



REGIONAL COMMITTEE

Provisional Agenda item 9

*Seventy-fifth Session
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Progress reports on selected Regional Committee resolutions

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

1. (a) Regional Plan of Action for the WHO Global Strategy on Health, Environment and Climate Change 2020–2030: Healthy Environments for Healthier Population (**SEA/RC72/R4**), and (b) Malé Declaration on Building Health Systems Resilience to Climate Change (**SEA/RC70/R1**);
2. Strategic Action Plan to reduce the double burden of malnutrition in the South-East Asia Region 2016–2025 (**SEA/RC69/R5**);
3. (a) South-East Asia Regional Health Emergency Fund (SEARHEF) (**SEA/RC60/R7**), and (b) Expanding the scope of the South-East Asia Regional Health Emergency Fund (SEARHEF) (**SEA/RC69/R6**);
4. Strengthening emergency medical teams (EMTs) in the South-East Asia Region (**SEA/RC71/R5**);
5. Ending preventable maternal, newborn and child mortality in the South-East Asia Region in line with the Sustainable Development Goals (SDGs) and Global Strategy on Women's, Children's and Adolescents' Health (**SEA/RC69/R3**);
6. Challenges in polio eradication (**SEA/RC60/R8**);
7. Measles and rubella elimination by 2023 (**SEA/RC72/R3**); and
8. Strengthening health workforce education and training in the Region (**SEA/RC67/R6**).

The High-Level Preparatory Meeting for the Seventy-fifth Session of the WHO Regional Committee for South-East Asia, held virtually on 18–20 July 2022, reviewed each progress reports and made recommendations on each of the report submitted. The recommendations made by HLP have been consolidated as Addendum 1 (SEA/RC75/14 Add. 1) to this Working Paper, for consideration by the Seventy-fifth Session of the WHO Regional Committee for South-East Asia.

The related Regional Committee resolutions covered in this Agenda item are appended to this Working Paper as Addendum 2 (SEA/RC75/14 Add. 2).

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1. (a) Regional Plan of Action for the WHO Global Strategy on Health, Environment and Climate Change 2020–2030: Healthy Environments for Healthier Population (SEA/RC72/R4), and (b) Malé Declaration on Building Health Systems Resilience to Climate Change (SEA/RC70/R1)

Background

1. The climate change emergency poses the single most important threat to human health, regional economy, livelihoods, and the natural environment in the South-East Asia Region. Climate change affects the social and environmental determinants of health – clean air, safe drinking water, sufficient food and a secure shelter. Between 2030 and 2050, climate change is expected to cause approximately 250 000 additional deaths per year from malnutrition, malaria, diarrhoea and heat stress. Among the WHO regions, South-East Asia has the highest estimated number of deaths due to climate change.

2. The Hon'ble Health Ministers of the Region at the Seventieth session of the WHO Regional Committee for South-East Asia held in Male', Maldives in September 2017, adopted the Male' Declaration, which agreed to the implementation of 10 action points by Member States and four action points for the Secretariat.

3. The Regional Plan of Action for the WHO Global Strategy on Health, Environment and Climate Change 2020–2030: Healthy Environments for Healthier Population (SEA/RC72/R4) was endorsed in 2019 and the Secretariat was requested to provide technical assistance to Member States on implementation of the action plan while strengthening environmental health information systems. In particular, it was asked to strengthen the availability, coverage and accuracy of the baseline information required to track progress in implementing this Regional Plan of Action for the WHO Global Strategy on Health, Environment and Climate Change, as well as the Male' Declaration on Building Health Systems Resilience to Climate Change. Details of the progress achieved were to be submitted to the Regional Committee Session planned in 2022, synchronized with the progress report on the implementation of the Male' Declaration on Building Health Systems Resilience to Climate Change (SEA/RC70/R1).

Progress made in the WHO South-East Asia Region

4. Through consultation with Member States, the Secretariat developed a "Framework for Action in building Health Systems Resilient to Climate Change in WHO South-East Asia Region 2017–2022" and supported Member States to address climate resilience. The Secretariat also developed the "Regional Plan of Action for the WHO Global Strategy on Health, Environment and Climate Change 2020–2030: Healthy Environments for Healthier Population" and further accelerated the implementation and technical guidance provided to Member States. WHO was accredited as a Green Climate Fund (GCF) Readiness Delivery Partner in 2020 and a webinar was organized to facilitate the health sector to access green climate financing and a regional readiness proposal to be submitted to GCF in the 2022 cycle of proposal applications.

5. Two virtual regional webinars were organized to facilitate regional and global best practices and knowledge-sharing among climate change and health focal points. The good practices and case studies on climate action in the Region are being documented. With technical support from WHO headquarters, the Regional Office organized a virtual training session for officials of the health and environment sectors at the national level on risk assessment mapping, with a focus on the integration of climate/weather information within surveillance systems to develop climate-informed health early warning systems.
6. Technical support was provided to Member States for revision of health national adaptation plans and for conducting vulnerability adaptation assessments. A capacity-building workshop was organized to further strengthen climate-resilient water safety and sanitation safety planning to ensure that water and sanitation systems in the Region are climate resilient.
7. Regional guidelines on climate-resilient and environmentally sustainable health-care facilities were developed based on the global guidelines and a star rating mechanism was used for assessing and evaluating health facilities in the Region. These tools and guidelines will be piloted and implemented in 2022.
8. Two standard operating procedures (SOPs) were developed to provide technical guidance to Member States on managing climate-sensitive diseases and related health outcomes, as well as a specific SOP for vector-borne disease surveillance – these will also be piloted and implemented in the Region in 2022.
9. The Regional Office supported the participation of health sector officials at global advocacy forums and platforms related to climate change and health (COP26) and developed a web-based advocacy toolkit on climate change and health. The toolkit aims to inspire individuals and communities in the Region to act on health and climate change, and do so based on the best available evidence. It provides a summary of key health-related climate issues faced by each of the Member States, offering tools, fact sheets, and infographics that can be downloaded and adapted for use in local campaigns. In 2021, the Secretariat also developed four online training modules on climate change and health.
10. To provide technical support to Member States in implementing the Male' Declaration and the Regional Action Plan, the Secretariat continues to mobilize funding through donors and partner agencies (such as UNDP – GEF, DFAT –Australia, DFID – UK, and SIDA – Sweden).
11. A monitoring framework with baseline indicators for better monitoring and evaluation of the Regional Plan of Action was also developed in 2021.

Challenges being faced

12. The COVID-19 pandemic did impact the progress of implementation during the past two-and-a-half years. However, despite the challenges described above, a lot has been achieved by the Region and Member States, for which WHO provided the needed technical guidance and support.

The way forward

13. Member States may consider extending the Framework for Action in building Health Systems Resilient to climate change in WHO South-East Asia Region 2017–2022 for another five years until 2027.
14. The Secretariat will continue to provide technical guidance and support for implementation of the Male' Declaration and the Regional Plan of Action.

2. Strategic Action Plan to reduce the double burden of malnutrition in the South-East Asia Region 2016–2025 (SEA/RC69/R5)

Background

15. The WHO South-East Asia Region bears much of the global burden of undernutrition. Increasing overweight and obesity and noncommunicable diseases (NCDs) are causing a double burden of malnutrition across countries. For a region that is focused on maternal and child undernutrition, overweight and obesity present a major challenge.

16. The Strategic Action Plan to reduce the double burden of malnutrition in the South-East Asia Region 2016–2025 was developed when the previous regional nutrition strategy ended. Its objective is to promote an enabling environment for effective implementation of nutrition policies to achieve better nutrition. The Action Plan recognizes the complex multistakeholder coordination required to support nutrition and the need to continue work on undernutrition while simultaneously addressing overweight and obesity through programmes and improving the food environment.

17. Acknowledging the importance of country leadership in reducing malnutrition, the Sixty-ninth session of the WHO Regional Committee for South-East Asia endorsed the resolution on the “Strategic Action Plan to reduce the double burden of malnutrition in the South-East Asia Region 2016–2025”. The Resolution (SEA/RC69/R5) requested Member States to consider adopting and implementing the Action Plan in accordance with their national priorities and context. It recommended strengthening policy and legislative frameworks and monitoring and evaluation of nutrition programmes. The Secretariat was requested to provide support to Member States in implementing the Action Plan, conduct mid- and end-term assessments and report the progress to the Regional Committee. The results of the mid-term assessment of 2021 are summarized below.

Progress made in the WHO South-East Asia Region

18. The Action Plan has had a significant influence on shaping the regional agenda on the double burden of malnutrition, through facilitating advocacy and dialogue, forging partnerships and enhancing country capacities.

19. Much of the progress is due to the increased political will and commitment of Member States to improve nutrition as a key development agenda. WHO’s strategic advantages of connectivity to global health networks, convening power and technical inputs have supported the adoption of strategies and technical packages to address malnutrition.

20. The development of national multisectoral nutrition policies, strategies, plans and guidance covering all forms of malnutrition has been a key advancement. Progress towards achieving global and country nutrition targets has been substantial. The regional number of stunted children (under 5 years) fell from an estimated 35.5 million (2015) to 30.1 million (2020). Four Member States are on track to reach the global target on stunting and all others are making progress. Ten Member States have met the target for six months exclusive breastfeeding rate. However, anaemia and low birth-weight rates remain stagnant.

21. Progress is seen in regulatory actions towards a healthy food environment through eliminating trans-fatty acids (TFA) from national food supplies, and on marketing of food and non-alcoholic beverages to children. All Member States have identified baseline population salt intake and set national targets. Some Member States have implemented salt reduction actions such as front-of-pack labelling, public food procurement policies and national-level behaviour change communication.

Challenges being faced

22. Member States continue to focus on undernutrition, but the rise in obesity also needs urgent attention due to its contribution to the NCD burden. Prevalence of overweight/obesity shows a steep rise in older children and adults and must be addressed.

23. The obesogenic food environment and commercial influences, and the food insecurity exacerbated by the post-COVID-19 economic downturn, affect the availability and access to healthy diets and threaten the fragile gains in nutrition achieved by countries.

24. Despite robust policies and strategies for nutrition, countries face implementation challenges, including inadequate resource allocation to nutrition programmes, coverage and quality of interventions, as well as poor human resources and inadequate enforcement of regulatory actions.

25. While monitoring and evaluation of nutrition indicators and programmes have improved, challenges remain in surveillance and non-utilization of data to inform policies and planning. Focused attention is needed to rectify surveillance gaps, including monitoring of unhealthy diets, overweight and obesity.

The way forward

26. Prioritizing and implementing the recommendations adopted by the Seventy-fifth World Health Assembly in May 2022 on preventing and managing obesity over the life-course, including potential targets and the obesity acceleration plan, are vital.

27. Member States can consider utilizing workplaces and schools as priority settings for health promotion to reduce all forms of malnutrition.

28. Optimizing infant and young child feeding, micronutrient supplementation, dietary diversification, and other critical interventions for children and women is essential to continue the momentum in place on reducing undernutrition. Social protection measures and other nutrition-sensitive programmes must be scaled up to counteract the rising global food insecurity considerations.

29. Further enhancing governance and accountability, strengthening human resources and capacity, and establishing mechanisms with clear sectoral accountabilities, roles and responsibilities to ensure a truly multisectoral process will have a significant impact in reducing malnutrition.

30. Data availability and monitoring for timely policy and programme decisions, and inclusion of overweight, obesity and diet-related factors in such decisions, alongside existing indicators on undernutrition, are vital.

31. WHO can coordinate with development partners and continue to support Member States in addressing undernutrition in the face of the post-pandemic situation, especially by focusing on anaemia, micronutrient deficiencies and low birth weight.

32. Country capacities to prevent and manage obesity/overweight across the life-cycle must be supported through provision of technical assistance and tools and sharing of lessons learnt.
33. Commercial determinants of malnutrition are a key factor that impedes the progress of food environment actions. WHO can further its leadership and technical support through regional-level discussions, and adoption of appropriate frameworks and tools, to help Member States recognize commercial determinants of nutrition and take remedial action.

3. (a) South-East Asia Regional Health Emergency Fund (SEARHEF) (SEA/RC60/R7), and (b) Expanding the scope of the South-East Asia Regional Health Emergency Fund (SEARHEF) (SEA/RC69/R6)

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

Background

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

35. The Fund is designed to provide financial support for the first three months following a disaster that occurs in an affected country. It is meant to support lifesaving health interventions and fill in critical gaps. It also has a window to receive funds from Member States. Funds can be released within 24 hours of receiving a request from a Member State, and a total amount of US\$ 350 000 can be released in two tranches.

36. The SEARHEF has set a record as “the emergency fund that is released fastest among all UN agencies”. The SEARHEF is overseen by a Working Group comprising representatives from Member States of the SE Asia Region. The Working Group has met eleven times since 2008.

Progress made in the WHO South-East Asia Region

37. Progress made by the Regional Health Emergency Fund in the WHO SE Asia Region include the following:

- Since its inception in 2008, the Fund has allowed for an immediate and flexible response to 43 emergency events occurring in 10 Member States of the Region, including the ongoing pandemic response.
- In the current biennium (2022–2023), the SEARHEF is yet to provide support for any emergency in the Region.
- Till date, SEARHEF has disbursed a total of US\$ 6.77 million since its inception.
- In the previous biennium (2020–2021), the unutilized balance of US\$ 300 000 was used to procure essential emergency medical supplies and equipment for the regional stockpile, such as interagency emergency health kits, laboratory and sample collection kits, personal protective equipment with approval from the 10th meeting of the Working Group.
- Eleven meetings have been held, till date, of the Working Group of the Fund, the last being held virtually on 5 July 2022.
- The SEARHEF balance from Assessed Contributions as of June 2022 is US\$ 1 000 000 for the current biennium of 2022–2023, while US\$ 100 000 is available from Voluntary Contributions.

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

39. To address the recommendation of the external evaluation to further strengthen monitoring of the utilization of SEARHEF, a dedicated website has been developed and was launched at the Eleventh Meeting of the Working Group in July 2022. This website carries information on all activities supported through SEARHEF, both in the Preparedness and Response streams. In addition, the reporting forms have been revised to obtain information on the utilization of funds.

40. Table 1 (given at the end of this report) includes the list of health emergencies that were supported by SEARHEF since its inception till December 2021, and the countries in which they occurred.

Challenges being faced

41. The main challenge has been the inability to increase the corpus of SEARHEF over time since its inception. The direct and indirect effects of the ongoing COVID-19 pandemic have negatively impacted proposals to strengthen the corpus of SEARHEF. The devastating effect of the COVID-19 pandemic on economies across the Region has had a negative impact on contribution by Member States to the emergency preparedness and response streams.

The way forward

42. The COVID-19 pandemic has proved beyond doubt the importance of emergency preparedness and readiness, including establishing sustainable financing mechanisms for an emergency response. As the Region is vulnerable to many natural disasters, it has been consistently investing in emergency preparedness and response, despite all challenges. Well before the COVID-19 pandemic, during the Seventy-second session of the Regional Committee for South-East Asia held in September 2019, Member States adopted a resolution to strengthen emergency preparedness capacities by scaling up risk assessment, increasing investments, and enhancing implementation of multisectoral plans.

43. The lessons being learnt through the course of this ongoing pandemic augment the importance of a sturdier SEARHEF. These are as follows:

- a. Need for strategic efforts to increase the SEARHEF corpus: The Secretariat holds SEARHEF Working Group meetings annually, and the need for increasing the corpus for SEARHEF has also been recognized by all Member States. During the Tenth as well as the Eleventh Meetings of the Working Group in August 2021 and July 2022 respectively, all Member States agreed to this and highlighted the importance of increasing the corpus.
- b. Need to enhance multisectoral collaboration: This has been highlighted by different global committees and recommended financing of pandemic preparedness and response. The Secretariat and Member States need to explore opportunities and synergies in the near future, in line with global-level discussions and agreements on sustainable financing of emergencies.

Table 1. List of health emergencies that were supported by SEARHEF since its inception in 2008 till December 2021

No.	Emergency supported by SEARHEF	Period		SEARHEF allocation in US\$
		Month	Year	
1	Cyclone Nargis in Myanmar	May	2008	350 000
2	Flash floods in Sri Lanka	June	2008	23 299
3	Kosi river floods (in two tranches) in Nepal	September	2008	325 000
4	Emergency health interventions for internally displaced populations (IDPs) in conflict-affected areas in northern Sri Lanka (in two tranches)	September	2008	350 000
5	Earthquake in North Sumatra province, Indonesia (in two tranches)	October	2009	300 000
6	Emergency health interventions for relocated IDPs affected by conflict in Sri Lanka	January	2010	175 000
7	Fire incident in Dhaka, Bangladesh	June	2010	175 000
8	Mt Merapi volcanic eruption in East Java province, Indonesia	November	2010	139 000
9	Critical health-care services to the resettled population affected by conflict in Sri Lanka	February	2011	175 000
10	Floods in Thailand (in two tranches)	July	2011	350 000
11	Torrential rains in DPR Korea (in two tranches)	August	2011	310 000
12	Fire outbreak/explosion in Yangon, Myanmar	January	2012	25 000
13	Provision of emergency health care in Rakhine State, Myanmar	June	2012	12 300
14	Flash floods in DPR Korea	July	2012	134 130
15	Population affected by storm in Maldives	November	2012	47 717
16	Procuring emergency medical supplies (fire outbreak and earthquake) in Myanmar	November	2012	30 778
17	Establishing health-care services for townships affected by communal conflict in Rakhine State in Myanmar	April	2013	175 000
18	Relief during emergency caused by flash floods in South Phyongan, North Phyongan, Kangwon and South Hamgyong provinces of DPR Korea	July	2013	175 000
19	Emergency response activities for the crisis situation emerging due to eruption of Mt Sinabung in North Sumatra Province of Indonesia	February	2014	144 068

20	Establish sustainable health-care services for townships affected by communal conflict in Rakhine State, Myanmar	May	2014	175 000
21	Complement the response and recovery activities conducted by MoH, Sri Lanka to support short- to medium-term needs of the health sector	November	2014	35 500
22	Complement the response and recovery activities conducted by MoH, Sri Lanka to support response and recovery activities from heavy floods and landslides in 22 (out of 25) administrative districts in Sri Lanka	December	2014	30 000
23	Rehabilitation efforts after the Nepal earthquake	April	2015	175 000
24	Strengthening the capacity of health institutions to meet the immediate needs of the population in drought-affected areas (88 counties and 20 cities in South and North Hwanghae, South and North Pyongyang provinces) of DPR Korea	July	2015	137 160
25	Enabling MoHS to help provide operational costs for post-disaster management of floods following heavy rain that affected health facilities in the Sagaing and Magway regions and Rakhine State of Myanmar	August	2015	26 000
26	Enabling MoHS to perform emergency medical interventions among flood-affected populations in Rakhine and Chin states, and Sagaing and Magway regions of Myanmar	August	2015	149 000
27	Providing emergency medical supplies and essential drugs for flood-affected populations in Rason City, North Hamgyong province, DPR Korea	September	2015	161 887
28	Response and recovery activities for flood victims by MoH Sri Lanka	May	2016	100 000
29	Assistance to MoH Bhutan to provide health sector aid to flood-affected populations	July	2016	161 624
30	Provision of emergency health care to flood-affected populations in Myanmar by MoHS	August	2016	175 000
31	Provision of emergency health care to populations affected by torrential rains and flood in the northern regions of DPR Korea	September	2016	175 000
32	Relief after floods and landslides in Sri Lanka	May	2017	175 000
33	Assistance to MoH&FW Bangladesh after Cyclone Mora	June	2017	170 000
34	Assistance to MoH&FW Bangladesh for activities in aid of population affected by Rakhine crisis	September	2017	175 000
35	Enabling MoH Maldives to carry out response activities by Health Protection Agency for victims of tropical storm Ockhi	December	2017	13 000
36	Providing essential health services to the conflict-affected population in Rakhine State of Myanmar by MoHS	February	2018	156 490

37	Addressing the immediate health needs of the displaced Rohingya population at Cox's Bazar (Grade 3 Emergency), Bangladesh	February	2018	137 842
38	Operations in aid of flood-affected areas in North and South Hwanghae provinces, DPR Korea	September	2018	171 975
39	Provision of life-saving health-care services to flood-affected populations, Myanmar	August	2019	160 000
40	COVID-19 preparedness and response in Thailand	January	2020	175 000
41	COVID-19 preparedness and response in Bhutan	March	2020	175 000
42	COVID-19 preparedness and response in Maldives	March	2020	175 000
43	Assistance to cover immediate health needs arising after flash floods and landslides, Timor-Leste	April	2021	175 000
Grand total				6 776 770

(b) Expanding the scope of the South-East Asia Regional Health Emergency Fund (SEARHEF) (SEA/RC69/R6)

Background

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

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

- a. address a priority gap, as found in the International Health Regulations (IHR, 2005) capacity assessments and/or SE Asia Region benchmark assessments;
- b. address gaps in core skills such as risk assessments or information management; and
- c. strengthen public health emergency operations centres (PHEOCs) in Member States of the Region.

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

- i. development and strengthening of policies and capacities;
- ii. development and implementation of training courses;
- iii. systems for disease surveillance, information and knowledge exchange across countries for risk assessments and risk communications;
- iv. strengthening PHEOCs;
- v. health emergency supply chain management system;
- vi. strengthening of emergency medical teams and their coordination;
- vii. assessment of health facilities for disaster risk reduction; and
- viii. strengthening of the health emergency workforce through the establishment of systems that include efficient recruitment and deployment.

Progress made in the WHO South-East Asia Region

47. From the total of US\$ 400 000 in Voluntary Contributions made by India and Thailand, US\$ 125 000 has been disbursed to three Member States in the Region – Bhutan (US\$ 50 000), Maldives (US\$ 50 000) and Sri Lanka (US\$ 25 000) – for strengthening PHEOCs and rapid response teams for surveillance.

48. The PHEOCs in all three countries of Bhutan, Maldives and Sri Lanka have been operationalized as part of the incident management system for the COVID-19 pandemic response.

49. The balance available, as of June 2021, is US\$ 275 000, including the programme support cost (PSC) charges, which are charged at the rate of 13% for the Voluntary Contributions. A total of US\$ 235 694 (excluding the PSC amount) is currently available under this stream.

50. Management of the Preparedness stream of SEARHEF is overseen by the same Working Group that manages the Response stream, comprising representatives from all 11 Member States. The Working Group has met 11 times since 2008. The Eleventh Meeting of the Working Group was held virtually on 5 July 2022.

Challenges being faced

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

- i. challenges in mobilizing domestic resources for preparedness activities;
- ii. global and regional donor environment for funding not being conducive; and
- iii. need for further strengthening of timely reporting on utilization of SEARHEF, as we expand to this new preparedness stream.

The way forward

52. The COVID-19 pandemic has highlighted the importance of emergency preparedness. Both Member States and the Secretariat need to leverage this situation to mobilize additional resources for this Preparedness Fund. Member States of the Region are encouraged to fund the Preparedness stream of SEARHEF as a good and highly rewarding investment.

4. Strengthening emergency medical teams (EMTs) in the South-East Asia Region (SEA/RC71/R5)

Background

53. On 7 September 2018, the Seventy-first session of the WHO Regional Committee for South-East Asia adopted a resolution on “Strengthening emergency medical teams (EMTs) in the South-East Asia Region (SEA/RC71/R5)”. This is the first such resolution adopted by any of the six WHO regions.

54. The resolution also called for establishment of a Regional EMT Working Group comprising representatives of Member States to support the implementation of the EMT Initiative and requested the WHO Regional Office to support the establishment and management of the Regional EMT Working Group. The South-East Asia Regional EMT Working Group was established in 2019. The Regional Office for South-East Asia, as the Secretariat of the Working Group, has since been collaborating with the South-East Asia Regional EMT Working Group. The Regional Office is committed to providing technical assistance and support for training, quality assurance, coordination and other activities for strengthening EMTs in Member States of the SE Asia Region.

55. To guide the work of strengthening the capacities of Member States, a dedicated team within the Health Emergencies Department of the WHO Regional Office for South-East Asia has been working in collaboration with WHO country offices to support implementation of the EMT resolution.

Progress made in the WHO South-East Asia Region

Capacity-strengthening, preparedness and training

56. To build an adequate roster of regional EMT coordinators who can be deployed to support Member States, WHO assisted in an intensive refresher training of the Emergency Medical Team Coordination Cell (EMTCC) in collaboration with the EMT Secretariat from WHO headquarters as well as the WHO Regional Office for the Western Pacific. The aim of this training was to update trained members of the global EMTCC cadre on the methodology and skills inherent to EMT coordination, with a focus on case management during the mobilization and operations phases, particularly during the COVID-19 pandemic. The training was conducted virtually in December 2020.

Quality assurance and classification

57. The Thailand EMT had emerged as the first EMT in the Region to be classified as a Type 1 (Fixed) EMT in 2019, following an elaborate classification process.

58. WHO continues to provide mentorship to the three emergency medical teams from the South-East Asia Region currently enrolled in the WHO verification programme: Bhutan EMT (BEMT), Muhammadiyah Disaster Management Centre (MDMC) EMT, Indonesia, and Sri Lanka Army Medical Assistance Team (SLAMAT). Mentorship visits, national EMT training and team member training sessions were conducted in Bhutan, Indonesia, and Thailand over the course of 2019. MDMC EMT, Indonesia, was planned to be verified in March 2020. However, due to the COVID-19 pandemic, this was postponed for an indefinite period. At the end of 2021, a discussion was held involving all the three levels of the Organization, to reactivate the mentorship process towards classification.

Global and regional commitment and partnerships

59. The South-East Asia Regional EMT Working Group has actively participated in the global EMT initiatives throughout the course of 2020 to 2022. Indonesia and Thailand have been alternately representing the Region in the Global EMT Strategic Advisory Group (SAG) meetings. As Co-Chairs of the Working Group, Indonesia and Thailand, with support from the Regional Office, presented updates, challenges, and key priorities of the Region during every EMT-SAG meeting held each semester.

60. The South-East Asia Regional EMT Working Group held its second meeting on 8 June 2022 to discuss the implementation of the EMT initiative in the Region. A total of 40 participants from nine Member States and two organizations attended the meeting. Progress made in the Region during the past three years was deliberated upon, in addition to India and Thailand being appointed as the Co-Chairs for the designated period of two years till 2024.

SE Asia Region emergency medical teams and the COVID-19 pandemic

61. During this current and ongoing response to the COVID-19 pandemic, all EMTs from Member States were deployed domestically to support the COVID-19 response; no EMT from the SE Asia Region was internationally deployed.

62. The MDMC EMT (Indonesia) was deployed in the country to respond to flash floods, earthquake, and volcanic eruption during 2020–2022.

63. There were several international EMTs deployed to the Region to support COVID-19 response operations: (i) partial deployment of the UK EMT to Cox's Bazar, Bangladesh in 2020; (ii) partial deployment of the Italian EMT to India in 2021; and (iii) partial deployment of the Australia EMT to Timor-Leste in 2021. All deployments were under bilateral country agreements.

Challenges being faced

64. In the South-East Asia Region, there are many national EMTs with varying capacities and, therefore, there is a strong need for quality assurance and national coordination.

65. The EMTs in the Region do not have extensive experience and the capability to respond to outbreaks. The focus of capacity-building has been on natural disasters. Therefore, capacity-building in the area of outbreak response is a priority need. This should also be coordinated with the rapid response teams of the ministries of health in all Member States.

66. The verification and classification process during the COVID-19 pandemic remains a challenge, given the competing priorities countries are faced with.

The way forward

67. The WHO Regional Office for South-East Asia will continue:

- a. to build the capacity of Member States in developing national EMTs in line with national requirements, adapting standards and quality assurance processes relevant to the national contexts; and
- b. the mentorship and verification process of EMTs that are already in the pipeline.

5. Ending preventable maternal, newborn and child mortality in the South-East Asia Region in line with the Sustainable Development Goals (SDGs) and Global Strategy on Women's, Children's and Adolescents' Health (SEA/RC69/R3)

Background

68. Ending preventable maternal, newborn and child deaths in Member States of the WHO South-East Asia Region continued to be a priority area during the past decade. The Regional Office for South-East Asia continued to collaborate with Member States and partners to set the roadmap to accelerate progress toward the SDG targets by providing technical assistance and strategic support.

69. Recognizing the significant progress made towards achieving the Millennium Development Goals 4 and 5 in the South-East Asia Region with a conspicuous decline in the child mortality rate and maternal mortality ratio across all Member States between 1990 and 2015, and the need to further build upon these achievements, the Sixty-ninth session of the Regional Committee for South-East Asia endorsed the resolution on "Ending preventable maternal, newborn and child mortality in the South-East Asia Region in line with the Sustainable Development Goals (SDGs) and Global Strategy on Women's, Children's and Adolescents Health (SEA/RC69/R3)".

70. The resolution called on Member States to consider the clauses of the Regional Flagship Priority to end preventable maternal, newborn and child mortality with a focus on newborn deaths. This Flagship Priority, subsequently rechristened in line with emerging developments as "Accelerating the reduction of maternal, neonatal and under-five mortality", is one of the eight Regional Flagship Priority Programmes that which will in tandem drive the roadmap for achieving the SDG 3 target in the Region.

71. The resolution further urges Member States to: (1) achieve universal access and coverage of essential intervention packages for reproductive, maternal, newborn, child and adolescent health (RMNCAH) with a focus on quality care for mothers and newborns; (2) review and strengthen national health systems, as appropriate, to identify gaps and solutions in relation to the needs of RMNCAH, which includes investing in midwifery skills and developing sustainable health financing mechanisms to reduce out-of-pocket expenses for safe childbirth and care of mothers and newborns; (3) strengthen the use of data for programme improvement in line with the indicators provided in the SDGs as well as allowing for its disaggregation; and (4) reinforce multisectoral and multistakeholder partnerships and commitments to address underlying social determinants of the health of women, children and adolescents.

72. The Secretariat was requested to provide support to Member States to update their national RMNCAH strategies and plans to address the coverage gaps for essential interventions for RMNCAH, with specific guidance on organizing, planning and setting up quality services for RMNCAH including data for planning.

Progress made in the WHO South-East Asia Region

73. The WHO South-East Asia Region achieved Millennium Development Goal (MDG) 4 related to the under-5 mortality rate (U5MR) by reaching the level of 39 per 1000 live births in 2016, soon after the target date of December 2015. Eight of the 11 Member States of the Region achieved their respective MDG 4 targets in 2016.

74. Three countries in the Region achieved the MDG 5A targets in 2015 (Bhutan, Maldives and Timor-Leste). Globally, only nine countries achieved the MDG 5A targets.

75. The SE Asia Region has demonstrated a 64% reduction in U5MR and a 56% reduction in neonatal mortality in the year 2020 (UNIGME Child Mortality Report, 2021) compared to the levels in 2000. There is a 75% reduction in U5MR and 66% reduction in newborn mortality compared to the 1990 levels. This reduction is higher than the global reduction over the same period and the second-highest reduction in U5MR and third-highest reduction in newborn mortality among all WHO regions.

76. As of 2020, five countries in the Region (the Democratic People's Republic of Korea, Maldives, Indonesia, Sri Lanka, and Thailand) have achieved a U5MR below the 2030 SDG target of 25 per 1000 live births. The neonatal mortality rate (NMR) in these countries has also fallen below the 2030 SDG target of 12 per 1000 live births.

77. As of 2020, another four countries are on track to achieve the U5MR and two countries are on track to achieve the NMR SDG targets by 2030, respectively, assuming that the annual rate of reduction for 2010–2019 (pre-COVID) would hold for 2019–2030.

78. Eight countries in the Region have documented a substantial decrease in stunting in under-5 children between 2015 and 2019 compared to their previous levels (Bangladesh, Bhutan, DPR Korea, India, Maldives, Myanmar, Nepal and Timor-Leste).

79. Between 2000 and 2017, the SE Asia Region witnessed the most significant decline in maternal mortality ratio (MMR); a 57% reduction in mortality compared to 38% globally. The point estimate for MMR in the SE Asia Region is 152 per 100 000 live births (MMIEG 2017). Such progress indicates that Nepal and Timor-Leste are on track to achieve the SDG country target of a two third reduction in the MMR from the 2010 value. The new maternal mortality estimate data are expected to be released at the end of 2022.

80. The recently published “Ending preventable maternal mortality (EPMM)” document reiterates that no country should have an MMR of more than 140 per 100 000 live births in 2030. The Democratic People's Republic of Korea, India, Maldives, Sri Lanka and Thailand are below the MMR of 140 per 100 000 live births.

81. The SE Asia Region has demonstrated a 50% reduction in the stillbirth rate for the 2000–2017 period. That is the second-highest reduction among all WHO regions. During this period, the Region has averted 244 000 stillbirths. Currently, six Member States (Bhutan, DPR Korea, Indonesia, Maldives, Sri Lanka and Thailand) have already achieved the 2030 national target of stillbirths (<12/1000 total births).

82. The WHO SE Asia Region has eliminated maternal and neonatal tetanus, in all districts across all 11 countries. Maldives, Sri Lanka, and Thailand have also eliminated mother-to-child transmission of HIV and syphilis.

83. Sustained investments in family planning programmes by Member States have contributed to a significant reduction in the total fertility rate (TFR) in most countries, with a weighted average for TFR in the SE Asia Region at 2.2; Bhutan, DPR Korea and Thailand report below replacement fertility levels. The Region has already reached the GPW13 target of 66% demand satisfied for family planning. However, the proportion of maternal deaths due to complications of unsafe abortion has remained the same in the Region.

84. All Member States of the Region have the key policies and guidelines in place on reproductive, maternal, newborn, child and adolescent health (RMNCAH) to support action. These include national policies and guidelines on antenatal care, childbirth, postnatal care for mothers and newborns, management of preterm and low birth-weight infants, early childhood development and integrated management of childhood illnesses, including pneumonia, diarrhoea and malnutrition, among others.

85. The Region has documented significant achievements in increasing the population-based coverage of essential RMNCAH interventions during the past 10 years. The reduction in maternal, newborn and child mortality and stillbirths is attributed to the increase in the regional average of high-impact, evidence-based interventions.

86. Bhutan, DPR Korea, Indonesia, Maldives, Nepal, Sri Lanka, Thailand, and Timor-Leste have achieved >75% coverage for antenatal care (ANC) in four visits; 82% of births in the Region are attended by skilled health personnel. Bhutan, DPR Korea, India, Indonesia, Nepal, Sri Lanka, Thailand, and Timor-Leste have achieved >75% coverage for skilled birth attendance, with 76% of pregnant women delivering in an institution. DPR Korea, India, Maldives, Nepal, Sri Lanka, Thailand, and Timor-Leste have achieved >75% coverage for institutional deliveries. Six countries have achieved >75% coverage of the proportion of children who are fully immunized; five countries have >65% coverage of breastfeeding in the first hour of birth and six countries have >65% postnatal care contact within the first two days after birth. Six countries have >65% coverage of vitamin A supplementation between 6 and 59 months of age; nine countries have >60% coverage of oral rehydration salts (ORS) for diarrhoea. In seven countries, >70% of children with suspected pneumonia are taken to an appropriate health-care provider.

87. In addition to progressive scaling up of coverage of evidence-based interventions for RMNCAH, the need for ensuring good quality of care has emerged strongly as a priority to accelerate the reduction in morbidity and mortality. In response, the WHO Regional Office for South-East Asia prepared a Regional Framework for improving the quality of care in RMNCAH in 2015, followed by creating a Regional Model for point-of-care quality improvement (POCQI), which initially focused on improving the quality of care for mothers and newborns at the time of birth in health facilities. All countries in the Region have developed policies for improving the quality of care and a majority have defined standards of RMNCAH care and undertaken assessments of the quality of care in health facilities and hospitals. Through a series of regional and national training sessions, POCQI has been introduced in more than a thousand hospitals across countries in the Region. Quality improvement has been institutionalized in maternal, newborn and child health programmes in Bangladesh and India. The POCQI model of the SE Asia Region has been introduced in other regions of WHO and in the global training packages.

88. A South-East Asia Region Technical Advisory Group (TAG) has been working to strengthen the regional technical advisory mechanism to support Member States in implementing high-impact approaches and monitoring progress. Considering the importance of sexual and reproductive health (SRH), a technical subcommittee on SRH was constituted under the SE Asia Regional Technical Advisory Group (SEAR-TAG) for Women's and Children's Health. So far, seven TAG meetings have been conducted.

89. The Regional Office has prepared strategic guidance to support Member States to strengthen their national programmes for RMNCAH. The Regional Strategy for accelerating reduction in newborn and child mortality and Regional Framework for accelerated actions for adolescent health were launched in 2018 and the Regional Strategic Framework for accelerating universal access to sexual and reproductive health and rights was launched in 2020.

90. The Regional Meeting of Parliamentarians in 2018 was organized to advocate for keeping the health of women, children and adolescents at the centre of universal health coverage (UHC), with a call to action for commitment and accountability to improve their health and well-being.
91. Policy and strategic gaps were identified and the policy dialogue in the country RMNCAH programmes, based on the RMNCAH policy survey findings, were initiated.
92. Evaluation was conducted of the adaptation and use of the *WHO Guidelines on reproductive, maternal and newborn health (RMNH) in the WHO South-East Asia Region* (2018–2019). The recommendations were disseminated and implemented as a management response.
93. A monitoring framework across the life-course to strengthen and standardize data collection across the Region has been developed and is being used for evidence-based planning and global reporting.
94. The Regional Office has prepared a Programme Managers' Training Package on RMNCAH to strengthen capacity at the national and subnational levels to achieve high population coverage of essential RMNCAH interventions. These were also used in other WHO regions to conduct regional- and national-level training. The strengthened capacity of the district management would ensure effective planning and implementation of RMNCAH programmes leading to accelerated reduction in mortality among mothers, newborns, children as well as stillbirths.
95. The Regional Office oriented Member States on the new WHO recommendations on antenatal care for a positive pregnancy experience at the Regional Meeting in 2018. It continued technical assistance to incorporate ANC and intrapartum care recommendations into national guidelines. Country adaptation was completed in Bangladesh, Nepal, Thailand and Timor-Leste.
96. A Pocketbook has been developed on maternal health care in small hospitals and management of first-trimester abortion for health-care providers in consultation with regional experts and based on WHO recommendations.

New programmatic innovations

97. The Global Sexual and Reproductive Health and Rights (SRHR) initiative started in 2019 with a special focus on reduction of maternal mortality due to complications of abortion through a health systems approach. The initiative is supporting the strengthening of safe abortion, post-abortion care and post-abortion family planning. WHO supported strengthening of the pre-service training curriculum by developing training tools on competency-based comprehensive abortion care for medical undergraduates. Access to medicines for medical abortion in the Region has been assessed to identify gaps in the availability and accessibility of essential medicines.
98. The Regional Office supported Member States in capacity-building of programme managers and representatives from professional organizations to develop and implement policy interventions by conducting training on policy dialogues to improve access to SRH services in countries.
99. Birth defects are the fourth major cause of child mortality in the Region now. The Regional Office has sustained an integrated online surveillance platform, the "SE Asia Region – newborn and birth defects (NBBD) for surveillance of birth defects in newborns, and stillbirths", and established a network of hospitals in Member States of the Region. At present, all countries in the Region have started collecting data on birth defects and are implementing interventions for the prevention and care of birth defects in their national health programmes. Till December 2021, 386 415 total births and 40 357 babies with birth defects have been reported to the database from participating hospitals in seven countries.

100. Death reviews are important to analyse the direct and underlying causes of death and to take action to prevent similar deaths in future by improving the access and quality of care. Countries in the Region have initiated programmes for maternal death surveillance and response (MDSR) and have recently introduced maternal and perinatal death surveillance and response (MPDSR) and child death reviews with the support of WHO. The Regional Office supported the development/update of national MPDSR guidelines and training packages in several settings in Bhutan, Nepal, Myanmar and Timor-Leste, and undertook the first virtual MDSR training programme in 2020. This has been expanded to add perinatal death review (MPDSR). The training package has been also used by other WHO regions.

101. The Regional Office also supported countries to adopt the new evidence-based strategies to address the preterm birth complications that account for more than 40% of newborn mortality. Strategic guidance has been provided for using antenatal corticosteroids and large-scale implementation of “kangaroo” mother care to improve the survival of preterm babies. The “zero separation policy” to ensure that mothers and their babies are kept together right from birth, as much as possible, has been adopted in the Region since 2018.

102. To work on improving the healthy development of children and adolescents, the Regional Office has supported countries to strengthen national programmes for nurturing care for early childhood development and adolescent health and well-being.

103. The tool to assess and utilize SRH services by adolescents was developed and assessment conducted in four Member States to strengthen adolescent health programmes.

104. Plans to sustain the gains and accelerate progress in ending preventable maternal, newborn and child deaths across the SE Asia Region were interrupted by the COVID-19 pandemic in 2020. In addition to the direct and indirect effects across the life-course, the COVID-19 pandemic poses numerous risks of interruption to essential interventions for prevention, promotion and treatment, and quality of care across the Region. Several mitigation efforts were initiated in the Region, including providing strategic and operational guidance to continue RMNCAH services, policy dialogue on evidence-based mitigation strategies, and assessment of delivery and monitoring of SRMNCAH services.

105. Several regional meetings and webinars were held to support Member States in the area of RMNCAH.

Challenges being faced

106. A fully functional health system is a prerequisite for delivering good-quality RMNCAH services. Shortage and inequitable distribution of skilled human resources, access to quality care 24/7 and essential supplies are key contributors to poor maternal and reproductive health outcomes. Financial barriers to access and utilization of maternal and reproductive services remain a formidable challenge in many countries of the Region.

107. Evidence-based interventions for achieving RMNCAH-related SDG targets are well known; the main reasons for missing the MDG targets and being off-track for the SDG targets for maternal, neonatal and child mortality include low and uneven coverage of evidence-based life-saving interventions across the life-course.

108. In the past two years, the major challenge has been related to the direct and indirect impact of the COVID-19 pandemic on programme implementation. Disruption of RMNCAH services due to several demand- and supply-side factors such as restrictions on travel and field missions have severely hampered opportunities to assist countries technically. Face-to-face regional meetings and training sessions were suspended, leading to the postponement of some workplan-related activities. Lockdown measures and re-purposing of RMNCAH staff for the COVID-19 response and staff suffering from COVID-19 infection compromised routine RMNCAH activities. Clinic sessions and community services were delayed, cancelled or limited in various regional countries, which created a pool of unprotected women and children posing a risk for poor RMNCAH outcomes in the future.

The way forward

109. The Department of Family, Gender and Life-Course (FGL) in the Regional Office will support Member States of the Region to keep RMNCAH at the centre of UHC to sustain the gains and accelerate progress towards achieving the SDG and Flagship targets. For this, an increase in domestic financing and equitably scaling up of the coverage of lifesaving interventions is required so that no one is left behind and good-quality health care is ensured.

110. Continued strategic and technical support to Member States through country support plans will be ensured, mainly focused on Bangladesh, India, Indonesia, Myanmar, Nepal and Timor-Leste, and context-specific support for the other Member States. Improving governance of the RMNCAH programme by establishing TAGs at the country level will be a high-impact strategy to accelerate progress towards the achievement of this Flagship Priority. Addressing health workforce issues such as strengthening midwifery services and supporting Member States to monitor RMNCAH services will catalyse other efforts. Continued support will be provided to Member States through WHO country offices to mitigate service disruption due to the pandemic and to maintain RMNCAH services.

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

Background

111. Five of the six WHO regions are independently certified as being free of all wild polioviruses. Global eradication of wild polioviruses type 2 and type 3 has been certified.

112. Globally, six cases of wild poliovirus type 1 (WPV1) have been reported in 2021, from Afghanistan (4 cases), Pakistan (1 case) and Malawi (1 case). In 2022, as of 21 June 2022, a total of 12 WPV1 cases have been reported; one from Afghanistan, 10 from Pakistan and one from Mozambique.

113. Outbreaks due to circulating vaccine-derived polioviruses (cVDPV), in particular, type 2 (cVDPV2), continue to affect countries of the African, Eastern Mediterranean and European regions, including Afghanistan and Pakistan. To stop cVDPV2 more effectively and sustainably, novel oral polio vaccine type 2 (nOPV2) continues to be rolled out through the WHO Emergency Use Listing (EUL) procedure.

114. The Seventy-fourth World Health Assembly noted the Global Polio Eradication Initiative (GPEI) Polio Eradication Strategy 2022–2026. The two goals of the new GPEI strategy are as follows:

- i. Goal One: to permanently interrupt poliovirus transmission in the final two WPV-endemic countries: Afghanistan and Pakistan, and
- ii. Goal Two: to stop cVDPV transmission and prevent outbreaks in non-endemic countries.

115. Successful implementation of the Polio Eradication Strategy 2022–2026 is underpinned by several enabling factors, including ensuring gender equality and gender-responsive programming, research, monitoring and evaluation, and ensuring a more integrated approach to eradication.

116. At its most recent meeting in June 2022, the Polio IHR Emergency Committee unanimously agreed that the risk of international spread of poliovirus remains a public health emergency of international concern.

117. In accordance with resolution WHA71.16 (2018) on “Poliomyelitis – containment of polioviruses”, Member States should continue to implement appropriate containment of type 2 polioviruses, as outlined in the global action plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use.

118. The Strategic Action Plan on Polio Transition (2018–2023) (SAP), as requested by the Seventieth World Health Assembly in decision WHA70(9) (2017), and noted by the Seventy-first World Health Assembly, has three key objectives:

- a) to sustain a polio-free world after eradication of the poliovirus;
- b) to strengthen immunization systems, including surveillance for vaccine-preventable diseases, to achieve the goals of WHO’s Global Vaccine Action Plan 2011–2020; and
- c) to strengthen emergency preparedness, detection and response capacity in countries to fully implement the IHR (2005).

119. The fifth report of the Polio Transition Independent Monitoring Board (TIMB) focuses on increasing interdependence between eradication and transition, making recommendations for actions by programmes to move forward towards the eradication and transition agendas.

120. A mid-term evaluation of the SAP was conducted by an external independent evaluation team, with recommendations on the way forward to enable successful implementation of the Action Plan. An executive summary of the evaluation report was submitted to the Seventy-fifth World Health Assembly in May 2022.

Progress made in the WHO South-East Asia Region

121. The South-East Asia Region of WHO was certified polio-free on 27 March 2014 and has since remained free of all WPV. No outbreaks of wild or cVDPV have been reported in the Region in 2021 and 2022 (as of 21 June 2022). The Regional Certification Commission for Polio Eradication (RCCPE) continues to provide oversight.

122. Despite the COVID-19 pandemic, all countries ensured that laboratory-supported surveillance (for acute flaccid paralysis and environmental surveillance) is sustained to detect any poliovirus transmission. In 2021, overall surveillance indicators in the Region were maintained above the global certification standards. However, there are national- and subnational-level variations in some countries and these are being addressed.

123. There was backsliding in immunization coverage in almost all countries during the initial few months of the COVID-19 pandemic in 2020. Following the actions taken by Member States, overall immunization coverage has improved in the Region. Efforts to strengthen immunization systems need to continue to achieve pre-COVID-19 coverage levels and to sustain them.

124. Four poliovirus essential facilities (PEF) have been identified in the Region (three in India and one in Indonesia). National authorities for containment have been established in both countries. Three designated PEFs have received the certificate of participation under the WHO Global Action Plan (GAPIII) Containment Certification Scheme (CCS) from the Global Certification Commission.

125. The South-East Asia Region has a single integrated network for surveillance and immunization that provides support not only for polio eradication, but also for measles and rubella elimination, surveillance of other vaccine-preventable diseases, strengthening immunization and responding to emergencies. The integrated network makes the Region the most advanced among all WHO regions for polio transition. The first steps for financial sustainability, including cost-sharing and domestic funding, were taken long before polio transition came onto the global agenda – a fact highlighted by both the TIMB and the mid-term evaluation reports.

126. There are five polio-priority countries in the Region – Bangladesh, India, Indonesia, Myanmar and Nepal. All countries have developed their national transition plans, adopting a country-centric approach, and steps are being taken towards financial sustainability.

- a. In Bangladesh, part of the operational costs of surveillance and immunization medical officers have been included in the government operational plans to ensure long-term financial sustainability of functions, with full transfer to the government planned for 2026.
- b. India is implementing its transition plan in line with the outcomes of the 2020 mid-term review. The Government of India has committed domestic resources to support phase 2 of implementation of the transition plan, which extends the scope of the network to wider public health functions, including emergency response, and measles and rubella elimination, while continuing support to routine immunization. As a step towards aligning the scope of work to future needs and priorities, the national polio surveillance project has been renamed as the national public health support programme.

- c. The Government of Indonesia has initiated actions to self-fund a large proportion of the surveillance, laboratory and immunization costs previously funded by the GPEI.
- d. The Government of Myanmar has developed a draft roadmap (2020–2024) to transfer all duties and responsibilities of the Regional Surveillance Officer network to the Ministry of Health and Sports. However, delays are anticipated in implementation of the plan.
- e. Discussions have been re-initiated with the Government of Nepal to explore options for sustainable financing.

Challenges being faced

127. The Region continues to be at risk of importation of WPV from endemic countries and of cVDPV emergence and/or importation from other WHO regions with ongoing outbreaks.

128. While the performance of immunization coverage and surveillance has improved in almost all countries, overall immunization coverage, acute flaccid paralysis case reporting and collection of samples during environmental surveillance remains below pre-COVID-19 levels in several countries.

129. Sustaining high routine immunization coverage, especially coverage with inactivated polio vaccine (IPV), sensitive surveillance, strong outbreak response capacity and containment of polioviruses in facilities during the post-certification period are needed.

130. While countries are making good efforts towards polio transition, predictable funding from partners/donors and longer-term commitment of domestic resources remain critical to ensure that integrated surveillance and immunization infrastructure and capacities continue to support essential polio functions and strengthen health systems.

The way forward

131. Sustaining high routine immunization coverage for both oral polio vaccine (OPV) and IPV, sensitive surveillance, strong outbreak response capacity and containment of polioviruses in facilities remains a priority for the Region.

132. All Member States of the Region must fully implement the Polio Eradication Strategy (2022–2026), including collective coordination for an emergency response, and ensuring vaccination of children who have not received any dose of polio vaccine in the past.

133. To mitigate any potential risk of slow-down in implementing the national transition plans amid the ongoing COVID-19 pandemic and lack of predictable funding, continued commitment of Member States and partners will remain a priority to maintain essential polio functions and contribute to strengthening immunization systems and help achieve coverage and equity goals.

7. Measles and rubella elimination by 2023 (SEA/RC72/R3)

Background

134. The Seventy-second session of the WHO Regional Committee for South-East Asia endorsed resolution SEA/RC72/R3¹ in September 2019, in which Member States of the Region adopted the updated goal of measles and rubella elimination by 2023. “Eliminate Measles and Rubella by 2023” is one of the eight Flagship Priority Programmes of the Region.

135. To ensure adequate technical guidance to accelerate progress towards the goal, a Strategic Plan for Measles and Rubella Elimination in the WHO South-East Asia Region 2020–2024 has been developed.

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

137. An independent external review of measles and rubella elimination in the WHO SE Asia Region was commissioned in the last quarter of 2021.

Progress made in the WHO South-East Asia Region

138. Significant progress has been made in the WHO SE Asia Region towards measles and rubella elimination since 2014. Five countries – Bhutan, DPR Korea, Maldives, Sri Lanka and Timor-Leste – have been verified to have achieved measles elimination while rubella elimination has been verified in two countries – Maldives and Sri Lanka.

139. The annual reported incidence of measles decreased by 79% between 2014 and 2020 (from 23.4 to 4.8 cases per million population). Similarly, the reported incidence of rubella declined from 5.1 in 2014 to 0.8 cases per million population in 2020.

140. Coverage with the first dose of a measles- and rubella-containing vaccine (MRCV1) in the Region increased from 66% in 2003 to 87% in 2014, and to 94% in 2019. This was followed by a decline in coverage to 88% in 2020 following the COVID-19 pandemic. A similar trend was observed for the second dose of measles- and rubella-containing vaccine (MRCV2) in the Region.

141. More than 619 million persons were vaccinated with MRCV through supplementary immunization activities between 2014 and 2020.

142. Laboratory supported case-based surveillance for measles and rubella has been initiated in all Member States. All Member States in the Region have at least one proficient national laboratory to support measles and rubella case-based surveillance. The measles–rubella laboratory network has expanded from 23 laboratories in 2013 to 58 in 2020, with 56 of these laboratories accredited as “proficient” for measles and rubella testing.

¹ Measles and rubella elimination by 2023. Doc no. SEA/RC73/R3. New Delhi: World Health Organization, Regional Office for South-East Asia, 2019. <https://apps.who.int/iris/bitstream/handle/10665/327923/sea-rc72-r3-eng.pdf?sequence=1&isAllowed=y> – accessed 3 Aug 2022.

143. The independent external review of progress towards measles and rubella elimination in the SE Asia Region conducted in 2021 observed that, while great progress has been made in the Region, greater political commitment and excellence in technical and operational deployment remain critical to achieving the 2023 target of measles and rubella elimination. The reviewers also highlighted that the immunization coverage and surveillance sensitivity required for elimination are not likely to be reached by all countries of the Region by 2023.

Challenges being faced

144. The COVID-19 pandemic has had a serious impact on measles and rubella elimination activities. Routine immunization sessions stopped or were severely affected for varying durations, either nationally or subnationally, in most countries leading to a decline in coverage of measles vaccination in 2020 and 2021. Similarly, surveillance for vaccine-preventable diseases was affected by the pandemic due to various reasons such as repurposing of health workers for the COVID-19 response, absence of health workers due to COVID-19 infection, lockdown measures and fear of infection among communities.

145. While efforts to revive immunization and surveillance are ongoing, the immunization coverage and sensitivity of measles and rubella surveillance are yet to be restored to the pre-COVID-19 pandemic level.

146. Significant challenges to achieve measles and rubella elimination in the Region remain, irrespective of the pandemic, the greatest of which is to improve the routine immunization programme to 95% or more coverage with two doses of an MRCV in all districts of all countries.

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

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

The way forward

149. High-level political and programmatic commitment to implement the Strategic Plan to Eliminate Measles and Rubella from the Region will have to continue to drive the agenda in the Region towards accelerated implementation of the Strategic Plan at the optimal level.

150. Full and timely implementation of the recommendations made during the 12th meeting of the WHO South-East Asia Regional Immunization Technical Advisory Group in 2021 and the 6th meeting of the WHO South-East Asia Regional Verification Commission for measles and rubella elimination in 2021 will be required to ensure that progress towards measles and rubella elimination by 2023 is on track. WHO and partners will have to ensure adequate technical support to Member countries for quality implementation of activities.

8. Strengthening health workforce education and training in the Region (SEA/RC67/R6)

Background

151. The availability, accessibility, acceptability and quality of health workers is well-recognized as fundamental to the achievement of universal health coverage (UHC) and the health-related Sustainable Development Goals. Successive waves of the COVID-19 pandemic have additionally brought to the fore the importance of health workers to health security and broader economic prosperity. Indeed, a key action point identified for Member States by the last High-Level Preparatory Meeting held in 2021 and further reflected in the Seventy-fourth session of the WHO Regional Committee for South-East Asia in September 2021, wherein the ministers of health signed the “Declaration by the Health Ministers of Member States at the Seventy-fourth Session of the WHO Regional Committee for South-East Asia on COVID-19 and measures to ‘build back better’ essential health services to achieve universal health coverage and the health-related SDGs” (SEA/RC74/R1). The Declaration called for strengthening investments in human resources for health (HRH), especially at the primary health care level, for effective response to health emergencies and to build resilient health systems.

152. Cognizant of longstanding and persistent challenges for HRH, the WHO South-East Asia Region has since 2014 had a dedicated focus on HRH, as part of its Flagship Priority on Universal Health Coverage. Notably, in 2014, the Sixty-seventh session of the Regional Committee for South-East Asia endorsed resolution SEA/RC67/R6 on “Strengthening health workforce education and training in the Region” and requested the Regional Director to report on progress in health workforce development to the Regional Committee every two years, starting in 2016, for a decade. The SE Asia Region Decade for Human Resources for Health Strengthening, 2015–2024, was launched at a regional meeting in Thimphu, Bhutan in 2014, with an initial focus on rural retention, transformative education, HRH information systems, and HRH in the context of UHC.

153. Three previous HRH-focused progress reports have been provided to the Sixty-ninth, Seventy-first and the Seventy-third sessions of the Regional Committee for South-East Asia. The first review, covering the period 2014–2016, noted difficulty in systematically monitoring data on HRH, weak national data systems and the need for greater linkage of HRH to service delivery, including UHC. The second review of progress, covering the period 2016–2018, additionally emphasized the importance of strengthening the collection and analysis of data with respect to frontline health workers, strengthening HRH governance and associated capacities, and supporting the evaluation of best practices in rural retention and transformative education. The third and mid-term review of progress, covering the period 2018–2020, highlighted the opportunity afforded by COVID-19 to further increase investments in the health workforce, to support and strengthen Member States’ HRH-related capacities, and to continue to monitor and report progress on HRH.

154. This fourth review of progress covers the period 2020–2022. It follows significant deliberation at national, regional and global levels on lessons learned from COVID-19. Perhaps the central lessons emerging from COVID-19, as discussed in depth both at the Seventy-fourth session of the WHO Regional Committee for South-East Asia as well as the Seventy-fifth World Health Assembly, is the importance of a strong foundation of primary health care in sustaining progress towards UHC, the health SDGs, and health security. Echoing the key message in the SE Asia Region Decade's second progress report, the COVID-19 pandemic has further clarified the need for focused attention on primary health care workforce teams as the critical enablers for realization of the vision of primary health care (as captured in multiple articles and reports, including the *South-East Asia Journal of Public Health*: Deep impacts of COVID-19: overcoming challenges in strengthening primary health care by targeting the health workforce, and the World Bank Walk the Talk: reimagining primary health care after COVID-19). As such, this fourth progress report includes a focus on primary health care workforce teams.

Progress made in the WHO South-East Asia Region

155. This fourth review of progress on the Decade for Strengthening Human Resources for Health in the SE Asia Region has been informed by a self-reported survey by Member States using the National Health Workforce Accounts online platform. The survey has 14 standard indicators that were agreed upon by Member States at a regional meeting in 2017. In addition to these indicators, Member States have additionally reported data on primary health care workers.

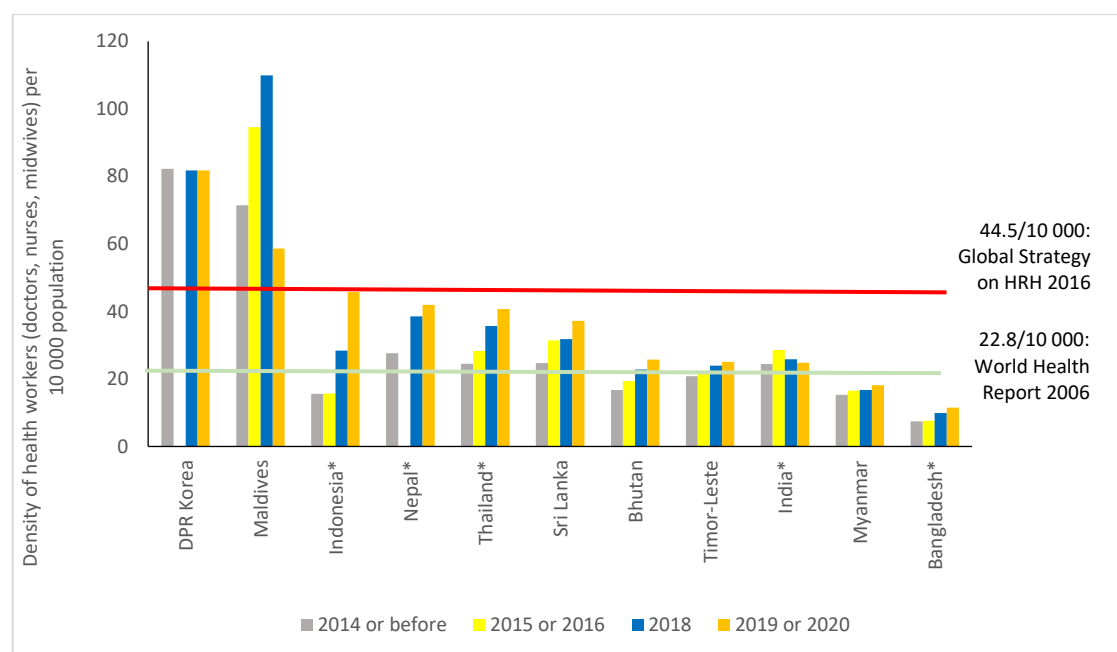
156. The following are the notable findings from the review of data provided through the National Health Workforce Accounts Platform as in June 2022:

- a. Since the start of the SE Asia Region Decade for HRH Strengthening, and unlike the decade prior to it, there has been a consistent improvement across most SE Asia Region countries in the availability of doctors, nurses and midwives (SDG 3.c.1 indicator). Currently, the regional average density of doctors, nurses and midwives stands at 28.05 per 10 000 population. This represents a 30.5% increase since the start of the SE Asia Region HRH Decade in 2014. As of July 2022, nine SE Asia Region Member States have surpassed the 2006 World Health Report-identified threshold of 22.8 doctors, nurses and midwives per 10 000 population (see Fig. 1). Moreover, three Member States have surpassed the 2016 Global Strategy on Human Resources for Health-identified threshold of 44.5 doctors, nurses and midwives to achieve the SDGs.

While the above findings are encouraging, it should be noted that they represent not only a substantial increase in production across the Region but also improvement in underlying HRH information systems. To elaborate, data for Indonesia in 2018 and prior data covered only the public sector, while data for 2019 and 2020 captures information on health workers in both the public and private sectors. Similarly, the relatively lower density of doctors, nurses and midwives in Bangladesh and Myanmar reflect difficulties in capturing data on both public and private sector health workers.

COVID-19 highlighted the need for robust HRH information systems. Across SE Asia Region countries, including through WHO support, significant efforts are under way to strengthen HRH information systems. As an illustration, India is in the process of launching a comprehensive health professional registry under the Ayushman Bharat Digital Health Mission. Similar efforts to strengthen HRH data on public and private sector health workers, including through WHO support, is under way in Bangladesh and Nepal. Moreover, in Maldives and Timor-Leste, through WHO support, efforts are under way to both improve HRH information systems and the ability to link to the routine facility-based health information system. The latter will enable strengthened information and policies related to HRH deployment and performance.

Fig. 1. Trends in the availability of doctors, nurses and midwives in SE Asia Region countries, 2014–2020

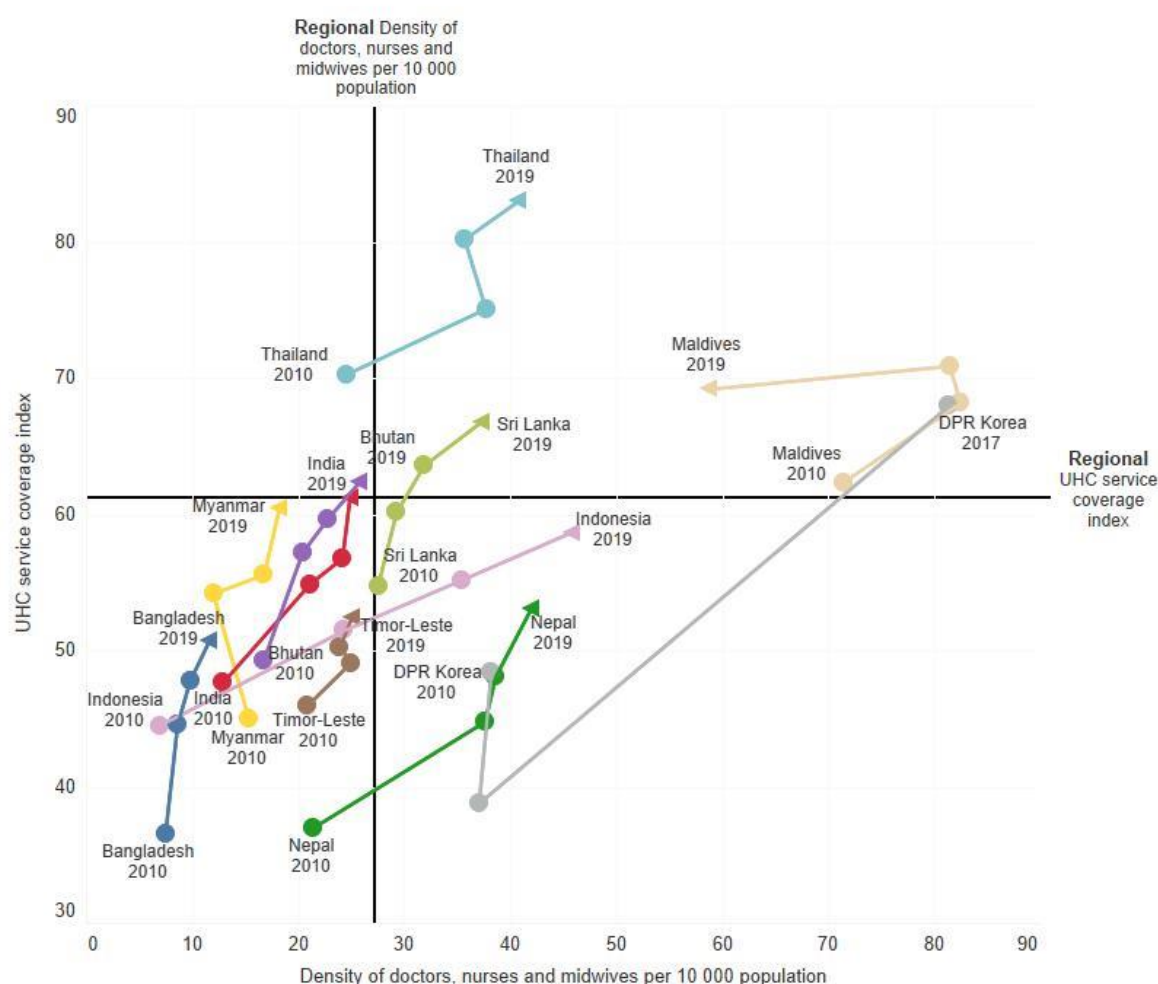


Source: Country data reported to WHO through the NHWA online platform (MoH & professional councils) as on 22 June 2022

- b. HRH, alongside access to essential medicines, is one of two focus areas of the Regional Flagship Priority on UHC. For the first time, progress with respect to the UHC Service Coverage Index (SDG 3.8.1) has been mapped alongside the density of doctors, nurses and midwives (see Fig. 2). The mapping of the two SDG monitoring health system indicators shows significant and consistent improvement in both UHC service coverage and density of doctors, nurses, midwives since the inception of the SE Asia Region's UHC Flagship, SE Asia Region's HRH Decade, and the global SDG agenda.

Mapping of the two SDG monitoring indicators also, however, cautions that the relationship between the UHC Service Coverage Index and the density of doctors, nurses and midwives in several countries is not necessarily linear. More doctors, nurses and midwives need not necessarily result in improved service coverage. Fig. 2 shows that countries can achieve significant improvement in service delivery and coverage without substantially increasing the density of doctors, nurses and midwives. Models of service delivery, and their efficiency and quality; financing and governance of the public and private sectors; availability and distribution of infrastructure, health workers and medical products across geographical areas, levels of health-care facilities and the public and private sectors; mechanisms for community engagement; and the role of additional occupations in health service delivery teams (including mid-level health workers, community health workers and volunteers, traditional health workers, and other allied and paramedical staff) are critical to the achievement of UHC, in addition to aggregate densities of doctors, nurses, and midwives. Most important, Fig. 2 serves as a reminder that improvement in the density of doctors, nurses and midwives, including with respect to WHO-identified thresholds, should be viewed as an indication of progress rather than an end in itself.

Fig. 2. Trends in UHC Service Coverage Index (SDG 3.8.1) and the density of doctors, nurses and midwives (SDG 3.c.1) in SE Asia Region countries, 2014–2020



Source: Global Health Observatory and NHWA Online Platform as on 22 June 2022

Note: UHC SCI 2010 mapped to density 2014 or earlier; UHC 2015 to density 2015–2016; UHC 2017 to density 2017–2018; UHC 2019 to density 2019–2020

Moreover, in addition to well-recognized challenges with respect to the distribution of health workers across geographical regions and across the public and private sectors, it is worth noting that distribution of public sector health professionals also varies significantly across levels of care in SE Asia Region countries. As an illustration, see Table 1, which identifies the proportion of Ministry of Health staff at the tertiary versus secondary and primary (district) levels across three countries. Given the increase in priority accorded to primary health care, including a global recommendation to increase financing for primary health care and the SE Asia Region Primary Health Care Strategy recommendation to, at a minimum, prioritize additional financing to the district/primary health care level, closer monitoring of health workers by level of care will be increasingly important.

Table 1. Percentage of Ministry of Health staff at tertiary level

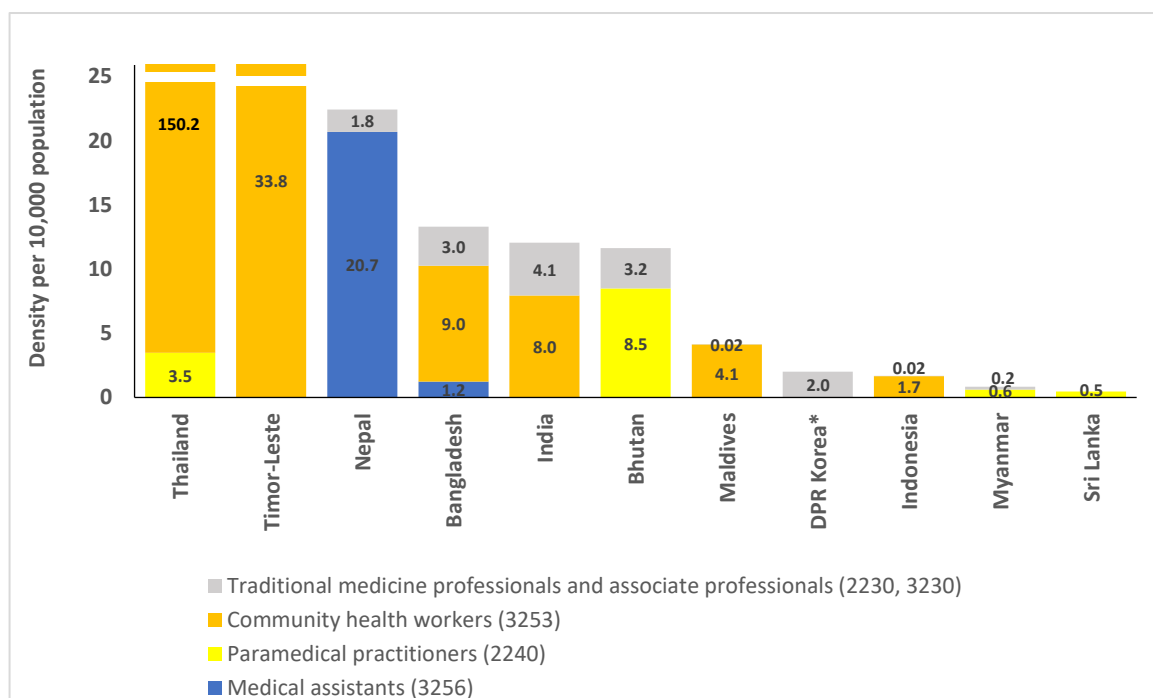
Countries in the SE Asia Region	MoH doctors (%)	MoH nurses (%)	MoH dentists (%)	MoH pharmacists (%)
Bangladesh	75.3%	75.0%	57.8%	49.3%
Thailand (under the MoPH Permanent Secretary)	68.9%	60.0%	44.7%	51.2%
Democratic People's Republic of Korea	Across occupations: 75–80% at primary health care level; 10–15% at county/district level; 3–5% at province level; 0.5–1% at central level.			

Source: Bangladesh, MIS DGHS/WHO Health Labour Market Analysis, 2021; Thailand, MoPH, 2022; DPR Korea, National Health Report, 2017

- c. At the Ministerial Roundtable held during the Seventy-fourth session of the Regional Committee for South-East Asia in September 2021, Member States of the Region emphasized the imperative and shared innovations to utilize the full array of health workers available in the Region, with a focus on primary health care workforce teams that are closest to communities. Primary health care workforce-related innovations from COVID-19 were also captured in the special edition of the *South-East Asia Journal of Public Health* on “Recalibrating PHC-centred systems for UHC in the new normal: lessons from COVID-19”, published in 2021. Across countries, surge capacity was enabled through optimizing the available health workforce, including using students and retired health workers, expanding scopes of practice and adopting digital technologies.

COVID-19 especially clarified the importance of fully counting, planning for, and investing in the full array of occupations that constitute the primary health care workforce, as critical to delivering essential health services and to strengthening health systems resilience.² In addition to doctors, dentists, nurses, midwives and pharmacists, Member States benefit from a variety of occupations, including medical assistants, traditional medicine professionals and associate professionals, paramedical practitioners, and community health workers, who have a direct role in the delivery of essential health services and a health emergency response. These health workers who are working closest to communities, but are often uncounted, are a major asset for health systems across the Region beyond COVID-19. Fig. 3 shows the contribution of these occupations, as mapped to the International Standard Classification of Occupations 2008, in providing services close to the community.

² Tangcharoensathien V. Deep impacts of COVID-19: overcoming challenges in strengthening primary health care by targeting the health workforce. WHO South-East Asia J Public Health. 2021;10 (Suppl S1):73–5.

Fig. 3. Availability of the primary health care workforce in the SE Asia Region, 2020

Source: Country data reported to WHO through NHWA online platform as on 22 June 2022

Moreover, in March 2022, over 100 representatives from Member States and partners participated in the Regional Meeting to Operationalize the South-East Asia Regional Strategy. Central to discussions at the meeting was the need across countries to strengthen the composition, competence, motivation and performance of primary health care teams. Member States requested support, including through the use of digital technologies, from WHO and partners for the development of primary health care teams; to strengthen team capacities to deliver an expanded package of essential health services and essential public health functions; and strengthened coordination to reduce fragmentation in the primary health care workforce.

WHO, through its country offices in the Region and the Regional Office, is increasingly focusing its support to strengthen primary health care teams, including ongoing work in Bangladesh, India and Sri Lanka. A shortage of medical specialists at district level is a major challenge across countries and a key constraint to performance at primary health care level. Work is currently under way across countries to map, project and address shortages in medical specialists.

157. The period saw a focus on health workforce governance. Notably, through WHO support, Bangladesh, Bhutan, Maldives, Nepal, and Sri Lanka undertook reviews and updated their national HRH strategies during the period. Ten SE Asia Region Member States currently have an HRH strategy that is up to date or is in the process of revision and/or endorsement. Increasing attention is being paid to linking national HRH strategies to priorities of service delivery and health system resilience. Member States, with WHO support, are also increasingly identifying HRH standards to deliver essential services across the various levels of care. The period has seen the development of HRH and service standards in Bhutan, India, Indonesia, Sri Lanka and Timor-Leste. Work is currently under way to develop HRH staffing norms for Bangladesh. Moreover, across SE Asia Region countries, WHO supported a variety of HRH-focused studies to operationalize national HRH strategies, essential service packages, and national health policies.

158. The use of the WHO Workload Indicator of Staffing Needs (WISN) was especially prominent during the period, with studies conducted in Bangladesh, Bhutan, India, Indonesia, Nepal and Sri Lanka. WISN studies were used for the development of HRH staffing norms in Bhutan and Sri Lanka. At the regional level, work is underway to garner learning on the use of the WISN tool and potential adaptations at the primary health care level. Health labour market studies were conducted in Bangladesh and India (state of Chhattisgarh) to inform national/subnational policies, with additional work underway in India (the states of Assam and Gujarat) and Sri Lanka.

159. Transformative education and rural retention remain key priorities and challenges in the Region. With respect to the former, aligning health professional education to health population needs, while desirable, remains a challenge due to the variety of interests that drive health professional education: i.e. individual, economic, labour and trade-related priorities. Rural retention, especially for occupations that have a demand in the private sector and in global markets, also faces real difficulties. The challenges are especially pronounced in countries with a prominent private sector role in education and delivery of health services. Despite these challenges, important progress is notable in the Region.

- a. Most important, to address challenges related to the cost, quality, and distribution of health professional education and the health workforce, landmark reforms have taken place through the Nepal Medical Education Act, 2019, India National Medical Commission Act, 2019, and India National Commission for Allied and Healthcare Professions Act, 2021. The reforms seek to align education with the respective national health needs, allow affordable and high-quality education to all strata of society, and promote the equitable distribution of health care and services. The new institutional structures with increased State oversight, with respect to the regulation of health professional education institutions, is expected to improve accountability, transparency and achieve a better balance across priorities of the State, professions, and civil society. Common entry and exit (licensing) exams are in the process of being instituted to ensure common national standards and improve the quality of health professional education, while regulations related to the cost of education are expected to improve accessibility to health professional education. The reforms are also directly targeted at improving primary care by influencing the geographical distribution of new health professional institutions and through linking scholarships to service in government.

- b. During the period, several SE Asia Region countries developed national training standards to align health workforce knowledge and skills with health system needs. Sri Lanka developed its National Health Facility Training Standards and Timor-Leste, with WHO support, is currently in the process of developing a training policy to enable a structured approach to strengthen health workforce knowledge and skills. During the period, WHO supported the Khesar Gyalpo University of Medical Sciences of Bhutan with development of guidelines for a one-year MBBS undergraduate internship programme in alignment with its health system context and needs. The WHO Global Competency Framework for Universal Health Coverage, launched in April 2022, is an important resource to strengthen health professional education in the Region. It is currently being translated into the Thai language, as requested by Thailand.
- c. Two important documents related to rural retention were published during the period: (i) *Improving retention of health workers in rural and remote areas: case studies from WHO South-East Asia Region* in 2020 and (ii) *WHO guideline on health workforce development, attraction, recruitment and retention in rural and remote areas* in 2021. The Regional Office held a regional webinar in 2021 to share experiences and lessons learned across Member States, with emphasis on a bundled approach to interventions, as highlighted in both publications. Rural retention, being particularly relevant to advancing primary health care, remains at the heart of WHO HRH-related dialogue with and support to Member States.
- d. The use of digital technology has emerged as an important element to support health workforce capacities and address health workforce gaps, especially in rural and remote areas. COVID-19 enabled key reforms in health professional regulation to assist greater use of digital technology. Examples include the establishment of telemedicine practice guidelines, laws, and standards in India, Indonesia, and Thailand, respectively, enabling health providers to provide telemedicine services while maintaining professional and safety standards.
- e. International migration and mobility of health personnel remains a key challenge in the Region (including in the context of transformative education and rural retention). Demographic changes and the impact of the COVID-19 pandemic have resulted in an increased demand for skilled health workers in high-income countries, with associated pressures in SE Asia Region countries. As an illustration, recently released data from the UK Nursing and Midwifery Council (NMC) for 2021–2022 identified 37 815 Indian nurses on the Council's register; an increase from 28 192 the previous year; and more than double the 17 730 registered four years ago.
- f. Given the escalating challenge of international migration, and the opportunity for greater cooperation between source and destination countries, the WHO regions of the Eastern Mediterranean, Western Pacific and South-East Asia convened the first Tri-regional Meeting on international health worker mobility in June 2021. In addition to Member State representatives, participants from the development, education, finance, health, labour, migration, trade and private sectors joined the dialogue. The Meeting emphasized that while health worker mobility serves many purposes, the perspectives and voices of health systems actors must reside at the centre of dialogue and cooperation on this topic. Following the meeting, focused support on the Code and global experiences thereof were shared with government representatives in India, Nepal and Sri Lanka, and there was also direct dialogue with the Department of Health of the United Kingdom of Great Britain and Northern Ireland.

- g. Six out of 10 eligible SE Asia Region countries provided national reports during the fourth round of reporting on the WHO Global Code of Practice on the International Recruitment of Health Personnel in 2021. The Region continues to have high reporting rates compared to other WHO regions. Three countries (Bangladesh, Bhutan, and Indonesia) reported 11 existing bilateral agreements. Out of these, four bilateral agreements had ministries of health as signatories. Several countries identified limited mechanisms to monitor and/or coordinate international health worker mobility. Indonesia stands out as a positive example in the Region, with an established mechanism for coordination with other relevant agencies; provisions in legislations and regulation in alignment with the Code; and an accountability mechanism for private recruiters.

160. Health professional regulation holds an important promise to address a number of explicit HRH-related priorities of the SE Asia Region, including transformative education, rural retention, health information systems, HRH governance, prioritization of UHC, and processes for international health worker mobility. Yet to this point, focused support in this area has been limited. The WHO Regional Office for South-East Asia, in partnership with Thailand's International Health Policy Programme and the Australia Health Practitioners' Regulatory Agency, is currently in the process of developing case studies that capture the diversity of systems, reforms, and alignment with health system goals, including focus on transformative education and rural retention. The process of developing case studies has highlighted the opportunity to enable greater sharing of lessons in the SE Asia Region across countries (likely to be particularly useful for smaller countries).

Challenges being faced

161. There has been tangible progress on HRH across all SE Asia Region countries. Yet, key challenges, as highlighted in the above sections, remain, not just in the number of health workers, but also in their optimum distribution, composition, competence and performance, especially with respect to providing care close to communities. The COVID-19 pandemic has both justified the WHO South-East Asia Region's decision to place focused attention on HRH as part of its Flagship Priority on UHC. It has also, however, pointed to the need to further accelerate progress in the remaining period of the SE Asia Region Decade of Strengthening Human Resources for Health and beyond.

The way forward

162. As part of the roadmap ahead, Member States may consider strengthening the capacities of their ministries of health to engage with stakeholders in other relevant sectors, such as education, home affairs, foreign affairs, labour, trade and the like, to ensure that health workforce development prioritizes health needs; and also proceed to bolster stewardship capacity to engage with private health-care providers to enhance public health values.

163. Investments in HRH must also be strengthened and optimized, especially with respect to primary health care teams. HRH information systems must be further strengthened and linkages explored with routine health facility data. HRH and service delivery information must be freely shared among countries as part of regional and global monitoring processes.

164. WHO will provide HRH-related strategic technical support to SE Asia Region Member States, with focus on improving the composition, distribution, competence, motivation and performance of primary health care workforce teams. This will entail providing focused support to strengthening HRH information systems, including potential linkages with routine health information systems. Cross-country knowledge- and experience-sharing, including on approaches to optimize primary health care workforce teams, on the use of digital technology to strengthen HRH capacities and address HRH-related gaps, and on innovations in health professional regulation, must also be enabled.

165. WHO is also scheduled to conduct a comprehensive assessment of the Decade for Strengthening Human Resources for Health in the South-East Asia Region, as called for by its first review of progress, with a focus on accelerating progress and responding to the changes consequent to the COVID-19 pandemic.

166. Almost eight years have passed since the Sixty-seventh session of the WHO Regional Committee for South-East Asia endorsed the resolution SEA/RC67/R6 on “Strengthening health workforce education and training in the Region”, with the Decade for Strengthening Human Resources for Health in the South-East Asia Region launched shortly thereafter. Unlike the 10 years prior to the launch of the SE Asia Region Decade, the four rounds of reporting progress show considerable and tangible improvement across all countries in the Region. At the same time, as exposed by COVID-19, gaps in the health workforce continue to be keenly felt across all countries.

167. Changing demographics; changing disease burden along with the increasing burden of noncommunicable diseases; climate change; health emergencies; and international mobility, all in a context of constrained economies, are putting significant pressure on health systems and health workers across SE Asia Region countries. Progress towards UHC and other health SDG targets, and health security requires accelerated progress with respect to the “Decade for Strengthening Human Resources in the South-East Asia Region” over its last two remaining years. A concerted focus across Member States, WHO and partners on strengthening investments in primary health care workforce teams will provide an important opportunity to advance progress on the SE Asia Region Decade and deliver on national, regional and global health goals.