Progress reports on selected Regional Committee resolutions

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

1. Promoting physical activity in the South-East Asia Region (SEA/RC69/R4);
2. South-East Asia Regional Action Plan to implement the Global Strategy to reduce harmful use of alcohol (2014–2025) (SEA/RC67/R4);
3. Access to medicines (SEA/RC70(3));
4. South-East Asia Regional Health Emergency Fund (SEA/RC60/R7);
5. Expanding the scope of the South-East Asia Regional Health Emergency Fund (SEARHEF) (SEA/RC69/R6);
6. Strengthening emergency medical teams (EMTs) in the South-East Asia Region (SEA/RC71/R5);
7. Intensifying activities towards control of dengue and elimination of malaria in the South-East Asia Region (SEA/RC71/R4);
8. Measles and rubella elimination by 2023 (SEA/RC72/R3); and
9. Challenges in polio eradication (SEA/RC60/R8).

The High-Level Preparatory Meeting for the Seventy-third Session of the WHO Regional Committee for South-East Asia, held virtually on 7–8 July 2020, reviewed each progress report and made recommendations, which have been consolidated as an addendum (SEA/RC73/9 Add. 1) to this Working Paper, for consideration by the Seventy-third Session of the WHO Regional Committee for South-East Asia.

The related Regional Committee resolutions/decisions covered in this Agenda item are appended to this Working Paper as Addendum 2 (SEA/RC73/9 Add. 2).
1. Promoting physical activity in the South-East Asia Region (SEA/RC69/R4) ...................... 1
2. South-East Asia Regional Action Plan to implement the Global Strategy to reduce harmful use of alcohol (2014-2025) (SEA/RC67/R4) ..................................................... 4
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1. Promoting physical activity in the South-East Asia Region (SEA/RC69/R4)

Background

1. Physical inactivity is one of the leading risk factors for premature death from noncommunicable diseases (NCDs), causing 3.2 million deaths a year globally. Physical inactivity together with sedentary behaviours increase the risk of many NCDs. Regular physical activity is a known protective factor for the prevention and management of NCDs such as cardiovascular disease, diabetes, and breast and colon cancer.2,3,4

2. Current global estimates of physical inactivity show that worldwide, 27.5% of adults5 and 81% of adolescents6 do not meet the existing WHO recommendations on physical activity for health2, with no improvement registered on this over the last decade. The prevalence of physical inactivity among the adult population of the WHO South-East Asia Region was 15% and that of inadequate physical activity among adolescents was 74%.

3. The Region also has a high gender discrepancy in physical activity (PA) levels. Apart from adolescents, women, older adults, underprivileged groups and poor people, and those with disabilities and chronic diseases are more likely to be physically inactive.

4. Effective promotion of physical activity needs a comprehensive framework, covering interventions that focus on individuals, targeted population groups and universally across populations.

5. Yoga has been integrated into traditional practices of physical and mental forms of exercise since ancient times, and contributes to the health and wellness of the people. The International Day for Yoga was declared by the United Nations General Assembly in December 2014. This day has been observed on 21 June every year since 2015, and is gaining momentum and popularity all over the world as a means to promote a healthy lifestyle.

Progress made in the WHO South-East Asia Region

6. The WHO Global Action Plan for the Prevention and Control of NCDs 2013–2020 has envisaged the promotion of physical activity through multisectoral and multi-stakeholder engagement. One of the “best buys” for the prevention and control of NCDs is the implementation of nationwide public education and awareness campaigns on physical activity.

7. The Global Action Plan on Physical Activity (GAPPA) 2018–20307 sets out four strategic objectives and 20 policy actions. This Action Plan was endorsed by the World Health Assembly and

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included a call for WHO to update the 2010 Global Recommendations on Physical Activity for Health.\(^2\)

8. The GAPPA recommends Member States to adopt the voluntary global target of 15% reduction of prevalence of physical inactivity by 2030. This is an extension from the 10% relative reduction of physical inactivity by 2025 (resolution WHA66.10). The target of 15% reduction is achievable considering the opportunity provided by GAPPA to accelerate actions and work in coordination with all relevant stakeholders. The resolution requested the Secretariat to further develop a monitoring framework by 2018, which will consist of impact and process indicators to monitor the implementation of this Action Plan.

9. The Regional Committee resolution on Promoting physical activity in the South-East Asia Region (SEA/RC69/R4) was unanimously adopted at the Sixty-ninth session of the WHO Regional Committee for South-East Asia in Colombo in 2016.

**Challenges being faced**

10. The Regional Office has implemented the Regional Committee resolution SEA/RC69/R4 on physical activity and sedentary behaviours. All SEA Region Member States have a clear national policy to promote physical activity integrated into existing policy frameworks of NCD prevention and control, healthy lifestyle campaign and health promotion. School health programmes in all countries also include an element of promotion of physical activity. Few countries, however, have a clear policy to address sedentary behaviour at the national level.

11. Most SEA Region Member States have installed surveillance systems, which contain survey elements on physical activity among adult and youth populations. These include the NCD STEP Survey, Global School Health Survey, District Health Survey and National Health Exam Survey.

12. The Regional Office for South-East Asia also supported the involvement of experts and nominated delegations from Member States of the Region for the development of GAPPA.

13. The Regional Office for South-East Asia has also emerged as a role model for physical activity, including for promoting PA at the WHO Governing Body and other meetings in the Region.

14. Good practices in the Region have been shared through WHO channels, including the WHO Bulletin and websites. These include promoting physical activity in public spaces, discussing the roles of the local government in its promotion in Thailand and India, the School Health Programme in Sri Lanka, and the setting up of open-air gymnasiums in Bhutan and Timor-Leste.

15. India is launching “Fit India Mission” by developing the Age Appropriate Fitness Protocols and Guidelines, which aim to improve physical fitness for all ages at the community level. Similarly, Maldives established outdoor gymnasiums and provided training to communities in their use in 10 different islands to promote physical activity.

16. The Regional Office for South-East Asia has established a repository webpage for materials promoting physical activity, including short videoclips received from Member States of the Region. WHO also conducted the “Walk the Talk” initiative at the Seventy-third World Health Assembly in Geneva on 17 May 2020.

17. The NCD country capacity survey (CCS) was carried out in 2019 and a Global Status Report (GSR) on Physical Activity is expected to be released in 2020. This report will contain current data on both health behaviours and determinants, as well as information on physical activity policy and infrastructure in the Region:
a. Only six out of the 11 Member States of the WHO SEA Region (the Democratic People’s Republic of Korea, India, Indonesia, Maldives, Nepal and Thailand) reported implementing nationwide public education and awareness campaigns on physical activity.

b. Five of the 11 Member States (India, Indonesia, Myanmar, Thailand and Timor-Leste) reported organizing mass participation events to encourage the people to take part in free opportunities that promote physical activity.

The way forward

18. The following plans and activities will advance the implementation of the regional goal of promoting physical activity among the population in Member States:

   a. developing a regional roadmap for implementation of the GAPPA (2021–2025) with wider consultation with Member States;

   b. organizing a regional virtual meeting with Member States on WHO Guidelines on physical activity and sedentary behaviours for children and adolescents, adults and older adults;

   c. developing case studies to document good practices such as promotion of physical activity in public open spaces and local initiative for physical activity; and

   d. supporting Member States in developing/revising their national strategy, policy and plan of action to promote physical activity (based on the regional roadmap for implementation of GAPPA).
2. **South-East Asia Regional Action Plan to implement the Global Strategy to reduce harmful use of alcohol (2014–2025) (SEA/RC67/R4)**

**Background**

19. The Sixty-seventh session of the WHO Regional Committee for South-East Asia endorsed the South-East Asia Regional Action Plan to implement the Global Strategy to Reduce the Harmful Use of Alcohol (2014–2025).

20. The vision of the Action Plan is to reduce the health and societal burden from alcohol consumption, with the goal of strengthening Member States with tools and building their capacity to address alcohol-related problems. The target is a 10% relative reduction in total adult per capita consumption within a calendar year in litres of pure alcohol, as appropriate, within the national context, to be achieved by 2025, compared with the 2010 baseline.

21. The Action Plan also fulfils the mandate accorded by the Political Declaration of the United Nations General Assembly on Noncommunicable Diseases in 2011 that led to the 2013 Sixty-sixth World Health Assembly resolution WHA66.23 on the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020. To further the action taken in this area, the Sustainable Development Goals included a target that calls for strengthening the prevention and treatment of substance abuse, including narcotic drug abuse and the harmful use of alcohol (Target 3.5).

22. The Action Plan embodies two broad strategies: (i) promoting the implementation of alcohol policy interventions in the 10 target areas as listed in the Global Strategy; and (ii) strengthening capacity, collaboration and coordination.

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

23. Since the endorsement of the Regional Committee resolution SEA/RC67/R4, Member States of the Region have achieved several milestones despite challenges in the enforcement of alcohol policies and resource mobilization. These achievements, however, remain inadequate to reverse the increasing trend of alcohol consumption in the Region.

**Strategy I: Promoting the implementation of alcohol policy interventions, listed in the Global Strategy (10 target areas)**

**Overall progress and milestones**

24. There are varying forms of progress and implementation undertaken in Member States ranging from recent initiatives on national data surveillance systems to national and subnational alcohol policy adoption.

25. Alcohol policy is also integrated into the national NCD action plans aligned with the 2025 NCD targets, as well as national mental health and substance abuse or narcotic control legislation and action plans. This structure adds leverage to the twin actions of introducing and implementing the multisectoral approach required for alcohol control. As part of their national multisectoral action plans for NCDs, all Member States have endorsed and incorporated the target of 10% relative reduction in harmful use of alcohol.
Strengthening capacity, collaboration and coordination

26. Tangible progress has been observed in alcohol treatment services in some countries with the inclusion of alcohol screening and brief intervention services at primary health care services. Complementary addiction services will be developed to provide support to users including to address substance use problems.

27. Alcohol brief interventions and screening have been integrated in the Package of Essential Noncommunicable (PEN) interventions (called PEN modules), which are rapidly being scaled up in most countries of the Region. In some countries, evaluations are underway to understand the implementation challenges and design improvement plans.

28. Online learning portals on management of alcohol use disorders are being developed by the Regional Office to strengthen capacity of health-care personnel in the prevention and management of harmful use of alcohol.

29. Regional capacity-building workshops on the prevention and management of harmful use of alcohol have been conducted, wherein the WHO-led “SAFER initiative” was introduced.

30. The Regional Consultation on the implementation of the Global Strategy and the way forward in New Delhi, India, on 17–18 October 2019, culminated in the development of a report on alcohol consumption in the SEA Region. This report makes specific recommendations for Member States in the 10 policy areas. The need for a legally binding policy on alcohol such as the WHO Framework Convention on Tobacco Control (WHO FCTC) was also mentioned.

31. A “Regional Knowledge Hub” on substance use and substance use disorders has been developed by the Regional Office in collaboration with the All India Institute of Medical Sciences (AIIMS) in New Delhi, India. The regional knowledge hub caters to the needs of the SEA Region regarding behavioural addiction, and includes policy, plans, programmes to address behavioural addictions, including alcohol and drugs.

32. Screening and initial management of alcohol use disorder is included in the Basic Health Service Package. This is a constitutionally mandated national package to be delivered at the primary care level for free. This package is at the initial stage of implementation.

Alcohol surveillance

33. STEP surveys, which have an alcohol module, were completed in three countries in 2019 (Bangladesh, Bhutan, Nepal), and in addition are ongoing in Maldives and Myanmar. The Regional Office experimented with an expanded “alcohol policy” survey module for the Region (with questions on exposure to advertising and marketing, testing for drink–driving, restrictions on physical availability of alcohol, among others).

34. In 2018, acknowledging the urgency to control and prevent the alcohol-related public health and development burden, WHO launched “SAFER”: an action package prioritizing five high-impact WHO “best buys” and “good buys”, which is one out of the 10 policy areas outlined in the Global Strategy. The prioritized domains are: S: Strengthen restrictions on alcohol availability; A: Advance and enforce drink driving counter measures; F: Facilitate access to screening, brief interventions and treatment; E: Enforce bans or comprehensive restrictions on alcohol advertising, sponsorship, and promotion; and R: Raise prices on alcohol through excise taxes and pricing policies. A detailed policy review was conducted for the SAFER package and a publication, “Making South-East Asia SAFER from alcohol related harm: Current status and way forward”, was developed. This publication provides the status of implementation of the SAFER policy action package in the WHO South-East Asia Region. The publication highlighted several gaps, especially in taxation and marketing, and this evidence helps in streamlining and prioritizing interventions in the Region.
35. A Regional Technical Advisory Group (NCD-RTAG) was established to provide technical guidance on all NCD risk factors, including alcohol.

36. The term of the Regional NCD Action Plan is till 2020; a new action plan with validity till 2030 is being proposed, and this will include key action points for addressing the harmful use of alcohol.

**Challenges being faced**

37. In terms of public policy to address harms from alcohol, Member States of the SEA Region are faced with the challenges of fragmentation and inadequate implementation of alcohol policy. Most Member States do not have alcohol-specific infrastructures including agency, policy and strategy, law and regulation. Of particular concern are the trade policies, which do not consider the harmful effect of alcohol. This may lead to difficulties for Member States in their efforts to regulate alcohol.

38. Coordination across sectors and capacity is minimal – there is no lead agency to head the collaboration and coordination processes.

39. Alcohol remains the only psychoactive and dependence-producing substance with a significant impact on population health that is not controlled at the international level by legally binding regulatory instruments. This absence limits the ability of national and subnational governments to regulate the distribution, sales and marketing of alcohol within the context of international, regional and bilateral trade negotiations, as well as to protect the development of alcohol policies from interference by commercial interests.

40. There is a rise in underage drinking among the population in most countries of the Region. Informal and illegal production of alcohol, issues such as violence, accidents and domestic violence and cultural and social norms on traditional alcohol are challenges unique to the Region. There is inadequacy of data and monitoring and surveillance systems, in particular data for monitoring impact of policy and evidence to counter the economic arguments in favour of alcohol. Community ownership and engagement is low in almost all Member States throughout the Region. The policy shift for home delivery and online sales of alcohol under the pretext of social distancing during the ongoing COVID-19 pandemic has led to increased consumption and rolled back to a large extent the gains achieved in alcohol control by policy-makers and stakeholders in recent years.

**The way forward**

41. The need for a legally binding instrument for implementing effective alcohol control policies is an important initiative to be taken to ensure alcohol control in the Region. Further the establishment of effective monitoring and surveillance systems for alcohol control to monitor the situation on consumption and related harms, including progress towards agreed targets, especially SDG Target 3.5, are recommended steps. Hence, it is necessary for governments and policy-makers to advocate and enforce the following actions to reduce the harmful use of alcohol in the Region:

   a. develop and implement comprehensive national alcohol policies;

   b. prepare appropriate taxation regimes, taking into account the current rates of abstinence and also considering the issue of unrecorded alcohol consumption;

   c. promote multisectoral collaboration to develop country-specific measures for addressing unrecorded consumption. This should incorporate components of enforcement as well as community action;
d. promote multisectoral collaboration and capacity-building on enforcement of the current alcohol control measures: advertising restrictions, physical availability, drink-driving and minimum age, among others;

e. adopt appropriate prevention measures among specific vulnerable groups and create community engagement for alcohol control;

f. promote the strengthening of the degree of comprehensiveness of SAFER measures, i.e. advertising, drink-driving countermeasures and services for users. The SAFER technical package will be useful guidance for Member States to prioritize and focus on the “best buy” interventions to accelerate the implementation of the Global Strategy; and

g. prioritize a regional initiative on underage drinking to protect/delay the age of initiation into drinking among young people.
3. **Access to medicines (SEA/RC70(3))**

**Background**

42. Improving access to safe, efficacious, quality and affordable medicines remains a critical focus of the WHO South-East Asia Region. In 2014, access to essential medicines was made a focus area under the Regional Flagship Programme for Universal Health Coverage.

43. This report emanates from the Regional Committee Decision of Member States (SEA/RC70(3)) on 10 September 2017 that the Regional Office present a report on progress made on this area of public health during the Seventy-third Session of the Regional Committee. The Decision advised the Regional Director to convene technical consultations to develop intercountry cooperation on four priority areas: a) share information on medicine prices, building on an existing WHO platform; b) share information on medicine quality, through the functions of the South-East Asia Regulatory Network (SEARN); c) initiate a collaboration on the procurement of antidotes for improved access to limited supplies of medicines for life-threatening conditions; and d) support bilateral cooperation agreements on improved access to medicines.

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

44. Following the Decision at the Seventieth session of the Regional Committee, inter-country technical consultations led to the adoption of the SEA Ministerial Delhi Declaration on “Improving Access to Essential Medical Products in the South-East Asia Region and Beyond” at the Seventy-first session in September 2018. The Delhi Declaration was significant as it went beyond medicines alone and included a commitment on ensuring access to the entire range of essential medical products (medicines, vaccines, diagnostics and medical devices) for achieving universal health coverage and progressing towards the 2030 Agenda for the Sustainable Development Goals.

45. The World Conferences (in 2017, 2018, 2019) on “Access to Medical Products for Achieving the SDGs 2030” in India focused on “improving access to medical products for public health, innovation and intellectual property”. Thailand’s annual International Trade and Health Conferences contributed to promoting new thinking on trade and health and access to health products. Further progress made is as follows:

a. **Sharing information on medicine prices, building on an existing WHO platform**: WHO developed the WHO essential medicines and health products price and availability monitoring mobile application (MedMon) to enable routine monitoring of the prices and availability of medicines. The tool has been piloted in certain countries of the SEA Region. MedMon is a multi-language electronic tool that builds upon the WHO Service Availability and Readiness Assessment (SARA) and Service Provision Assessment (SPA) surveys and the WHO/Health Action International (HAI) methodology on measuring medicine prices, availability and affordability and price components. This allows users to rapidly collect and analyse data on the price and availability of medicines in health facilities and pharmacies regardless of sector or location.

b. **Share information on medicines quality, through the functions of SEARN**: Since the First Annual Meeting of SEARN in New Delhi, India, on 11–12 April 2017 and the setting up of a Steering Group and Working Groups (WGs), regulatory agencies have been actively engaged in improving quality of medical products. The Second SEARN Meeting in Colombo, Sri Lanka, on 21–23 March 2018, and the Third SEARN Meeting in New Delhi, on 22–23 April 2019, led to specific activities on quality of medical products for the five Working Groups in SEARN. These activities are guided by regulatory agencies of specific countries. Some of their recent activities include:
i. WHO External Quality Assurance Assessment Scheme (EQAAS) workshop.

ii. Joint assessment of fixed dose combinations of anti-retroviral for accelerated registration of priority health products.

iii. Vigilance guidance for SEARN being developed with the Medicines and Healthcare Products Regulatory Agency (MHRA) of the United Kingdom of Great Britain and Northern Ireland.

iv. Regulatory updates including sharing of regulatory information on quality personal protective equipment/diagnostic kits/devices and related updates from international agencies for regulators through the information sharing platform including for COVID19.


As a result of the COVID-19 pandemic, a virtual meeting of SEARN for National Regulatory Authorities with WHO headquarters was organized on 7 May 2020 to update on regulatory parameters for access to medical products updates on the pandemic.

c. **Initiate a concrete collaboration in the procurement of antidotes for improved access to these limited supplies of medicines for life-threatening conditions:** The Initiative for Coordinated Antidotes Procurement in the South-East Asia Region (iCAPS) was launched in early 2018 to procure antidotes for a wide range of common poisonings. The draft initiative of the iCAPS operational manual and scale-up plan has been finalized. This systematic approach for antidote procurement is expected to improve procurement efficiency by aggregating demand, reducing costs and coordinating quality assurance.

d. **Support bilateral cooperation agreements on improved access to medicines:** bilateral cooperation agreements for improved access to medicines need to be expedited.

**Challenges being faced**

46. Despite progress, significant challenges remain on monitoring of the price and availability of medicines and supporting bilateral cooperation, e.g. the range of medicines is large, and it is important to ascertain the quantity and periodicity of requirements to enable adequate supply mechanisms to promote improved access.

47. In the context of the current COVID-19 pandemic, “the need for all countries to have unhindered, timely access to quality, safe, efficacious and affordable diagnostics, therapeutics, medicines and vaccines, and essential health technologies, and their components, as well as equipment,” is critical.8

48. For improving equitable access in view of the Roadmap for Access to Medicines, Vaccines and other Health Products, 2019–2023, and in the context of the COVID-19 pandemic, the Region needs to focus on: research and development that meets public health needs and improves access to health products; application and management of intellectual property to contribute to innovation and promote public health and appropriate prescribing, dispensing and rational use.

49. Intercountry cooperation and bilateral cooperation including through SEARN for market authorization will promote access and availability for affordable for COVID19 health technologies. The Region should leverage its capacity for production of medical products (medicines, vaccines, diagnostics, devices), including personal protective equipment (PPEs).

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The way forward

50. To ensure equitable access to medicines and health technologies in the circumstances of the COVID-19 pandemic, WHO and Member States must engage with relevant stakeholders for “affordable diagnostics, therapeutics, medicines and vaccines in voluntary pooling and licensing of patents” consistent with the provisions of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) and the flexibilities within the Doha Declaration on the TRIPS Agreement and Public Health. For this purpose, follow-up of the May 2020 “Call to Action for ensuring equitable access to health technologies through sharing of knowledge, intellectual property and data necessary for COVID-19 detection, prevention, treatment and response” is critical. The recommendations of the Global Strategy and Plan of Action on public health, innovation and intellectual property (resolution WHA71/13) are relevant for increased access to medicines, medical supplies and vaccines including through the access to COVID-19 Tools (ACT) Accelerator.

51. Deeper engagement by Member States and WHO for continued progress through intercountry cooperation on sharing information on prices of medicines, engagement for medical products regulatory collaboration through SEARN, collaboration in procurement of antidotes, and on the promotion of bilateral cooperation agreements on improved access to medicines has become essential now more than ever before. The Delhi Declaration of the Seventy-first session of the Regional Committee in 2018 that encompasses products beyond medicines is critical to inform further progress on access to all medical products (medicines, vaccines, diagnostics and devices) in the Region.
4. South-East Asia Regional Health Emergency Fund (SEA/RC60/R7)

Background

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

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

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

a. Since its inception in 2008, the Fund has allowed for an immediate and flexible response to 42 emergency events occurring in nine Member States of the Region.

b. In the current biennium (2020–2021) SEARHEF has supported three emergency events in Bhutan, Maldives and Thailand, all for COVID-19 response operations.

c. Till date, SEARHEF has disbursed a total of US$ 6.6 million since its inception.

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

e. Eight meetings have been held, till date, of the Working Group of the Fund, the last being in July 2019, via videoconference. Due to the ongoing COVID-19 pandemic the ninth meeting of the Working Group has not yet been scheduled.

f. Balance available: The SEARHEF balance from Assessed Contributions as of date is US$ 575 000 for the current biennium of 2020–2021, while US$ 100 000 is available from Voluntary Contribution funds.

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

56. The table below gives a list of disasters that were supported by SEARHEF, since its inception till June 2020, and the Member States in which they occurred.
<table>
<thead>
<tr>
<th>No.</th>
<th>Emergency</th>
<th>Period</th>
<th>SEARHEF allocation in US$</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Month</td>
<td>Year</td>
</tr>
<tr>
<td>1</td>
<td>Cyclone Nargis in Myanmar</td>
<td>May</td>
<td>2008</td>
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<tr>
<td>2</td>
<td>Flash floods in Sri Lanka</td>
<td>June</td>
<td>2008</td>
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<tr>
<td>3</td>
<td>Kosi river floods (in two tranches) in Nepal</td>
<td>Sept.</td>
<td>2008</td>
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<td>4</td>
<td>Emergency health interventions for internally displaced populations (IDPs) in conflict-affected areas in northern Sri Lanka (in two tranches).</td>
<td>Sept.</td>
<td>2008</td>
</tr>
<tr>
<td>5</td>
<td>Earthquake in North Sumatra province, Indonesia (in two tranches)</td>
<td>Oct.</td>
<td>2009</td>
</tr>
<tr>
<td>6</td>
<td>Emergency health interventions for relocated IDPs affected by conflict in Sri Lanka</td>
<td>Jan.</td>
<td>2010</td>
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<td>7</td>
<td>Fire in Dhaka, Bangladesh</td>
<td>June</td>
<td>2010</td>
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<td>8</td>
<td>Mt Merapi volcanic eruption in East Java province, Indonesia</td>
<td>Nov.</td>
<td>2010</td>
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<tr>
<td>9</td>
<td>Critical health-care services to the resettled population affected by conflict in Sri Lanka</td>
<td>Feb.</td>
<td>2011</td>
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<tr>
<td>10</td>
<td>Floods in Thailand (in two tranches)</td>
<td>July</td>
<td>2011</td>
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<tr>
<td>11</td>
<td>Torrential rains in DPR Korea (in two tranches)</td>
<td>Aug.</td>
<td>2011</td>
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<tr>
<td>12</td>
<td>Fire outbreak/explosion in Yangon, Myanmar</td>
<td>Jan.</td>
<td>2012</td>
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<tr>
<td>13</td>
<td>Provision of emergency health care in Rakhine State, Myanmar</td>
<td>June</td>
<td>2012</td>
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<tr>
<td>14</td>
<td>Flash floods in DPR Korea</td>
<td>July</td>
<td>2012</td>
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<tr>
<td>15</td>
<td>Support to population affected by storm in Maldives</td>
<td>Nov.</td>
<td>2012</td>
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<tr>
<td>16</td>
<td>Support to Myanmar for procuring emergency medical supplies (fire outbreak and earthquake)</td>
<td>Nov.</td>
<td>2012</td>
</tr>
<tr>
<td>17</td>
<td>Support to Myanmar for establishing health-care services for townships affected by communal conflict in Rakhine State</td>
<td>April</td>
<td>2013</td>
</tr>
<tr>
<td>18</td>
<td>Support for relief for emergency caused by flash floods in South Phyongan, North Phyongan, Kangwon and South Hamgyong provinces of DPR Korea</td>
<td>July</td>
<td>2013</td>
</tr>
<tr>
<td>19</td>
<td>Support to emergency response activities to the crisis situation emerging from due to Mt Sinabung eruption in North Sumatra Province, Indonesia</td>
<td>Feb.</td>
<td>2014</td>
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<tr>
<td>20</td>
<td>Establish sustainable health-care services for townships affected by communal conflict in Rakhine State, Myanmar</td>
<td>May</td>
<td>2014</td>
</tr>
<tr>
<td>21</td>
<td>Complement the response and recovery activities conducted by the MoH of Sri Lanka to support short- to medium-term needs of the health sector</td>
<td>Nov.</td>
<td>2014</td>
</tr>
<tr>
<td>22</td>
<td>Complement the response and recovery activities conducted by the MoH of Sri Lanka to support response and recovery activities from heavy floods and landslides in 22 (out of 25) administrative districts in Sri Lanka</td>
<td>Dec.</td>
<td>2014</td>
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<tr>
<td>No.</td>
<td>Description</td>
<td>Month</td>
<td>Year</td>
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<tr>
<td>23</td>
<td>Support rehabilitation efforts after the <strong>Nepal</strong> earthquake</td>
<td>April</td>
<td>2015</td>
</tr>
<tr>
<td>24</td>
<td>Support strengthening the capacity of health institutions to meet immediate needs of the population in drought-affected areas (88 counties and 20 cities in South and North Hwanghae, South and North Pyongang provinces) of <strong>DPR Korea</strong></td>
<td>July</td>
<td>2015</td>
</tr>
<tr>
<td>25</td>
<td>Support MoH to help provide operational costs for post-disaster management of floods following heavy rain that affected health facilities in the Sagaing and Magwe regions and Rakhine State of <strong>Myanmar</strong></td>
<td>Aug.</td>
<td>2015</td>
</tr>
<tr>
<td>26</td>
<td>Support to MoH for emergency medical interventions for flood-affected populations in Rakhine and Chin states and Sagaing and Magway regions of <strong>Myanmar</strong></td>
<td>Aug.</td>
<td>2015</td>
</tr>
<tr>
<td>27</td>
<td>Support emergency medical supplies and essential drugs for flood-affected populations in Rason City, North Hamgyong province, in <strong>DPR Korea</strong></td>
<td>Sept.</td>
<td>2015</td>
</tr>
<tr>
<td>28</td>
<td>Support to MoH of <strong>Sri Lanka</strong> for response and recovery activities for flood victims</td>
<td>May</td>
<td>2016</td>
</tr>
<tr>
<td>29</td>
<td>Support to MoH of <strong>Bhutan</strong> to provide health sector assistance to flood-affected populations</td>
<td>July</td>
<td>2016</td>
</tr>
<tr>
<td>30</td>
<td>Support to MoH of <strong>Myanmar</strong> for provision of emergency health care to flood-affected populations</td>
<td>Aug.</td>
<td>2016</td>
</tr>
<tr>
<td>31</td>
<td>Support for provision of emergency health care to populations affected by torrential rains and flood in the northern regions of <strong>DPR Korea</strong></td>
<td>Sept.</td>
<td>2016</td>
</tr>
<tr>
<td>32</td>
<td>Support to <strong>Sri Lanka</strong> after floods and landslides</td>
<td>May</td>
<td>2017</td>
</tr>
<tr>
<td>33</td>
<td>Support to MoH of <strong>Bangladesh</strong> after Cyclone Mora</td>
<td>June</td>
<td>2017</td>
</tr>
<tr>
<td>34</td>
<td>Support for MoH of <strong>Bangladesh</strong> for activities for population affected by Rakhine crisis</td>
<td>Sept.</td>
<td>2017</td>
</tr>
<tr>
<td>35</td>
<td>Support for MoH of <strong>Maldives</strong> for response activities by HPA/MoH for victims of tropical storm Ockhi</td>
<td>Dec.</td>
<td>2017</td>
</tr>
<tr>
<td>36</td>
<td>Support to MoHS to provide essential health services to the conflict-affected population in Rakhine State, <strong>Myanmar</strong></td>
<td>Feb.</td>
<td>2018</td>
</tr>
<tr>
<td>37</td>
<td>Support to address the immediate health needs of the displaced Rohingya population at Cox's Bazar (Grade 3 Emergency), <strong>Bangladesh</strong></td>
<td>Feb.</td>
<td>2018</td>
</tr>
<tr>
<td>38</td>
<td>Support operations for flood-affected areas in North and South Hwanghae provinces, <strong>DPR Korea</strong></td>
<td>Sept.</td>
<td>2018</td>
</tr>
<tr>
<td>39</td>
<td>Provision of life-saving health-care services to flood-affected populations, <strong>Myanmar</strong></td>
<td>Aug.</td>
<td>2019</td>
</tr>
<tr>
<td>40</td>
<td>Support for COVID-19 preparedness and response, <strong>Thailand</strong></td>
<td>Jan.</td>
<td>2020</td>
</tr>
<tr>
<td>41</td>
<td>Support for COVID-19 preparedness and response, <strong>Bhutan</strong></td>
<td>March</td>
<td>2020</td>
</tr>
<tr>
<td>42</td>
<td>Support for COVID-19 preparedness and response, <strong>Maldives</strong></td>
<td>March</td>
<td>2020</td>
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</tbody>
</table>

**Grand total**: 6 601 770
Challenges faced and the way forward

57. Based on the evaluation findings, the following recommendations have been prioritized for actionable interventions by the Secretariat and are being implemented:

a. **Need for strategic efforts to increase the SEARHEF corpus:** There are several reasons that vindicate the need for an increased SEARHEF corpus, including the following:

   - Higher number of emergencies witnessed in the Region, with the present corpus being capable of catering to a maximum of six emergencies in a biennium.
   - Prevalence of other funds such as the United Nations Central Emergency Response Fund (CERF) and WHO’s Contingency Fund for Emergencies (CFE), which can provide higher amount of funding in a similar timespan as SEARHEF.
   - Barring one biennium (2012–2013), the SEARHEF corpus exceeded its limit in every biennium in the last 10 years, which necessitated additional funding requirements.
   - Increase in price of goods and services globally in the last 10 years. The maximum limit of SEARHEF was fixed at US$ 350 000 in the year 2008.

b. **Need for increasing the corpus amount of SEARHEF:** This was raised during various Working Group meetings. All these factors point towards the need to make dedicated efforts to increase the corpus. During the Secretariat’s ongoing discussions with international financial institutions, in the context of the COVID-19 response, contributions channelled via SEARHEF have been presented as the preferred means of funding.

c. **Effective utilization of standardized templates and improved internal communication:** The format for the utilization report has been revisited and a new template has been suggested to overcome the issues. It was also suggested that regular sensitization workshops be organized by the country offices, specifically for MoH officials responsible for managing SEARHEF funds.

   - In the context of the COVID-19 pandemic response, a webinar with all WHO country offices was conducted on 19 February 2020 on operational planning and resource mobilization. Participants were briefed on SEARHEF.
   - Internal approvals for the disbursement have been transferred to an electronic portal.

d. **Improvement in monitoring, reporting and evaluation:** One of the key gaps in the management of the Fund appears to be the lack of output and outcome data for use of SEARHEF.

   - The format of the utilization report has been revised and will be rolled out for reporting on disbursements made in this biennium.
5. Expanding the scope of the South-East Asia Regional Health Emergency Fund (SEARHEF) (SEA/RC69/R6)

Background

58. The Sixty-ninth session of the WHO Regional Committee for South-East Asia endorsed resolution SEA/RC69/R6 on “Expanding the scope of SEARHEF” to include a “preparedness stream” that would strengthen key aspects such as disease surveillance, health emergency workforce and health emergency teams. There was also an expressed need for increasing the amount in the tranches for emergency funding from SEARHEF. It was anticipated that support for basic preparedness activities may cost US$ 200 000 per country per biennium. Thus, the minimum corpus per biennium was set at US$ 2.2 million. The target date for implementation of the SEARHEF preparedness funding stream was decided to be 1 January 2018. As of June 2020, Thailand and India had contributed an amount of US$ 200 000 each towards the SEARHEF preparedness stream as Voluntary Contributions.

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

   a. Address a priority gap as found in the IHR capacity assessments and/or SEA Region benchmark assessments.
   b. Address gaps in core skills such as risk assessments or information management.
   c. Public health emergency operations centres (PHEOCs).

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

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

Progress made in the WHO South-East Asia Region

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

62. The HEOCs in all three countries of Bhutan, Maldives and Sri Lanka have been operationalized as part of the incident management system for the COVID-19 pandemic response.
63. The balance available, as of June 2020, is US$ 275,000, excluding the Programme Support Cost (PSC) charges, which have charged at the rate of 13 per cent for the Voluntary Contributions.

64. Management of the preparedness stream of SEARHEF is overseen by the same Working Group comprising 11 representatives from Member States that manages the response stream. The Working Group has met eight times since 2008. The eighth meeting of the Working Group was held via videoconferencing in July 2019.

**Challenges being faced**

65. Major challenges being faced by SEARHEF have been articulated in the recommendations made by the Working Group during its eighth meeting. 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**

66. The eighth meeting of the SEARHEF Working Group held in July 2019 recommended that the Secretariat develops a phased implementation plan for the recommendations of the evaluation, and provide updates on discussions with key donors on using SEARHEF as the main channel to support preparedness work in the Region. The COVID-19 pandemic has brought to light the importance of emergency preparedness and both Member States and the Secretariat need to leverage this situation for mobilizing additional resources for this preparedness fund.
6. Strengthening emergency medical teams (EMTs) in the South-East Asia Region (SEA/RC71/R5)

Background

67. On 7 September 2018, 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.

68. The resolution also established 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. A comprehensive effort to implement this resolution over the course of 2019 and 2020 is currently underway and the Regional Office for South-East Asia is committed to provide technical assistance and support for training, quality assurance, coordination and other activities for strengthening EMTs in Member States of the SEA Region.

69. Following the adoption of Regional Committee resolution SEA/RC71/R5, a dedicated team was established within the Emergency Operations Unit of the WHO Regional Office for South-East Asia. To guide the work in strengthening capacities of Member States, the team, comprising one staff member and one consultant, developed a dedicated roadmap for each Member State of the SEA Region in collaboration with the respective WHO country office. A comprehensive mapping exercise of EMT capacities throughout the Region was conducted. More than 214 national and international emergency medical teams were identified, coming from governments, NGOs, militaries and international organizations throughout the Region.

Progress made in the WHO South-East Asia Region

Capacity strengthening, preparedness and training

70. From 2018–2019, the WHO Regional Office has conducted National EMT Trainings in Thailand, Indonesia, Bangladesh, Bhutan and DPR Korea, and provided inputs and support to various simulation exercises across the Region. The main objective of these training activities is to introduce to Member States the WHO EMT Initiative and related coordination and quality assurance methodologies, the mentorship and verification process, as well as global principles and standards. It also provides a platform to familiarize national EMTs with lessons learned from recent emergencies, and to introduce to them standards and methodologies developed at the global level.

71. Furthermore, it is also aimed to build sustainable capacities in the national and subnational health emergency health operations centres (HEOCs) that will be able to coordinate the response of EMTs in any type of emergency, utilizing the South-East Asia Regional Health Emergency Fund (SEARHEF) preparedness stream. Participants to these national training courses were officials from the ministries of health, HEOCs, national EMT staff, and officials from collaborating ministries, major hospitals, the military, local and international NGOs and UN agencies.

Efficient, timely and coordinated response

72. To build a sufficient roster of regional EMT coordinators that can be deployed to support Member States, WHO supported an intensive six-day Emergency Medical Team Coordination Cell (EMTCC) training. This was facilitated by the Project for Strengthening the Association of Southeast Asian Nations (ASEAN) Regional Capacity on Disaster Health Management (ARCH Project), on 17–22 February 2019, in Bangkok. During the training, participants were trained on the WHO EMTCC methodology, taking into consideration ASEAN standard operating procedures for Regional Standby Arrangements and Coordination of Joint Disaster Relief and Emergency Response Operations (SASOP), and related coordination mechanisms in the region.
73. Thirty-two representatives from all ASEAN Member States participated, including three Member States of the WHO SEA Region (Indonesia, Myanmar and Thailand). The first three days of the workshop focused on presentations and interactive mentoring exercises using an earthquake case study, which was followed by a two-day field simulation exercise. The WHO South-East Asia Regional Office will continue to conduct and support capacity-building activities to ensure a sufficient roster of regional EMT coordinators that can be deployed to support Member States if required.

**Quality assurance and classification**

74. WHO continues to provide mentorship to the four 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, Sri Lanka Army Medical Assistance Team (SLAMAT), and Thailand Emergency Medical Team. These four EMTs formally submitted an expression of interest to be classified by WHO as an internationally deployable EMT over the course of 2018. Mentorship visits, national EMT trainings and team-member trainings were conducted in Thailand, Bhutan and Indonesia over the course of 2019. The first mentorship visit to the Sri Lanka Army Medical Team is planned to be conducted before the end of the year 2020.

75. On 30 and 31 July 2019, the Thailand Emergency Medical Team successfully completed the WHO verification process as a Type 1, fixed EMT and became the first EMT to be verified from the South-East Asia Region. Under the leadership of the Ministry of Public Health of Thailand the international EMT is building on the strong national capacities of 77 medical emergency response teams (MERT) across Thailand.

76. The Thailand EMT has previously been successfully deployed to Myanmar in response to Cyclone Nargis in 2008, to Nepal during the response to the devastating earthquake of 2015, and to Lao People’s Democratic Republic in response to the dam collapse in Attapeu province in 2018.

77. Muhammadiyah Disaster Management Centre (MDMC) EMT, Indonesia, was planned to be verified in March 2020. However, due to the COVID-19 pandemic, this is postponed indefinitely. The Sri Lanka Army Medical Assistance Team (SLAMAT) is likely to be verified by 2021. To expand the cohort of available mentors in the SEA Region, representatives from the WHO Regional Office for South-East Asia, Indonesia, Sri Lanka and Thailand took part in the fourth WHO Emergency Medical Teams Mentors Workshop held on 22–24 January 2019 in Geneva, Switzerland.

**Global and regional commitment and partnerships**

78. On 12–14 June 2019, the Royal Government of Thailand hosted the Third Emergency Medical Teams (EMT) Global Meeting in Bangkok. Over three days, 400 participants from 90 countries around the world met and discussed recent developments, key topics and good practices from the provision of clinical care to populations affected by health emergencies.

79. As part of this global event, the South-East Asia Regional Emergency Medical Team Working Group held its first meeting to discuss the implementation of the EMT Initiative in the South-East Asia Region. A total of 37 participants from nine Member States and five organizations attended the meeting. The South-East Asia Regional Emergency Medical Team Working Group was created following the adoption of Regional Committee Resolution SEA/RC71/R5 on “Strengthening emergency medical teams (EMTs) in the South-East Asia Region” in September 2018.

80. Key topics that were discussed during the meeting included: regional arrangements and priority setting, sharing of lessons learned among teams, and the creation of a network of national focal points to share information and collaborate on further work in the area. To date, eight of the 11 Member States of the WHO South-East Asia Region have formally designated an EMT national focal point to ensure operational readiness and appropriate information exchange at the right levels and with the right entities at all times.
81. EMT national focal points represent their country in the EMT Regional Working Group and are the key counterparts for WHO as well as for the wider EMT community. Following deliberations during the Regional Working Group meeting, the South-East Asia Regional Governance Note on EMT was endorsed by consensus by all members of the Regional Working Group on 29 July 2019. This key policy document describes the formation and functioning of the Regional EMT Working Group, pursuant to resolution SEA/RC71/R5.

**SEA Region emergency medical teams and the COVID-19 pandemic**

82. During this current and ongoing response to the COVID-19 pandemic, no EMT from the SEA Region was internationally deployed. However, SLAMAT, an EMT from Sri Lanka, was deployed domestically to support quarantine facilities for repatriated citizens from abroad. It was involved in the management of health facilities at quarantine sites as well as management of health services for the people under quarantine. EMTs in Indonesia and Thailand were not domestically deployed, instead, their members were supporting provincial and district hospitals by implementing EMT methods. Nepal EMDT (emergency medical deployment team), consisting of doctors and nurses from the Ministry of Health, was deployed to strengthen district hospitals.

**Challenges being faced**

83. In South-East Asia, there are many national EMTs with varying capacities and, therefore, there is a strong need for standards setting and national coordination. Therefore, a quality assurance mechanism based on national context is a critical input.

84. EMTs in the Region do not have extensive experience and capabilities to respond to outbreaks. 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.

85. Countries are facing difficulties with the verification and classification process during the COVID-19 pandemic. There should be a strategic approach to conduct real-time verification during and after COVID-19 outbreaks in countries as the situation permits.

**The way forward**

86. It is essential to continue capacity-building of Member States on the development of national EMTs for domestic purposes. Considering the experience of the COVID-19 pandemic, it is very difficult to depend on international deployment of EMTs. As this was part of the original strategy for EMTs in the SEA Region as per resolution SEA/RC71/R5, we can continue to leverage this as the pandemic evolves in the SEA Region’s Member States.

87. It is also necessary to fast-track building capacities of national EMTs to respond to outbreak situations, so that we are prepared for the various waves of outbreaks of COVID-19 that will continue to occur until suitable vaccines are available.

88. Countries must also continue to develop strategies on establishing National EMT accreditation systems. This will allow for quality assurance of National EMTs for domestic deployments to be adapted to the national contexts.
7. **Intensifying activities towards control of dengue and elimination of malaria in the South-East Asia Region (SEA/RC71/R4)**

**Background**

**Malaria**

89. Malaria continues to remain a major public health challenge in spite of intensive global efforts to roll back the disease. In 2018, an estimated 228 million cases of malaria occurred worldwide, compared with 251 million cases in 2010 and 231 million cases in 2017. Most of these cases were in the World Health Organization’s African Region (93%), followed by the South-East Asia Region (3.4%) and the Eastern Mediterranean Region (2.1%). Almost 85% of the global malaria burden rests with 19 countries in sub-Saharan Africa and India. There were an estimated 405 000 deaths from malaria globally, compared with 416 000 estimated deaths in 2017 and 585 000 in 2010.

90. To galvanize global efforts to control and eliminate malaria, the WHO Global Technical Strategy for Malaria 2016–2030 (GTS), endorsed by the World Health Assembly in 2015, set ambitious yet attainable targets for 2030, together with strategic milestones for 2020 and 2025. Milestones for 2020 are to reduce malaria case incidence and mortality rates globally by at least 40% compared with 2015 baseline levels; eliminate malaria in at least 10 countries that were malaria endemic; and prevent the re-establishment of malaria in countries that are malaria-free. The GTS shares the same timeline as the Sustainable Development Goals (SDGs), which in its Goal 3, Target 3 calls on the world to end the epidemic of malaria by 2030.

91. Between 2015 and 2018, 31 countries in the world, where malaria is still endemic, reduced case incidence significantly and were on track to reduce incidence by 40% or more by 2020. Without prompt and tangible change, the GTS milestones for morbidity in 2025 and 2030 are not likely to be achieved.

92. In 2016, WHO identified 21 countries – known as “E2020 countries” – with the potential to interrupt local transmission by the year 2020. Three of them are in the SEA Region: Bhutan, Nepal and Timor-Leste.

93. An estimated 1.61 billion people in the WHO South-East Asia Region are at risk of malaria. The disease is endemic in nine of the 11 countries of the Region, accounting for 50% of the burden outside the WHO African Region. In 2018, the Region had almost 8 million estimated cases and about 11 600 estimated deaths. Three countries accounted for 98% of the total reported cases in the Region, India being the largest contributor (58%) followed by Indonesia (30%) and Myanmar (10%).

94. In November 2017 at a high-level meeting of the 11 Member States of the Region in New Delhi, India, ministers of health of all Member States made a commitment towards a malaria-free South-East Asia Region by 2030 by signing the Ministerial Declaration on Accelerating and Sustaining Malaria Elimination. In parallel, the Regional Action Plan 2017–2030 towards “0. Malaria-Free South-East Asia Region” was launched.

95. This was followed by the signing of the "Ministerial Call for Action to Eliminate Malaria in the Greater Mekong Subregion before 2030" in May 2018 in Geneva at a Side-event held during the Seventy-first World Health Assembly, highlighting the commitment to a country-led and country-owned response to antimalarial drug resistance.
Dengue

96. Dengue has emerged as the most widespread and rapidly increasing vector-borne disease in the world. Of the 2.5 billion people around the world living in dengue-endemic countries and at risk of contracting dengue fever, 1.3 billion live in dengue-endemic areas in 10 countries of the SEA Region. All Member States in the Region, except the Democratic People’s Republic of Korea, being endemic to dengue, the Region contributes to more than half of the global burden of the disease. Five countries (India, Indonesia, Myanmar, Sri Lanka and Thailand) are among the 30 most highly endemic countries in the world. In spite of the control efforts, there has been a significant increase in the number of dengue cases over the years, though improvement has been made in case management and reduction of case-fatality rates (CFR) to below 0.5%.

Fig. 1: Dengue cases and deaths in the SEA Region from 2015 to 2019

Fig. 2: Case-fatality rate in the SEA Region from 2015 to 2019
The context of the progress report

With the overall objective of making the Ministerial Declarations operational, an Agenda item on malaria and dengue was included in the Agenda for the Seventy-first session of the WHO Regional Committee for South-East Asia in September 2018 (SEA/RC71/8). This led to the Regional Committee resolution on “Intensifying activities towards control of dengue and elimination of malaria in the South-East Asia Region” (resolution SEA/RC71/R4). The resolution requests reporting on progress in implementing it. This progress report covers the period from September 2018 until May 2020.

Progress made in the WHO South-East Asia Region

Malaria

Despite being the second highest contributor to the global malaria burden, the WHO South-East Asia Region in recent years has made remarkable progress, achieving the sharpest and most consistent reductions among all regions – by 73% in reported cases and 93% in reported deaths compared with 2010.

Two of the 11 countries in the Region – Maldives and Sri Lanka – were certified as malaria-free in 2015 and 2016 respectively, and continue to maintain this status. Timor-Leste had no indigenous cases since July 2017 while Bhutan had only six indigenous cases in 2018 (and two in 2019 as per provisional data).

Despite being the highest-burden country of the Region, India showed a 49% and 60% reduction in reported cases in 2018 compared with 2017 and 2016 respectively. Two other countries in the Region reported substantial decline in their cases between 2017 and 2018: Bangladesh by 64% and Thailand by 49%. Other malaria-endemic countries too continued to make impressive progress towards elimination.

All endemic countries in the Region are on track to reduce malaria incidence by at least 40% by the end of 2020 compared with 2015 levels, in line with the GTS milestone. All aim to eliminate malaria by 2030 at the latest.

Continuing the declining trend, reported malaria deaths in the Region dropped to 165 in 2018, which is a reduction by 93% and 45% compared with 2010 and 2017 respectively. India, Indonesia and Myanmar accounted for 58%, 21% and 12% of the total reported deaths in the Region respectively. Apart from malaria-free Maldives and Sri Lanka, Bhutan, the Democratic People’s Republic of Korea and Timor-Leste continued to record zero indigenous deaths.

In order to accelerate towards elimination and prevention of a re-establishment of malaria, WHO in collaboration with international and national development partners, supported national government efforts to implement multiple activities as highlighted below:

- To emphasize the importance of cross-border action to eliminate malaria, the publication titled "An urgent front: Cross-border collaboration to secure a malaria-free South-East Asia Region" was released during the Seventy-first session of the Regional Committee for South-East Asia in New Delhi in September 2018.

- In response to the WHO Director-General’s aggressive new initiative to accelerate progress against malaria, that was announced at the Seventy-first World Health Assembly in May 2018, WHO and the Roll Back Malaria Partnership to End Malaria (RBM) launched the “High burden to high impact (HBHI)” initiative in November 2018. Adopting this approach, India, being the only country outside sub-Saharan Africa included in this initiative, conducted a meeting of high-burden states, in collaboration with WHO and RBM.
In February 2019, during the “SEA Data demand and use workshop” organized by the Global Fund, the priority need for cross-border collaboration between Bhutan’s border districts with the relevant states of India was discussed and prioritized in the light of risk of Bhutan missing its malaria elimination targets by 2020. A similar emphasis was made during the Malaria Elimination Oversight Committee Meeting held in Geneva in February 2019.
As part of efforts to translate political commitment into action on the ground, a meeting of the national malaria programme managers was held in March 2019 in India on operationalizing the Ministerial Declaration on Accelerating and Sustaining Malaria Elimination in the South-East Asia Region. This was followed by the regional workshop on surveillance, monitoring and evaluation.

Monitoring and analysing malaria burden trends, which is done to track the progress made by Member States of the Region as a component of data processing for the World Malaria Report, was completed through collection, review and validation of data. This led to the publishing of country- and region-specific information and profiles in the world malaria reports for 2018 and 2019. More vigorous monitoring and analysis was carried out for the region’s countries under the E2020 initiative.

Technical assistance was provided, in collaboration with the Health Emergency Team, to the Rohingya refugee camps in Cox’s Bazar, Bangladesh, to prevent outbreaks of vector-borne diseases.

In order to promote, build, strengthen and coordinate partnerships, countries were guided on cross-border collaboration as a priority for malaria elimination efforts. WHO was involved in organizing several related meetings: The Global Fund organized a workshop on “Peer-to-peer exchange on the prevention of re-establishment of malaria transmission” in South-East Asia, in Bhutan in August 2019, which was technically supported by WHO drawing expertise from all three levels of the Organization (including the participation of the Director of the Global Malaria Programme). This was followed by the Cross-Border Meeting on Malaria Elimination held in Bhutan in September 2019. The “Meeting on cross-border collaboration on malaria elimination along the India-Bhutan Border” held in Guwahati, India, in November 2019 provided a platform to review and share updates on malaria elimination with special focus on districts on the international border between the two countries.

Comprehensive assessment of Bhutan’s progress and prospects in malaria elimination was conducted through field visits by a team led by the Director of the Global Malaria Programme with participation from the WHO Regional Office for South-East Asia, followed by a surveillance assessment along the nation’s international border with India.

Independent joint malaria programme reviews were conducted in Bangladesh, Indonesia, Myanmar and Timor-Leste.

Quality assurance (QA) of malaria microscopy was strengthened through WHO External Competency Assessment of Malaria Microscopists (ECAMM), that were combined with mentoring of potential new ECA facilitators for sustainability of this regional QA scheme.

Therapeutic efficacy studies (TES) and integrated drug-efficacy surveillance (iDES) were reviewed in network meetings (BBINS network, which provides a platform to monitor the antimalarial drug resistance-related data in Bangladesh, Bhutan, India, Nepal and Sri Lanka) in 2018 and 2019. Similarly, the Pacific Network Meeting was held in July 2019, which saw Indonesia and Timor-Leste participating. The Greater Mekong Subregion (GMS) Network meeting in October 2019 included Myanmar and Thailand.

The Regional Data Sharing Platform (RDSP), established in 2014 by WHO to facilitate malaria surveillance data-sharing in the Greater Mekong subregion, continues as a significant example of regional collaboration to support malaria elimination efforts in the Subregion.

Technical assistance to establish a District Health Information System (DHIS2)-based malaria module in the Health Management & Information System (HMIS) in Bhutan was provided. The system is functioning well now and is cited by many developmental partners as an example for other countries.
The “Workshop on leveraging Global Fund proposals for TB, HIV and Malaria in SEA Region countries towards universal health coverage and elimination targets” was successfully conducted in Bangkok in February 2020. Proposals were reviewed and technical guidance provided for further improvement.

Several countries were supported for development/revision of their national strategic plans and the Global Fund proposals on malaria.

Webinars and technical seminars on World Malaria Day 2020, organized by the Indonesia National Malaria Programme in collaboration with the WHO Country Office and the Regional Office, for continuity of essential health services and case management for malaria during the COVID-19 pandemic, were successfully conducted.

Virtual meetings with country focal points for continuity of malaria services for risk assessment and mitigation for malaria prevention and control during the COVID-19 pandemic have been regularly held.

Strategic information on malaria drug resistance was facilitated through reviewing and coordinating the submission of malaria therapeutic efficacy study (TES) proposals by the Research Review Committee of the WHO Regional Office.

Designation of a WHO collaborating centre in Thailand was completed and re-designation of centers in India and Myanmar is being processed.

Advocacy efforts for malaria in the Region were intensified through World Malaria Day commemorations every year at regional and country levels.

Dengue

From 2015 to 2019, dengue cases in the SEA Region increased by 46% (from 451,442 to 658,301), whereas deaths decreased by 2% (from 1,584 to 1,555), representing a case-fatality rate reduction from 0.35% to 0.24%. A variety of factors are responsible in the SEA Region for expansion and distribution of dengue mosquito vector and viruses; namely, high rates of population growth, inadequate water, sewage and waste management systems, rise in global commerce and tourism, global warming, changes in public health policy, and the development of hyper-endemicity in urban areas, among others. The current situation of the high burden of dengue cases in the SEA Region is coupled with the absence of effective treatment and lack of comprehensive vector control.

Technical support on entomological surveillance and response for prevention and control of dengue was provided to Maldives (April–May 2019), Nepal (July 2019) and Bangladesh (July–August 2019).

Four virtual trainings on prevention and control of dengue were conducted for Nepal (two batches on 9 and 10 June 2020), Cox’s Bazar (15 June 2020) and Bhutan (16 June 2020). In each batch about 70 participants were present from different sectors, such as health, planning and policy-makers, entomologists, NGOs, etc.

Progress towards malaria elimination and dengue control has been made possible through multisectoral collaboration, partner engagement and the involvement of all three levels of WHO.

Challenges being faced

The Region’s progress in its efforts towards malaria elimination and dengue control is being reported at a time when the COVID-19 pandemic has engulfed the world, straining health systems and rapidly increasing the demand on health facilities and health-care workers, threatening to leave health systems overstretched and unable to operate effectively.
Malaria

109. Despite significant progress, Member States of the SEA Region face major challenges, some technical and other operational, as malaria epidemiology as well as socioeconomic and health systems in this Region exhibit enormous complexity:

a. High-burden areas exist close to low-burden areas, requiring different programmatic approaches within countries (especially large countries).

b. Sustained financing for malaria elimination is a big challenge as domestic financing in the Region for malaria is low and external funds are increasingly being phased out as most countries are emerging as middle-income countries.

c. Many countries need to strengthen their surveillance systems, including case-based surveillance and relevant data platforms, to make surveillance a core intervention, as a prerequisite to achieving elimination. Although reported cases continue to decrease in the public sector, estimates indicate that there are still gaps in reporting from the private sector and in treatment seeking, especially in the large countries.

d. Many people in malaria-affected areas continue to lack access to life-saving malaria prevention tools, mainly long-lasting insecticidal mosquito nets (LLINs) or indoor residual spraying (IRS), diagnostic testing and treatment. With malaria being rolled back so significantly in most Member States of the Region, malaria transmission often remains entrenched in difficult-to-reach remote areas and among vulnerable and at-risk populations, including disadvantaged communities, communities in border and conflict areas, and refugees and migrants.

110. The South-East Asia Region accounts for 53% of the global burden of *Plasmodium vivax*. This necessitates a change in the management of malaria cases, including finding practical ways to ensure the safety of radical treatment with primaquine, and achieving high rates of adherence to the treatment regimens.

111. Multidrug resistance, including partial resistance to artemisinin and resistance to partner drugs resulting in failure of artemisinin-based combination therapies (ACT), is detected in multiple locations in the Greater Mekong Subregion. Monitoring malaria drug resistance throughout the Asia-Pacific Region to ascertain the potential spread and emergence of new strains is a top WHO priority.

112. Resistance of malaria-transmitting mosquitoes to insecticides, widespread in some Member States of the Region, is a further threat to eliminating the disease.

113. Collaboration across borders is required to ensure that countries reaching elimination can achieve and sustain their achievements.

Dengue

114. Challenges in control and prevention of dengue in the Region include:

a. rise in number and size of densely populated urban cities;

b. increased global travel facilitating the spread of the virus;

c. lack of an effective dengue vaccine;

d. extensive and indiscriminate use of insecticides resulting in insecticide resistance;

e. weak programmatic capacity (financial and human resource);
f. poor intersectoral collaboration; and

g. weak or ineffective integrated surveillance (epidemiological, entomological and meteorological) and early warning and response systems (EWARS).

The way forward

115. There is strong commitment to eliminate malaria in the Region, reflected in the commendable and intense efforts and progress made by Member countries. This momentum needs to be sustained and further accelerated to prevent, rapidly detect and treat, malaria to benefit everyone, everywhere. Priorities in going forward will be as follows:

a) Recognizing the heavy toll that malaria exacts on vulnerable populations, as well as the fragility of health infrastructure in some areas in the Region, sustaining efforts to prevent, detect and treat malaria while combating the COVID-19 pandemic currently becomes crucial at this point for achieving a malaria-free SEA Region. This encompasses the following:

- As the COVID-19 pandemic continues to rage, there should be emphasis to ensure that malaria prevention, diagnostic and treatment activities are not scaled down.
- All people living in places where malaria is reported should seek diagnosis and care as soon as possible if developing a fever.
- Ensuring access to core malaria prevention measures is an important strategy for reducing the strain on health systems. These include vector control measures, such as insecticide-treated nets and indoor residual spraying.
- Any intervention must consider the importance of both lowering malaria-related mortality and ensuring the safety of communities and health workers.

b) The seven key action areas described in the Agenda item on “Malaria: From declaration to action, and intensifying dengue vector control” (SEA/RC71/8) and re-emphasized in the resolution on “Intensifying activities towards control of dengue and elimination of malaria in the South-East Asia Region” (SEA/RC71/R4), need continued attention and must be action upon. They are:

- Emphasis on the local response and adoption of a subnational framework.
- Generation of data as the core of planning.
- Translation of political commitment into action on the ground.
- Needs assessment coupled with resource mobilization.
- Operationalization of cross-border initiatives.
- South-to-South collaboration on medicines and other commodities.
- Reviewing and reporting to the Regional Committee on the progress in malaria elimination and dengue vector control in the SEA Region.
8. Measles and rubella elimination by 2023 (SEA/RC72/R3)

Background

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

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

118. The WHO South-East Asia Regional Verification Commission (SEA-RVC) for measles and rubella elimination has updated the norms and standards to verify measles and rubella elimination in Member countries of the Region.

Progress made in the WHO South-East Asia Region

119. Significant progress has been made in the South-East Asia Region towards measles and rubella elimination since 2014.

120. Five countries in the South-East Asia Region – Bhutan, DPR Korea, Maldives, Sri Lanka and Timor-Leste – have been verified by the SEA-RVC as having achieved and sustained endemic measles elimination. Two countries in the Region – Maldives and Sri Lanka – have interrupted transmission of endemic rubella for more than 12 months since.

121. An estimated 72% reduction in mortality due to measles has occurred in 2018 in the Region compared with 2000. As of December 2019, the SEA Region – home to one fourth of the global population – contained only 10% of the global burden of reported measles cases compared with 25% in 2018, and 17% of the global burden of reported rubella cases compared with 31% of the corresponding global burden in 2018.

122. The estimated coverage with the first dose of measles-containing vaccine (MCV1) in the Region in 2019 was 94% compared with 63% in 2000. In 2019, seven Member States of the Region – Bangladesh, Bhutan, DPR Korea, India, Maldives, Sri Lanka and Thailand – achieved 95% or more coverage for MCV1, while the remaining four – Indonesia, Myanmar, Nepal and Timor-Leste – reported coverage between 84% to 94%.

123. The estimated coverage with the second dose of measles-containing vaccine (MCV2) in the Region in 2019 was 88% compared with 3% in 2000. In 2019, four Member States – Bangladesh, DPR Korea, Maldives and Sri Lanka – achieved 95% or more coverage for MCV2, five Member States – Bhutan, India, Myanmar, Thailand and Timor-Leste – achieved coverage between 80% and 94%, and two Member States – Indonesia and Nepal – reached coverage levels of less than 80%.

124. An estimated 205 million children were reached through mass vaccination campaigns with measles and rubella (MR) vaccine in the Region in 2019. Almost 297 million children had already been reached through such campaigns with a measles-rubella (MR) vaccine in the Region in 2017 and 2018. There are plans of conducting MR vaccination campaigns in a few Member States in 2021.

125. As of end-2019, all Member States in the Region are administering two doses of MCV under their routine immunization programmes as well as at least one dose of rubella-containing vaccine (RCV) in their programme.
126. Laboratory supported case-based surveillance for measles and rubella has been initiated in all Member States in alignment with the Regional guidelines, with India and Indonesia expected to complete the expansion by end-2020. Congenital rubella syndrome (CRS) surveillance has been initiated in all 11 Member States, either as sentinel surveillance or as part of the case-based surveillance system.

127. 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 50 in 2019, with 41 laboratories accredited as “proficient” for measles and rubella testing.

**Challenges being faced**

128. Immunity gaps for measles and rubella remain in various population groups in a few Member States due to suboptimal coverage of measles- and rubella-containing vaccines under their routine immunization programmes.

129. Surveillance sensitivity remains below the desired targets in two of the largest Member States in the Region in 2019, leading to under-reporting and underestimation of the exact disease burden in these countries.

130. Laboratory network support, especially for diagnostic kit procurement services, is becoming a challenge. Most Member States are still dependent on WHO for procurement of laboratory diagnostic kits for measles and rubella.

131. Financial insufficiency to accelerate implementation of activities for measles and rubella elimination remains a challenge to achieving the 2023 target. A study on costing of measles and rubella elimination has estimated that reaching the measles and rubella elimination goal by 2023 is achievable at an additional cost of US$ 1.55 billion during 2020–2023. This equates to an estimated expenditure of US$ 0.19 per capita per year above the current levels of investment on immunization.

132. The COVID-19 pandemic has had a significant impact on the Regional Flagship Priority Programme on Measles and Rubella Elimination. Coverage of the 1st and 2nd dose of measles and rubella-containing vaccine under routine immunization significantly declined during the first few months of 2020 as the pandemic spread, compared with corresponding months of 2019, thereby increasing the immunity gap and vulnerability to measles and rubella outbreaks. Similarly, surveillance for measles and rubella has been affected with a decline in the number of suspected measles-rubella cases reported following the COVID-19 pandemic. Surveillance has been partially affected in six countries and significantly affected in two countries, mostly due to re-purposing and diversion of surveillance staff for the COVID-19 response. Mass vaccination activities for measles and rubella that had been planned to be conducted in the first and second quarter of 2020 in Bangladesh, Indonesia, Maldives and Nepal have been postponed due to the outbreak of COVID-19.

**The way forward**

133. A costed Strategic Plan for Measles and Rubella Elimination 2020–2024 has been developed for achieving and sustaining measles and rubella elimination in the South-East Asia Region. Member States are expected to adopt and adapt the Regional Strategic Plan, develop country-specific costed national plans, and accelerate optimal implementation of such plans to achieve and sustain measles and rubella elimination by 2023.
134. Countries in the South-East Asia Region are in the process of developing and refining strategic, operational and policy guidelines for reviving immunization and surveillance activities during the ongoing COVID-19 pandemic. A close watch on the performance of the various strategic objectives of the regional and national plans will be critical to identify gaps in performance at national and sub-national levels following the COVID-19 pandemic and to develop tailored strategies to plug these gaps thereafter.

135. A framework for a post-2020 Regional Vaccine Action Plan that is aligned with the Global Immunization Agenda 2030 (IA2030) is under development. The strategic priorities and key focus areas for the post-2020 plan are being identified by the relevant stakeholders with the aim of strengthening the performance of immunization and surveillance programmes in the Region.

136. 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 the accelerated implementation of the strategic plans at the optimal level.
9. Challenges in polio eradication (SEA/RC60/R8)

Background

137. The Seventy-Second World Health Assembly noted the Polio Endgame Strategy 2019–2023 that will guide the programme until global polio-free certification is achieved. The key components of the strategy are eradication, certification and integration.

138. Strategy for the Response to Type 2 Circulating Vaccine-Derived Poliovirus (cVDPV2) 2020–2021; An Addendum to the Polio Endgame Strategy 2019–2023, provides risk mitigation measures to stop cVDPV2 spread.

139. In April 2020, the Strategic Advisory Group of Experts (SAGE) on Immunization endorsed the use of a new vaccine, under emergency use listing (EUL), in outbreaks due to cVDPV2. The new vaccine is called novel oral polio vaccine type 2 (nOPV2) and it has a substantially low risk of seeding new vaccine-derived poliovirus (VDPV2).

140. The Post Certification Strategy (PCS), noted by the Seventy-first World Health Assembly, which includes guidance on facility containment of polioviruses, protecting populations and detecting and responding to a polio event, will provide guidance to maintain a polio-free world after global certification.

141. The Seventy-first World Health Assembly in 2018 adopted resolution WHA71.16 in which the Health Assembly urges Member States to intensify efforts to accelerate poliovirus containment progress. A Strategic Action Plan on polio transition was presented to the Seventy-first World Health Assembly in May 2018.

142. The Strategic Action Plan has three key objectives:

   i. Sustaining a polio-free world after eradication of poliovirus.
   
   ii. Strengthening immunization systems, including surveillance for vaccine-preventable diseases, to achieve the goals of WHO’s Global Vaccine Action Plan.
   
   iii. Strengthening emergency preparedness, detection and response capacity in countries to fully implement the International Health Regulations (2005).

143. The Polio Oversight Board (POB) has given a call to action to support COVID-19 response that is driven by two principles:

   i. to ensure that the polio programme fully plays its part in the COVID-19 response; and
   
   ii. to end polio with urgency and determination when the emergency due to the COVID-19 pandemic ends.

Progress made in the WHO South-East Asia Region

144. The WHO South-East Asia Region reported the last polio case due to wild poliovirus on 13 January 2011 and was certified polio-free on 27 March 2014. The Regional Certification Commission for Polio Eradication (RCCPE) has confirmed during its annual meetings, the last of which was held in September 2019, that the Region has remained free of all wild polioviruses (WPV).
145. The last WPV3 in the South-East Asia Region was detected in October 2010. With no wild poliovirus type 3 reported anywhere in the world since November 2012, the global eradication of this strain was certified by the Global Certification Commission (GCC) in October 2019. In September 2015 the GCC had also certified global eradication of wild poliovirus type 2 (WPV2).

146. Circulating vaccine-derived polioviruses of type 1 (cVDPV1) were confirmed in Indonesia and Myanmar in 2019. One case was reported from the Papua province of Indonesia while six cases were reported from the Kayin State of Myanmar. Both countries have responded aggressively to the cVDPV1 outbreaks.

147. In May 2020, the WHO Regional Director for South-East Asia, following recommendations made by the virtual outbreak response assessment (OBRA), declared the closure of the polio outbreak due to cVDPV1 in Indonesia.

148. Environmental surveillance for poliovirus detection is established in six countries in the Region – Bangladesh, India, Indonesia, Myanmar, Nepal and Thailand.

149. IPV is now available and is being administered in all countries of the Region under their routine immunization programme. Four countries in the Region, namely Bangladesh, India, Nepal and Sri Lanka, are administering two doses of intradermal IPV.

150. Containment activities as per the WHO Global Action Plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use (GAP III) are steadily progressing. Four poliovirus essential facilities (PEF) have been identified (three in India and one in Indonesia) in the Region. National authorities for containment have been established in both countries. All four designated PEFs received the certificate of participation under the GAPIII containment certification scheme (CCS) from the Global Certification Commission (GCC). Implementation of other CCS requirements is ongoing, including capacity-building of auditors.

151. There are five polio priority countries in the Region from a polio transition planning perspective – Bangladesh, India, Indonesia, Myanmar and Nepal. A country-centric approach is being adopted to develop polio transition plans in these countries of the Region. The pace of development and implementation of national transition plans in countries is being guided by country readiness (technical, financial and managerial capacity), available financing, as well as operational modalities, as illustrated below.

a) The Government of Bangladesh has endorsed the national polio transition plan and is on track with the planned implementation in three phases.

b) Recent endorsement of the national plan in India by the Government of India and transfer of domestic resources to cover the gaps reflects its commitment to priorities outlined in the plan.

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

d) In Myanmar, the national transition plan is under active consideration for endorsement by the government.

e) The endorsement of the national transition plan of Nepal, developed in 2017 in consultation with the Government and the National Polio Legacy Committee, has been delayed due to the ongoing federalization process in the country.
152. Polio infrastructure is providing support during the COVID-19 pandemic for various activities such as coordination, surveillance, contact tracing, specimen shipment and testing, capacity building and logistics.

153. The WHO South-East Asia Regional Polio Transition Steering Committee established to provide leadership and oversight of the transition process held its first meeting in New Delhi, India in December 2019.

**Challenges being faced**

154. Maintaining polio-free status in the context of the risk of importation of WPV or emergence of cVDPVs remains a challenge in the Region. There is a risk of importation of cVDPVs from the People’s Republic of China, Malaysia, Pakistan and the Philippines.

155. Effect of the COVID-19 pandemic on polio eradication activities such as routine immunization coverage of bOPV and IPV, and laboratory supported surveillance, also poses an impediment.

156. Sustaining high routine immunization coverage, sensitive surveillance, strong outbreak response capacity and containment of polioviruses in facilities during the post-certification period continues to merit attention.

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

**The way forward**

158. All Member States of the Region must maintain and further strengthen actions required to maintain the polio-free status of the WHO South-East Asia Region until global polio-free certification is achieved and beyond.

159. Appropriate actions to mitigate the risk of spread of wild poliovirus following an importation are being taken by all Member States in the Region. To minimize the risks and consequences of potential VDPVs, Member States should ensure high routine immunization coverage, conduct surveillance for timely detection of the emergence of cVDPV, and maintain strong outbreak response capacity.

160. There must be a resumption of polio eradication activities that are disrupted by the COVID-19 pandemic at the earliest opportunity while minimizing the risk of COVID-19 transmission among frontline workers and communities and ensuring that the benefits of carrying out the activity outweigh the risks.

161. Complete containment of polioviruses as per the Global Action Plan III must be ensured to mitigate the risk of exposure of communities to any type 2 polioviruses, following the switch from tOPV to bOPV, as well as to wild poliovirus type 3 materials as interruption of their transmission was certified by the GCC in October 2019.

162. Countries are making steady progress against the three objectives outlined in the strategic action plan on polio transition. The recent involvement of immunization workforce to support governments in the COVID-19 response reinforces the value of WHO-managed networks in areas “beyond polio”. To mitigate any potential risk of slowdown in implementing the national transition plans amid the COVID-19 pandemic, continued commitment of Members States and partners will remain critical to maintain essential polio functions, strengthen immunization systems and help achieve coverage and equity goals.