobacco products), increasing immunization coverage in urban areas, strengthening medicine management and improving health service quality, antimicrobial resistance, as well as malnutrition and micronutrient deficiencies.

### Focusing on priority areas

15. The WHO Country Office (WCO) has identified three crucial goals in the context of the country to significantly impact the achievements in all the flagship areas: (i) IHR compliance to be achieved by 2016 and sustained thereafter; (ii) integrated systems strengthening to achieve universal health coverage by 2030; and (iii) health workforce development in Bangladesh to align with global standards.

16. During the review period, several outputs and outcomes as detailed below were achieved in the flagship areas:

- the measles and rubella immunization campaign targeting to vaccinate 53 million children aged 9 months–15 years. Introduction of inactivated polio vaccine (IPV) and pneumococcal conjugate vaccine (PCV) into the national immunization programme;
- imposing a 1.0% health development surcharge on all tobacco products in line with the WHO FCTC;

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IPV and PCV vaccines were introduced in the immunization programme.

– was adopted. The Government of Bangladesh has set a target of elimination of lymphatic filariasis by 2017.

### Aligning WHO collaboration, strengthening health partnerships

17. The WHO Country Cooperation Strategy (CCS) 2014–2017 spells out the strategic directions, priority areas and strategic approaches for WHO’s collaborative engagement to complement the government’s health development efforts. The following key outcomes of WHO’s collaborative efforts have been achieved.

- Development, reviews or revisions of policy/strategy/management documents, such as the maternal health strategy and standard management protocols for maternal health, manual on mental health, the national TB control strategy 2015–2020, laws and policies on NCDs; improvement plans on health system strengthening at primary, secondary and tertiary level hospitals; and guidelines, manuals and preparedness and

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The Work of WHO in the South-East Asia Region

DOTS continues to be the cornerstone of TB control.

- The training on HIV counselling and testing, and training of trainers on ART care and management.
- Introduction of rapid diagnostic methods (Gene X-pert) and strengthening laboratory capacity on LED microscopy and electronic registration of TB data in 210 centres.
- Training district and upazila core groups on implementation of the “Revised and Enhanced Leprosy Elimination Strategy.”

18. WHO is an active member of the UN Country Team (UNCT) in Bangladesh. The UNDAF Action Plan 2012–2016 is attuned and aligned to national development priorities and the MDGs, and WHO contributes to the realization of the Action Plan indicators through joint programmes with other United Nations agencies. These include the partnership with UNFPA and UNICEF for implementing the joint maternal and newborn health (MNH) Initiative funded by CIDA that aims at improving the maternal and newborn health situation in Bangladesh.

19. The mechanisms for development assistance to the government include pool funding, nonpool funding and parallel funding. Contributions to the pool fund of the HPNSDP have been pledged by a consortium of donors led by the World Bank/International Development Association. Most of the United Nations agencies are nonpool contributors. WHO is a leading nonpool contributor to the HPNSDP.

20. Several donors and international agencies provide technical and financial support to implement innovative partnerships in Bangladesh that complement the HPNSDP including: Global Fund to Fight AIDS, Tuberculosis and Malaria; GAVI Alliance; Stop TB; Health 4 Initiative for Maternal, Newborn and Child Health (H4+); Global Newborn Action Plan; and Global Measles Control Initiative.
Bhutan
21. Bhutan emerged from least-developed country status to join the lower-middle-income country group owing to its increasing GNI per capita (Atlas method)\(^8\) of US$ 2330, and it is important to note that the poverty headcount ratio at national poverty lines\(^9\) is 12.0% of the population (reduced from 23.2% in 2007)\(^10\). Health is one of nine key domains under the “Gross National Happiness” (GNH) policy, and the National Health Policy articulates investment in the health sector as being essential for both happiness and well-being. The health domain contributed 14% to GNH, the highest contribution among the nine GNH domains. A new government was formed in 2013 and national development priorities are outlined in the 11th Five-year plan 2014–2018\(^11\), which defines key outputs, activities and indicators for all sectors.

**Advancing on universal health coverage**

22. To progress in achieving UHC and health equity, various outcomes related to policy changes, institutional capacity and access were achieved. The National Health Policy was formulated and the National Health Bill drafted, as well as the guidelines for establishing private hospitals and diagnostic centres in the country. The government pays for all treatment, including treatment abroad, and there are no private medical practitioners. As of 2014, a network of 31 hospitals, 205 basic health units (BHUs), 49 indigenous hospitals, 23 subposts and over 519 outreach clinics distributed over all 20 dzongkhags (districts) and 205 gewogs (subdistricts) provided free health care services to over 90% of the population, the remaining 10% being high-altitude nomadic herders who are hard to reach. The action plans for the four major towns of Thimphu, Phuntsholing, Gelephu and Samdrup Jongkhar were developed using the Urban Health Equity Assessment and Response Tool (Urban HEART). This will help to identify unequal health determinants, unequal health risks and unequal health outcomes and thus reduce health inequities in urban towns through application of a

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health equity lens in policy-making and resource allocation decisions while planning health equity interventions.

23. The road map for strengthening telemedicine services has been finalized, and will be followed by development of the National Strategy Plan for Telemedicine. To better respond to the threat of antimicrobial resistance (AMR) and in line with the regional priorities, the standard treatment guidelines and national antibiotic guidelines were revised. The drafting of the National AMR policy and action plan is underway to offset the threat of microbial resistance in the country.

24. In Bhutan, 56% of the population is below 25 years, and current data indicate the vulnerability of this group to teenage pregnancy, substance abuse, HIV and STIs as a result of their limited knowledge and partial access to health services. There is a high adolescent fertility rate, according to the Bhutan Multiple Indicator Survey 2010. Among women 20–24 years, 15.3% have had a live birth before 18 years of age, a proportion that has remained almost unchanged over the last 25 years. Early childbearing is almost 10 times more common among women with less education and also more common in rural areas.

25. The increasing trend of NCDs is largely caused by changes in lifestyle. The Noncommunicable Disease Risk Factor Survey (STEP survey) conducted in 2014 revealed that 7.4% of the population smoke tobacco and 19.7% use smokeless tobacco. Every second male and every third female in Bhutan are reported to regularly consume alcohol (50% and 33% respectively). The National Mental Health Strategy was developed to integrate mental health into primary care services. A mental health curriculum has been incorporated in the Royal University of Medical Sciences and 90% of health professionals were oriented on mental health. A National Suicide Survey was conducted, which led to the drafting of the National Suicide Prevention Programme and related national strategy, as well as the National Strategic Framework and Policy to Reduce Harmful Use of Alcohol.

26. Despite the difficult terrain, Bhutan managed to supply 94% of rural households with a rural water supply scheme and maintain a high functional rate of 77% as of 2014. The Water Regulation of Bhutan 2014 became effective from 1 January 2015. The regulations require all urban and rural water suppliers to form WSP teams to develop, implement and maintain WSPs.

Overcoming barriers of access and new challenges

27. While on track in progress towards achieving the MDGs, the gains made in maternal and child health and prevention and control of communicable diseases are not uniform.
throughout the country, indicating the need for more focus on vulnerable districts and populations. Within the lifecycle, there is the need to build capacity on newborn health, adolescent health and health of the elderly. A number of nutrition problems need to be addressed through multisectoral approaches, particularly maternal anaemia, micronutrient deficiencies in school children and child stunting.

28. The prevalence of noncommunicable diseases (NCDs) has increased considerably, and accounts for about 70% of the reported burden of disease. The government is also facing new challenges posed by climate change, rural-urban migration, emerging diseases and risk of natural disasters.

29. There are a number of health system issues, including insufficient human resources for health, constraints in health care financing, and gaps in the health information and management system. For example, there is a shortage of health professionals in the country (12 health professionals per 10 000 population). Training programmes have been revised to improve the quality of in-country medical education; a new postgraduate residency training programme in pediatrics and gynaecology, general surgery and ophthalmology started in July 2014.

30. The difficult geographical terrain further compounds the challenges of shortage of human resources for health and limits the provision of services as close to communities as possible, especially in remote rural areas.

31. Bhutan’s current five-year development plan, the 11th Five-Year Plan 2014–2018, clearly defines the challenges and the national health priorities, which states that the Ministry of Health will continue its efforts towards achieving universal health coverage (UHC). Key health priorities include: responding to the growing burden of NCDs and the consequent increased cost of care; further reduction of maternal and child deaths by investing in skilled birth attendants and newborn care; sustaining case detection and treatment of HIV/AIDS and TB; working towards elimination of malaria and neglected tropical diseases; addressing the double burden of malnutrition, specifically the high prevalence of stunting and anaemia in women and children, the high level of vitamin B deficiency in schools, and the rising trend of overweight and obesity; and strengthening the capacity to respond to emergencies. All of these priorities are also reflected in the WHO Country Cooperation Strategy and, in part, in the One UN/
The difficult terrain is a challenge in providing services to remote areas.

UNDAF Plan, both of which are also aligned to the 11th Five-Year Plan, and are in full harmony with the regional flagship areas.

Harmonizing national priorities with the regional flagships

32. The WHO Country Office in Bhutan has been working with UN agencies and other health development partners to build a common health agenda that responds to the priorities of the government. In 2014, the new Country Cooperation Strategy (CCS) 2014–2018 was printed and disseminated. The CCS is aligned with the 11th Five-Year Plan of the Royal Government of Bhutan and the UNDAF/One UN Plan 2014–2018, as well as the priorities of WHO’s 12th General Programme of Work 2014–2019 and regional priority programmes. Some of the key outcomes aimed for are:

- The plan for measles elimination and strengthening the surveillance system developed.
- The National NCD action plan and the National Strategic Framework and Policy to Reduce Harmful Use of Alcohol developed, and the nationwide NCDs STEP survey completed. The National Health Promotion Strategy, based on the principles of health-in-all policies, developed and endorsed by the government in March 2015. The package of essential interventions (PEN) expanded to all primary health facilities.
- The Infant and Young Child Feeding Policy developed and staff of all BHUs trained. National Birth Defect Action Plan developed and Birth defects Surveillance System in three main hospitals established.
- Feasibility study on use of drones for telemedicine conducted and the Telemedicine Strategy developed. Health professionals in different areas, including traditional medicine, trained. Avian and pandemic influenza communication strategy updated.

Maternal and child health care is a continuing priority.

- Ebola preparedness and response plan developed and IHR capacity strengthened at points of entry, laboratory, and in management and risk communication.
- Seismic vulnerability assessment and contingency plan developed in three hospitals.
- The Leprosy Control Programme completed the focal survey in selected districts, and training was provided on early detection and management of leprosy for new health care providers.

**Contributing to WHO global results chain**

33. During the review period, some key outcomes of WHO support have been achieved, with particular emphasis on policy/strategy changes, institutional capacities and levels of service coverage, among others, as follows:

- development of the plan for measles elimination, the national NCDs action plan, the national strategy on alcohol, the infant and young child feeding policy, the national birth defects action plan, the national health promotion strategy (health-in-all policies), the Ebola preparedness action plan, the national strategy for the prevention of zoonotic diseases;
- strengthening surveillance system for measles and establishment of birth defect surveillance system, establishment of cancer register;
- water safety planning expanded to all districts;
- capacity-building of health professionals in different areas; and
WHO partners with MoH as well as intersectorally with other related ministries.

**Strengthening cooperation/collaboration with development agencies/stakeholders**

34. The WHO Country Office of Bhutan works with United Nations agencies and other development partners to advocate and mobilize multisector contributions and support for better health outcomes. WHO is a signatory of the One UN Plan/UNDAF 2014–2018 whose outcomes are linked to the CCS for the same period.

35. WHO has been working very closely with the Ministry of Health and other ministries and national agencies active in the area of health. Even though the WHO mandate rests within the health sector, the WHO Country Office in recent times has been working in partnership with the Ministry of Agriculture and Forest, Ministry of Education, Ministry of Labour, Ministry of Works and Human Settlement, as well as specialized agencies such as BAFRA, BNCA, the Drug Regulatory Authority (DRA), NEC and a few NGOs that are now actively working in the health sector.
36. The Democratic People’s Republic of Korea has witnessed significant public health and health system challenges during the past two decades. These, among others, have been associated with geopolitical factors. The development and humanitarian context is affected by periodic natural emergencies in the form of floods and drought, which, in turn, pose a threat to access to public health services and result in outbreaks of communicable diseases and affect food security. The main vulnerabilities are the long and harsh winter periods, combined with torrential rains in the summer, leading to floods and landslides in (but not confined to) mountainous areas. Annual floods between 2007 and 2013 severely affected the livelihoods of the population, with large economic losses and adverse implications on the health status of the people. At the same time, prolonged dry spells during 2014 raised the specter of water and power shortages in 2015.

**Maintaining access to health services**

37. Noticeable improvements are seen in children and women’s health care access, particularly in terms of access to emergency obstetric care, immunization and integrated management of childhood illness. Survey data, including census and population-based surveys for nutrition, document gradual recoveries in nutritional status and in the reduction of maternal and child mortality.

38. High antenatal care coverage has reportedly been achieved (98%) with improved quality. The proportion of pregnant women who “visited a health facility more than four times and received more than two tests” reached 84.3% in 118 counties. However, sustainability in these achievements depends heavily on future availability of funds and further donor support (Figure 4). These efforts were supported through the collaborative programme “Improving Women’s and Children’s Health” funded by the Democratic People’s Republic of Korea through WHO, with support from Italian cooperation and UN CERF. The maternal mortality ratio has reportedly decreased to 68.1 per 100 000 live births (2012 Annual Health Report) from a baseline of 105.0 per 100 000 live births in 2005. The reported proportion of one-year-olds immunized against measles is high (99.1%); as is the figure for DTP-3 (93.1%); OPV3 (99.0%); BCG (98.1%); and tetanus toxoid (TT2+) coverage (98.9%). Almost all under-two-year-olds receive vitamin A supplementation. The under-five mortality rate decreased from 48.2 per 1000 live births in 1999 to 29.0 per 1000 live births in 2012. Control of
communicable diseases is an area where progress has been significant. The TB control programme has brought the notification rate and treatment success rates in line with global targets (Figure 4). Sustained programmatic attention to malaria prevention and control led to a 96% reduction in cases from up to 300,000 in 2001 to 11,000 in 2014.

**Implementing regional priorities**

39. The flagship priority areas are relevant to the health achievements in the country. Case-based surveillance on measles and rubella has been instituted, the measles laboratory was provided with technical and logistical support, and plans are underway to initiate congenital rubella syndrome sentinel surveillance. The plan for implementation of the national measles-rubella campaign was finalized, to be undertaken from April 2015. However, the regional goal for measles elimination and rubella control by 2020 may not be met unless the measles-rubella vaccine is included in the immunization schedule, for which domestic funding is required.

40. A multisectoral technical workshop for development of the national NCD strategic action plan was conducted. In addition, public awareness on the hazards of smoking and tobacco industry interference was strengthened by health promotion activities in a multisectoral forum. There is a need for further advocacy for tobacco control at the highest level possible, as well as for multisectoral coordination to control key risk factors for NCDs.
41. The quality of medical education and training and the number of years required to graduate as a medical doctor is inconsistent and compromises the quality of care of health care providers. Availability of essential drugs, medical products and medical equipment is severely limited at most levels, posing a key constraint for health services. Access to essential medicines and technologies, as part of fulfilling the right to health, is recognized by the country’s constitution. The public health system reportedly provides free medicines included in the national list of over 300 medicines. However, the severe shortage of essential drugs prevails in the country. Reportedly, a majority of diseases are treated with Koryo traditional medicines, except for those covered by major donors such as the Global Fund and the Democratic People’s Republic of Korea. The logistic management network requires improvement in structural, operational and accountability areas. Many Ri clinics, county hospitals and laboratories are in poor condition and require renovation. National resources for this endeavour seem limited.

42. As part of emergency preparedness, significant progress was made in 2014. WHO supported the Ministry of Public Health to develop a draft national strategic plan in preparedness and response for all health emergencies and facilitated a national workshop on the Review of National Plan on Emergency Preparedness and Response to Health Needs of Population, followed by a simulation exercise involving all provincial health directors. This strengthened national and provincial health directors’ capacities in preparedness for health consequences in emergencies. Furthermore, stockpiles were upgraded to prepare for floods. In the context of Ebola outbreaks in West Africa, disease preparedness activities, particularly for EVD have been given special attention and consideration. WHO and the national health authorities mounted EVD preparedness activities, aimed at increasing awareness, surveillance preparedness, activating the early alert and response system through preparing rapid response teams, including specialized health workers and laboratory staff, infection prevention and control, screening at points of entry, etc.

Facing public health challenges

43. The fundamental challenge facing public health officials is to secure adequate operational financing for quality medicines, equipment and referral transport. There are ongoing challenges for optimizing the potential of the health system, which is
supported by one doctor for every 130–250 households.\textsuperscript{13} There are also indications of urban-rural differences in nutritional outcomes, which suggest that policy should focus on meeting the health needs of populations in more difficult-to-access areas. There are therefore significant planning, human resource and health financing governance challenges to public health (Box 1). The public health development strategy needs to be carefully balanced between technical efforts for disease control and broader system development for sustainable public health improvement. Attention needs to be focused on humanitarian emergency preparedness, also, given the vulnerability of the population and health systems to periodic natural emergencies and geopolitical tensions.

44. Other challenges include vertical programme-specific health information, limited surveillance and laboratory capacity to detect illness or to launch emergency response, management and supportive supervision skills; suboptimal quality of care due to an imbalanced skills mix, shortage of medical equipment and basic medicines, response capacity to public health needs in emergencies and public health events of international concern.

45. Some persistent health issues include high burden of some communicable diseases, lack of preparedness to “unfamiliar” emerging and re-emerging infectious diseases, for example, Ebola virus disease and avian influenza; maternal mortality and unsafe abortion; and high prevalence of low birth weight and childhood malnutrition. The persistence of these health problems has been largely attributed to supply, managerial and resource (including domestic) constraints.

Box 1: Increasing quality of human resources for health in Democratic People’s Republic of Korea

There are approximately 80,000 physicians, 93,000 nurses, over 7,000 midwives, almost 9,000 pharmacists and about 6,000 pharmaceutical technicians and assistants serving in the public sector. This workforce is reported to be divided uniformly across the country. Villages have between 6 and 10 doctors. Each doctor provides service to 250 household members in the capacity of household doctors. WHO has consistently supported capacity-building of the health workforce. For the 2014–2015 biennium, the WHO Country Office is processing a record 31 fellowship groups involving 115 fellows, programmatically linked to: (a) management of noncommunicable diseases and clinical subjects (13 groups with 48 fellows); (b) maternal and child health (10 groups with 50 fellows); (c) tuberculosis and malaria, both for the first time (five groups with 16 fellows) and funded by assessed contributions; and (d) vaccine-preventable diseases (two groups with six fellows). The estimated total cost for implementing these fellowships is a record US$ 1.8 million – and, overall, with greater public health relevance than before. Compared with the previous biennium, WHO supported 27 fellowship groups, involving 101 fellows, representing a total investment of US$ 1.5 million.

\textsuperscript{13} Ministry of Public Health, Democratic People’s Republic of Korea annual report, 2013.
WHO collaboration and health partnerships

46. Besides providing technical support for the successful implementation of WHO collaborative assistance in health programmes including telemedicine for patient referrals, capacity-building for health and health promotion, WHO has also supported the country in strengthening health infrastructure. Salient achievements included assessing general trends in the health situation, preparing the medium-term strategic plan for health sector development and providing technical support in specific preventive and curative (or rehabilitative) areas.

47. Influenza surveillance in the country was reviewed – for the first time – by an international expert with WHO support, assisting the country to assess achievements and gaps, as well as to help steer better technical direction for pandemic influenza preparedness funds additionally mobilized in 2014. International evaluations of the national malaria and tuberculosis programmes were also conducted in 2014, both for the first time. Based on the recommendations of the programme reviews, the National Strategic plans for malaria and TB have been updated.

48. WHO, through the United Nations Strategic Framework (UNSF), works closely with UN partners including UNICEF and UNFPA to help ensure harmonization of efforts in policy coordination, systems development, equipment and essential medicines supply and emergency preparedness. WHO supported the formulation of a Medium-Term Plan (MTSP) for the development of the health sector in the Democratic People’s Republic of Korea in 2010–2015. This provided a framework to facilitate alignment of development investment by specifying strategic areas, a national monitoring and evaluation framework and financial gaps for priority interventions. In September 2014, WHO technically supported a mid-term review of the plan. The review encompassed sessions to discuss future directions for the next cycle 2016–2020 (MTSP 2) and assisted with framing directions for partnership in the new cycle.

49. Despite limited technical and financial resources being received by the country, cooperation from WHO, other resident and nonresident UN agencies (UNICEF, UNFPA, WFP and FAO; and UNDP, UNIDO and UNESCO respectively), international agencies (such as IFRC) and several donors (Italian Development Cooperation; Swiss Development Cooperation; European Union) is robust and contributes to national health development in the country.
50. There were strong and sustained efforts by the Government of India to strengthen health systems and health services in the country. Several new initiatives include projects to cover every household with total sanitation by the year 2019; ensure access to a range of financial services and entitlements to the poor; develop a physical and institutional infrastructure in villages including smart schools, universal access to basic health facilities and housing for homeless villagers; and focus on educating and enabling the girl child. These are some of the key efforts to address the underlying social determinants of health with a significant potential to catalyze rapid improvements in the health status of the citizens of India.14

Scaling up the unfinished MDG agenda

51. India has made notable progress towards achieving the targets of MDGs. There has been considerable success in reducing maternal mortality and controlling priority communicable diseases; however, lagging behind are achievements in under-five and infant mortality although recent trends show acceleration towards achieving these targets. This would require more focus on equitable coverage, quality of care and instituting accountability mechanisms throughout all levels of care. The maternal mortality ratio is 167 per 100,000 live births (2011–2013) compared with 178 per 100,000 live births (2010–2012 estimates). The MDG target is 140 per 100,000 live births by 2015. The under-five mortality rate is estimated at 49 per 1000 live births in 2013 (the 2015 target is 42 per 1000 live births).

52. The lessons learnt from polio eradication are being used for intensifying routine immunization, which included introduction of new vaccines such as inactivated polio vaccine (IPV) and rubella under the universal immunization programme. The Government of India has also set the goal of measles elimination by 2020. Laboratory-supported measles-rubella surveillance has been expanded across the country and steps are underway for shifting from outbreak-based to case-based surveillance after the completion of national measles-rubella campaigns.

- India has validated all the states and Union Territories for elimination of maternal and neonatal tetanus. This exercise was completed in April 2015 and it is another milestone following the achievement of polio-free status.

The Standards for TB Care in India – a path-breaking initiative – has been launched to introduce uniform standards for TB care in all sectors.

53. Strategies for elimination of mother-to-child transmission of HIV using multidrug regimen (Option B+) have been rolled out across the country.

Building sustainable progress towards universal health coverage

54. The Government of India has accelerated its work to achieve UHC through the proposed National Health Assurance Mission (NHAM). While in principle the NHAM has the political support, commitment and ownership from the highest levels of leadership, including the Prime Minister, the details are being discussed and worked out to ensure adequate role differentiation between the centre and the states as well as long-term fiscal sustainability. This is an unprecedented opportunity for all stakeholders to work together with the Ministry of Health and Family Welfare (MoHFW) in designing an appropriate strategy for advancing UHC in India. Progress towards achieving UHC is an area that cuts across all the priority health programmes. For example, evaluation of Free Medicines Scheme initiatives in the states and dissemination of lessons and experiences has been an important contribution towards UHC goals. Some of the key challenges currently addressed include:

- Inadequate health financing and service provision modalities slowing advance of the UHC agenda. Reconsideration of mechanisms to address high out-of-pocket expenditure and ensuring sustainable health financing policies for UHC (Figures 5 and 6).
- Improving management of human resources for health to address issues related to regional disparities, skill mix, skill development and retention as well as performance management.
- Strengthening health information systems to avoid duplication and redundancies, ensuring that data are valid and of good quality and adequately used for decision-making, regulation and overall stewardship of the health system.

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- Development of models for people-centred integrated services to ensure equity in the use of those services, considering balanced role of the public and private sectors in service provision while ensuring adequate instruments for engagement and regulation of the private sector.
- Promotion of quality in health service provision as one of the key goals of UHC to ensure effectiveness of health services and implementation of interventions at all levels with proper monitoring and evaluation mechanisms.
- Strengthening stewardship capacity of the MoHFW to drive intersectoral actions required to overcome fragmentation and silos in social protection and health programmes; manage public health emergencies and the impact of epidemiologic,

**Figure 5:** Out-of-pocket health expenditure as proportion of total health expenditure

![Graph showing out-of-pocket health expenditure as a proportion of total health expenditure.](Image)


**Figure 6:** Government health expenditure as proportion of GDP

![Graph showing government health expenditure as a proportion of GDP.](Image)

*Source: World Health Statistics 2013, 190 countries; India’s 12th Five-Year Plan document.*
Addressing other health and health-related priorities

56. India became the first country to set national targets in line with the global indicators for monitoring NCDs and develop a multisectoral action plan for implementation of the United Nations General Assembly resolution on NCDs. The government established a high-level multisectoral commission for tobacco in 2014; work is underway to expand the same for other NCDs. During the year, greater attention was focused on the discourse on NCDs and reinforced the key messages: “whole of government,” “whole of society” and “health-in-all policies” approach. The UN Interagency Task Force on NCDs review mission to India was successfully conducted in 2014, the first in the Region. WHO’s focus on NCDs is to address comorbidities in an integrated manner rather than CDs and NCDs in isolation.

57. With the ongoing biggest-ever Ebola virus disease outbreak in West Africa, major efforts have been towards strengthening preparedness for an Ebola outbreak in the country. This builds on the efforts to strengthen the core capacity of IHR in addressing a range of emerging infections, including Crimean-Congo haemorrhagic fever (CCHF); Middle East respiratory syndrome coronavirus (MERS-CoV); and seasonal/pandemic influenza. Points of entry (ports and airports) for the purpose of IHR (2005) have been strengthened and contingency plans have been developed for all designated points of entry; similar work is being initiated for designated ground crossings for India. The government is also strengthening the infrastructure required at designated points of entry to be able to respond to emergencies.
58. To build national capacity for preventing and combating antimicrobial resistance (AMR), WHO is engaged at multiple levels to support the implementation of the Global Action Plan for AMR in India.

59. Three major evaluation exercises – the Joint Monitoring Mission for six vector-borne diseases, the sixth independent appraisal of yaws eradication programme and the midterm evaluation of the leprosy programme – were conducted. In this context, the national policies and strategies for control of malaria and visceral leishmaniasis are aligned with WHO recommendations.

Results of WHO collaboration

- WHO has strongly reinforced its position as a valued partner, and technical cooperation with the government and other partners at the central and state levels has decisively moved to strategic policy dialogue and technical advice.

- WHO has actively engaged as the designated technical partner to MoHFW in the formulation of the new National Health Policy and design of different components of the National Health Assurance Mission, the key vehicles of the UHC agenda in the country.

- Of the several developments on the TB front where WHO has played a role during the year, the one that stands out is the Standards for TB Care in India – a path-breaking initiative to introduce uniform standards for TB care in all sectors.

- WHO has helped with the revision of country-specific guidelines on the use of ARV in accordance with WHO consolidated guidelines and has helped roll out the Integrated Bio–Behavioural Survey in 31 states of India.

- The revised pack warnings on tobacco products have been developed with WHO’s support; the country is now placed as a global leader in this area.

- WHO has also contributed to making India’s roads safer and saving lives by providing technical support for drafting comprehensive road safety legislation.

- More than 43 medicinal products manufactured in India have been successfully prequalified by WHO during 2014 alone, bringing the total number of Indian manufactured products to 350.
Exercising the leading role in health and collaborating with agencies

60. WHO exercises the leadership position of the Organization on health at the country level among UN agencies through active participation in the United Nations Development Action Framework (UNDAF) and in several Core Committees and Task Forces of the UN Country Team (UNCT). WHO is chair of the UNDAF Working Group on UHC comprised of UNICEF, UNDP, UNFPA, UNAIDS, ILO and UNESCO. Through this, the UN leadership in the UHC agenda, including NCDs in the country, has been fostered by working closely with both the line ministries such as health and labour welfare as well as the national strategic planning institutions (the erstwhile Planning Commission and now the NITI Aayog). WHO is also a member of several other UNDAF working groups dealing with all key social determinants of health and governance. The WHO Representative chairs the UNCT Task Force on UHC and co-chairs, along with the Head of UNICEF, the Task Force on the First 1000 Days.
Indonesia
61. Indonesia launched the UHC initiative on 1 January 2014 and the government is committed to achieve the target of 100% coverage by 2019. With this political commitment, UHC will be the national health priority for years to come. In global health, Indonesia has been an active member in ASEAN and a lead country in some areas of health such as traditional medicine and healthy borders.

62. The National Health Plan sets out four major goals for 2015–2019, with specific targets established for each of these goals: (1) improved health status of the population; (2) improved community nutritional status; (3) increased financial protection; and (4) increased equity in health services.

**Progressing in health outcomes and impacts**

63. Significant progress has been made in detecting and treating tuberculosis in the last two decades with the prevalence of TB dropping from 474 per 100 000 population in 2000 to 272 per 100 000 population in 2013 with the case detection rate increasing from 20% to 72% over the same period. However, with a TB mortality rate of 25 per 100 000 population, it is estimated that about 64 000 people died of TB in 2013, and multidrug-resistant TB is an increasing threat (Table 2).

64. The prevalence of HIV/AIDS has increased from 0.38% to 0.46% in 2014 although the pace of increase has slowed down in recent years and some of the key affected population groups such as indirect female sex workers and people who inject drugs show encouraging signs of reduction of their HIV prevalence.16

65. Although 39% of the population lives in malaria-free areas of the country, mostly in the provinces of Bali and Java, 17% are in high-transmission areas, especially the eastern provinces of Papua, Maluku, Sulawesi and Nusa Tenggara, and 44% are in low-transmission areas. Interventions have been scaled up to prevent and treat malaria as well as to strengthen malaria surveillance. Malaria is targeted for elimination by 2030.

66. Neglected tropical diseases, leprosy, lymphatic filariasis (to be eliminated through mass drug administration), schistosomiasis and yaws are a problem in specific areas

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of the country. The number of new cases of leprosy did not change significantly from 2005 to 2012, when the number was 18,994, the third highest in the world after India and Brazil. Dengue and chikungunya are a matter of increasing concern throughout the country.

67. Indonesia has been free of polio since 2006 and a strong acute flaccid paralysis (AFP) surveillance system is in place. The routine immunization system has improved as measured by increased DPT3 coverage. Measles coverage among one-year-olds has increased from 58% in 1990 to 80% in 2012, and a case-based measles surveillance has been developed and strengthened in all provinces. HiB vaccine has been introduced in a pentavalent product that also provides booster doses for DTP and measles as part of the national childhood immunization schedule.

**Focusing on major health challenges**

68. While substantial progress has been made in Millennium Development Goal 1 (nutrition) with the proportion of underweight children reduced from 31% in 1989 to 19.6% in 2013,\(^\text{17}\) stunting or low height-for-age has now become the major issue of the nutritional status of under-five children. In addition, increasing obesity and poor quality diets are major risk factors for noncommunicable diseases. Indonesia is a member of the Scaling-Up Nutrition Initiative and has made nutrition a priority for the country with a multisectoral platform to focus on 'the one-thousand days around births' movement.\(^\text{18}\)

69. Another challenge is achieving the MDG 5 target in maternal mortality.\(^\text{19}\) Despite achievements of increased access to skilled birth attendance and antenatal and postnatal care and rapid growth of available registered midwives, difficulties in retaining them in remote areas still hinder steady maternal health service in the areas thereby impacting on the ability to reduce maternal mortality rate (MMR).

70. The proportion of government expenditure on health remains relatively low. In 2012, the World Bank reported that 3% of the country’s GDP was spent on health,

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\(^{19}\) WHO Global Health Observatory. Available at [http://www.who.int/gho/countries/idn.pdf?ua=1](http://www.who.int/gho/countries/idn.pdf?ua=1), accessed on 27 March 2015.
a substantial increase from less than 1% prior to 2007; however, it is still lower than almost all countries of the WHO South-East Asia Region.

71. Based on the national human resource in health planning document of the Ministry of Health (2014), there have been significant improvements of the physician ratio including specialists since 2012. The ratio of physicians is 38.1 per 100,000 population, whereas the ratio of specialists is 9.9 per 100,000 population. However, Indonesia is facing a problem with regard to physician distribution among provinces. There are gaps between Java Island and the eastern part of Indonesia. Jakarta has the highest ratio (52.9 physicians per 100,000 population) while East Nusa Tengarra has a ratio of 1.6 physicians per 100,000 population. Decentralization of the health system has also made it more difficult to implement in-service training, vital to ensuring the quality of services, as well as to collect and analyse the number and placement of health workers.

Table 2: Selected Millennium Development Goal achievements, Indonesia, 1990–2013

<table>
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<tr>
<th>Indicator</th>
<th>Statistics</th>
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| Under-five mortality rate (per 1000 live births)                          | 84  
| Maternal mortality ratio (per 100,000 live births)                        | 430  
| Deaths due to HIV/AIDS (per 100,000 population)                           | 0.4  
| Deaths due to malaria (per 100,000 population)                            | 2.1  
| Deaths due to tuberculosis among HIV-negative people (per 100,000 population) | 71  

* 1990 for under-five mortality and maternal mortality; 2000 for other indicators.
** 2012 for HIV/AIDS and malaria; 2013 for other indicators.
Source: WHO, Global Health Observatory, April 2015.

Responding to national health priorities and challenges

72. WHO’s work in the country focused on technical support, norms and standards, and building sustainable institutional capacity. Among others, the following major outcomes were produced:

- National policies and plans on environmental health and sustainable development were developed;
- Maternal, neonatal, child, adolescent and reproductive health quality care improvement framework and strategies to further expand access to quality interventions were drafted;
Routine immunization remains a priority.

- Re-accreditation of the four national measles laboratories was conducted by WHO. Three public health laboratories were assessed as additional accredited measles-rubella testing sites;
- The MOH HRH Strategic Plan 2015–2019 and strategic plan for strengthening nursing were developed;
- Operational research was carried out in the area of pictorial health warnings in coordination with the National Institute of Health Research and Development.

73. Further, the four strategic directions and the flagship priority areas as identified by the Regional Office are highly relevant to the country and to the national health plan. Therefore, focusing on their implementation fits well with the government’s vision and efforts to address national health challenges.

74. Cerebrovascular diseases are the first two main causes of premature deaths; road injuries is third, compared to 1990 when the top three causes of premature deaths were from communicable diseases. Three factors, namely unhealthy diet, elevated blood pressure and tobacco smoking are dominant and are major behavioural risk factors for NCDs. Reinforcing development in the prevention and control of noncommunicable

improved quality in maternal and reproductive health care has been achieved.

Diseases, WHO in Indonesia has established linkages with the national secretariat of parliamentarians to provide expert opinion on national health priorities as a ‘whole office approach’.

75. Case-based measles and rubella surveillance is operational in all 34 provinces with a new emphasis on reporting of suspected cases from hospitals and private clinics.

76. Maternal, neonatal, child, adolescent and reproductive health quality care improvement framework and strategies have been developed to further expand access to quality interventions. Reproductive health and adolescent health guidelines to implement and monitor effective interventions and reproductive health operations research training modules for capacity-building have also been developed.

77. To address the shortage of trained health professionals, the Ministry of Health has developed an HRH Strategic Plan 2015–2019. Policies on antimicrobial resistance (AMR) and its application have been reviewed, and a strategy in policy development to address AMR was drafted.

78. Thirty national and international participants were trained on disaster risk reduction under the auspices of the International Training Consortium (ITC-DRR). Training focused on general aspects of emergency management and health cluster coordination. WHO in Indonesia supported the Centre for Health Crisis (CHC) as health cluster co-lead on
establishing subclusters and their functions. Presidential regulation for maintaining continuity of essential services during emergencies is being considered as part of safe operations of health facilities during an emergency.

79. A roadmap to eradicate yaws by 2020 and eliminate leprosy by 2019 has been developed. The roadmap envisages the complete interruption of transmission (absence of new cases of yaws) by 2017.

**Strengthening partnership at the country level**

80. During the review period, there was extensive cooperation between WHO, the UN, bilateral and multilateral agencies and other stakeholders in health. From the UN agencies, UNICEF, UNFPA, UNAIDS and UNDP were the most frequent collaborators in the areas of immunization, control of malaria, HIV/AIDS, nutrition, and maternal and child health. Particularly, in the implementation of priority policies such as expansion of early diagnosis and treatment of HIV within the Strategic Use for ARVs; immunization cold chain and logistics; supporting in-country SUN initiatives; UN pandemic contingency plans; and disaster management related to reproductive health and MCH areas, among others.

81. Cooperation with other multilateral and bilateral agencies (such as USAID, GAVI, KNCV, DFAT, Global NTD Network, Sasakawa Foundation, ASEAN Secretariat, the Thai Health Fund, the World Bank, EU, JICA, etc.) resulted, among others, in the following: technical assistance to all key areas of the TB control programme; supporting the national integrated NTD action plan for LF and STH elimination; monitoring GAVI-funded activities; partnership to reduce leprosy burden at the subnational level; tobacco control; road safety studies; nutrition and food insecurity; and strengthening the health system for emerging infectious diseases and pandemic preparedness.
82. Maldives is playing an ever-growing role in regional and global diplomacy. Elected chair of the Small Island Developing States (SIDS) in 2014, Maldives continues to be an active member of the WHO Executive Board (EB) since January 2012, its role culminating in undertaking the chairmanship of the WHO EB’s Special Session on Ebola and its 136th EB in January 2015.

83. Following new elections, all branches of the new government were formed and in place by March 2014. The health sector priorities since then have been primarily guided by a 100-day sectoral plan and the manifesto of the presiding party, which pledged an expansion and improvement of health services, availability of maternal and child health care on every island, improving quality of laboratory services, strengthening cancer diagnostics and treatment, improving medical emergency response, evacuation and referrals. This brought about a number of health reforms in 2014, including the introduction of general practitioner services; delegation of the management of the tertiary hospital IGMH, Vilimale Health Centre and Hulhumale Hospitals to a Board independent of the Ministry of Health; and entering into partnership with the State Trade Organization to outsource medical supplies.

Making progress and sustaining prior gains

84. Maldives maintains its sustained control over communicable diseases, maintaining the regional record as a malaria-free zone since 1984. No cases of such vaccine-preventable diseases (VPDs) as measles, rubella, neonatal tetanus, pertussis, or diphtheria have been registered since 2010. Near universal immunization coverage (99%) allows the country to sustain low prevalence of VPDs. The introduction of IPV in the national immunization schedule launched by the Government of Maldives in March 2015 is yet another step towards the global goal of polio eradication by 2018. Maldives is the second country in the South-East Asia Region to introduce IPV and the first country using national funding for it. Maldives has already achieved five out of the eight MDGs in 2008, ahead of the 2015 deadline, making it an MDG+ country.22

85. Progress has been substantial in health-related MDGs: reducing child mortality (MDG4), improving maternal health (MDG5) and combating HIV/AIDS, malaria and other diseases (MDG6). One of the primary drivers of this performance has been the strong and sustained allocations in the national budget and spending of approximately 40% on the social sector (average over 2000–2010) – more than any other South Asian country. Infant mortality and U5 mortality rates have decreased from 18 per 1000 live births for the former and 26 per 1000 live births for the latter to 9 and 11 per 1000 live births in 2012 respectively – a remarkable step towards achieving MDG4. MMR remained low at 31 per 100 000 live births in 2013.23 Improved access to maternal and neonatal health services, including 96% of deliveries attended by skilled health

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Many medium-term strategic plans have been developed for specific public health programmes. Staff put Maldives well ahead of many countries in the South-East Asia Region, but it is still behind countries with a similar GDP.

**Addressing challenges of achieving universal health coverage**

86. The health system faces major human resource challenges, including lack of and a high turnover of expatriate staff, who occupy most professional positions. This, combined with shortage of medicines and basic medical supplies remains a constraint for ensuring quality of care. In 2014 there was one tertiary hospital (IGMH), five regional hospitals, 14 atoll hospitals and 169 primary health centres (30 health posts and 139 health centres).\(^\text{24}\) However, the health infrastructure (other than in the capital Malé) is underutilized, the average hospital bed occupancy rate for atoll hospitals being 20%.

87. In February 2014, health insurance Aasandha was relaunched as Unlimited Aasandha (Husnuva Aasandha) to expand the service coverage and remove the annual cap. The escalation of health care expenditure remains a major concern,\(^\text{25}\) which is also heightened due to a growing proportion of ageing population and increasing

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Substantial progress has been achieved in MDGs related to child mortality and maternal health.

prevalence of NCDs. Low-income families in remote locations are the most vulnerable when overseas medical care is sought and household out-of-pocket expenses have increased significantly due, largely, to transport cost. Total household expenditure on health accounts for disproportionally higher household expenses among the poorest quintile, while at the same time, dependent informal sector workers and poorer segments of the population seem to have benefited most from the Aasandha national health insurance scheme.26

88. A new Health Master Plan has been discussed to define the strategies to be achieved within the next 10 years. The outlined strategies are: (I) build trust in the national health system; (II) reduce disease and disability among the population; and (III) reduce inequities in access to health care services and medicines.

89. A number of medium-term strategic plans developed in 2014 also provide a direction for the implementation of specific public health programmes.

90. Due to environment and climate change, diseases like dengue, scrub typhus and typhoid are reported more frequently around the country. For example, 781 dengue fever cases, 145 typhoid cases, and 54 scrub typhus cases were registered in 2014. Incidences of acute respiratory infections (ARI) are high, at 172,032 cases in 2014. The implications on societal health of high level of unemployment among youth and women coupled with a reported increase in drug abuse is immense and includes violence against women and children, risks of STIs/HIV/AIDS, increased need for mental health treatment and rehabilitation services, which are significant. Furthermore, high divorce (11 per 1000 inhabitants/year) and remarriage rates contribute to the high number of lifetime sexual partners raising sexual and reproductive health care and social concerns.

Accelerating efforts on national priorities within the framework of regional flagships

91. National consultations on the 2016–2025 Health Master Plan (HMP) and the roll out of the 2016–2020 United Nations Development Assistance Framework (UNDAF) for the Republic of Maldives are the two processes where the regional priorities have found their seamless reflection.

92. Lab-supported surveillance with monthly reporting of individual measles case-based data to SEARO and the implementation of sentinel surveillance for congenital rubella syndrome (CRS) at hospitals of Malé were done to facilitate the documentation of the achievement of measles elimination target in Maldives.

93. In 2014, national policies to reduce the burden of NCDs were developed, including advocacy to accelerate the implementation of FCTC and the review of tobacco taxation policies. It paved the way for the development, finalization and costing of the National NCD Multisectoral Plan.

94. The Ministry of Health developed a proposal to strengthen quality of obstetric and neonatal care targeting 2–3 hospital facilities in the country. The ministry articulated the need to support a research study to understand the driving forces behind maternal and newborn health service utilization.

95. Operationalization of the HRH Strategic Plan 2014–2018 started with the most crucial task of accounting for health workforce and analyzing the patterns to address gaps. The Maldives Food and Drug Administration conducted a situational analysis of “Medicines in Health Care Delivery: Maldives” in May 2014. The National Social Protection Agency (NSPA) reviewed the legal framework and regulations related to social protection and health insurance scheme.

96. A 2014–2016 detailed IHR Action Plan has been developed. The plan outlines important steps for coordination, event and lab-based surveillance, building local capacities on emergency response and crisis communication. Health emergency preparedness

Box 2: Cooperating with other UN, bilateral and multilateral agencies

From April to October 2014, the WHO Representative has undertaken the role of Acting UN Resident Coordinator and led the new 2016–2020 UNDAF roll out process in partnership with the Government of Maldives, which included evaluation of the current UNDAF and situational analysis for priority setting. WHO steers the UN collaboration and partnerships in enhancing national and subnational capacity for universal health coverage, prevention and control of diseases and delivery of quality health services.

The “Low Emissions and Climate Resilient Development” (LECReD) is a three-year US$ 9 million Multi-Donor Trust Fund project from the Danish Government that adheres to UNDAF outcome 9: “Enhanced capacities at national and local levels to support low carbon life-styles, climate change adaptation, and disaster risk reductions.” This is the first project in Maldives jointly implemented by seven United Nations Agencies: UNDP, UNICEF, UNOPS, UNFPA, UN WOMEN, WHO and FAO, with UNDP coordinating the project as a managing agency. WHO supports the health aspects of the Joint Work Plan of this project and has a total budget of US$ 452 000.
drills (a table-top exercise and a “real-scenario” Ebola preparedness emergency drill involving airport, police, customs, military, national public health personnel and WHO internationally identified laboratory and sample transportation staff) were organized by the government.

97. To sustain lymphatic filariasis (LF) elimination, the Ministry of Health with WHO support organized a country-wide screening and produced the draft Lymphatic Filariasis Elimination Dossier to record the success of Maldives.

Managing technical cooperation; implementing and monitoring international commitments

98. Recognizing the requirements for the introduction of the injectable inactivated polio vaccine (IPV) planned to start from March 2015 and to strengthen the central immunization programme team, WHO secured direct technical assistance for the Health Protection Agency of the Ministry of Health for 5.5 months since November 2014. Consequently, the National Technical Advisory Group on Immunization (NTAG) became functional by the end of 2014.

99. Reducing the burden of Neglected Tropical Diseases (NTDs) is another priority. WHO supported the government in implementing the roadmap on NTDs. The National Conference on Dengue Prevention and Control was held and a national action plan drafted.

100. WHO provided technical support for the development, costing and dissemination of the national strategic plans for both TB and HIV, and steered a technical dialogue for regional collaboration, including GFATM, in these programme areas (Box 2). A step-by-step guidance to set up a population-based and hospital-based cancer registry was provided to strengthen the National Cervical Cancer Screening in Maldives.

101. A revision of the Maldives Thalassemia Clinical Protocols with technical assistance from the Thalassemia International Federation and Cyprus Thalassemia Centre (WHO Collaborating Centre) was one of the main WHO contributions in the area of NCDs during 2014.

102. Recognizing the growing need for mental health services, WHO supported the review of the current situation, advocacy, development and consensus building on the Maldives National Mental Health Policy. The policy aims at creating a robust governance structure for mental health, developing a comprehensive network of community-based mental health services, preventing mental disorders and advocating for human rights of people with mental disorders.

103. Other major outcomes of WHO work in the country included the National Environmental Health Action Plan and the National Medicine Policy (draft), the National Reproductive Health Strategy 2014–2018, and the National Multisectoral Action Plan on Road Safety (draft).
Myanmar
104. Myanmar Health Vision 2030 has been developed and the National Health Plan 2011–2016 has been updated to address the fast-evolving policy changes and increased investment in the health sector. Myanmar signed the International Health Partnership (IHP+) Global Impact in January 2014.

105. The country is also currently experiencing a demographic transition. Its total population is estimated to be around 51.4 million and as per the 2014 census is expected to generate a demographic dividend now and in the future. Although Myanmar’s transition in the areas of democratization and peace building is evolving rapidly, ongoing civil tensions have increased humanitarian needs.

Making progress despite challenges

106. The health situation in Myanmar is steadily improving. The country is not on track to fully achieve the MDGs by 2015. The targets of halting and reversing the spread of HIV/AIDS, malaria and TB have been met. However, additional efforts are needed to reach the target to reduce TB prevalence and to reach universal access to treatment for HIV/AIDS. And more efforts will be needed to reduce child mortality and improve maternal health (MDGs4 and 5).

107. WHO in Myanmar has prepared a new Country Cooperation Strategy (CCS) 2014–2018, which supports the country’s National Health Policy, Strategy and Plan. The Government of Myanmar also developed the Strategic Directives for Universal Health Coverage (UHC) in Myanmar. WHO supported activities on health systems strengthening focused on achieving the government’s UHC initiatives.

108. The Myanmar Country Coordinating Mechanism (M-CCM), chaired by the Minister of Health, has expanded to become the Health Sector Coordination Committee (M-HSCC) covering MNCH, health system strengthening, emergency response and operational research in addition to existing programme areas – HIV, TB and malaria. WHO plays a critical role as secretariat or as active member of technical and strategy groups that serve as technical bodies of M-HSCC.

109. In line with the regional priority of measles elimination and rubella control, Myanmar has just completed one of its biggest and most successful immunization campaigns that targeted over 17.4 million children aged between 9 months and 15 years with the measles-rubella vaccine; in addition, two new vaccines are being introduced in the short term, i.e. rubella and IPV.

110. An important event was the completion of the Third Nationwide TB Drug-Resistance Survey. This survey showed a rate of multidrug-resistant tuberculosis (resistance to at least isoniazid and rifampicin) of 5.0% among new cases and 27% among retreatment cases. There is an increasing trend of MDR-TB, though the increase is not significant among new cases. The resistance rate among new cases is much higher in Yangon (around 11%). As a result of this survey, the NTP has revisited its expansion plan for MDR-TB services with full coverage of Yangon Region in 2015.

111. The National Malaria Control Programme (NMCP) with technical support from WHO and Technical and Coordination support by Emergency Response to Artemisinin Resistance (ERAR) set the goal to eliminate malaria by 2030, consistent with the draft Malaria Elimination Strategy in the Greater Mekong Subregion. The Myanmar National Strategic Plan for Malaria prevention and control, 2010–2016, was updated to include artemisinin resistance containment and elimination as one of the objectives. There was also a regional commitment on malaria elimination by Asia Pacific Leaders Malaria Alliance (APLMA) during the East-Asia Summit in Naypyitaw, Myanmar, during November 2014, and 18 leaders agreed to the goal of an Asia Pacific free of malaria by 2030.

112. Two strategic documents were drafted and launched – the National Strategic Plan for Birth Defect Prevention and Surveillance (2014–2018) and the National Strategic Plan for Reproductive Health 2014–2018.

113. Myanmar is one of the countries hardest hit by the HIV epidemic. In 2013, the number of people living with HIV was estimated to be 196 053, and 125 043 patients are in need of ART. ART provision started in 2005 by the National Programme with 2500 patients, but by the end of 2013 that number had risen to 67 643, indicating an average increase of around 7500 patients a year. 2014 is a landmark year in that the ART treatment reached more than 85 000 patients (68% base on CD4 350). This achievement is linked to the provision of ART at the township level. To maintain the quality of ART services, WHO worked with NAP and partners in the country to develop a Standard Operating Procedure (SOP) of ART in a decentralized setting, thus resulting in doubling the reach of ART in 2014 in the decentralized sites.
Facing disparities in access to health services

114. Important disparities are apparent in access to benefits between rural areas, where about 70% of the population resides, and urban areas. In the health sector, constraints to improve the health status of people include: access to basic health services; inequities and service availability; disparities in availability and affordability of essential medicines; adequate infrastructure and public expenditure; and trained health personnel.

115. Reducing maternal mortality as per MDG5 represents a major challenge and will require significant efforts to meet the goal. About 88% of deliveries take place at home with maternal deaths overwhelmingly predominant in rural areas. Additional efforts are needed to meet the MDG target of halving the TB prevalence rate by 2015 as compared with 1990. The main challenges include finding the many undetected/unreached TB cases, scaling up multidrug-resistant (MDR) TB management and reducing the dual burden of TB and HIV/AIDS. 28

116. With regard to HIV/AIDS, the epidemic is considered to have stabilized nationally since 2000, with hot spots of high HIV transmission identified at several locations. Continued focus is needed on most-at-risk groups to maintain the initial positive achievements. Major challenges also exist to scale up HIV treatment, which now covers only about 1 in 3 of those in need.

Focusing on national priorities within framework of regional flagship areas

117. The health system strengthening programme supported by Global Alliance for Vaccines and Immunization (GAVI) was initiated and expanded in a phased manner, starting with 20 townships in 2012, expanding to 40 new townships in 2013, another 60 townships in 2014, but in 2015, it stopped at only 120 townships (almost 36% of township coverage) in all of Myanmar.29 It provides free service for delivering a comprehensive package of health services with key PHC components, supplies of medicines and equipment, and ensures workforce availability in hard-to-reach areas. The

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government also developed the Strategic Directives for Universal Health Coverage (UHC). A key achievement of the Ministry of Health in 2014–2015 has been the development of the “National Policy on Health Laboratories in Myanmar,” which would also strengthen the ministry’s MOH capacity to address antimicrobial resistance (AMR).

118. In the area of noncommunicable diseases, the Epilepsy Initiative as a joint WHO/Ministry of Health collaborative community-based programme aims to reduce the treatment gap and ensure access to treatment for people living with epilepsy. It has been implemented through training of medical officers, basic health staff and voluntary health workers in five project townships of Hlegu, Hmawbi, Thanlyn, Kawhmu and Lewe in 2014. An additional three townships will be scaled up in 2015.

119. With regard to maternal and child health, Myanmar’s commitment for Family Planning 2020 and its goal (of enabling 120 million more women and girls to use contraceptives by 2020) has been launched. The U5MR declined steadily and if this trend continues, the country will achieve the MDG4 (reduce child mortality) target on schedule.

120. The Humanitarian Response Plan for 2015 was developed in consultation with partners and the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) that included a financial appeal for the entire health sector.

121. Under the National Leprosy Control Programme, a proposal for implementing enhanced activities was developed.

Results with WHO’s collaboration

122. As the lead partner in health in the country, WHO works closely with the Ministry of Health. The WHO CCS is the basic framework of collaboration, which also takes into account priorities identified within national health plans. In addition to the results already mentioned, the following major outcomes were achieved:

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Box 3: Path to Universal Health Coverage in Myanmar

Myanmar aspires to achieve Universal Health Coverage (UHC) as part of its Vision 2030 for a healthier and more productive population. UHC would help achieve the twin goals of any health sector, i.e., improved health outcomes and reduced financial burden on the poor and vulnerable, due to health expenditures. To achieve the goals and targets of strengthening the health system towards the provision of equitable universal coverage, it is vital to focus on ways to improve health outcomes, enhance financial protection and ensure consumer satisfaction. Realizing the current critical challenges and to achieve the aspirational goals, the following nine strategic areas have been identified.

1. Identify the Essential Health Package ensuring access to comprehensive quality health services for all;
2. Enhance HRH Management through implementation of the Health Workforce Strategic Plan to address the current challenges hindering equitable access to quality services;
3. Ensure the availability of quality, efficacious and low-cost essential medicines, equipment and technologies including supply chain management and infrastructure at all levels;
4. Enhance the effectiveness of public-private partnerships;
5. Develop alternative health financing methods and risk pooling mechanisms to expand the fiscal space for health to alleviate the catastrophic health care expenditure of the community and enhance financial protection;
6. Strengthen community engagement in health service delivery and promotion;
7. Strengthen the evidence-based information and comprehensive management information system including nonpublic sector;
8. Review the existing health policies and adopt the necessary polices to address the current challenges for UHC; and
9. Intensify the governance and stewardship for attainment of UHC.


- The National Service Availability and Readiness Assessment (SARA). Along with SARA, WHO also supported Data Quality Assessment of HMIS. The entire exercise will be completed by August 2015.
- Humanitarian Response Plan for 2015. Leading the health cluster in crisis-affected areas: supporting mobile clinic visits and rapid response teams, supporting distribution of health kits, covering needs of both IDPs and residents.

Coordinating rapidly rising development assistance to Myanmar

123. The Myanmar Country Coordinating Mechanism has expanded to become the Myanmar Health Sector Coordination Committee covering health system strengthening, MNCH, emergency response and operational research, in addition to existing programme areas – HIV, TB and malaria. WHO plays critical roles as secretariat and/or active member of technical and strategy groups.

124. The Three Diseases Fund (3DF) provided funds to fight HIV/AIDS, TB and malaria from 2006 to 2012. WHO served as the fund executing agency and manager of the Fund Flow Mechanism according to the zero-cash flow policy. The 3DF has now transitioned to its phase II, the Three Millennium Development Goal (3MDG) Fund since January 2013. Between 2012 and 2016, the seven donors of 3DF plus USAID will be providing funds to the 3MDG Fund to move from a project-style approach to more comprehensive sectoral support to strengthen the health system. Besides HIV, TB and malaria, which have become a smaller part of the 3MDG grants, the 3MDG will focus mainly on HSS and MNCH. WHO together with UNICEF, UNFPA and UNAIDS have submitted a joint proposal to 3MDG, aimed at strengthening the health system and addressing the gap in providing support to MNCH. This proposal is to be signed in 2015.

125. Myanmar was the first country to benefit from the Global Fund New Funding Mechanism to fight the three diseases during 2013–2016. GAVI support to health system strengthening in Myanmar is in its third year, with a total of 120 of the 330 townships being covered for system strengthening.

126. The World Bank, which recently established its office in the country, has been a major force and is committed to work with the government on UHC.
Nepal
The second constituent assembly and parliamentary elections were held in November 2013 after which the independent interim government handed over the responsibilities to the newly-elected political parties. There was also a change realized in the Ministry of Health and Population. The political parties are striving to develop an inclusive constitution, which may have an effect on the functioning of the health sector. Therefore, the health sector with its new Health Policy 2014 (NHP-2014),\textsuperscript{32} including the Nepal Health Sector Programme 3 (draft NHSP-3), recognizes the sociopolitical reforms in the country and has strategies and plans in line with these changes. The NHP-2014 envisions the fundamental right for ensuring equitable access to quality health services to people. Sustaining the achievements made in the control of communicable diseases, the impact of recent devastating earthquakes, floods and landslides, and the growing burden of NCDs present Nepal with a triple burden.

Nepal is globally ranked 11th on the Global Earthquake Safety Initiative\textsuperscript{33} and with Kathmandu, according to Geo-Hazard International, being the most earthquake-vulnerable city in the world. In 2013 alone, 25 earthquakes occurred in the country ranging from 4.4–6.0 in magnitude according to the National Society for Earthquake Technology (NSET). \textbf{On 25 April 2015, a devastating earthquake struck measuring 7.8 on the Richter Scale — the strongest in Nepal in 80 years; it took a toll of thousands of lives and destroyed infrastructure (see Box 4).} A second earthquake of 7.3

\begin{figure}[h]
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\includegraphics[width=\textwidth]{earthquake.jpg}
\caption{The earthquake on 25 April 2015 resulted in loss of thousands of lives.}
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\item[\textsuperscript{33}] http://geohaz.org/projects/gesi.html.
\end{itemize}
magnitude hit on 12 May, causing further loss of life and damage to dwellings already weakened by the first quake. In addition to earthquakes, Nepal has also been experiencing other disasters such as floods in the Far-Western and Mid-Western regions, drought, heat and cold waves in the Terai region and forest fires.

Improving health status of children and mothers

129. Over the years, Nepal has made steady progress in improving the overall health outcome of its citizens. Particularly, the country has made impressive progress on child survival and maternal health, which are targets 4 and 5 of the Millennium Development Goals (MDGs). A steady decline in mortality among women and children is a major achievement. Between 1996 and 2014, the maternal mortality ratio dropped from 539 to 170 per 100,000 live births; under-five mortality and infant mortality rates dropped from 118 to 38 and 79 to 33 per 1000 live births respectively (see Figure 18, Chapter 3); and neonatal and post neonatal mortality was reduced, though less drastically, from 50 to 23 and 29 to 11 per 1000 live births respectively. The percentage of children with stunting decreased from 57% in 2001 to 37% in 2014, and children with underweight decreased from 43% in 2001 to 29% in 2011 (Figure 7). Immunization coverage during the last five years has consistently remained above 90% for diphtheria, pertussis and tetanus (DPT 3) and polio and 88% for measles and rubella (MR). As a result, Nepal has achieved polio-free status, the measles mortality reduction goal, maternal and neonatal tetanus (MNT) elimination status, and control of Japanese encephalitis. The country also introduced inactivated polio vaccination in 2014.

130. Similarly, significant progress has been noted in control of HIV, TB and malaria. New HIV infections declined from a peak of 8329 in 2002 to 1408 in 2013 and are projected to decrease further to 720 in 2020. The TB treatment success rate (TSR) was 90% and the case detection rate 78% in 2013. The challenges in the tuberculosis control programme are that drug-resistant and extensively-drug-resistant cases are increasing and there is low case finding in some districts. The microstratification in

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Box 4: Rapid assessment of health impact of earthquake

A rapid assessment of health care facilities by WHO and the Ministry of Health and Population in the earthquake-stricken areas has found that hospitals in four of the worst-affected districts are completely destroyed or too badly damaged to function. Five other major hospitals, providing important health care in the districts, were found to be functioning but urgently in need of additional medical supplies.

Preliminary findings from the assessment show that while there was a shortage of supplies, sufficient health personnel were available to treat patients arriving in the functioning hospitals.

According to WHO’s Country Representative for Nepal “WHO staff have been working round the clock to gather this snapshot of the damage inflicted on Nepal’s hospitals and clinics by the earthquake.” “This information will be a vital tool in guiding the short- to medium-term response by national and international health care providers, determining where to move health teams and supplies in the country.”

Teams visited 21 hospitals in 14 of the districts most severely impacted by the 25 April earthquake to gather information and found that a total of 17 hospitals were still operational.

Many hospitals informed the assessment teams that they were experiencing a shortage of supplies, including essential medicines, surgery kits, IV fluids, antibiotics and suturing materials, while tents and mattresses were also required. WHO had provided essential medicines and supplies to treat 120 000 people for three months, as well as trauma and surgical kits.

WHO coordinated the deployment of foreign medical teams and humanitarian organizations to priority districts based on the needs of affected populations and the capacities of partner organizations.

Field hospitals were set up on the site of the four nonfunctioning district hospitals, identified as Ramachhap, Nuwakot, Chautara and Rasuwa. The five hospitals found to be functional but needing urgent support included Gorkha District Hospital, Patan Academy of Health Sciences, Dhading District Hospital, Hetauda District Hospital and Alka hospital in Lalitpur.

According to the head of WHO-SEARO’s emergency response team, “the fact that hospitals do not need additional staff, and that thousands of patients are receiving treatment, shows that the preparedness measures taken by Nepal for emergencies are making a difference.” “But we must continue replenishing medical supplies, ensuring patients are treated, and that those who require rehabilitation receive it.”

While the rapid assessment provides a snapshot of pressing needs in the aftermath of the quake, additional and ongoing assessments will provide a better picture with which the government and health sector can tailor the delivery of medical relief. According to official figures received on 1 May, 6200 deaths have been recorded while approximately 14 000 people are injured.

Significant progress reported in HIV, TB and malaria control.

Source: WHO. Achieving the Health-related Millennium Development Goals in the South-East Asia Region: Measuring Indicators. 2014. WHO SEARO.

2013 for the malarial parasite showed 52% of the population at risk, which is much less compared with the earlier figure (from 2012) of 84%.\(^{35}\)

131. While the Global Burden of Diseases Study estimates that lower respiratory infections, diarrhoeal diseases and neonatal encephalopathy remain the main causes of premature death in Nepal, it highlights that Nepal is facing an increasing burden of noncommunicable diseases (NCDs) as well as injuries. NCDs account for 60% of total deaths, 80% of outpatient contacts and 39% of DALYs lost.”\(^{36}\) Major NCDs in Nepal are cardiovascular diseases, diabetes, cancer, chronic respiratory diseases, oral diseases and mental disorders. These burdens are further exacerbated by rising health care costs that have resulted in high out-of-pocket expenditure (55% in 2008/09) despite increasing government expenditure on health.\(^{37}\)

**Overcoming equity gaps and socioeconomic barriers to health**

132. The overall progress in health outcomes and aggregate improvements showcased here masks the significant equity gap that persists. Many citizens face several barriers – economic, sociocultural, geographical and institutional – in accessing quality health care services. Economic barriers such as high user fees, unaffordable transport, medicines and

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associated costs; geographical challenges such as location of health facilities, physical distance and time taken to reach a facility, and lack of transport are major barriers. Institutional gaps exist in availability and retention of human resources at point-of-care, stock-outs of drugs and operating hours of health facilities.

133. In addition, Nepal is a country of diverse ethnicity with different sociocultural beliefs, religious and spiritual practices. There is a need for improved programme approaches and for planning to address local community health needs.

134. The major policy directive document, NHP 2014, is built upon the premise that health is an integral and indivisible part of a nation’s socioeconomic development, and investment in health is fundamental to further national development. It recognizes that several state line agencies and non-State actors working for social and economic development are part of the health sector in their differing capacities.

135. The document placed universal health coverage as a priority. Improving the coverage of quality services to all people in Nepal at a minimal affordable cost is the major area of focus. Equity in health systems (EQUITY), quality health services for all (QUALITY), health systems reform (REFORM) and multisectoral collaboration (BEYOND HEALTH) are the major strategic directions for the next five years.

**Taking forward national priorities within the framework of regional flagships**

136. One of the most impressive linkages between the regional flagships and Nepal’s changes in the health sector are the continued efforts towards achieving universal health coverage. The government is using different approaches such as removal of user fees, incentivizing health service use and introducing a premium-based insurance scheme.

137. Recently, there is an interest to shift from the health sector confinement to not only health but to see health as a development agenda. This is not so new but has continued to evoke major discussions in the context of health sector reform.

138. Finally, the publication of the new health policy 2014 and Nepal’s health sector programme-3 (NHSP3), 2015–2020, with an emphasis on equity, universal coverage and multisectoral collaboration is an important step.

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towards alignment of Nepal’s health policies and programmes with WHO’s global and regional focus areas.

Achieving tangible results

139. The following achievements are directly linked to WHO and other partners’ support in terms of translating global evidence into policies, programmes and their implementation, for example, through the alignment of Nepal’s activities in harmony with WHO guidelines:

- NHSP3 implementation plan and monitoring and evaluation framework.
- Assessment of the National Medicines Laboratory functioning and developing a timeframe to strengthen the laboratory.
- Revision of HMIS tools and adoption of district health information system (DHIS-2).
- STEP survey results published and disseminated.
- Guidelines for maternal and perinatal death surveillance and response implementation.
- Technical support to implement Water Safety Plan in 200 different water supply systems in rural and urban areas.
- Hospital waste management guidelines updated and endorsed.
- National Disaster Response Framework – development and finalization of health component.

International cooperation and health partnerships

140. The WHO Country Office for Nepal, in close collaboration and support from the Regional Office and headquarters has played and is continuously playing a vital role in the country’s health achievements to date and through 2014–2015. There have been a number of external development partners and bilateral and multilateral agencies supporting various health programmes. IHP+ was signed in 2007 and the Nepal Health Development Partnership (country compact) was signed in 2009.

141. Joint Annual Reviews of external development partners have been conducted since 2005 and joint consultative meetings for the annual work plan and budget started in 2010. Joint annual reviews have been focusing on progress against results, taking into consideration the indicators in the health sector monitoring and evaluation framework. In addition, performance in financial management and procurement is being reviewed. Alignment to the national health programmes and harmonization between partners in health have enhanced aid management, accountability and transparency.
142. Sri Lanka is poised for a new phase of development and progress as it joins the league of middle-income countries. The per capita total expenditure on health is estimated at US$ 88; out of which 45–50% is out-of-pocket expenditure – a major challenge faced by the health system. A growing and somewhat unregulated private sector with higher costs accentuates inequality and, on the other side, retaining health care providers in rural areas poses a challenge as there are increasing demands for higher benefits. The system faces the new challenges of rapid epidemiological, demographic and economic transformation that demand increasing public investment and financing of public health services and other public goods, enhancing and balancing the role of the private sector and ensuring an appropriate policy environment for increasing productivity and inclusive growth.

143. Towards the end of 2014, the country went through a democratic national electoral process leading to presidential elections and elected its new President and government with a peaceful transition. The government launched a ‘100 days programme’ outlining its commitment to promote reconciliation, accountability and human rights and also outlining key priority activities in the health sector including a pledge to increase allocation to health.

Achieving major outcomes

144. Sri Lanka is known for its achievements in health with a strong and robust system and is on its way to achieving MDGs related to health. The “100 days programme” has received people’s affirmation and support from the international community including the United Nations, bilateral and multilateral agencies.

145. Building on the early successes, ‘NCD success stories’\(^{40}\) were drafted with the aim to disseminate to other countries and facilitated the first regional training for NCD programme managers. Supporting multisectoral action, the Ministry of Social Affairs optimally utilized the social officers for promoting healthy behaviours and demand generation. One of the key outcomes was to review and revise the Mental Health Policy and develop the National Mental Health Plan (2015–2020) as well as the Alcohol Policy to address alcohol abuse. National strategic plans for adolescents and children were developed, and planning processes with district plans to reach the last mile for reducing maternal and child mortality were improved.

146. Sri Lanka has an excellent immunization programme with consistently high coverage with all antigens in its National Immunization Programme. The country is striving towards elimination of vaccine-preventable diseases, including Japanese encephalitis and neonatal tetanus. Sri Lanka reports an infant mortality of 9.9 per 1000 live births, better than many wealthier countries.

**Tackling noncommunicable diseases and finishing the lifecycle agenda**

147. The country is faced with a shifting burden from communicable to noncommunicable diseases (NCDs) that include an increasing number of cases of injuries and mental ill health. The increasing NCD burden among non-affluent communities and the chronic kidney diseases of uncertain etiology (CKDu) affecting the farming communities are important challenges. Cardiovascular diseases, neuropsychiatric disorders and diabetes are three leading causes of death. Not surprisingly, the major share of out-of-pocket spending is for medicines. Additionally, the growing elderly population, rising incidence of injuries and occupational health pose new challenges for achieving universal health coverage as the government faces the challenge of managing citizens’ expectations within the free health care system.

148. The country also faces challenges of regional disparity with higher IMR in the northern province and populations in the plantation sector.\(^{41}\) It is also recognized that years of civil strife have left some provinces lagging in terms of health indicators, and inequities and regional disparities have made some sections of the population more vulnerable. The nation continues to remain disaster-prone with a dry spell in the early part followed by landslides and floods in the latter part of the previous year.

149. The key health priorities are: revised essential drugs and medicine policy with an independent National Medicine and Drug Regulatory Authority and to make medicines available at an affordable cost; increasing pictorial warning on cigarette packets to

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80% (Box 5); maternity benefit allowance of LKR 20,000 cash to pregnant women; laws for prevention of gender-based violence and child abuse; addressing chronic kidney disease of uncertain etiology, establishing a Noncommunicable Diseases Bureau; strengthening the food and drug administration authority; and integrating traditional medicine as a unified system for service delivery. Other important areas where the “100 days programme” focuses and has implications for the health sector include the government’s intent of addressing the increasing cost of living, boosting the economy through competitive social marketing, creating job opportunities and strengthening engagement with the international community.

Box 5: **Sri Lanka goes for 80% of pictorial health warnings on tobacco packs**

Sri Lanka ratified the WHO Framework Convention on Tobacco Control in 2003 and has taken concrete action on one of the main recommendations on pictorial warnings.

It has been a long battle in implementing pictorial warnings on cigarette packaging and the progress made to date has been commendable. Although challenged by the tobacco industry, the government went ahead with 60% pictorial warnings on cigarette packets as of January 2015.

As part of the election pledges made by the current President and the zestful drive of the Minister of Health, the legislation that makes it compulsory to carry pictorial warnings covering 80% of cigarette packs was passed unanimously in parliament on 20 February 2015 and is under implementation.

**Addressing national priorities within the framework of regional flagships**

150. In line with the flagship priorities on strengthening coverage and to reduce out-of-pocket spending on health, the Ministry of Health, supported by WHO, initiated work on health intervention and technology assessment (HITAP) in support of UHC, advocating the establishment of a multi-stakeholder steering committee on UHC and facilitating the government-owned process of developing national health accounts (NHA).

151. A rapid assessment of medicines in the health care delivery system covering supply, selection, use, regulation and policy has been undertaken in support of the government’s policy on essential drugs and medicines.

152. With relatively high immunization coverage, Sri Lanka is prepared to achieve measles elimination. The National Advisory Committee on Communicable Diseases is reviewing and revising current strategies and plans to undertake special campaigns in certain areas and study population immunity to measles.
Commendable progress has been achieved in reproductive, maternal and child health.

Coordinating and collaborating with partners

156. Sri Lanka continues to be prone to disasters and therefore efforts towards preparedness and surveillance remain a priority. Assessment of health facilities and supporting the safe hospital programme is one of the common priorities for the Ministry of Health.

157. The close partnership between WHO and the Ministry of Health is instrumental for overall health achievements. WHO is also the lead partner in matters of health and has the role of coordinating other agencies’ involvement in health and development. A few recent examples are:

- a tripartite coordinated review (with FAO and OIE) of the National Rabies Control Programme — first of its kind in the South-East Asia Region, leading to the strategy and plan for its elimination by 2020;
the first country to carry out the national assessment for the implementation of the global strategy and plan of action on public health, innovation and intellectual property to promote public health innovations (GSPA-PHI);

- establishing ‘drugs and therapeutic committees’ at the health facility level, which contributed to rational use of drugs, an efficient and effective drug supply system and compliance to essential drugs and medicine lists; and

- to understand and analyse the in-patient morbidity and mortality in hospitals, WHO supported the development of eIMMR as the single key source for such statistics and with additional World Bank funding to the health system; and facilitated the scaling-up of 190 main hospitals across the country.

158. As a member of the United Nations Country Team (UNCT), WHO ensures coordination and participation in relevant collaborative activities. This collaboration and partnership is important to also understand, assess and gauge the engagement of other UN agencies in a given political scenario and to prepare WHO better. The year 2014 has been particularly challenging with the government’s approach of limited engagement with the UN and the international community. Regular UNCT meetings and discussions allowed WHO to be well informed and strategize for its continued involvement and support to the government. Together with UNICEF, FAO and WFP, WHO also participated and supported the Presidential Nutrition Secretariat. WHO worked closely with UNFPA, UNICEF and UNAIDS in the areas of reproductive, maternal, newborn and child health.

159. WHO maintained harmonious relations with agencies, extending support to the health sector even though there was limited collaboration with these in the past year. Among others, the World Bank supported the government’s National Health Development Plan across thematic areas in addressing maternal and child health nutrition, prevention and control of noncommunicable diseases and health system improvements with a smaller component of support for innovation, results monitoring and capacity-building. As a technical partner, WHO contributed to project appraisal and given WHO’s ongoing support for policy, strategy and programme work for noncommunicable diseases, it continues to collaborate with the World Bank to ensure uniformity and application of evidence-based guidelines and to collaborate strategically to address the gaps.
160. Thailand is now a middle-income country (MIC) and, over the years, it has made remarkable progress in health. Further, given the institutions and the technical capacities in the country, Thailand is also increasingly providing development support to other countries. And, at the same time, the country is also emerging as an active player in the global and regional health forum.

161. The government has indicated that its priority in public health would be overhauling the health insurance system. It also highlighted as priorities: disease prevention, monitoring and responding to epidemic diseases, road safety, encouraging physical exercise, and reducing and preventing teen pregnancy.

162. One of the significant developments during the period under review was the policy discussions on the universal coverage scheme (UCS) that covers health insurance of 76% of Thai citizens since 2013. The discussions continued in the second half of 2014 and impacted progress in some health policy developments.

163. These political developments also had a positive impact on public health policies. The most significant of which is the tobacco law – the 85% graphic health warning on tobacco packages took effect, and a new more stringent tobacco product control law is being considered.

164. During 2014, there was “normal” flooding in various provinces. These were managed effectively by the government and the health needs were addressed by the Ministry of Public Health. There was an earthquake in northern Thailand that damaged infrastructure including hospitals. This gave WHO an opportunity to put safe hospital assessment high on the agenda of the CCS priority programme on Disaster Risk Management.

**Promoting intersectoral collaboration**

165. In 2014, Thailand declared itself to be compliant with the establishment of IHR core capacities and now needs to maintain and consolidate the progress that has been made. The country has a strong intersectoral collaboration in the context of IHR among animal and human health sectors (see box 6).
166. The Ministry of Public Health’s proposal for 85% graphic health warning on tobacco packages in 2013 was challenged in court and an injunction was issued. In 2014, the Supreme Court overturned the lower court’s injunction and the Ministry of Public Health started implementing the regulation for increasing the graphic health warning from 55% to 85%. Later in 2014, the Ministry of Commerce and the Consumer Protection boards also implemented the ban on import, sale and service of e-cigarettes and water-pipe tobacco. Other major achievements include the successful completion of negotiations with the Global Fund under the New Funding Model, and the Joint HIV-TB Concept Note supported by WHO staff. Thailand is also implementing and funding ‘End AIDS’ by 2030, with an ambitious “Test and Treat” approach.42

167. Moreover, with its current programme, Thailand is likely to be one of the first countries in Asia to eliminate mother-to-child transmission of HIV, with transmission rates below 3%.

**Box 6: Integrated Food Safety model in Chiang Rai**

In Chiang Rai Province, an Integrated Food Safety project has been implemented starting in July 2014. The project aims to strengthen food safety from farm to table, as well as promoting and supporting the local food economy system, with the objective of improving quality of life, strengthening local communities to be self-reliant as well as preserving natural resources and the environment. In this way, food security is also strengthened at the community level.

The way this works is that food safety ‘stakeholders’ are working together to build and link networks of farmers, restaurants and consumers to ensure that the best quality organic food is made available for everyone to eat. The project also involves the tourist sector through promoting and supporting ‘community-based’ tourism through homestays on the farms that are involved.


**Addressing major health challenges**

168. The government sees overhauling the health insurance system as a major challenge and a priority. This is especially relevant considering (1) the shift in burden of disease from communicable to noncommunicable diseases (Figure 8); (2) the population is ageing fast; and (3) many of the 2–4 million non-Thai migrants who are vital for the economy are not covered by the health insurance system.

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### Figure 8: Top ten causes of death, Thailand, 2012

<table>
<thead>
<tr>
<th>No. of deaths (000s) 2012</th>
<th>Crude death rate 2000–2012</th>
<th>Change in rank 2000–2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischaemic heart disease (13.7%)</td>
<td>68.8</td>
<td>▲</td>
</tr>
<tr>
<td>Stroke (10.3%)</td>
<td>51.8</td>
<td>▲</td>
</tr>
<tr>
<td>Lower respiratory infections (9.4%)</td>
<td>46.8</td>
<td></td>
</tr>
<tr>
<td>Road injury (5%)</td>
<td>24.9</td>
<td>▲</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease (4.7%)</td>
<td>23.6</td>
<td>▲</td>
</tr>
<tr>
<td>HIV/AIDS (4.1%)</td>
<td>20.7</td>
<td>▼</td>
</tr>
<tr>
<td>Diabetes mellitus (4.1%)</td>
<td>20.7</td>
<td>▲</td>
</tr>
<tr>
<td>Liver cancer (3.8%)</td>
<td>18.8</td>
<td>▲</td>
</tr>
<tr>
<td>Trachea, bronchus, lung cancers (3.5%)</td>
<td>17.4</td>
<td></td>
</tr>
<tr>
<td>Kidney diseases (2.5%)</td>
<td>12.7</td>
<td></td>
</tr>
</tbody>
</table>

*Source: Global Health Observatory. Available at www.who.int/gho/countries/tha.*

169. Unregistered migrant workers in border areas, mainly at the Cambodia-Thailand border, feeling insecure, started returning to their countries. This, coupled with the slowing down of the economy, prompted the government to establish one-stop centres for registration of Cambodian, Lao P.D.R. and Myanmar migrant workers. The government also offered special Ministry of Public Health-sponsored insurance at a reduced premium. This Ministry of Public Health policy benefited from the recommendation made by the Ministry of Public Health-WHO jointly convened Migrant Health Task Force, a body including stakeholders from the government, international agencies, civil society organizations and NGOs. WHO has supported the Ministry of Public Health with capacity-building and activities related to guidelines while rolling out this initiative and is continuing to address the hurdles faced in implementation.

170. The other major challenge is human resource for health (HRH). The challenge is more an issue of distribution of health personnel rather than numbers where geographically the northeastern region and rural areas face scarcity while cities, mainly Bangkok, benefits disproportionately and private health care facilities absorb limited human resources at the detriment of the public sector. On a more structural side, the
delay in decentralization of health services and shortage of upcoming mid-level public health leaders will continue to affect the public health system in the mid- to long term.

**Linking national priorities to regional flagships**

171. In the last quarter of 2014, a large joint national/international review of the national vaccination programme was conducted with WHO and external partners’ support. This led to the renewal of Thailand’s commitment to support the achievement of global and regional objectives, including polio eradication and measles elimination. Sufficient resources will be allocated to achieve a high-quality measles and rubella (MR) campaign in 2015 among 2.5–7 year-olds and the introduction of inactivated polio vaccine (IPV) by December 2015.

172. In the area of noncommunicable diseases, WHO is technically supporting discussions to include NCD modules in the Thai Field Epidemiology Training Programme (FETP). Once finalized, the module could serve as a regional resource.

173. Universal health coverage is guaranteed for all Thais. As indicated above, the majority of the uncovered population consists of migrants mainly from neighbouring countries. To ensure that they are also covered, WHO has included Border and Migrant Health as a new priority programme in the RTG-WHO CCS. WHO’s role as a convener of the Migrant Health Task Force enabled it to influence the health policy significantly.

174. Work is being undertaken in Thailand to strengthen actions to counter the growing threat of antimicrobial resistance. Areas defined for this work include surveillance, infection control, rational drug use and research. To take this work forward, a ‘National Alliance for AntiMicrobial Resistance’ has been established. WHO is technically participating in these actions and discussions, and is supporting the effort in 2015.

**WHO’s role as lead technical partner in health**

175. WHO attends the monthly UN Country Team meetings and has been involved in a number of UNPAF-related activities. However, as the joint team structure is in the process of being replaced by a more robust form, WHO technical involvement is limited to long-term issues.
176. WHO in Thailand collaborates with other UN agencies on specific technical areas. Agencies include the IOM on border and migrant health issues; UNFPA and UNICEF on adolescent health; and ILO on social protection.

177. Finally, unlike other countries, Thailand is also the hub for many regional UN organizations and as such, WHO is often asked to represent the regional office at other technical regional meetings hosted by other organizations. Any such engagement is liaised with SEARO.

178. Thailand is heavily involved in a number of ASEAN and non-ASEAN regional fora. These include ASEAN UHC forum as well as entities such as AAAH. WHO has provided technical support and collaborated with Thailand in such fora to ensure that the common messages of UHC and also HRH are advocated for.

179. In addition, WHO works closely with the Ministry of Public Health and other bilateral entities and donors such as the Bill and Melinda Gates Foundation (BMGF), the Department of Foreign Affairs and Trade (DFAT) and the US President’s Malaria Initiative through the Emergency Response to Artemisinin Resistance project on malaria control in the Greater Mekong Subregion.
Timor-Leste
180. The government of Timor-Leste is committed to providing universal health care. The basis for the programmes and reforms of the government in 2014 is the Strategic Development Plan 2011–2030. The Programme of the Fifth Constitutional Government (2013–2017) states that the government will ensure access to good health care, nutritious food, clean drinking water and good sanitation. The government has affirmed its commitment to provision of universal health care, as reflected in the address of the Minister of Health, at the Sixty-seventh session of the World Health Assembly in Geneva in May 2014. The Minister stated that “Timor-Leste is now focusing on health systems strengthening to ensure universal access to promotive, preventive, curative and rehabilitative health services. This requires development and implementation of robust national health policies, strategies and plans. It will also focus on improvement of technical and institutional capacities for policy, planning and health financing.”

181. In January 2014, Timor-Leste became the first country in Asia-Pacific to launch a national campaign under the United Nations Zero Hunger Challenge, which seeks to ensure universal access to food in the face of looming threats such as climate change.

### Progressing towards achieving MDGs

182. In December 2014, three of the “12 good news stories” identified by the Government of Timor-Leste related to health:

- recording a greater-than-75% decrease in the incidence of malaria cases over the period 2000–2013;
- life expectancy at birth has risen to 66 years, up from 50 in 1990;

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receiving World Health Organization’s South-East Asia Region Award for Excellence in Public Health for National Malaria Control Programme and noting that Timor-Leste has achieved its MDG target for malaria (Box 7).

183. Timor-Leste is on track to reduce under-five mortality to reach the MDG4 goal. Leprosy has been declared eliminated as a public health problem; the country is polio-free and maternal and neonatal tetanus has also been eliminated.

**Addressing challenges of access and scale-up of services**

184. Since 70% of the population lives in rural areas isolated by mountainous terrain and poor road conditions, access to health services poses a major concern. The factors inhibiting access to health care include: inadequate human resources for health; weak hospital referral systems; limited infrastructure; health service delivery limitations; weak health information systems; lack of proper medicine procurement and forecasting system; and weak intersectoral action for health.

**Box 7: Timor-Leste honoured with WHO Award for Excellence in Public Health**

WHO honoured the National Malaria Control Programme (NMCP) of Timor-Leste with the newly instituted Award for Excellence in Public Health in September 2014, which was conferred by the WHO Regional Director for South-East Asia Region, Dr Poonam Khetrapal Singh, during the Sixty-seventh Session of the Regional Committee for South-East Asia. The noteworthy contributions of the NMCP were highlighted and commended. In 2006, malaria cases numbered over 223,000 in Timor-Leste with over 68 deaths. With WHO technical assistance and strong political commitment, the NMCP launched a vigorous antimalarial effort across the country. By 2013, malaria cases declined dramatically to 1040 with only three deaths. With the incidence of <1 case per 1000 population, the country achieved its MDG target for malaria.

Dr Singh congratulated the National Malaria Control Programme for its success and said, “The National Malaria Control Programme of Timor-Leste is to be commended for saving lives and achieving the MDG target for malaria in such a short time and with such a dramatic result. It can well inspire other malaria control programmes in developing countries.” With strong political commitment, advances in diagnostic testing and treatment and financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria, Timor-Leste has made huge strides in the prevention and control of malaria. Today, all areas where there is a risk of malaria have control and prevention measures in place. NMCP staff conduct entomological surveys each month to study and understand the main vectors and to develop efficient measures to deal with them and protect the population from malaria. All public health facilities are equipped to diagnose and treat the disease and the government is reaching out to remote communities by training community health volunteers to diagnose malaria, treat uncomplicated cases and refer more complicated cases to the nearest health facility.
Malnutrition among children continues to be a concern.

185. The nutritional status of children is a major concern. Although the levels of stunting and wasting in children decreased from 58% to 50.2% and from 18.6% to 11% respectively in 2014, these rates are still among the highest in the Region. The percentage of underweight under-five children in 2014 was 37.7%, down from approximately 46% in 2001. 48

186. Even though immunization coverage in Timor-Leste has gradually increased over the years, it has become stagnant at around 70% to 80% for several antigens. 49 About 23% of one-year-olds have not received vaccinations. 50

187. Maternal and under-five child mortality, though improving, remains high.

188. Lymphatic filariasis (LF), soil-transmitted helminths (STH) infection and yaws are a major public health challenge. A survey conducted in 2012 found LF seroprevalence of 17.5% and STH prevalence rate of 29% among children aged between 7 and 16 years. 51 Although leprosy has been eliminated at the national level, it remains endemic in some districts.

49 http://www.searo.who.int/entity/immunization/data/timor_leste_epi_factsheet_2013.pdf?ua=1).
189. Overall, Timor-Leste faces a double burden of disease: while communicable diseases such as malaria, dengue and tuberculosis continue to pose a public health challenge, noncommunicable diseases (NCDs) such as heart disease and chronic lung disease have emerged among the 10 leading causes of death.\textsuperscript{52}

190. The main priorities of the government to address the above challenges include provision of health services (integrated delivery of health care services), investment in human capital (a comprehensive workforce plan), infrastructure investment (to improve access to health services) and health management and administration (major organizational reforms to improve its management capacity).

**Addressing national priorities within the framework of regional flagships**

191. The national priorities set out in national health plans cover seven regional flagship priority areas as well.

192. The national laboratory was provided with equipment and reagents required for serological and molecular biological diagnosis of measles, rubella and JE.

193. The National Strategy for the Prevention and Control of Noncommunicable Diseases, Injuries, Disabilities and Care of the Elderly and NCD National Action Plan (2014–2018) was developed. The first Noncommunicable Disease Risk Factor Survey (STEP survey) was conducted, and advocacy on NCD prevention and control was supported through development of TV spots and posters; advocacy meetings on harmful effects of tobacco with members of parliament; and support for the drafting of tobacco legislation.

194. UHC elements have been addressed. The regulatory system for pharmaceutical products in Timor-Leste was assessed – development of the Pharmacy Law; development of the Essential Drug List 2014; and training workshops on Rational Use of Antibiotics for health care professionals, to mention a few. The National e-health Strategy (2015–2024) and the National Laboratory Strategic Plan 2015–2019 were also drafted. Towards strengthening human resources for health, activities supported include: the formulation of the code of medical ethics; capacity-building of the Faculty of Institute of Health Sciences (INS) for curriculum development and in-service training for both clinical services; and leadership and management skills. The

\textsuperscript{52} Ministry of Health, National Health Strategic Plan 2011–2020, Dili, 2011.
staff of the Ministry of Health was supported to attend training courses and regional meetings. Towards improving quality of health services, a number of standard operating procedures have been developed for clinical care and public health.

195. In the area of emergency risk management, the draft Health Cluster Emergency Preparedness and Response Plan and the draft Health Cluster Contingency Plan were developed; a district level simulation exercise (SimEx) on public health in an emergency to improve disaster preparedness was conducted, as well as the EHA benchmark assessment in districts. In addition, the following plans and strategies were initiated:

- The five-year master plan (2015–2020) on integrated Neglected Tropical Diseases (NTDs) with a focus on elimination of lymphatic filariasis and yaws was approved;
- the Reproductive, Maternal, Newborn, Child and Adolescent Health Strategy (2015–2019);
- the National Strategic Plan for School Health (2014–2018);
- the National Blood Policy and National Blood Programme (2014–2018);
- the National Laboratory Strategic Plan (2015–2019);
- the National e-health Strategy (2015–2024); and
Mobilizing resources and collaborating with major partners in health

196. WHO provided assistance for mobilization of resources from the Global Fund and GAVI. Under the EU-WHO Universal Health Coverage Partnership, several collaborative initiatives were supported: development of Reproductive Maternal Newborn and Child and Adolescent Health Strategy (2014–2018) in collaboration with UNFPA and UNICEF; development of a Manual of Procedures for Partnership Governance (in collaboration with NHSSP-SP); development of the “Partnership Framework Agreement” (in collaboration with NHSSP-SP); strengthening intersectoral collaboration for health with a focus on Malnutrition and Maternal Mortality (in collaboration with UNICEF and UNFPA); development of the Pharmacy Law (in collaboration with NHSSP-SP); and development of the Essential Drug List 2014 (in collaboration with NHSSP-SP).

197. In collaboration with USAID and the World Bank, WHO supported officials for the Ministry of Health and Ministry of Finance to participate in the Asia Regional Flagship Course on Health System Strengthening and Sustainable Financing. WHO in collaboration with the World Bank supported a training programme on Health Care Waste Management.

198. WHO assisted in strengthening coordination among development partners and relevant government counterparts by regularly conducting the National Health Sector Coordination meetings. WHO cochaired the Health Development Partners’ forum meetings with Australian Aid. Consequently, a Joint Annual Health Sector Review was convened by the Ministry of Health in December 2014 for reviewing progress, identifying issues and recommendations for areas of improvement in the health sector. It had active participation of development partners. WHO plays a key role in advocacy and decision-making in the country coordinating mechanism (CCM) of the Global Fund.
3. The Regional Office – A closer look at flagship priority areas

A. Universal Health Coverage – focus on human resources for health and essential medicines

1. The universal health coverage (UHC) agenda is helping to stimulate a more strategic or ‘big picture’ policy debate by WHO with governments and with development partners, and foster interdepartmental collaboration in the Regional Office. Advancing UHC beyond health financing faces two major challenges, namely the health workforce and essential medicines.

2. Five countries in the Region face critical shortages of health workers (Figure 9). All countries face challenges in workforce distribution, retention and performance. Access to health services will not improve significantly without strengthening the health workforce. The three most common causes of health system inefficiency concern medicines – underuse of generics and higher-than-necessary prices; substandard and counterfeit medicines; and inappropriate and ineffective use of medicines.53 There are major inefficiencies in medicines management, and there is scarce information on availability and use of medicines in countries in the Region.

![Figure 9: Health professionals (physicians, nurses and midwives) per 10 000 population, 2014, in SEAR countries](source)

Supporting countries towards the goal of UHC

3. In 2014, the Regional Office was engaged in four types of contributions to advance UHC at the country level.

4. First, following the commitment to UHC by Member States, as reflected in global and regional resolutions, it convened two major regional consultations in 2014 to review evidence, share knowledge and stimulate and support country action:
   - Accelerating Universal Health Coverage in the South-East Asia Region; and
   - Strengthening Human Resources for Health in South-East Asia: time for commitment and action.

5. The first event, related to improving strategic communication and accountability as part of WHO management reform, was designed to increase awareness among policy-makers and managers that progress towards UHC takes time but is possible from any starting point. Advancing UHC involves tackling two dimensions: improving people’s access to needed services and protecting people from financial hardship as a result of ill health. The meeting discussed country experiences with improving both these dimensions and identified possible ‘quick wins’; it also discussed how to improve the evidence base for UHC policies and how to measure progress. The second event brought together country teams of senior stakeholders to review evidence and WHO recommendations on rural retention and transformative education of health workers. Participants, in groups, then drafted two-year integrated HRH action plans with a focus on retention and education. These plans are now being reviewed by key national stakeholders. At the same time, a ‘Decade of health workforce strengthening in SEAR’ was launched in November 2014, recognizing that a sustained effort will be required in this complex area.

6. Second, in the context of WHO management reform, which focuses on information managed as a strategic asset, the Regional Office supported skills development to generate evidence for UHC, in particular evidence to manage health care costs; reduce out-of-pocket payments especially by the poor (Annex 1); and reduce inefficiencies in resource use. Examples of Regional Office support for national skills development in 2014 include:
   - Situation analyses of medicines supply, selection, use, policy, regulation and coordination, carried out by national teams with external support, in four countries.
   - Health intervention and technology assessments, currently underway in six countries, in collaboration with Health Intervention Technology Assessment Programme (HITAP). These will inform the development of benefit packages.
   - Joint HQ/Regional Office support for the regular production of national health accounts.

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A special issue of the SEA Journal of Public Health was devoted to UHC.

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54 http://vortal.htai.org/?q=node/142.
7. Third, a special issue of the WHO South-East Asia Journal of Public Health pulled together recent regional evidence on universal health coverage. This included articles on interventions to expand access to care, improve financing, and measure UHC.

8. Fourth, the Regional Office expanded work in intellectual property rights and trade and their implications for public health in the Region, given new global developments. An example of this support is demonstrated in Sri Lanka, where a national assessment of the situation on Public Health Innovation and Intellectual Property was conducted using the GSPA-IPR assessment tool, which is a first of its kind globally. This led to practical recommendations on how the government can be more effective in promoting health product innovation. SEARO’s activities were reflected in WHO’s report to the WTO on Trade-Related Aspects of Intellectual Property Rights (TRIPS).

Strengthening Regional Office integration of UHC activities

9. There is strong collaboration among diverse technical units to foster a strong regional capacity to support countries in advancing UHC. Examples of current cross-programme collaboration within the Regional Office include:

- The medicines situation analyses generated information on availability of drugs used for NCDs (NCD flagship) and antibiotic use (AMR flagship).

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Box 8: Recommended “best buys”

**Risk factor disease interventions**

- **Tobacco use**
  - Raise taxes on tobacco
  - Protect people from tobacco smoke
  - Warn about the dangers of tobacco
  - Enforce bans on tobacco advertising

- **Harmful use of alcohol**
  - Raise taxes on alcohol
  - Restrict access to retailed alcohol
  - Enforce bans on alcohol advertising

- **Unhealthy diet and physical inactivity**
  - Reduce salt intake in food
  - Replace trans fat with polyunsaturated fat
  - Promote public awareness about diet and physical activity (via mass media)

**Cardiovascular disease (CVD) and diabetes**

- Provide counselling and multi-drug therapy (including blood sugar control for diabetes mellitus) for people with medium-high risk of developing heart attacks and strokes (including those who have established CVD)
- Treat heart attacks (myocardial infarction) with aspirin

**Cancer**

- Hepatitis B immunization beginning at birth to prevent liver cancer
- Human papillomavirus (HPV) vaccination to prevent cervical cancer
- Screening and treatment of precancerous lesions to prevent cervical cancer

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Medical products, vaccines and trade/intellectual property issues involved collaboration with the vaccines programme as well as traditional medicine.

Health intervention and technology assessments helped in assembling evidence on national cost-effectiveness of NCD delivery packages, and the health and economic impact of tobacco and alcohol consumption.

Civil Registration and Vital Statistics (CRVS) strengthening now has significant momentum in countries of the Region. Within the Regional Office, stronger links are being made with the NCD flagship areas, where better cause-of-death data are needed.

B. Prevention of NCDs with focus on “best buys”

Prioritizing primary prevention and multisectoral actions

10. Noncommunicable diseases (NCDs) such as heart disease and stroke, cancer, diabetes and chronic lung disease are now the leading killers in the South-East Asia Region. Of particular concern is that these diseases are causing premature deaths—one half of deaths caused by NCDs are among people aged less than 70 years who are often breadwinners for families and productive national citizens. NCDs are the most common causes of high out-of-pocket expenditure for individuals and families, and are straining fragile health systems.

11. Unless concerted action is taken at this stage, country economies could be set back by NCDs through increasing demands on health care systems and lost productivity. To be successful, it is critical that the risk factors for NCDs are addressed and among these – prevention and control of tobacco use and salt reduction – are the most cost-effective interventions. The determinants of NCDs lie outside the health sector; as are the solutions to address NCDs. By forging collaboration with other sectors such as education, housing, transport, food and agriculture, justice, labour, trade, commerce, etc., determinants of NCDs need to be taken up with a ‘whole of society/government’ approach. In adopting the UN Political Declaration on NCDs and subsequent WHA and RC resolutions, Member States have committed to a set of actions for prevention and control of NCDs (Box 8).
12. NCDs are now recognized as priority in all Member States. Despite aggressive advocacy and legislative mechanisms to curb the tobacco epidemic, tobacco use is still quite prevalent (Figures 10 and 11). Increased resources have been allocated to NCDs in some countries — India, Indonesia and Sri Lanka. Major achievements in tobacco policies include improvement in tax systems and increase in tax of tobacco products in India and Indonesia; expansion of 100% smoke-free public places in Bangladesh, Indonesia, Myanmar; implementation of large graphic health warnings in Nepal, Sri Lanka and Thailand (see pictures); mass media campaigns in Timor-Leste; advocacy campaigns and awareness programmes on tobacco industry interference in six countries; and ban on manufacture, sale and distribution of gutka (chewable tobacco) in most states of India. The most notable impact of this policy intervention is that display of gutka has vanished.

13. Multi-risk factor NCD surveys among adults and youth were carried out in many countries. Global Youth Tobacco Survey (GYTS) data were analysed for three countries. Findings suggest that tobacco use, specifically smokeless tobacco use in countries of this Region, is on the rise. Current smoking among adults is showing a downward trend in most of the countries; however, trend of smokeless tobacco use among adults shows an upward trend. There has been a tremendous increase in compliance of tobacco control laws at the subnational level in Bangladesh, India and Indonesia. The national NCD and tobacco control programme at state and district levels is one of the exemplary best practices in India and one of the notable achievements in the Region. Tobacco cessation strengthening was done in Bhutan. In India, 5% taxation was levied on sweetened beverages.

“Best Buys” – addressing challenges of NCDs effectively

14. There are numerous challenges to the effective prevention and control of NCDs. The limited domestic and international resources for NCDs are largely spent on tertiary health services and there is a lack of effective multisectoral action and mechanisms. There is also the challenge of scaling-up capacity of human resources, particularly at the primary health care level, in some SEAR countries.

15. Some of the solutions to the above challenges include advocating with countries to increase allocation of domestic resources and to use innovative financing mechanisms, as well as to prioritize primary prevention; establishment of high-level coordination mechanisms for NCDs to facilitate collaboration of all sectors of society in the prevention of NCDs; concerted efforts to strengthen health workforce capacity, and ensuring availability of essential NCD diagnostics and medicines.

16. Four areas are built around the NCD “best buys.” In the context of managerial reform and better accountability, 20 deliverables related to NCDs have been identified that are in line with global UN commitments. Some major deliverables in four priority areas were as follows:

17. NCDs prioritized as a development agenda. The Regional Office conducted a regional meeting to advocate to high-level officials from nonhealth ministries. Also,
a regional training workshop empowered country teams to develop multisectoral policies and plans for NCD prevention and control. NCD targets have been set in eight countries. With multi-stakeholder consultations, NCD action plans are being drafted and budgeted in nine SEAR countries. NCDs have been included into the UNDAF in India and Timor-Leste.

18. **Reduction of risk factors.** Member States are intensifying implementation of the WHO Framework Convention for Tobacco Control (WHO FCTC). Pictorial warnings covering a significant area on tobacco product packages have been implemented in Bangladesh (50%), India (40%), Indonesia (40%), Thailand (85%), Nepal (90%) and Sri Lanka (80%) (see pictures). In India, almost all states have banned the production, distribution and sale of *gutka*. To mitigate the impact of air pollution, India has recently set up a national task force on indoor and ambient air pollution. A comprehensive

![Figure 10: Percentage of current tobacco users among youth aged 13–15 years, in selected countries of South-East Asia Region](image)

nutrition policy is being drafted in Bhutan and Nepal. The Regional Office convened an expert group and consultative meetings on salt and iodine and household air pollution.

19. Early detection of NCDs. During 2014–2015, WHO PEN pilot programmes were supported in four countries. Countries were supported in developing guidelines for cervical cancer.

20. NCD evidence. Four countries carried out e-STEPS surveys (Bhutan, Myanmar, Sri Lanka and Timor-Leste). A regional workshop was carried out to support countries in data analyses. Global school health surveys (GSHS), GYTS (Figures 10 and 11) and research on cost-effectiveness of NCD services were conducted in a number of countries to improve evidence related to NCDs. Research on smokeless tobacco-attributable all-cause mortality was conducted in India, trends of smokeless tobacco use among youth in countries of the Region and economics of smokeless tobacco in Bangladesh and India.

Integrating work of Regional Office on NCD prevention and control

21. The work on NCD prevention and control is a collaborative effort in the Regional Office. Major deliverables included:

- GSHS carried out in Bangladesh and Maldives;
- guidelines for cervical cancer;
- case study on NCDs in emergency;
- regional consultation on sodium and iodine;
- household air pollution meeting;
- national health systems focal persons invited to the NCD training; and
- increased capacity of NCD consultants in One Health Tool (OHT) for costing.

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**Figure 11:** Percentage of current smokeless tobacco users among youth in selected countries of South-East Asia Region

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C. Finishing the task of eliminating diseases on the verge of elimination

22. Lymphatic filariasis (LF), visceral leishmaniasis (VL or kala-azar), leprosy and schistosomiasis are targeted for elimination from the South-East Asia Region while yaws is targeted for eradication. These are neglected diseases affecting the poorest of the communities, pushing them further into poverty. Elimination of these diseases would not only contribute to better health but also elevate these communities from poverty and bring significant socioeconomic benefits.

Scaling up elimination activities

23. Despite the progress made by Member States in the Region towards the elimination targets (Figures 12 and 13), several challenges remain. An increasing number of LF-endemic districts in the Region are reaching the elimination target. To accelerate elimination efforts, the high operational cost and the large requirement for diagnostics to undertake transmission assessment surveys (TAS) to scale down mass drug administration (MDA) requires additional resources. While Member States are making very good progress on eliminating VL as a public health problem, emergence of new foci and increasing number of post-kala-azar dermal leishmaniasis (PKDL) cases are posing challenges in sustaining the achievement. Further, sustained efforts are needed to continue to strengthen the capacity of national programme managers. While there is good donor support in general, there is less donor interest and support for the elimination programmes of these diseases in smaller Member States. This requires more focused attention so that better and more meaningful assistance can be provided to these countries in a timely manner.

24. Several of these diseases are vector-borne, and the capacity to manage vectors is generally weak in the Region.

Figure 12: Regional progress towards LF elimination (2015)

Source: Country reports.
Significant progress towards elimination

- Three major VL-endemic countries in the Region (Bangladesh, India and Nepal) have now harmonized the treatment policy according to the current WHO recommendation.

- Ministers of health from VL-endemic countries (Bangladesh, Bhutan, India, Nepal and Thailand) and the Regional Director have signed a Memorandum of Understanding for regional collaboration, setting a target of 2017 – or earlier – for elimination of the disease as a public health problem from the South-East Asia Region.

- Nepal has reached the VL elimination target in all endemic districts and has been maintaining it for the past two years while Bangladesh and India have achieved the target in 92% of Upazilas and 74% of Blocks respectively. The incidence in Bhutan and Thailand is very low and within the elimination target.

- Three of nine countries endemic for LF (Maldives, Sri Lanka and Thailand) have achieved elimination that has been verified by international expert missions. These three countries have now prepared the country dossier required for certification of disease elimination.

- Bangladesh, India and Nepal have achieved 100% MDA coverage and are scaling down MDA after achieving the target.

- By the end of 2015, Bangladesh is expected to have completed MDA in all districts where treatment is required while India is expected to have less than 90 of the 256 endemic districts requiring MDA. This will have a significant positive impact on the global LF elimination programme.

- Indonesia and Timor-Leste are gearing up for a major scaling-up of MDA and achieving 100% geographic coverage.

- The Region is maintaining the target of leprosy elimination as a public health problem at the national level, and countries are now focusing on achieving the subnational
level target and bringing down the occurrence of grade 2 disability.

- India has sustained yaws-free status and has submitted the country dossier to get official recognition and certification.

25. Member States in the Region are fully committed towards achievement of the targets to eliminate and eradicate the targeted diseases. The performance of the Region undoubtedly relies heavily on the commitment from countries and the progress that they make. WHO works in harmony and unison with Member States to provide all possible support and strengthen their capacity.

- Member States have national strategic plans for all the diseases targeted for elimination or eradication, either in the form of an integrated plan or separate plans for each disease.

- National guidelines and treatment policies are developed in line with WHO guidelines and national strategic plans, developed or updated during the review period (dengue treatment guideline in India and Timor-Leste; schistosomiasis guideline in Indonesia).

- Several Member States have either revised their action plans or developed roadmaps in view of new evidence and knowledge (Integrated NTD plan in Indonesia and Timor-Leste updated; dengue strategic plan in Maldives developed).

- Annual rounds of MDA accompanied by strong awareness campaigns are held in endemic countries requiring mass treatment.

- Regular programme review meetings are held and course corrections made to remain on track for elimination.

26. There has been strong advocacy from the Regional Office to allocate more resources to the national programmes to expand the programme and accelerate interventions to achieve targets. In this regard, there has been an increase in resource allocation from both headquarters and the Regional Office that has been channeled to the national programmes, resulting in a significant improvement on the programme coverage from the two countries lagging behind.
27. Of all new detected leprosy cases in the world, 72% occurred in the Region (Figure 14). Informing about leprosy while evoking a responsible behavioural change in members of the community, diagnosing leprosy and treating the affected well by health professionals are all key areas of the upcoming 2016–2020 global leprosy strategy. The Bangkok Declaration (2013) set up a global leprosy elimination target of less than one case per million by 2020. WHO is working with The Nippon Foundation, Novartis Foundation for Sustainable Development (NFSD), International Federation of anti-leprosy associations (ILEP) and the networks of persons treated for leprosy to create the roadmap for the last mile in leprosy elimination.

Adding value to the work at the country level

28. SEARO spearheaded and facilitated the signing of the Memorandum of Understating on the Elimination of kala-azar from the South-East Asia Region, which reflects the strong political commitment from the top health leadership of endemic countries in the Region to strengthen efforts towards elimination of the disease.

29. The “Dhaka Declaration on Vector-borne Diseases” in 2014 is an important regional commitment that includes several of the diseases targeted for elimination.

30. WHO provides strategic direction to Member States in the form of Regional Strategies for the elimination of the targeted diseases. New and revised strategies for LF and VL have been drafted.

31. Technical Advisory Groups are established to advise the Regional Director on moving forward with the regional agenda on elimination of neglected tropical diseases. A regional task force has been established consisting of eminent experts from the Region to guide and advise the Regional Director on further accelerating the progress in the Region and overcome challenges identified.
32. Free drugs are being provided to the LF, VL, leprosy and schistosomiasis control programmes in all endemic countries. Limited support on the diagnostics for the LF and VL programmes is also being provided. WHO continues to train national programme staff to strengthen their capacity in programme management and address programmatic issues and challenges at the country level. With the inclusion of diseases targeted for elimination among the flagship programmes, additional resources from WHO are being channeled to the national programmes. This shall enable several countries to expand their interventions to achieve larger geographic coverage and accelerate progress.

Committed to eliminate/eradicate targeted diseases

33. Implementation of WHO reforms (programmatic governance management) can be seen in the work of various departments:

- In consonance with WHO reform, NTDs targeted for elimination have been declared as a flagship priority area by the Regional Director and additional resources made available.
- The regional strategies on diseases targeted for elimination are aligned with WHO’s NTD roadmap.
- Bottom-up planning has been undertaken with a clear result chain between Regional Office and Country Offices through well-structured deliverables and matching activities, ensuring improved and focused technical and policy support to Member States.
- Three levels of the Organization are working in unison and close collaboration with Member States to maximize the technical strength of WHO and its presence at the country level.

34. Operational research on NTDs and strengthening the research capacity of Member States are the areas where internal collaboration within the Regional Office was crucial. Since large quantities of drugs and diagnostics were provided to Member States through WHO, a concerted effort has been maintained to ensure timely and smooth delivery of goods to the national programmes.
D. Building national capacity for prevention and control of antimicrobial resistance (AMR)

35. Extensive and continuous irrational use of antimicrobial agents combined with the ongoing genetic changes in the pathogens as part of their survival mechanism has resulted in the widespread emergence of resistance in most of the common pathogens. This antimicrobial resistance has assumed ominous proportions and most of the commonly used – and affordable drugs – have become ineffective against diseases of public health importance. In Thailand, data on mortality and economic loss due to AMR show the impact of AMR on human health and the national economy – it is estimated to be almost US$ 2 billion per year and to cause 30 000 deaths annually in Thailand alone.

AMR – putting the focus on an emerging threat

36. In spite of several initiatives and obvious serious consequences of AMR – being cross-cutting in nature – it has not yet received the attention it deserves. AMR requires ownership and active participation of several relevant stakeholders with strong national leadership. It is essential that every stakeholder has clarity about its role in combating this menace.

37. The First WHO AMR Global Report (2014) shows that there are many gaps in the available information on the magnitude of resistance and its impact on societies in most countries. Strengthening or revising existing regulations and their implementation is important for ensuring rational use of antimicrobials and also to maintain quality of drugs. There are gaps in existing laboratory surveillance systems as well. Action is required for establishing standard AMR surveillance for providing comparable information (data) on magnitude and trends in resistance for informing treatment protocols, tailoring interventions and monitoring effects of interventions. Given the magnitude of the problem and urgency in combating AMR, it is critical to scale up national efforts.

38. AMR is accorded high priority by all Member States. It is important to advocate with national authorities to place AMR high on the national health agenda and to allocate necessary resources to address the problem.

39. Recognizing the importance of this subject, SEARO developed a simple and practical “Regional Strategy on Prevention and Containment of AMR” in 2010, which was endorsed by the WHO Regional Committee for South-East Asia through “resolution (SEA/RC/63/R4).” To further provide political support, health ministers of the Region articulated their joint commitment through the “Jaipur Declaration on Antimicrobial resistance” in 2011. Since then, all Member States in the Region were provided technical, advocacy and educational support that has resulted in strengthening of their respective governance of AMR, designating national focal points, improving regulatory capacity, enhancing capacity for laboratory surveillance, rational use of quality antibiotics and educating communities. WHO has been closely monitoring progress being made by
40. The importance of this topic led to adoption of an AMR resolution at the Sixty-seventh World Health Assembly. WHO has developed a global action plan (GAP) through extensive consultations with relevant stakeholders as per the resolution on AMR. The Regional Office provided substantial technical inputs in the drafting of GAP, articulating regional needs and priorities. The overall goal of the action plan is to ensure for as long as possible continuity of the ability to treat and prevent infectious diseases with effective and safe medicines that are quality assured, used in a responsible way, and accessible to all who need them. The AMR GAP aligns completely with the South-East Asia Regional Strategy on Containment of Antimicrobial Resistance (2010) and the Jaipur Declaration on AMR (2011). The indicators to monitor the progress of GAP are being drafted and will include those mentioned in the SEA Regional Strategy as starting points.

**Delivering on the AMR agenda**

41. The Regional Office is working closely with Member States through WCOs in developing deliverables and time-bound action plans in line with a global action plan on AMR; it is also using the regional strategy on AMR and the Jaipur Declaration on AMR as guidance documents. A Regional Technical Advisory Group (R-TAG) has been established to advise the Regional Director on innovative ways to swiftly move forward.

42. WHO is working closely with Member States to enhance national capacity.

- Member States have initiated establishing a comprehensive and integrated national approach to combat AMR.
- National focal points have been designated in almost all Member States. Multisectoral steering committees to steer the process have been either formed or are in the formation process.
- Drafting and finalization of national antibiotic policies is on the agenda of Member States. A national antibiotic policy is either formed or is being developed in almost all Member States of the Region.
- Regional and national training courses have been organized to build the capacity for undertaking laboratory-based surveillance of AMR. Networks for lab-based surveillance
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of resistance are in operation in many Member States to generate data on magnitude and trend of resistance, evidence-based treatment guidelines and impact of the national efforts in containing AMR.

- Several national treatment guidelines are now available to promote rational use of antimicrobial agents.
- A few operational research studies have already commenced.
- Special attention is being paid to reducing healthcare-associated infections by improving infection control practices.
- Building capacity of prescribers for rational and evidence-based use of antimicrobial agents in humans as well as animals is also under consideration by Member States.
- Community awareness campaigns are being launched and information, education and communication materials have been developed and distributed.
- Using the Regional Strategy on AMR, Thailand drafted and is implementing a comprehensive national programme that is yielding excellent data on the burden of AMR; the national plan also incorporates multiple activities to address all aspects of AMR.

E. Scaling up capacity development in emergency risk management in countries

43. The WHO South-East Asia Region is vulnerable to disasters. The World Disaster Report 2013 reveals that in the past decade, 37% of global mortality from disasters occurred in countries of the Region, and the percentage was much higher during previous years. The tsunami of December 2004 has been the turning point for the Region with lessons drawn, applied and resources invested to build capacities.

44. Member States were instrumental in establishing the South-East Asia Regional Health Emergency Fund (SEARHEF), which has helped meet immediate financial needs of SEAR countries for a quick response in emergencies since 2008. Moreover, to strengthen the agenda of a comprehensive risk management approach to emergencies and potential disasters, the 12 Benchmarks for Emergency Preparedness and Response provide a framework for national capacity-building and a tool for assessments. The work to address gaps identified by these assessments has become more apparent and clearer in terms of priorities in countries. Alongside strengthening the health sector capacity in countries, WHO-SEARO and WCOs in the Region have invested in preparedness planning, drills and stockpiling in countries for a more rapid Disaster preparedness by countries is the key to effective response.
response. A holistic approach is required to integrate capacities in prevention, risk reduction, preparedness, response and recovery across all hazards.

45. To respond to this urgent need, the Regional Office has established the Health Security and Emergencies (HSE) Department to enable the Regional Office to have the technical capacity to support Member States to prepare and respond to disasters and other emergencies including disease outbreaks.

Implementing the risk reduction framework

46. With the new Global Disaster Risk Reduction Framework (Sendai Framework for Disaster Risk Reduction) in 2015 ratified at the highest level by Member States of the UN, with health being a central goal of the document — WHO-SEARO is well placed to further implement this regional agenda. As the Regional Office is also newly transitioning to a more integrated approach in programming for health emergencies covering both humanitarian events and epidemics/pandemics, this area will have a more comprehensive approach to developing capacities in countries. With the background of Ebola in West Africa showing that the world is not well prepared, this regional flagship becomes all the more relevant.

47. Still, one of the main challenges is adapting to the different health systems and disaster management systems in each country – which are the key partners in getting these capacities in place. Moreover, funding is always available for the response phase as opposed to the more important prevention and preparedness phases.

48. By laying down the fundamental capacities and being able to measure these in a more systematic way, this priority programme can move clearly step-by-step with partners.

Ebola virus outbreak catalyzed national preparedness responses

49. The Ebola virus outbreak, mainly in the three West African countries of Guinea, Liberia, and Sierra Leone, killed over 11 000 and affected over 26 000 people. The outbreak had the potential to spread to any part of the world. On 8 August 2014, WHO declared the Ebola epidemic to be a “public health emergency of international concern,” thereby initiating an automatic response by all countries to strengthen preparedness and surveillance within the framework of the International Health Regulations (IHR2005).

50. All countries moved rapidly to strengthen surveillance, particularly at ports of entry, and to establish laboratory networks for rapid diagnosis. The Regional Office issued a series of technical guidelines on all aspects of emergency response and disease control. Member States also moved rapidly to strengthen infection control, identified isolation units in the event of arrival of an Ebola-infected person, and trained health workers to handle potential infective materials and infected persons. WHO procured minimal required personal protective kits (PPE) and facilitated countries to procure more. WHO provided technical assistance to several countries to assess ‘readiness’ of their preparedness response.
51. More importantly, knowing that the epidemic should be controlled at the source, WHO-SEARO provided support by deploying over 40 staff of various expertise to West Africa from August 2014. These included epidemiologists, logisticians, administrators, IT experts, an emergency coordinator, infection control specialists and surveillance medical officers.

**The Nepal earthquakes – WHO’s rapid and effective response**

52. While Ebola preparedness was in full swing in all Member States, disaster struck Nepal, precipitating an immediate emergency response.

53. On 25 April 2015, the 7.8 (RS) magnitude earthquake in Nepal resulted in massive damage to the country’s infrastructure and significant loss of life and injuries. A second powerful quake of 7.3 (RS) on 12 May exacerbated the impact of the first earthquake in specific districts. The combined effect was total deaths exceeding 8000 and more than 17 000 injured: close to half a million houses were damaged, either fully or partially. Over a thousand health facilities (1059) and close to half of those (402) were completely damaged. Most of these were primary health care centres/health posts delivering basic health care services in remote areas.

54. Within hours of the massive earthquake and in its initial response, WHO was able to have the Emergency Operations Room up and running in the Ministry of Health in Kathmandu. WHO was also able to hand over four emergency health kits comprising medicines and medical supplies sufficient to meet the health needs of 40 000 people. At the same time, the first tranche of US$ 175 000 from SEARHEF was released to meet the immediate health needs of earthquake-affected people. Simultaneously WHO quickly mobilized critical staff comprising an emergency response coordinator, epidemiologists, logisticians, communications specialists, coordinators and WASH specialists, etc. to support the WHO Country Office in assisting the government’s response to this tragedy.

55. The value added by WHO is the coordination of the many foreign medical teams, and over 130 health partners, assessment of needs and coordinating response by agencies, and setting up surveillance to monitor Over 8000 people died in the Nepal earthquake. Within hours, relief operations had commenced.
potential outbreak of diseases. The work of WHO in Nepal during this crisis is a clear demonstration of WHO’s health leadership in emergencies and crises and helped to strengthen that capacity further with this experience.

**IHR++ – key to future preparedness**

56. The IHR2005 provides the framework for the development of specific capacities in countries to enable them to respond effectively in the event of a public health emergency. Nine countries of the SEA Region requested extension of the target to achieve fully all core capacities as laid out in IHR2005; the 2016 target has been set for achieving all IHR Core Capacity in SEAR countries.

57. An M&E tool for IHR is being developed and will be tested through the Asia Pacific Strategy for Emerging Diseases (APSED). States Party IHR core capacity self-monitoring reports for 2014 are currently available from six countries. All Member States are making progress with improvement in:

- establishment of national IHR focal points;
- increased legislation;
- coordination and transparency in reporting events;
- early warning systems used more systematically;
- better communication and collaboration between the animal and human health sectors;
- establishment of emergency response and coordination structures; and
- improved international mechanisms to share information for rapid response.

58. Implementation continues to be a challenge for several Member States for chemical and radio-nuclear hazards and point of entry.

**F. Measles elimination and rubella control**

59. All 11 Member States of the Region have had well-functioning national immunization programmes (Figure 15) 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% to 78%; an estimated 286 million children (95% of the target) were vaccinated in supplemental immunization activities (SIAs); measles incidence decreased 73%, from 59 to 16 cases per million population; and estimated measles deaths decreased 63%. The history of polio also demonstrates the high quality of these programmes; the last case was on 11 January 2011 and the South-East Asia Region was certified polio-free on 27 March 2014. Building on these successes, in September 2013, the Sixty-sixth meeting of the Regional Committee for South-East Asia resolved to adopt the goal of measles elimination and rubella/congenital rubella syndrome (CRS) control in the Region by 2020.
60. All 11 Member States of the Region have enthusiastically taken up this challenge and have plans to implement the strategies fully. Bhutan, Democratic People’s Republic of Korea and the Maldives may have already eliminated measles through sustained high routine immunization coverage and supplemental immunization activities (SIAs) over the years. As of this report, nine (82%) of 11 Member States had two doses of an MCV in the routine immunization schedule, and six (55%) had a rubella-containing-vaccine (RVC) in the routine immunization schedule. Nine (82%) have conducted a nationwide catch-up measles SIAs, and India covered higher risk areas. In addition, six (55%) have implemented measles-rubella (MR) national SIAs. All Member States conduct laboratory-supported measles and rubella surveillance with case-based surveillance following SIAs. Sentinel surveillance for CRS is just starting, with notable progress already in Bangladesh, Indonesia and Nepal. With the implementation of a nationwide MR campaign in Timor-Leste, initiation of a nationwide campaign in India in the near future and Indonesia expected to implement its campaign in 2018, it is clear that Member States are accelerating their efforts to eliminate measles and to control rubella (Figure 16).

**Measles elimination is feasible despite some challenges**

61. Bangladesh, Sri Lanka and Thailand may have already achieved significant control of measles and rubella, but to eliminate measles and control rubella and CRS will require

![Table: Estimated coverage* with the first and second dose of measles-containing vaccine (MCV), and number of reported measles cases,§ by country — World Health Organization South-East Asia Region, 2003 and 2014§§](http://www.who.int/immunization/monitoring_surveillance/data/en)
increased efforts. Nepal has also made good progress and is to introduce a routine second dose in the third quarter of 2015. Myanmar conducted a high-quality national MR SIA in the first quarter of 2015 and is in the process of introducing a second dose including an RCV for the first time in the routine system and implementing case-based surveillance. Timor-Leste is scheduled to conduct their national MR SIA in the third quarter of 2015 followed also by a routine second dose, introduction of an RCV and case-based surveillance.

62. There are remaining challenges, the greatest of which is to improve routine immunization programmes to the extent that more than 95% coverage with two doses is reached in all districts. This will be an unprecedented achievement. Vaccine security is an ongoing challenge as the secure supply of the MR vaccine is insufficient to meet the combined needs of routine immunization programmes and SIAs, and the increased cost of the two-dose routine schedule, inclusion of rubella and the expansion of SIAs will be significant. These challenges are particularly acute in the largest countries, as India and Indonesia combined will require hundreds of millions of additional doses of MR for SIAs and over 80 million doses annually for routine immunization. These are the main reasons that national MR SIAs in India and Indonesia are unlikely to be completed before 2018.

G. Ending preventable maternal, newborn and child deaths with focus on neonatal deaths

63. All countries have made significant progress towards the achievement of MDGs in the Region. However, some of the countries are unlikely to reach MDG goals 4 and 5 by the end of 2015. More importantly, despite the steady decline of under-five mortality, the neonatal mortality continues to remain a challenge for most countries of the Region. Given that situation, the Regional Director identified “ending preventable
maternal, newborn and child deaths with focus on neonatal deaths,” as one of the seven flagship programmes. Neonatal deaths constitute a much higher percentage of the child mortality in our Region, compared with an average of up to 45% globally (Figure 19).

64. At the regional meeting held in April 2014 in Kathmandu, a Joint Statement was issued by Regional Directors of WHO South-East Asia Region, UNICEF Regional Office for South Asia, and Asia Pacific Regional Office of UNFPA, affirming their commitment to strengthen the regional partnership and harmonize country support to end preventable maternal and child deaths. This priority area of ending preventable maternal, newborn and child deaths addresses the unfinished agenda of reducing the regional burden of maternal and child mortality and progress beyond 2015 (Figures 17 and 18). The major challenge here includes inadequate access to service delivery for vulnerable populations, particularly in India and Indonesia.

**Steady progress with tangible outputs**

65. During the review period, several major outputs and outcomes have been achieved, as follows:

(i) Support was provided to all countries to enhance awareness of adolescent health issues, with a focus on STI and HIV, NCD risk behaviour during adolescence, preconception care and healthy transitions package, and also technical support provided to countries to prepare national plans of action to address these, and with globally agreed indicators to monitor performance.


(iii) Adoption of the every newborn action plan and preparation of plans for prevention and surveillance of birth defects to strengthen country response to address persistently high neonatal mortality and stillbirths.

(iv) Scaling up integrated approaches and improving quality of care to address major causes of childhood mortality such as pneumonia and diarrhoea as well as inclusion of an early childhood development package.

(v) Development and dissemination of Regional Framework for Improving Quality of Care for Maternal-newborn-child-adolescent Health, and scaling up maternal death surveillance and response.
(vi) Adaptation and adoption of ‘Safe Abortion: WHO Guidance’ for health systems with capacity-building using “Clinical practice handbook for safe abortion services.”

(vii) A Regional Technical Advisory Group (TAG) has been formed to guide the policies and strategies to improve maternal, child and adolescent health and to reduce maternal, under-five and neonatal mortality in countries of the Region.

Figure 17: Maternal mortality ratio – trend in WHO SEAR countries, 1990–2013

BAN – Bangladesh
BHU – Bhutan
DPRK – Democratic People’s Republic of Korea
IND – India
INO – Indonesia
MAV – Maldives
MMR – Myanmar
NEP – Nepal
SRL – Sri Lanka
THA – Thailand
TLS – Timor-Leste

Source: WHO, Global Health Observatory.

Figure 18: Trends in child mortality reduction in SEAR, 1990–2013 (2015 projection)

USMR – Under-five mortality rate
IMR – Infant mortality rate
NMR – Neonatal mortality rate
MDG – Millennium Development Goal

66. The issues that need to be addressed to improve maternal and child health are multi-causal and, therefore, the response also needs to include intersectoral and multi-stakeholder efforts. As a result, collaboration with sister agencies has markedly improved through regular teleconferences, joint meetings and joint country missions.

67. Specific initiatives of collaboration and integration across technical units include: (i) integrated approaches to reduce childhood diarrhoea and pneumonia – a pilot collaboration between immunization and child health programmes; pilot projects in Bangladesh and India supported by WHO; (ii) integrated pilot demonstration projects for cervical cancer prevention through immunization and screening – pilot projects in Nepal and Bangladesh supported by WHO.

68. The strong collaboration with ministries of health of countries has been very encouraging. These and other activities undertaken in various flagship areas are aimed at a common goal – better health for all in the South-East Asia Region.

Annexes

1. Composition of total health expenditure by type of expenditure in the South-East Asia Region

2. Levels and trends of total health expenditure on health as a percentage of gross domestic product by WHO Regions

3. Financial implementation by budget centre

4. Financial implementation by category
Annex 1

Composition of total health expenditure by type of expenditure in the South-East Asia Region

Note: No data available for Democratic People’s Republic of Korea.


As shown in the graph, the government share of total health expenditure countries of the Region varies from 12% in Myanmar to 85% in Bhutan. The regional average at 35% is about half of the global average. Thus, out of over 60% of private spending, direct out-of-pocket spending represents more than 50% (almost three times the general norm of <15–20%). What is desirable is a higher share of prepayment plan schemes of health insurance. While this does not appear to exist in Timor-Leste, it is <1% of total health expenditure in Bangladesh, Bhutan and Myanmar; about 2% in Nepal, Maldives and Sri Lanka, and reaches only as high as 9% in India and Indonesia, and 15% in Thailand.

BAN – Bangladesh
BHU – Bhutan
IND – India
INO – Indonesia
MAV – Maldives
MMR – Myanmar
NEP – Nepal
SRL – Sri Lanka
THA – Thailand
TLS – Timor-Leste
Annex 2

Levels and trends of total health expenditure on health as a percentage of gross domestic product by WHO Regions


SEAR – South-East Asia Region
EMR – Eastern Mediterranean Region
AFR – African Region
WPR – Western Pacific Region
EUR – European Region
AMR – Region of the Americas
## Annex 3

### Financial implementation by budget centre

*(as of 15 June 2015)*

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## Financial implementation by category
*(as of 15 June 2015)*

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<th>Category</th>
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<th>Allocated Budget</th>
<th>Distributed Resources</th>
<th>Resources (% of allocated budget)</th>
<th>Utilization (Expenditure plus Encumbrances)</th>
<th>Utilization (% of allocated budget)</th>
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</table>
This Report describes the work of the World Health Organization in the South East Asia Region during the period 1 January – 31 December 2014. It highlights the achievements in public health and WHO’s contribution to achieving the Organization’s strategic objectives through collaborative activities.

This Report will be useful for all those interested in health development in the Region.