This Report describes the work of the World Health Organization in the South-East Asia Region during the period 1 January 2012 to 31 December 2013. It highlights the achievements in public health and WHO’s contribution to achieving the Organization’s strategic objectives through collaborative activities.

This Report will be useful for all those interested in health development in the Region.
The Work of WHO in the South-East Asia Region

Biennial Report of the Regional Director 1 January 2012 – 31 December 2013
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Preface

The work of WHO in the South-East Asia Region during the 2012-2013 biennium builds on earlier collaborative activities with Member States. It seeks to increase national capacity in public health and deliver health and economic benefits to the population of the Region.

This report highlights key changes in public health. With regard to communicable diseases, the South-East Asia Region remained polio-free during the biennium, which paved the way for the formal certification of eradication in early 2014, making South-East Asia the fourth WHO Region to achieve this status. To maintain the Region’s polio-free status, WHO will work with all concerned to combat the threat of importation of polio virus from areas of the world where it remains endemic.

WHO will utilize the expertise and infrastructure that has been developed for polio eradication, to reach the target set by the Region to eliminate measles by 2020. More broadly, a regional strategic plan for 2013-2020 will optimize the use of vaccines to reduce childhood deaths and other vaccine-preventable conditions.

The Region has made progress towards the achievement of Millennium Development Goal 6 for HIV, TB and malaria, benefitting particularly from substantial financial support from the global community. Leprosy elimination status at the national level has been sustained and the challenge now is to get rid of this scourge at the subnational level. Notable progress has also been made in eliminating lymphatic filariasis, yaws and kala-azar.

Work to augment national core capacities as defined in the International Health Regulations (2005) continues. These capacities are required to ensure an appropriate public health response to all potential hazards, but particularly for combating new and emerging communicable diseases such as MERS CoV and Influenza A H7N9.

Noncommunicable diseases (NCDs) in this Region are now the major killers of people in their most productive years. The rising burden of cardiovascular diseases, cancers, chronic respiratory disorders, diabetes and mental illness is driven by widely prevalent, lifestyle-related risk factors. These in turn are influenced by people’s economic and social circumstances. NCDs are cutting short lives, pushing
Preventing and managing NCDs has to focus on proven, evidence-based, cost-effective and affordable “Best Buy” interventions that reduce exposure to risk factors. Implementation requires a multisectoral approach to address the social, environmental and economic determinants of health – the causes of the causes. This in turn means promoting “Health in All Policies” and making healthy people central to all national development efforts.

A regional strategic action plan for the period 2013–2020 has been adopted with 10 regional targets for the prevention and control of NCDs. Member States have also intensified implementation of the WHO Framework Convention for Tobacco Control (FCTC) and are strengthening primary health care systems for delivery of NCD services to affected people. WHO will continue to provide technical support and build national capacity for development and implementation of multisectoral policies and interventions for addressing NCDs.

Universal health coverage (UHC) is a game-changer for public health. It is also central to the debate about the next generation of global development goals post-2015. Member States in the Region and civil society have made important contributions to this debate through Regional consultations held in early 2013, underscoring the significance of UHC both as a means to improve health status as well as an end by itself with respect to improved health equity.

The Regional Strategy for Universal Health Coverage (2012) developed in consultation with Member States and international experts was endorsed by the Sixty-fifth session of the Regional Committee for South-East Asia in September 2012. It documents lessons learnt from country experience and suggests practical ways forward.

In South-East Asia out-of-pocket health spending – particularly on medicines – is a key cause of impoverishment. The UHC strategy highlights the importance of increased government expenditure on health as a key component of social protection and as a means of decreasing inequity in health.

Cost containment in health systems more broadly is a critical issue for affordable and sustainable UHC. This is especially true in countries in this Region where unregulated private provision of care is common, and where the emphasis on curative care in response to the increasing burden of NCDs outweighs prevention.
The biennium also saw greater attention being paid to health issues of vulnerable groups especially children, women and the elderly. However, MDG 4 and MDG 5 are far from being achieved. WHO has worked on preventing unsafe abortions, the health of newborns, prevention and control of birth defects and augmenting national capacity for managing health of women and children.

Several countries in the Region have been affected by emergencies during the last two years. The vulnerability of this Region to emergencies is well known, but responses to mitigate risks, especially to people’s health caused by these events have markedly improved.

A unique feature of WHO’s support for emergencies is the South-East Asia Regional Health Emergency Fund, which was established in 2008 and which, to date, has provided support during 20 events in nine countries. The SEARHEF has also served as a model for other regions.

The first WHO Collaborating Centre in the world on disaster risk reduction in the area of public health became operational in Indonesia during this biennium. Further, the Inter-Regional and National Public Health Emergency Management in Asia and the Pacific (PHEMAP) courses have been conducted and continue to be updated.

In conclusion, despite several financial, technical, and human-resource constraints under which the health systems in different Member States operate, substantial gains have been made in improving the health of communities. WHO is proud to have contributed to these achievements and remains committed to supporting Member States in their endeavour to improve the health of their people.

Dr Poonam Khetrapal Singh
Regional Director
# Acronyms and abbreviations

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<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AEFI</td>
<td>adverse events following immunization</td>
</tr>
<tr>
<td>AIIMS</td>
<td>All India Institute of Medical Sciences</td>
</tr>
<tr>
<td>ANC</td>
<td>antenatal care</td>
</tr>
<tr>
<td>ANC 4</td>
<td>antenatal care coverage (with at least four visits)</td>
</tr>
<tr>
<td>ASEAN</td>
<td>Association of Southeast Asian Nations</td>
</tr>
<tr>
<td>ASHAs</td>
<td>accredited social health activists</td>
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<tr>
<td>CD4</td>
<td>cluster of differentiation 4</td>
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<tr>
<td>CEWG</td>
<td>Consultative Expert Working Group on Research and Development</td>
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<tr>
<td>COIA</td>
<td>Commission on Information and Accountability for Women’s and Children’s Health</td>
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<tr>
<td>COMBI</td>
<td>communication for behavioural impact</td>
</tr>
<tr>
<td>CPR</td>
<td>contraceptive prevalence rate</td>
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<tr>
<td>CRVS</td>
<td>civil registration and vital statistics</td>
</tr>
<tr>
<td>DGHS</td>
<td>Directorate General of Health Services (Bangladesh)</td>
</tr>
<tr>
<td>DIPECHO</td>
<td>Disaster Preparedness Programme of the European Community Humanitarian Office</td>
</tr>
<tr>
<td>DTP</td>
<td>diphtheria/tetanus/pertussis [vaccine]</td>
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<tr>
<td>eCODIRS</td>
<td>electronic cause of death integrated reporting system</td>
</tr>
<tr>
<td>FAO</td>
<td>Food and Agriculture Organization of the United Nations</td>
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<tr>
<td>GAPP</td>
<td>Global Action Programme for the Prevention and Control of Pneumonia</td>
</tr>
<tr>
<td>GAVI Alliance</td>
<td>Global Alliance for Vaccines and Immunisation [formerly]</td>
</tr>
<tr>
<td>GSBS</td>
<td>global school-based student health survey</td>
</tr>
<tr>
<td>GSM</td>
<td>Global Management System</td>
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<tr>
<td>GTCS</td>
<td>generalized tonic–clonic seizure</td>
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<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>OCW</td>
<td>Orange City Water</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
</tr>
<tr>
<td>OIE</td>
<td>World Organisation for Animal Health</td>
</tr>
<tr>
<td>OPEC</td>
<td>Organization of Petroleum Exporting Countries</td>
</tr>
<tr>
<td>OpenHIE</td>
<td>Open Health Information Exchange</td>
</tr>
<tr>
<td>OpenMRS</td>
<td>Open Medical Record System</td>
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<tr>
<td>PHEMAP</td>
<td>Public Health and Emergency Management in Asia and the Pacific</td>
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<tr>
<td>PKDL</td>
<td>post-kala-azar dermal leishmaniasis</td>
</tr>
<tr>
<td>R&amp;D</td>
<td>research and development</td>
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<tr>
<td>RWRS</td>
<td>Regional Working Reference Standards</td>
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<tr>
<td>SAARC</td>
<td>South Asian Association for Regional Cooperation</td>
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<tr>
<td>SEAMEO TROPED</td>
<td>Southeast Asian Ministers of Education, Tropical Medicine and Public Health Network</td>
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<tr>
<td>SEARHEF</td>
<td>South-East Asia Regional Health Emergency Fund</td>
</tr>
<tr>
<td>STEPS</td>
<td>WHO STEPwise approach to Surveillance</td>
</tr>
<tr>
<td>TB/HIV</td>
<td>tuberculosis-related HIV</td>
</tr>
<tr>
<td>TBTEAM</td>
<td>Tuberculosis Technical Assistance Mechanism</td>
</tr>
<tr>
<td>The Union</td>
<td>International Union Against Tuberculosis and Lung Disease</td>
</tr>
<tr>
<td>TRIPS</td>
<td>trade-related aspects of intellectual property rights</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
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<tr>
<td>UNDG</td>
<td>United Nations Development Group</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNDSS</td>
<td>United Nations Department of Safety &amp; Security</td>
</tr>
<tr>
<td>UNEP</td>
<td>United Nations Environment Programme</td>
</tr>
<tr>
<td>UNESCO</td>
<td>United Nations Organization for Education, Science and Culture</td>
</tr>
<tr>
<td>UN-HABITAT</td>
<td>United Nations Human Settlements Programme</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>UN SWAP</td>
<td>United Nations System-Wide Action Policy on Gender Equality and Empowerment of Women</td>
</tr>
<tr>
<td>UN-Water GLAAS</td>
<td>United Nations-Water Global Analysis and Assessment of Sanitation and Drinking-Water</td>
</tr>
<tr>
<td>Urban HEART</td>
<td>Urban Health Equity Assessment and Response Tool</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>US CDC</td>
<td>United States Centers for Disease Control and Prevention, Atlanta</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WHO FCTC</td>
<td>WHO Framework Convention on Tobacco Control</td>
</tr>
<tr>
<td>WSP</td>
<td>water safety plan</td>
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<tr>
<td>WTO</td>
<td>World Trade Organization</td>
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2012–2013 programme delivery highlights

- All Member States remained polio-free in 2012–2013. By February 2014, the Region expects to be certified polio-free.

- The Sixty-fourth Regional Committee declared 2012 the “Year of Intensification of Routine Immunization”. Efforts were undertaken to improve immunization coverage. The WHO Regional Office for South-East Asia drafted a strategic framework for guiding immunization programmes to develop plans of action. Technical support and funding were also provided to priority countries. Member States have been implementing plans to hold more outreach sessions, build immunization staff capacity, and ensure vaccine availability.

- The *Haemophilus influenzae* type b (Hib) vaccine (in the form of a pentavalent vaccine with combination DTP+HepB+Hib) was introduced in four Member States in 2012 and one in 2013, bringing the total number of countries in the Region using the vaccine to 10. Based on requests from Member States, technical support was provided through guidelines and monitoring and evaluation before, during, and post vaccine introduction.

- A regional strategic plan to develop and implement integrated approaches to controlling neglected tropical diseases in South-East Asia was launched.
The Regional Office assisted Member States in conducting assessments of their implementation of International Health Regulations (2005) (IHR (2005)) core capacities, with particular emphasis on surveillance and monitoring of communicable diseases.
Overview

1. Notable progress was made in the prevention and control of communicable diseases in the South-East Asia Region in 2012–2013; however, the Region still bears a significant burden of communicable diseases. All Member States in the Region remained polio-free in 2012–2013. Routine immunization for vaccine-preventable diseases was intensified. Many countries are on target to eliminate some neglected tropical diseases and are taking measures to prevent and control others. Steady progress towards implementation of the IHR (2005) has been made to strengthen country capacity in core areas, including: surveillance; risk assessment; emergency preparedness; vigilance at points of entry; laboratory investigation; and, risk communication.

Poliomyelitis eradication and certification

2. All Member States in the Region were able to maintain their polio-free status in 2012–2013. Bangladesh, India, Myanmar, Nepal, and Thailand conducted protective polio immunization campaigns. Surveillance and immunization reviews were conducted in Bangladesh, India, and Maldives, and at the state level in India. Meetings of the South-East Asia Regional Certification Commission for Polio Eradication were held as scheduled, and it was agreed that the regional polio-free certification process would be accelerated to achieve final certification by early 2014.
Nepal stays vigilant to prevent the return of polio

High up in the Nepalese district of Humla, where most villages are between 3000–5000 m above sea level, a female community health volunteer visited 5-year-old Kiran (altered name) at his home. Kiran was complaining that suddenly he was unable to move his legs and that his arms had also started to become very weak.

Muscle weakness or paralysis could be due to a number of different viral or bacterial infections, or from other causes. In Nepal, community health volunteers are trained to be on high alert for these complaints. One of the conditions that they are looking for is acute flaccid paralysis. Children with acute flaccid paralysis are investigated to exclude poliomyelitis infection due to wild poliovirus.

Immediate action – reporting, testing, and surveillance

“A single confirmed case of this highly infectious disease is a cause for extreme concern,” said the national Expanded Programme on Immunization manager of Nepal. “Female community volunteers are the pillar of our surveillance network to detect and report any case of acute flaccid paralysis. Every time there is a suspected case of acute flaccid paralysis, we take urgent action.” The health volunteer immediately reported the suspected case to the district health officer and organized for Kiran to travel to the Humla district hospital – a formidable challenge in a remote mountainous district where, if unassisted, it can take 10 days to walk to the nearest road.

At the hospital, Kiran was thoroughly examined and two stool samples were collected, 24 hours apart. As the highest concentrations of poliovirus are found within 2 weeks of when the first paralysis symptoms appear, the speed of the process is crucial. The samples were stored immediately in a refrigerator and transported in cold conditions (2–8°C) maintained with ice packs to the WHO Country Office Kathmandu. From there, they were sent to a WHO-accredited polio laboratory in Bangkok, Thailand.

While waiting for the laboratory results, one of the WHO surveillance medical officers in Nepal travelled to Humla district hospital to conduct a thorough investigation. This included searching for other children with the same symptoms as Kiran, as well as examining polio immunization coverage through the routine immunization programme, investigating the recent travel history of the child and his family, and checking other relevant information that may help in understanding the epidemiology of Kiran’s symptoms and in deciding the type of action required to prevent further spread of the disease.
3. Looking to the future, and in line with the endgame strategy, a regional consultation in December 2012 established consensus that inactivated polio vaccine would be introduced by all countries in the Region in their routine immunization schedule, prior to the switch from trivalent to bivalent oral polio vaccine and eventual cessation of polio vaccination.

**Equitable access to vaccines**

4. The Sixty-fourth Regional Committee declared 2012 the “Year of Intensification of Routine Immunization”. Member States have been implementing their respective plans to ensure equitable access to vaccines for all populations in the Region. The Regional Office provided technical support through monitoring missions and feedback on the implementation and corrective measures for plans of action. The focus on outreach to hard-to-reach, underserved, and marginalized populations through mapping, targeting and catch-up immunization drives was intensified, where appropriate, as was capacity-building of immunization staff and improving vaccine management and vaccine safety.

5. By the end of 2013, an additional five Member States – the Democratic People’s Republic of Korea, Indonesia, Maldives, Myanmar, and Timor-Leste – had
introduced the Hib vaccine in the form of a pentavalent vaccine combination (DTP+HepB+Hib) in their national immunization programmes, bringing the total number of countries in the Region to utilize this combination to 10. Coverage with the third dose of DTP vaccine increased in the Region as a result of intensification of routine immunization.

6. Coverage with the first dose of measles vaccine was an estimated 86% for the Region, based on official country estimates. An estimated 64 million children between the ages of 9 months and 14 years received measles immunization through campaigns in India, Myanmar, and Nepal in 2012. In India, the phased measles immunization campaign has reached an estimated 41.5 million children. At the Sixty-sixth Session of the Regional Committee in September 2013, Member States adopted resolution SEA/RC66/R5 which set the target year of 2020 for measles elimination and rubella/congenital rubella syndrome control.

7. The Regional Office continued to support Bangladesh, India, Indonesia, Myanmar, Nepal, and Sri Lanka in conducting sentinel surveillance for invasive bacterial diseases and rotavirus, and assisted with the development of an evidence database for consideration when introducing available vaccines against these antigens.

8. Indonesia was validated as having eliminated maternal and neonatal tetanus in all provinces except four, covering 97.4% of its national population. India validated maternal and neonatal tetanus elimination in 15 states and initiated the process in four additional states. With the phased validation of India and Indonesia, the number of countries that have been validated for maternal and neonatal tetanus elimination remains at nine.

9. A series of regional meetings and consultations on new vaccine introduction and the polio endgame provided consensus and guidance that will be reflected in, and define the development of, the regional strategic plan for immunization and vaccines for 2013–2020.

**Neglected tropical diseases**

10. The WHO South-East Asia Region bears the second highest burden of neglected tropical diseases among WHO regions. The Regional Office has sustained and expanded its efforts to combat vector-borne diseases and neglected tropical diseases. Priority neglected tropical diseases in the Region include dengue fever, rabies, leprosy, lymphatic filariasis, visceral leishmaniasis (kala-azar), trachoma and yaws. These diseases affect the poorest communities, and prevention and control of
neglected tropical diseases contributes significantly to achievement of the Millennium Development Goals (MDGs) as well as improving social and economic well-being.

11. Substantial success has been achieved in eliminating some neglected tropical diseases of public health importance in the South-East Asia Region in recent years. Dengue is the only vector-borne disease with an increasing trend; however, case fatality rate of dengue has been brought down to less than 0.5% and sustained, while chikungunya continues to be a re-emerging problem. Out of the nine endemic countries in the Region, three countries have already reached the point of elimination for lymphatic filariasis by reducing microfilaria rate to less than 1% after more than 5 years of mass drug administration. More than five rounds of mass drug administration have been done in 621 implementation units, some of which were administered during 2012. The microfilaria rate was reduced to less than 1% in 575 implementation units. Human mortality due to rabies has been significantly reduced in Sri Lanka and Thailand, and production of neural tissue vaccine has been discontinued across the Region. Another neglected tropical disease being targeted for elimination in the Region is visceral leishmaniasis (kala-azar). The Region is making good progress in eliminating kala-azar and reaching the elimination target of 2015. Kala-azar cases have been reduced from more than 50 000 in 2007 to 14 754 in 2013, while reported deaths have come down from more than 200 to 24 in the same period (Figure 1.1).

**Figure 1.1: Reported cases and deaths from kala-azar, 2001–2013**

Source: Country reports, 2013
12. Since post-kala-azar dermal leishmaniasis (PKDL) is thought to be the source of continuous transmission of kala-azar, a PKDL consortium meeting was organized in June 2012. WHO provided guidelines on PKDL case management and control. In Indonesia, of 18 352 people targeted by the national schistosomiasis programme, 14 102 people were treated, according to an assessment taken in September 2012. Parasite surveys took place in Myanmar and Timor-Leste in 2012. Myanmar has successfully reduced the prevalence of active trachoma to less than 5% in all endemic districts. A new strategy – the Morges Strategy – for yaws was endorsed in 2012, using single-dose oral azithromycin. The first meeting of the Steering Committee of the South-East Asia Regional Network of Centres of Expertise in Tropical Diseases was held, and is a step towards building and increasing effective networks of expertise.

13. At the end of 2010, all 11 Member States of the Region had successfully eliminated leprosy as a public health problem at the national level. However, leprosy remains endemic in several subnational areas, particularly in six countries – Bangladesh, India, Indonesia, Myanmar, Nepal, and Sri Lanka – where more than 1000 new cases are detected annually. Innovative activities are escalating in order to achieve the target of less than one new case with grade 2 disability per 1 million population by 2020, according to the WHO publication Accelerating
work to overcome the global impact of neglected tropical disease: a roadmap for implementation. Activities include contact examinations, active case-finding, and advocacy. Leprosy has been integrated into the health-care system in all Member States in the Region. As a result, leprosy programme activities have expanded to areas where general health-care services are available.

14. Commitments from countries has always been high, and is even more so after the Bangkok Declaration Towards a Leprosy-free World was pledged in July 2013 by the high-burden leprosy countries. It is encouraging to witness an increase in the allocation of national funds to the programme in some countries of the Region. At the same time, donors have maintained their level of support to the programme through WHO. WHO is focusing its support in two main areas: early case detection, and treatment and advocacy.

**Surveillance and monitoring of communicable diseases**

15. All 11 Member States in the Region have a list of priority diseases, conditions, and case definitions for purposes of surveillance, as well as units designated for surveillance of public health risks. During 2012 and 2013, 10 of 11 countries reported how they analyse surveillance data on epidemic-prone and priority diseases at least weekly at national and subnational levels.

16. Surveillance systems were reviewed as a part of a formal assessment of IHR (2005) core capacities undertaken in the Democratic People’s Republic of Korea and Maldives, both with WHO support. To help strengthen technical capacity for surveillance, WHO provided technical support to a national workshop on integrated disease surveillance, and a training of trainers workshop for supervisors of field epidemiology training programmes. A risk management training course for facilitators, focusing on event surveillance, was jointly organized by the Regional Office and WHO headquarters.

**Knowledge and tools for prevention and control of communicable diseases**

17. Regional training for detection of viral pathogens was organized at the National Institute of Virology, a WHO collaborating centre in Pune, India. A regional workshop was convened to share information on progress made by Member States in
implementation of the Jaipur Declaration on Antimicrobial Resistance. In this area, Member States are establishing comprehensive and integrated national approaches to combat antimicrobial resistance, which are backed by legislative and regulatory mechanisms. Additionally, several national treatment guidelines promoting the rational use of antimicrobial agents have been produced by countries in the Region. Regional and national training courses have been organized to build capacity for laboratory-based surveillance. Community-based education materials are also being developed and communications campaigns have been launched to educate and raise awareness about antimicrobial resistance. WHO will continue to work with national authorities in providing technical assistance to augment national capacity in preventing and containing antimicrobial resistance.

18. National-level laboratory training courses were supported in Bangladesh, Indonesia, Nepal, and Thailand. Several countries were provided diagnostic materials for establishing diagnosis of emerging and epidemic-prone diseases. Bangladesh, Bhutan, and Nepal were supported in strengthening their capacity to screen donated blood for infectious markers, especially HIV, hepatitis B, and hepatitis C.

1 Acknowledging the growing global importance of antimicrobial resistance, the health ministers of all Member States of WHO’s South-East Asia Region adopted the Jaipur Declaration on Antimicrobial Resistance in 2011. The Declaration recognizes the imperative that national governments accord utmost priority to this problem to preserve efficacy of antibiotics in the fight against microbial diseases.
Strengthening IHR (2005) capacity

19. Ten countries in the Region have submitted self-monitoring data on IHR (2005) core capacity in 2013. The results indicated that all countries were making steady progress towards full implementation. However, radionuclear and chemical safety capacities as well as capacities at points of entry, need to be further strengthened according to the self-monitoring data from the countries. All 11 countries have requested a deadline extension to June 2014 for establishment of core capacities. Myanmar was supported in its review and development of a plan of action to strengthen its implementation of IHR (2005) at points of entry, and similar support was provided to strengthen implementation at Nepal’s international airport. WHO headquarters, regional, and country offices participated in an internal global WHO exercise designed to test the functionality of the newly developed Emergency Response Framework.

20. To implement IHR (2005) properly, appropriate national-level legal frameworks are essential. However, different countries have different legislations, policies, regulations, and requirements, which support IHR implementation to varying degrees. Therefore, the first workshop on IHR legislation in the Region, the “Regional Workshop on Public Health Legislation for International Health Regulations” held in Yangon, Myanmar in April 2013, reviewed the current status of national legal frameworks for IHR implementation, and identified gaps, key elements, and the
way forward through strengthening human, financial, and technical resources. WHO advocates assessment and revision of national legislation to comply with IHR (2005), and facilitates the provision of legal technical assistance to Member States.

21. To strengthen radionuclear and chemical capacity under IHR (2005), a regional strategy was developed and approved by Member States during a meeting held in Bangkok, Thailand, in October 2013.

22. A roadmap to strengthen core capacity for points of entry was also developed during a regional meeting on IHR (2005) core capacities at points of entry, held in Kochi, India in June 2013. It called for strengthening human resources at points of entry based on identified needs, including a points of entry needs assessment; ensuring issues related to points of entry are part of medical training curricula, including field epidemiology training programmes; and, advocating for the inclusion of public health emergencies in existing emergency/disaster response plans (all-hazards approach).

Detection, assessment, and response to epidemics and other public health emergencies

23. Capacity-building for detection and response to epidemics was emphasized in 2012, with WHO supporting 11 participants nominated from seven Member States (Bhutan, Indonesia, Maldives, Nepal, Sri Lanka, Thailand, and Timor-Leste) for three months of field epidemiology training at the National Centre for Disease Control in India, and to develop a similar three-week national training programme in Myanmar. Additionally, a training workshop was held for influenza data management and epidemiological analysis in Bangkok, Thailand in February 2013. A training module on communication for behavioural impact (COMBI) for emerging infectious diseases in the Region was initially tested in Bhutan in 2012 and then in Sri Lanka in 2013.

24. Training on clinical recognition, case management, and control of emerging infectious diseases and zoonoses was organized in Bhutan and Myanmar, with resource persons from WHO collaborating centres in Thailand. Laboratory professionals from India, Indonesia, Myanmar, and Thailand underwent training on leptospirosis diagnosis and networking at the WHO Collaborating Centre for Leptospirosis in Port Blair, India.
25. To strengthen core capacity for points of entry, an intercountry training on ship sanitation inspection was held in Kochi, India in 2013 to improve the WHO learning programme on ship inspection, train ship inspectors on the issuance of ship sanitation certificates, and develop a potential pool of trainers for proper inspection and delivery of ship sanitation certificates.

26. The Regional Office for South-East Asia also supported the development of guidelines for the detection, surveillance, and case management of plague and guidelines for the prevention and control of Nipah virus infection. Rapid diagnostic kits for plague have been stockpiled at the regional level in New Delhi, India. Activities for prevention and control of dengue were scaled up in all Member States except the Democratic People’s Republic of Korea, which has not reported dengue, and the Third Asia-Pacific Dengue Workshop was held in Singapore in 2012.

27. To observe preparations for international mass gatherings, WHO supported an official from Myanmar to participate in the Paralympics Observer Programme in London, United Kingdom in collaboration with the WHO Collaborating Centre for Mass Gatherings and Extreme Events in the Health Protection Agency. The Regional Office also supported an expert to work with Myanmar in preparing for the Southeast Asian Games in 2013. Training on risk communication for communicable
diseases at mass gatherings was also held in Nay Pyi Daw, Myanmar, for the heads of epidemiology units of every state.

28. The summary recommendations of a consultation on the implementation of the “Pandemic Influenza Preparedness Framework for sharing of influenza viruses and other benefits” were presented at the Sixty-fifth Regional Committee Meeting in September. A draft regional strategy for viral hepatitis was developed and agreed in a regional consultation in July 2012 and finalized in 2013.

29. A Strategic Framework for Elimination of Human Rabies Transmitted by Dogs in the South-East Asia Region was advocated at the country level, and Bangladesh and Sri Lanka have developed national strategies for rabies elimination based on Regional Strategic Framework. WHO has been working with the SAARC Secretariat and its Member States to improve surveillance, response, prevention and control of communicable diseases including cross-border collaboration. WHO facilitated development and finalization of the SAARC Strategy for Prevention and Control of Communicable Diseases, which was endorsed by the SAARC Health Ministers’ Meeting held in Malé, Maldives in April 2012. WHO, along with the Food and Agriculture Organization of the United Nations (FAO) and the World Organisation for Animal Health (OIE), facilitated the development of the SAARC Rabies Elimination Project, which was submitted to the SAARC Development Fund for consideration. WHO also supported efforts to create awareness on rabies, including activities for capacity-building for rabies diagnosis in Bangladesh and Sri Lanka. Myanmar phased out production and use of nerve-tissue rabies vaccine in 2012 by introducing cost-effective intradermal rabies vaccination.

30. Many infectious diseases are emerging at the human–animal interface and close collaboration between human health and animal health sectors is essential. A regional meeting on zoonotic diseases was organized in Chiang Mai, Thailand in August 2013, to review progress made in implementing the Strategic Framework for Prevention and Control of Zoonoses in the South-East Asia Region and to discuss zoonotic influenza, rabies and antimicrobial resistance as priority issues at the human–animal interface. The meeting came up with practical recommendations for strengthening surveillance and response for endemic and emerging zoonoses in the changing context. FAO, OIE and WHO have established a functional tripartite coordination mechanism at the regional level and are working together to provide technical support for better surveillance and response to emerging zoonotic events, including avian influenza A(H7N9). The three partner organizations organized regional workshops in Indonesia, Nepal, and Thailand to share experiences and
good practices in establishing a functional coordination mechanism between human health, animal health, and other sectors.

31. The year 2013 saw the emergence of new diseases such as Middle East respiratory syndrome coronavirus (MERS-CoV) in the Middle East and avian influenza A(H7N9) in China, both of which could threaten South-East Asia. To ensure that the Region is prepared for such a threat, a regional workshop on emerging infectious diseases and novel coronaviruses was held in Colombo, Sri Lanka in October 2013, which led to the development of action plans that could be adopted by countries in the Region.

Effective operations and response to declared emergencies due to epidemic and pandemic-prone diseases

32. The Regional Office did not receive requests for direct support to outbreaks in 2012–2013. Support was provided to India, Indonesia, and Thailand to establish laboratory capacity for the diagnosis of the recently recognized novel coronavirus known as MERS-CoV.

33. IHR (2005) core capacity assessments conducted in the Democratic People’s Republic of Korea and Maldives included a review and recommendations for the improvement of arrangements for various aspects of public health emergency preparedness and response. To identify professionals for possible deployment by WHO during a public health emergency, a training workshop on strengthening regional capacity for outbreak response, jointly organized by WHO headquarters and the Regional Office, was held in Indonesia. The Regional Office provided support for rumour surveillance in the United Kingdom’s Health Protection Agency operations room during the opening week of the 2012 Olympics.
HIV/AIDS, tuberculosis, and malaria

2012–2013 programme delivery highlights

- Implementation of the Stop TB Strategy continued in the South-East Asia Region in 2012–2013. The regional Green Light Committee was established under the Regional Advisory Committee on MDR-TB to support Member States in meeting the challenges of drug-resistant tuberculosis.

- Member States in the Region have either adopted or are reviewing their current HIV treatment guidelines in line with the WHO Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach, June 2013. All countries have committed to elimination of mother-to-child transmission of HIV and have adopted Option B+ to provide antiretroviral therapy (ART) for all HIV-positive pregnant women. ART coverage has increased in most countries. Thailand has already achieved 71% coverage and is poised to reach the universal access target of 80% coverage.

- Countries were supported for review and update of existing national strategies and guidelines. WHO guidelines and tools were discussed and disseminated at the Eleventh International Congress on AIDS in the Asia and the Pacific held in Bangkok, Thailand in November 2013.

- Technical and management support were provided to all malaria-endemic countries for implementation of collaborative programmes, including the implementation of external grants. The programmes in Bhutan, Myanmar, Nepal, Sri Lanka, and Timor-Leste were further strengthened following an external review of the malaria programme facilitated by WHO. Activities to
contain artemisinin resistance in Myanmar and Thailand were scaled up. In collaboration with the WHO Regional Office for the Western Pacific, a regional hub to address artemisinin resistance in the Greater Mekong Subregion was set up in Cambodia and resources were mobilized. These activities contributed to a reduction of malaria cases in the Region.

**Scale-up of ART programmes, 2008–2012**

<table>
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<tr>
<th>Country</th>
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<td>Myanmar</td>
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<tr>
<td>All countries</td>
<td>30%</td>
<td>50%</td>
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</table>

Sources: Universal access country reports 2013; Global AIDS response progress reports 2013 and Revised UNAIDS estimates.
Overview

1. Tuberculosis mortality rates have decreased by more than 40% since 1990, putting the Region on track towards achieving its MDG target of a 50% reduction in deaths by 2015 (Figure 2.1). However, in 2012, the South-East Asia Region represented 39% of the global burden of tuberculosis, or 450 000 deaths.

2. The HIV/AIDS epidemic shows signs of reversal in high-burden countries due to effective strategies, increased access to life-saving ART, and health systems strengthening. Consequently, the estimated number of people living with HIV/AIDS in South-East Asia – 3.4 million – has remained stable for the past five years, while the number of new infections has declined in four of the five high-burden countries: India, Myanmar, Nepal, and Thailand.

3. ART coverage increased from 39% in 2010 to 55% in 2012 in the Region. More than 938 000 eligible people living with HIV, including children, received treatment in 2012 (Figure 2.2).

4. Progress was also made in malaria control in 2012–2013. The number of confirmed malaria cases declined by 12% from nearly 2.3 million in 2011 to just over 2 million in 2012; the number of reported malaria deaths fell by 32.7%, from 1821 to 1226 (Figure 2.3). Malaria in the Region is limited to focal areas that are hard to reach, including along international borders, as well as in some urban/peri-urban areas in India. Sri Lanka, one of the six countries in the Region aiming for malaria elimination, has had no indigenous (locally acquired) case since November 2012 and may be able to achieve its elimination goal soon.
Figure 2.1: Trends in tuberculosis control, 1990–2012


Figure 2.2: Percentage of persons with advanced HIV infection receiving ART, 2003–2012

Source: Global AIDS response progress reports 2013.
5. Challenges remain, however, such as multidrug-resistant tuberculosis (MDR-TB) – with an estimated 90 000 MDR-TB cases among all tuberculosis cases notified in 2012 – and management of TB/HIV coinfection.

6. In the field of malaria control, a key challenge is the emergence of resistance of *Plasmodium falciparum* to artemisinin-based combination therapy in the Greater Mekong Subregion, which seriously threatens global gains in malaria control. A further challenge is prevention of malaria resurgence in areas where local transmission is already either interrupted or has been brought down to very low levels, such as in Bhutan, the Democratic People’s Republic of Korea, Nepal, Sri Lanka and most parts of India, Indonesia and Thailand.

**Guidelines, policy, strategy, and tools for treatment and care**

7. **Tuberculosis:** The Regional Strategic Plan for TB Care and Control 2012–2015 and the Regional Response Plan for TB/HIV Collaboration 2012–2015 have been updated. In 2012–2013, the focus was on provision of a new framework to scale up drug-resistant tuberculosis management. Technical support was provided to
Bangladesh, the Democratic People’s Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Thailand, and Timor-Leste to either revise national plans or to develop MDR-TB control expansion plans. Regional workshops were organized by the Regional Office on tuberculosis control planning, implementation, and monitoring; the TB/HIV response plan; programmatic management of drug-resistant tuberculosis; and, promoting the roles of nongovernmental organizations and civil societies in community-based tuberculosis care and control. The Regional Office also convened meetings of the national tuberculosis control programme managers and partners, the South-East Asia Region Technical Working Group on Tuberculosis, and the Regional Advisory Committee on MDR-TB.

8. **HIV/AIDS**: The global WHO *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: Recommendations for a public health approach, June 2013* were disseminated to the countries in the Region. Many of the countries have already adapted their national guidelines in line with the WHO recommendations. In collaboration with the WHO Regional Office for the Western Pacific and United Nations Development Programme (UNDP) Asia-Pacific Regional Centre, a training package on addressing stigma and discrimination in health-care settings and improving access to HIV and sexually transmitted infection prevention, care, and treatment services for men who have sex with men and transgender people was developed and disseminated to countries.
9. **Malaria:** The global guidelines on disease surveillance for malaria control and elimination were adapted. A Region-specific framework for micro-stratification of malaria risk areas was developed to better target interventions. Bhutan, the Democratic People’s Republic of Korea, and Nepal have begun implementation. WHO provided appropriate technical guidelines, the micro-stratification framework, and support for programme reviews in Bhutan, Myanmar, Nepal, Sri Lanka, and Timor-Leste and for technical missions to Bhutan, the Democratic People’s Republic of Korea, Nepal, and Sri Lanka, all of which led to strengthened malaria control programmes.

**Support for prevention, treatment, and care interventions**

10. **Tuberculosis:** WHO provided technical support to all Member States in a number of areas, including: strengthening laboratory quality control and assurance; culture and drug-susceptibility testing; introduction of rapid molecular testing; development of national guidelines; and, human resource development for tuberculosis control. The Regional Office also provided support on the scale-up of programmatic management of drug-resistant tuberculosis.

11. **HIV/AIDS:** Updated WHO global and regional guidelines for HIV prevention, care, and treatment were shared with countries, and capacity was built through regional and national workshops. Progress towards elimination of mother-to-child transmission of HIV and syphilis was discussed during the Ninth Meeting of the Asia-Pacific United Nations Task Force for the Prevention of Parents-to-Child Transmission. Situational analysis on the status of elimination of mother-to-child transmission interventions, policy guidance, and progress in targets and indicators were documented through a review of literature and country consultations.

12. **Malaria:** WHO technical support for malaria activities included national trainings in Bangladesh, Bhutan, the Democratic People’s Republic of Korea, Myanmar, Nepal, and Timor-Leste. Improving the quality of microscopy services was initiated in all countries to support case management and surveillance. WHO provided financial support for international trainings – conducted by the Department of Clinical Tropical Medicine at Mahidol University in Thailand (WHO Collaborating Centre for Clinical Management of Malaria), and other training institutions – in various aspects of malaria for national staff in Bhutan, the Democratic People’s Republic of Korea, and Timor-Leste.
Myanmar: expansion of ART coverage

Since the initiation of a national ART programme in 2005, Myanmar has made impressive achievements in the scale-up of ART. In 2012, about 125,500 HIV-positive people were estimated to be in need of ART (Global AIDS response progress reports 2013). Of these, 53,700 people (about 46%) received the treatment. Compared to 2009, when ART coverage was only 13%, this reflects a more than three-fold increase in coverage in three years. In 2012, almost 76% of children estimated to need ART were receiving the treatment. ART coverage was found to be higher among children (aged under 15 years) compared to adults. The analysis from the 2010 cohort of patients initiated on ART demonstrated that 87% adults and 94% children were retained on ART after 12 months.

This achievement is significant given the limited funding for antiretroviral drugs up until the last five years. ART services, under the flagship of the national AIDS programme, were introduced with technical and financial support from Management Sciences for Health, Netherlands (in 2003), and then supported through the Fund for HIV/AIDS in Myanmar, the Global Fund Round 3, and the Three Diseases Fund (from 2005). Funding was then accelerated in 2011 through the Global Fund Round 9.

The HIV response has contributed towards strengthening the community as well as the public health system, through capacity-building of human resources, the decentralization of services, coordination between civil society and the public health system, and the strengthening of laboratory capacities to carry out investigations for patient monitoring. The response also involves close collaboration between the HIV and TB programmes. Further strengthening and scale-up, as well as close convergence with maternal and child health and prevention of mother-to-child transmission programmes on related activities, are ongoing.

Myanmar plans to attain universal ART coverage for all eligible patients by 2015, through rapid adaptation of the global guidelines, followed by strategic planning and programming for ART scale-up in the country. The national AIDS programme has initiated orientation of partners to the WHO Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach, June 2013, to prepare for early adaptation and roll-out.

The WHO 2013 guidelines, which recommend starting ART in adults living with HIV when their CD4 count falls to 500 cells/mm³ or less, will have implications on resource planning and service delivery in the coming years. To meet the universal access target for ART, adaptation of service delivery models to strengthen the readiness of health systems and the continued engagement of civil society will be critical. Further action is required in terms of diagnostics and treatment simplification through the use of fixed-dose combinations and point-of-care, decentralization of services, and improved quality of care to strengthen the testing–treatment linkage and retention in care.
Equitable access to essential medicines, diagnostics, and commodities

13. **Tuberculosis:** Assistance continued to be provided for timely procurement of anti-tuberculosis drugs through grants and direct procurement mechanisms. All 11 Member States used Global Drug Facility services and products, and accessed low-cost and quality-assured fixed-dosage combination drugs. With the exception of the Democratic People’s Republic of Korea, all countries in the Region successfully transitioned from Global Drug Facility grants to direct procurements for adult formulations of first-line anti-tuberculosis drugs. Funding is available either domestically or from the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund). In addition, India, Indonesia and Thailand used domestic funding to procure part/all of their first-line medicines through their own channels. When using domestic funding, they do not use the services of Global Drug Facility. For paediatric medicines, several countries continued to receive support through Global Drug Facility grants. Second-line anti-tuberculosis drugs were procured through the Global Drug Facility and funded by the Global Fund in all countries except Maldives, where the health ministry is procuring small quantities of second-line drugs on a case-by-case basis.
14. **HIV/AIDS**: Access to affordable and quality medicines was facilitated through a review of existing pricing at country level compared to regional and global pricing. Technical support was provided to countries to review existing drug regimens for simplification, harmonization, and optimization through the use of more efficacious fixed-dose combinations. Through WHO collaborating centres, Member States were also supported in expansion of HIV diagnostics through the use of point-of-care technologies including CD4 monitoring, early infant diagnosis, and viral load testing for monitoring ART (where feasible).

15. **Malaria**: Technical support to improve quality of planning, microscopy, drugs, surveillance, and response was provided to Bhutan, Bangladesh, India, Myanmar, Nepal, Sri Lanka, and Timor-Leste. Quality and coverage of malaria microscopy services are also being improved, following an informal regional consultation.

### Strengthening surveillance, evaluation, and monitoring

16. **Tuberculosis**: WHO provided technical support for tuberculosis prevalence and drug-resistance surveys in Bangladesh, Indonesia, and Thailand. The Organization also provided technical support to countries for strengthening routine surveillance systems. Efforts to strengthen national tuberculosis surveillance systems are focusing on quality of data, with the main emphasis being on completeness of case reporting, and accurate compilation and reporting of data. Joint monitoring missions were conducted in India, Indonesia, Nepal, Thailand, and Timor-Leste during 2012–2013.

17. **HIV/AIDS**: Technical support was provided for monitoring HIV drug resistance through early warning indicators. Interlinked monitoring systems for HIV, tuberculosis and malaria were supported in Myanmar. HIV programme reviews were supported in Indonesia, Myanmar, Nepal, and Timor-Leste. WHO assisted countries in collecting, collating, and analysing data for Global AIDS Response Progress Reporting in 2012 and 2013. Capacity-building for surveillance, monitoring, and evaluation through a regional workshop on strategic information management was provided for all Member States.

18. **Malaria**: Technical support was provided to all malaria-endemic countries to strengthen malaria surveillance. Bangladesh, Bhutan, India, Myanmar, Nepal, and Sri Lanka agreed to collaborate in strengthening surveillance and response along international borders, and Nepal and Bangladesh have already started relevant activities with WHO support. Drug-resistance monitoring was carried out in Bangladesh, India, Indonesia, Myanmar, Nepal, Thailand, and Timor-Leste. WHO
facilitated malaria programme reviews in Bhutan, Myanmar, Nepal, and Timor-Leste, and a framework for review in Bangladesh was developed.

**Political commitment, resource mobilization, and partnerships**

19. *Tuberculosis*: A regional workshop on tuberculosis control planning, implementation, and monitoring led to increased momentum to strengthen coordinated efforts in these areas through the Tuberculosis Technical Assistance Mechanism (TBTEAM). Across the Region as a whole, domestic funding for tuberculosis control continues to account for about 50% of funding for national tuberculosis control programmes, while the Global Fund accounts for almost 45% of funding for tuberculosis activities. Ten Member States currently benefit from funds mobilized through the Global Fund, over the previous rounds of Global Fund grants and through the single stream of funding, the transitional funding mechanism, and the new funding model. Maldives is planning to apply for the new funding model of the Global Fund grant for 2015. Nepal is successfully implementing a National Strategy Application (NSA) grant that was approved by the Global Fund in 2009.

20. In addition, Member States benefit from funds from other development partners and donor governments – with the exception of Bhutan and Maldives, where the only external funds are provided through WHO country budgets. Despite the funding available through governments and various donors in the Region, the funding gap is about one fourth of the overall budget of tuberculosis control programmes estimated for 2014. To mobilize greater commitment for tuberculosis control in the Region, WHO – at country, regional and headquarters level – continued to interact with several donor and development partners. The Region is represented on the Stop TB Partnership Coordinating Board and the Board of the Global Fund.

21. Staff from the Regional Office and country offices participated in, and contributed to, workshops and meetings held by WHO headquarters and partner agencies, namely the Strategic and Technical Advisory Group for Tuberculosis (STAG-TB) meeting; the Regional Advisers’ meeting; the TBTEAM meeting; the Union World Conference; and, the Global Laboratory Initiative meeting.

22. *HIV/AIDS*: Ongoing technical support was provided to countries for accessing resources through the Global Fund. Partnerships and collaborations were strengthened through strategic memorandum of understanding with the Joint United Nations Programme on HIV/AIDS (UNAIDS) Asia-Pacific Regional Support Team and the Thai Red Cross AIDS Research Centre. Technical collaboration was entered into with
the Regional Office for the Western Pacific to expand HIV prevention, care, and treatment in the Region through the WHO Network for HIV and Health. Resources were generated through UNDP’s regional grant for HIV among men who have sex with men to disseminate the WHO-UNDP training package. Additionally, there was technical and financial collaboration with UNICEF to expand activities for elimination of mother-to-child transmission of HIV.

23. **Malaria:** WHO provided support to develop proposals and negotiations for the extension of Global Fund grants in the Democratic People’s Republic of Korea, Myanmar, Nepal, and Timor-Leste, as well as for the Three Millennium Development Goals Fund in Myanmar. WHO participated in “Malaria 2012”, a high-level conference for the Asia–Pacific Region, hosted by Australia. In November 2012, the WHO Global Malaria Programme in Geneva mobilized US$ 15 million for activities to be implemented over a three-year period to support artemisinin-resistance containment in the Greater Mekong Subregion.

**New knowledge, intervention tools, and strategies**

24. **Tuberculosis:** National tuberculosis programmes and partners are engaged in carrying forward several operational research projects. Other research projects are supported by WHO country offices through funds available at country level
from the Global Fund. Examples include knowledge, attitude and practice studies in Timor-Leste; public–private mix models in Bangladesh, India, and Myanmar; hospital DOTS in Indonesia; seasonality in tuberculosis notifications; use of isoniazid preventive therapy in India, Indonesia, and Myanmar; outcomes from cross-border tuberculosis control in Thailand; mortality studies in India, Indonesia and Myanmar; and, approaches to community-based tuberculosis care in several countries. National workshops on operations research priority setting and dissemination are held regularly in India. India, in collaboration with the International Union Against Tuberculosis and Lung Disease (The Union) and other stakeholders, is conducting several operational researches. Bangladesh, India, Indonesia, Myanmar, Nepal, Sri Lanka, and Thailand were benefitted by TB REACH-approved projects.

25. **HIV/AIDS:** Technical and financial support was provided to Indonesia and Thailand for implementation science research on the use of ART as prevention among key populations.

26. **Malaria:** Bangladesh, Indonesia, Myanmar, Nepal, and Timor-Leste were provided with support to conduct drug-resistance studies and organize training on good clinical practices for therapeutic efficacy studies for malaria. In addition, Bhutan used modern information technology for surveillance and response to eliminate malaria. Assessment of the longevity and efficacy of long-lasting insecticidal nets in Nepal was supported. In collaboration with the Regional Office for the Western Pacific, research agenda to eliminate drug-resistant *Plasmodium falciparum* in the Greater Mekong Subregion was developed. Actions for strengthening health services in border areas in the Greater Mekong Subregion were agreed upon, following a biregional meeting on healthy borders.
Noncommunicable diseases, including mental and neurological disorders and injuries

2012–2013 programme delivery highlights

- The World Health Day theme for 2013 was high blood pressure. Numerous regional- and country-level advocacy events were carried out to raise awareness about the burden of high blood pressure as well as ways for its early detection and management. In 2013, the health ministers of the South-East Asia Region adopted the New Delhi Declaration on High Blood Pressure as a token of their highest level of commitment to addressing high blood pressure and other noncommunicable diseases (NCDs).

- The Action plan for the prevention and control of noncommunicable diseases in South-East Asia, 2013–2020 was developed in consultation with Member States and experts, and was endorsed by Member States at the Sixty-sixth Session of the Regional Committee. Subsequently, several countries have started developing national multisectoral action plans and setting national targets in line with global and regional targets.

- Sri Lanka designated 2013 the “Year of Preventing Noncommunicable Diseases”. Regional meetings were convened in 2012 and 2013 to set priorities and actions to address NCDs, build surveillance and research capacity, and increase access to NCD interventions.
- A regional workshop was conducted in Sri Lanka, to discuss priority research for delivering NCD interventions through primary health care and development of research protocols. Regional training on the global school-based student health survey (GSHS) was conducted in Hua Hin, Thailand. WHO STEPwise approach to Surveillance (STEPS) surveys were completed in Maldives and Nepal.

- An NCD e-resource package was developed to build capacity of heads of WHO offices on NCDs.

- The Regional Office advocates a community-based approach to childhood mental disorders including autism, and provided technical assistance to Member States to implement components of this strategy. The “Childhood Disability Screening Tools: the South-East Asian Perspective” was developed, which reviews and standardizes screening tools for low- and middle-income countries for detection of childhood mental disorders in community settings.

- All 11 Member States have developed national plans for reducing injury or violence. Six targeted countries – India, Indonesia, Maldives, Myanmar, Sri Lanka, and Thailand – have established, or are in the process of establishing, a unit for injury and violence prevention in their ministry of health. Capacity-building in the prevention of injury and violence, as well as on injury surveillance, was regularly facilitated through regional and national trainings and field visits.
Overview

1. NCDs, including mental and neurological disorders and injuries, are the leading cause of mortality, morbidity, and disability in the South-East Asia Region (Figure 3.1).

Figure 3.1: Estimated proportion of deaths by cause, 2008

Source: WHO Global Health Observatory 2011.
2. Four main diseases are responsible for the majority of deaths from NCDs in the Region: cardiovascular diseases, cancers, chronic respiratory diseases, and diabetes. The increasing burden of NCDs is mainly due to adoption of unhealthy lifestyles, globalization, trade and marketing, unplanned urbanization, and demographic and economic transitions. NCDs are driven by behavioural risk factors (i.e. tobacco use, physical inactivity, unhealthy diet, and harmful use of alcohol), which in turn lead to metabolic risk factors – overweight/obesity, high blood pressure, increased blood glucose, and raised blood lipids. The prevalence of these common risk factors in the Region is very high. By eliminating them, it is possible to reduce 80% of heart disease and stroke, 80% of type 2 diabetes, and over 30% of cancers.

3. According to WHO estimates, approximately 450 million people globally suffer from mental, neurological, behavioural, or substance use disorders. One in four people will be affected by a mental disorder at some stage of life. Fourteen percent of the global burden of disease is attributable to mental, neurological and substance use disorders and almost three quarters of this burden occurs in low- and middle-income countries. Among the 10 leading causes of years lived with disability in low- and middle-income countries, three are mental disorders.

4. Around 5 million people die from injuries each year worldwide – nearly 16 000 people every day. The South-East Asia Region accounts for 28% of global injury deaths and 30% of disability-adjusted life years, with unintentional and intentional injuries contributing 69% and 31% of deaths, respectively. Injuries are among the top three leading causes of death, hospitalization, and disability in the Region. Of the WHO regions, the South-East Asia Region has the second highest prevalence rate of moderate disability (16%) and the third highest for severe disability (2.9%).

5. NCDs are not merely health problems, but also place a huge socioeconomic and developmental burden on countries in the Region due to high health-care costs, loss of productivity, and premature mortality. The main strategies and WHO’s programme for prevention and control of NCDs are based on three pillars: (a) surveillance – mapping the epidemic; (b) health promotion and reduction of risk factors; and (c) early detection and management – strengthening the health-care system.

Advocacy and support for tackling NCDs

6. High-level advocacy was conducted for NCDs aimed at parliamentarians, health ministers, senior health advisers, and other high-level officials from ministries of health and other ministries through various regional meetings. A regional meeting
Strengthening the primary health care system to address mental and neurological disorders in Bangladesh

WHO estimates that approximately 450 million people suffer from mental, neurological, behavioural or substance use disorders globally. Traditionally, care for these disorders has been provided by a limited number of highly skilled mental health professionals in tertiary care hospitals, depriving the vast majority of those in need of care. Evidence for the limited outreach of this traditional model is the huge treatment gap (people in need of care but not receiving it) of 87–95% for patients with epilepsy, and 25–98% for patients with psychosis.

The regional strategy is to make mental health care accessible, affordable and acceptable to all by strengthening the existing primary health care system. In Bangladesh, a pilot project on strengthening the primary health care system to deliver care for mental and neurological disorders was conducted in Sonargaon Upazila. The objective was to identify generalized tonic–clonic seizure (GTCS) among children in the community and to manage these cases with phenobarbitone (or carbamazepine, as a back-up medication for cases not responding to phenobarbitone). All children (11 669) aged 5–14 years in two unions of Sonargaon Upazila were assessed. The treatment gap at the beginning of the project was 87%. Currently, almost all children requiring medication are being treated, bringing the treatment gap down to 5% (Figure 3.2).

The project implementation process included translating the South-East Asia regional manual on identification of GTCS into the local language and training doctors, nurses, and health workers in the application of this manual. After identification, suspected GTCS cases were taken by the health workers to the upazila health complex, where diagnosis was confirmed, treatment given and patients were kept under follow-up by primary health care doctors and nurses. The impact of this project has encouraged the Government of Bangladesh to scale up the project in other areas of the country.

on NCDs, including mental health and neurological disorders, was conducted comprising 130 participants from health and non-health sectors in Member States, who discussed the need for multisectoral actions for prevention and control of NCDs.

7. NCDs were also an agenda item at the Sixty-sixth Session of the Regional Committee, resulting in the adoption of resolution SEA/RC66/R6 endorsing the regional action plan and 10 regional targets for the prevention and control of NCDs.
Figure 3.2: Impact evaluation of project on reduction of treatment gap of epilepsy in Sonargaon Upazila, Bangladesh

<table>
<thead>
<tr>
<th>Implementation</th>
<th>Activities</th>
<th>Outputs</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inputs</td>
<td>Development of training modules</td>
<td>Number of training modules developed</td>
<td>Percentage reduction in treatment gap</td>
</tr>
<tr>
<td>Financial and material resources</td>
<td>Training of health workforce</td>
<td>Number of training sessions conducted</td>
<td>Percentage reduction in morbidity and mortality</td>
</tr>
<tr>
<td></td>
<td>Supply of medications</td>
<td>Number of health workers trained</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Number of patients identified, treated and referred</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Activities undertaken for development of training modules, training of health workforce and procurement of medicines</td>
<td>Number of training modules for doctors, nurses and health workers on GTCS translated into local language: 3</td>
<td>Treatment gap reduced from 87% to 5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of training sessions for health workforce conducted: 24</td>
<td>Morbidity and mortality estimation ongoing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of health workforce trained: 50</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Number of patients identified: 112</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of patients treated: 70 (42 were already under treatment)</td>
<td></td>
</tr>
</tbody>
</table>

Source: Strengthening primary care to address mental and neurological disorders. WHO-SEARO, New Delhi, 2013.

Support for the development and implementation of policies, strategies, and regulations for NCDs

8. Technical support was provided to Myanmar to develop a national policy on NCDs, and to Indonesia to develop a multisectoral action plan for reducing childhood obesity. A regional consultation on oral health strategy was convened in Nepal. An expert meeting on population sodium reduction strategies for the prevention and control of NCDs was convened in India to develop regional strategies for population salt reduction and methods to monitor salt intake.

9. The World Health Assembly in its Sixty-fifth Session in May 2012 adopted resolution WHA65.4 – on the global burden of mental and neurological disorders and the need
for a comprehensive, coordinated response from health and social sectors at the country level – and called upon WHO to develop a comprehensive mental health action plan, which was submitted to the Sixty-sixth World Health Assembly in May 2013. The overall goals of the *Mental health action plan 2013–2020* are to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights, and reduce mortality and disability for persons with mental disorders. The Regional Office for South-East Asia is providing support to Member States within the framework of the comprehensive mental health action plan.

10. The *Global status report on road safety 2013* was validated, analysed, and published with support from Bloomberg Philanthropies and participation from all 11 Member States in the Region. A factsheet on road safety status in the South-East Asia Region was also published and disseminated in 2013. These publications have provided guidance to Member States for the development and implementation of policy, strategy, and regulations in respect to road safety. The Second UN Global Road Safety Week was observed, with the support of WHO, and national workshops on road safety were held in Bhutan, India, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand, and Timor-Leste. Six countries have developed national plans on road safety – Bhutan, India, Indonesia, Myanmar, Sri Lanka, and Thailand.

11. WHO supported Member States in the adoption of laws and regulations on tobacco control. Technical support was provided to Bangladesh to amend its tobacco control legislation; Indonesia to adopt a regulation on tobacco control; Myanmar to adopt ministerial directives; and Timor-Leste to draft tobacco control legislation. The Regional Office reprinted guidelines on the implementation of WHO Framework Convention on Tobacco Control (WHO FCTC) articles, and disseminated them to all Member States.

**Improvements in capacity for NCD data collection and analysis**

12. To build capacities in using the STEPwise approach to chronic disease risk factor surveillance and data analyses, the Regional Office for South-East Asia conducted a regional STEPS training workshop in India. Country-level technical assistance was provided in conducting STEPS in Maldives, Nepal, and Timor-Leste. To build capacity of countries in collecting risk factor data from adolescents, a regional workshop was organized in Hua Hin, Thailand in December 2013 to train national staff in GSHS.

13. Development of the Mental Health Atlas involves a series of exercises for data collection. The Regional Office coordinates the data collection with Member States
14. A regional training course on injury, epidemiology, prevention and care, focusing on injury surveillance and injury-related data systems, was organized in October 2012 at Khon Kaen Regional Hospital in Thailand. Technical support was provided as part of the development process for the establishment of national injury surveillance in Indonesia and India.

15. Support was provided to Myanmar and Indonesia for translation, printing, and dissemination of ICD-10 chapter XX, to enable the successful identification and coding of causes of injury. Technical support was provided to establish and maintain sentinel injury surveillance-cum-trauma registries in Bangladesh, India, Indonesia, and Thailand. Piloting of an injury surveillance model was supported in Fatmawati Hospital in Jakarta, Indonesia. Technical support was provided to Bhutan and Sri Lanka to improve the injury information systems to be able to provide data on major causes of injury.

**Compiling evidence on cost-effective NCD interventions**

16. A regional NCD status report summarizing the burden of NCDs and risk factors, as well as national response in the Region, was published and disseminated. In addition, a review was undertaken on sodium intake in Member States. A consolidated report was prepared to summarize population sodium consumption and interventions to reduce consumption. A review paper on burden and trends in childhood obesity in India was prepared.

**Multisectoral, population-wide programmes and capacity-building of health systems**

17. Increased multisectoral capacity in injury and violence prevention was built through national multisectoral training on road safety (in Bhutan, Indonesia, India, and Timor-Leste), workshops for developing national injury plans or strategies (in India, Nepal, and Sri Lanka), and workshops on violence prevention (in Thailand).

18. Technical support was provided to develop an evaluation framework and processes for the prevention of child drowning through a multisectoral project in
Thailand, which achieved a reduction in drowning mortality in children (aged under 15 years) from 11.1 per 100 000 in 2006 to 8.4 per 100 000 in 2012.

19. Development of deafness and blindness prevention and rehabilitation plans was supported in Bangladesh, Bhutan, India, Indonesia, Sri Lanka, and Thailand, and a national committee on the prevention of deafness was established in Thailand.

20. A regional meeting on NCDs, including mental health and neurological disorders, was held in Myanmar to facilitate the exchange of best practices in multisectoral actions. The regional strategy for addressing mental and neurological disorders has been to strengthen the existing primary health care system through training and ensuring the provision of essential medicines. The strategy is to train community-based health workers to identify the most common mental and neurological disorders. Once identified, the patients are taken to the nearest trained primary health care physician. Impact indicators and targets for monitoring progress of these programmes have also been developed. Impact evaluation shows that with minimal new investment in training, the treatment gap of mental and neurological disorders can be substantially reduced. This population-wide programme is sustainable as it builds on the existing national health care delivery system.
Improving the ability of health and social systems to prevent and manage NCDs

21. During 2012, technical support was provided to five countries – Bhutan, Indonesia, the Democratic People’s Republic of Korea, Myanmar, and Sri Lanka – for strengthening primary health care to deliver a package of essential NCD interventions. In Bhutan, WHO provided technical support for assessing the impact of the intervention project. A regional workshop was conducted in Sri Lanka to discuss priority research for delivering NCD interventions through primary health care and development of research protocols. Discussions were initiated with Nepal to introduce a package of NCD interventions as part of the primary health care system.

22. A monograph on *Strengthening primary care to address mental and neurological disorders* was developed and disseminated to Member States in 2013. The monograph provides insights into projects in Bangladesh, Bhutan, Myanmar, and Timor-Leste, where the treatment gaps for mental and neurological disorders were substantially reduced through strengthening the existing primary health care system. The Depression Identification Instrument and Psychosis Identification Instrument have been developed and piloted at primary health care settings in Bangladesh, Bhutan, and India. The simple instruments will help health workers identify these two priority mental health conditions and refer for appropriate care.
23. Tobacco cessation manuals – designed for use by doctors, nurses, and health workers – were developed and disseminated to Member States in the Region. Country capacity on tobacco cessation techniques was strengthened in Bangladesh, Bhutan, India, Nepal, and Sri Lanka.

24. The Regional Office’s *Injury prevention and control: a handbook for undergraduate medical curriculum* has been integrated into the undergraduate curriculum of two medical schools in India. The Consortium of Thai Medical Schools has also accepted its integration into the curriculum as a requirement of competency for medical students.

25. Integration of violence and injury prevention and care into national public health programmes has materialized in Thailand (through inclusion in the revised Maternal and Child Health Handbook) and Indonesia, and is under process in Sri Lanka. A regional meeting of national programme managers on injury and violence prevention and care, held in Jakarta, Indonesia in June 2013, has efficiently catalysed the countries in advancing the agenda.

26. Bangladesh has established a successful intervention site and research in child drowning prevention. Thailand has a national programme for preventing child drowning under the leadership of the Ministry of Public Health, in which a reduction in death rate has been shown at local and national levels. A drowning prevention document for the Region is in the final stage of development, and an intercountry drowning prevention workshop is planned for 2014.

27. The emergency medical system, particularly emergency trauma care, has been strengthened through two sessions of intercountry training and through system development in all Member States, notably in Bangladesh (where 18 batches of national trainings have been held) and the Democratic People’s Republic of Korea.

28. A factsheet on disability in the South-East Asia Region was developed and disseminated to all Member States before the UN High-level Meeting on Disability and Development in September 2013.

29. WHO supported the organization of the Wheelchair Service Training Package: Basic Level in India in 2013. The *Situation analysis of community-based rehabilitation in the South-East Asia Region* and the *Compilation of community-based rehabilitation practices in the WHO South-East Asia Region* were developed, published and disseminated. Indonesia was supported in improving research and data quality on disabilities, and provincial public safety centres were standardized.
Reproductive, maternal, newborn, child and adolescent health, and healthy ageing

2012–2013 programme delivery highlights

- Preventing unsafe abortion to reduce maternal mortality was advocated through a multi-stakeholder meeting, following which a regional document on mapping of abortion policies, programmes, and services (along with country factsheets) was developed and disseminated.

- Quality of care was identified as an overarching issue in all Member States of the Region. Countries developed workplans for improvement of quality of care, a framework is being developed, and tools are being provided.

- A regional report on the extent of implementation of maternal death reviews in five countries was finalized and the findings were used as the basis for expanding maternal death reviews into maternal death surveillance and response, as a thematic area under the roadmap of the recommendations of the Commission on Information and Accountability for Women’s and Children’s Health (COIA) of the UN Secretary-General’s initiative “Every Woman, Every Child”.

- A network of nine WHO collaborating centres for maternal and reproductive health was initiated. The Regional Office has begun to develop protocols for the management of infertility at the primary health care level and for conducting surveillance on stillbirths.

- The situation of cervical cancer control in Member States was assessed, including secondary prevention through screening and primary prevention through vaccination against the human papillomavirus (HPV), and a regional strategic framework for comprehensive control of cervical cancer was developed. To date, only one country in the Region – Bhutan – has introduced the HPV vaccine through a national vaccination programme.
Facility-based newborn care was strengthened in India, Maldives, and Myanmar and was introduced in Bangladesh.

Five countries – Bangladesh, Bhutan, Maldives, Nepal, and Timor-Leste – have scaled up coverage of integrated management of childhood illnesses (IMCI) to more than 75% in their respective districts.

To improve delivery of child health services, community-based approaches were strengthened in Member States using a more integrated approach. Following a regional workshop on the Global Action Plan for the Prevention and Control of Pneumonia (GAPP), Bangladesh and Myanmar initiated integrated community case management for pneumonia and diarrhoea. Support has been provided to undertake a demonstration project in selected districts in Bangladesh based on coordination principles of the GAPP framework.

Adolescent health programmes saw some appreciable progress with support from WHO to further strengthen national strategies for adolescent health in Bhutan, India, Maldives, and Sri Lanka, which in the near future will strengthen service delivery. Support was provided to Maldives to conduct national training of trainers on adolescent-friendly health services. In collaboration with WHO headquarters, the global modules on adolescent mental health have been applied in Sri Lanka.

To improve delivery of reproductive health services, Bangladesh made further progress in the delivery of menstrual regulation services to include expansion of the provision of safe abortion services to women in the early stages of an unplanned or unwanted pregnancy.

Bhutan has launched a pilot project in Khaling-eastern Dzongkhag to determine the feasibility of providing community-based health care for elderly citizens in order to promote productivity, vitality, and happiness. Financial and social benefits continued to be provided to the elderly population in the Democratic People’s Republic of Korea, Maldives, and Timor-Leste during 2012–2013.

Member States have realized the importance of improving the quality of care for women, newborns, children and adolescents, while scaling up the implementation of evidence-based interventions. In response to their request, a regional meeting on improving the quality of care for reproductive, maternal, newborn, child and adolescent health was organized in December 2013. Discussions took place on a regional framework for a collaborative approach for improvement of the quality of care and assessment tools. Recommendations for the way forward were developed and will be implemented.
Overview

1. The South-East Asia Region – home to a quarter of the world’s population – has a disproportionately higher burden of morbidity and mortality among mothers, newborns, and children than other WHO regions.

2. While there have been improvements in reproductive, maternal, newborn, and child health and survival, these still remain areas of concern for achieving MDGs 4 and 5. Despite declines in the maternal mortality ratio between 1990 and 2010 in the South-East Asia Region, it still falls short of the required rate to meet MDG 5. Member States have also shown declines in under-five mortality from 109 per 1000 live births in 1990 to 55 per 1000 live births in 2012 (Figure 4.1). Some Member States are likely to achieve the MDG 4 target, but the Region as a whole is unlikely to reach its MDG 4 target (36 per 1000 live births) by 2015. Newborn mortality has shown even lower rates of decline and is currently responsible for more than half of under-five deaths.

3. About one fifth of the Region’s population are adolescents (aged 10–19 years) who need support to encourage and promote their health and development. All Member States are now examining various options for responding to this demographic challenge.

4. In a Region as diverse as South-East Asia, and with the broad scope of reproductive health, achieving universal access to reproductive services is challenging. However, some progress has been made in family planning, prevention of unsafe abortions,
and prevention and control of cervical cancer. In collaboration with Member States, work in emerging areas such as birth defects prevention and control, early childhood development, and preconception care has been initiated in 2012–2013.

5. As in all other parts of the globe, the proportion of elderly individuals (aged 60 years and above) in the Region is rapidly rising, along with the accompanying challenges in every sector of life – especially the health sector.

**Scaling-up towards universal access to effective interventions**

6. The Regional Office for South-East Asia assisted Member States with a review of programmes in an effort to identify barriers and address ways to improve access
to evidence-based interventions and services. Reproductive, maternal, newborn, and child health programmes were reviewed in Bhutan, the Democratic People’s Republic of Korea, and Timor-Leste. The Reproductive Health Programme in Bhutan identified possible areas for technical support from WHO and UN partners. The findings of an internal evaluation of the Improving Women’s and Children’s Health Project in the Democratic People’s Republic of Korea were used to strengthen maternal and child health services, with a focus on improving access. Following the review, Timor-Leste developed an integrated reproductive, maternal, newborn, child, and adolescent health strategy to address the continuum of care through a life-course approach. The Regional Framework for Reproductive Health was reviewed through an informal expert group, which placed renewed significance on improving service delivery and greater emphasis on equity and quality of services.

7. Updated guidelines on the four cornerstones of family planning to improve contraceptive use and reduce the unmet need for family planning were disseminated to Member States. To address the challenge of human resource availability, WHO has begun developing guidelines on the rational use of human resources for maternal, newborn, and child health, by which some specific tasks previously carried out by physicians and other professional medical staff (who are generally in short supply in most countries) have been identified and proven by evidence
that they can be carried out by lower-level health personnel such as paramedical staff, thereby increasing access to services without compromising quality. India has utilized the guidelines in empowering its lay health workers, known as accredited social health activists (ASHAs), to use misoprostol tablets for the prevention of postpartum haemorrhage.

8. Support was provided for review of the adolescent health programme in Bhutan, followed by development of a national strategy for adolescent health. Review and strengthening of child health plans has been initiated in Bangladesh. Support has been provided to initiate strengthening of the reproductive, maternal, newborn, child, and adolescent health strategy in Timor-Leste and a roadmap has been agreed upon.

**Strengthening national research capacity**

9. The Regional Office, through its Research Review Committee, reviewed a proposal submitted by the WHO Country Office India for a study on the use of injectable iron sucrose to manage severe anaemia in pregnancy, recognizing that the prevailing treatment using iron tablets is generally not effective. Additionally,
the Regional Office – through collaboration with the WHO Collaborating Centre for Research and Training in Reproductive Health at the Indian Council of Medical Research (ICMR) in India – contributed to a study on the epidemiology of infertility, an emerging public health problem in India. This was followed by the development of guidelines, for use in all Member States, on managing infertility at the primary health care level.

10. A detailed study on the situation of strategies, programmes, and services for the control of cervical cancer was carried out by an external consultant in 2013. The findings were used to develop a regional situation analysis and also to draft a regional strategic framework for comprehensive cervical cancer prevention and control in the South-East Asia Region. The Regional Office supported the WHO Collaborating Centre for Research and Training in Reproductive Health at ICMR in India to develop and pilot a stillbirth surveillance protocol, which was further field tested and expanded in 2013 in 10 sites in India, as well as in Nepal and Sri Lanka. An implementation research project is being funded by WHO headquarters on understanding factors for scaling up skilled attendance at birth in hard-to-reach districts in Nepal.

11. Following a networking meeting of WHO collaborating centres in 2012, a regional network of centres for maternal and reproductive health is being established, which will facilitate and further enhance joint collaborative work among the centres and with the Regional Office.


13. The Regional Office supported development of a proposal to pilot an integrated surveillance system for neural tube defects and congenital rubella syndrome in Sri Lanka, which has been submitted to the United States Centers for Disease Control and Prevention, Atlanta (US CDC), for funding. A project on community- and hospital-based surveillance of birth defects in selected districts of Bangladesh was supported.

14. A regional neonatal-perinatal database network has been initiated in collaboration with the WHO Collaborating Centre for Training and Research in Newborn Care at the All India Institute of Medical Sciences (AIIMS) and selected countries, to study neonatal morbidity and mortality profiles and trends.
Improving maternal care and progress in maternal mortality reduction

15. The reduction in the maternal mortality ratio in the Region since 1990 continued in 2012. The WHO South-East Asia Region, along with the Western Pacific Region, recorded the highest annual rate of decline between 1990 and 2010 at 5.2%. This still falls short, however, of the 5.5% decline required by MDG 5. It should be noted that these estimates, because of the relative rarity of events in surveys, have wide confidence intervals and are therefore rather unstable. The rate for skilled attendance at birth remains a major challenge, with a regional average of 59% and vast intercountry differentials. Based on data from the World health statistics 2013, Figure 4.2 illustrates the correlation between skilled attendance at birth and the maternal mortality ratio in countries of the South-East Asia Region.

Figure 4.2: Correlation between skilled attendance at birth and maternal mortality ratio

![Correlation chart](chart.png)

**DPR Korea**: Democratic People’s Republic of Korea

Note: The first figure in parentheses is the skilled attendance at birth percentage (2005–2012) and the second figure is the maternal mortality ratio per 100,000 live births (2010).


16. The World health statistics 2013 also reported improvement, albeit modest, in the use of contraceptives and reductions in unmet need for family planning. The coverage of antenatal care (ANC) also saw a positive increase in the percentage of women receiving at least four ANC visits (ANC 4). Figure 4.3 illustrates these improvements.
17. To improve delivery of reproductive health services, Bangladesh made further progress in the delivery of menstrual regulation services to include expansion of the provision of safe abortion services to women in the early stages of an unplanned or unwanted pregnancy.

18. Maternal health care in Sri Lanka underwent a major change as focus was shifted to improving quality of ANC while the number of visits was optimally reduced. This change was also an opportunity for Sri Lanka to strengthen its prevention of mother-to-child transmission of HIV and congenital syphilis.

19. A programme managers meeting for all maternal and reproductive health country programme managers and WHO focal points was held in Phuket, Thailand in June 2013, and provided an opportunity for joint planning and sharing experiences.

20. Six focus countries – Bangladesh, the Democratic People’s Republic of Korea, India, Indonesia, Myanmar, and Nepal – were eligible for catalytic funding from COIA and have begun to strengthen their efforts to expand maternal death reviews.
to maternal death surveillance and response. This includes an effort to capture all maternal deaths by mandatory notification within 24 hours, strengthening of civil registration, conducting a thorough maternal death review followed by appropriate responses, and using these for improving quality of care and for instituting surveillance on maternal deaths. The Regional Office supported Maldives in 2012 to implement recommendations made by a consultant in 2011 for review or audit of maternal near-miss cases.

21. The Regional Office provided inputs to the development of guidelines on management of postpartum haemorrhage, induction of labour, task shifting (to optimize health workers’ roles), and treatment of eclampsia and pre-eclampsia, which were disseminated to countries for implementation and adaptation.

Improving neonatal survival and health

22. Considering that newborn mortality remained high in the Region, WHO extended technical assistance at the country level especially for training on essential newborn care. Based on the framework for elimination of paediatric HIV and congenital syphilis, work was carried out in 2012 to finalize the implementation guide for country use. The biennium saw serious efforts in understanding birth defects, with the aim of bringing attention to this growing problem, building county capacities,
and initiating surveillance to introduce and strengthen preventive actions such as preconception care and improved ANC.

23. Neonatal health interventions are being strengthened at community and facility level and by strengthening nursing and midwifery care. The Democratic People’s Republic of Korea, India, Indonesia, Maldives, and Nepal have strengthened postnatal care for newborn programmes.

24. In collaboration with WHO headquarters, a review of the status of implementation of a joint WHO–UNICEF statement on home visits to improve postnatal care has been carried out. The Regional Network for Newborn Health at the WHO collaborating centre based at AIIMS in New Delhi, India was strengthened, and corresponding national networks for newborn health were supported in Bangladesh, India, Myanmar, and Nepal. These networks are establishing a standard neonatal–perinatal database to understand neonatal and perinatal morbidity and mortality and undertake corrective actions for improving the quality of care provided to sick newborns. Standard treatment protocols for managing common newborn conditions in small hospitals also have been developed and disseminated. The protocols have been converted into mobile apps and field tested. Through the list serve, a monthly e-blast and a quarterly newsletter sharing updates on neonatal health and birth defects are being sent with the support of WHO.

25. E-training courses on essential newborn care and sick newborn care have been developed by the WHO Collaborating Centre for Training and Research in Newborn Care at AIIMS in India, with support from the Regional Office. These have been applied to in-service as well as pre-service training of nurses and medical officers in selected institutions in Bangladesh, India, Maldives, and Sri Lanka to build capacity of doctors and nurses. These interventions will contribute to standardizing quality of care for newborns, thus contributing to a reduction in neonatal mortality in countries and the Region.

26. A regional consultation was organized in Kathmandu, Nepal in August 2013 jointly with UNICEF to provide regional inputs to the Every Newborn Action Plan. This will provide further impetus for newborn health in the Region.

**Improving child health and development**

27. The Child and Adolescent Health and Development programme of the Regional Office, in collaboration with UNICEF’s South Asia, and East Asia and the Pacific regional offices, has developed and launched the South-East Asia Regional Strategic
Framework for Improving Neonatal and Child Health and Development. The framework highlights the importance of addressing the social determinants of child health through a multisectoral approach, strengthening of health systems for delivering life-saving interventions across the continuum of care, ensuring an equitable scaling up of implementation of life-saving interventions, and improving quality of care for newborns and children. Facility-based IMCI for strengthening hospital care of sick newborns and children has been supported in India and Myanmar. The Integrated Management of Childhood Illness Computerized Adaptation and Training Tool (ICATT) application for computer-based training on IMCI was supported in Bangladesh, India, and Indonesia. The strategic directions recommended in the regional framework are being used by Member States to strengthen national strategies for child health. The Regional situation and progress report on MDG 4 is being finalized, based on the most recent data from global reports and reports of national surveys (such as demographic and health surveys and multi-indicator cluster surveys). The situation report will also highlight the social and economic disparities in newborn and child health.

28. Advocacy by the Regional Office to relevant constituencies and stakeholders at international, regional, and country levels has led to additional focus on early childhood development and prevention of birth defects by Member States.

29. Early childhood development through counselling on age-appropriate play and communication by trained community health and nutrition workers has been
started in India. The Regional Office supported pilot implementation at two sites in collaboration with the WHO Country Office India. Based on the positive initial experience with 10 000 population, a scale-up phase has been planned to cover 100 000 population at each site.

30. In partnership with US CDC, a regional strategic framework for the prevention and control of birth defects has been developed in consultation with Member States. A regional consultation and a workshop for birth defect surveillance were organized and countries are moving ahead to consider incorporation of birth defects surveillance into their public health and nutrition programmes. Support has been provided to Bangladesh and Sri Lanka to develop national plans for prevention and control of birth defects. Support was also provided to strengthen national activities for birth defects prevention and surveillance in Thailand.

Evidence-based strategies and policies for adolescent health

31. Recent focus has been placed on promoting evidence-based policies and strategies for adolescent health and scaling-up of adolescent health programmes in all Member States of the Region. Bangladesh, Bhutan, India, Indonesia, Sri Lanka, Thailand, and Timor-Leste are progressively scaling up implementation of national standards for adolescent-friendly health services. Maldives and Myanmar were supported in building capacity for strengthening adolescent health programmes. Countries’ adolescent health programmes have been reviewed with support of the Regional Office and national strategies have been developed to address adolescent health issues through a variety of approaches. The national adolescent health strategy in Sri Lanka was strengthened with the support of the Regional Office.

32. The Regional Office provided support to address access and utilization issues related to family planning and safe abortion services among adolescents in the Region. A regional programme managers’ course for adolescent health and HIV prevention among young people has been developed and piloted.

33. A regional expert group consultation on preconception care was organized in New Delhi, India in August 2013 to strengthen the care across the life-course continuum, and to advocate and develop consensus for developing a preconception care programme for the Region. Global consensus on the package of interventions for preconception care, and global and regional experience in delivering such services, were presented in the meeting. Consensus has been achieved on the needs and content of services for preconception care through “healthy transitions
for adolescents” and “pre-pregnancy care” packages. Such packages will help to address health risk factors and behaviours to prevent adverse reproductive health outcomes (such as newborn mortality, morbidity related to prematurity, and birth defects) and improve the overall health of men and women, as well as prevent chronic conditions including NCDs in the long term.

Strategies to attain reproductive health goals and targets

34. In 2012–2013, activities were carried out to address the different components of reproductive health. Through reviews of country situations and the dissemination of updated guidelines, family planning was strengthened to improve contraceptive use. While family planning contributes towards primary prevention of unwanted pregnancies, there is a need to ensure access to safe abortion services and provide post-abortion care. Countries in the Region were introduced to the updated guidelines on preventing unsafe abortion. Bangladesh made further progress in reproductive health care through its menstrual regulation programme. Although this service has been in place since 2007 in government facilities and in nongovernment clinics through a donor-supported public–private partnership model, in 2012 it was strengthened with the development of comprehensive evidence-based national guidelines for menstrual regulation. In collaboration with partners, country-level workshops with a specific focus have been supported such as medical abortion
and expansion of the provider base in India, and post-abortion care in Myanmar and Sri Lanka.

35. Technical assistance was extended to India and Nepal for expanding the basket of contraception options through a strategy for scaling up postpartum family planning (including postpartum intrauterine contraceptive devices).

36. Together with the United Nations Population Fund (UNFPA), WHO supported the organization of capacity-building workshops on quality and counselling for family planning and disseminated WHO tools and guidelines for programme managers, representatives of professional associations, and partners from Member States.

37. Serious efforts were made to strengthen the comprehensive control and prevention of cervical cancer in Member States, including assessing their readiness for the introduction of the HPV vaccine for primary prevention. To date, only Bhutan has introduced the vaccine to adolescent girls. A regional meeting in support of this effort also provided best practices as currently utilized in the Department of Obstetrics and Gynaecology at Chulalongkorn University in Bangkok, Thailand. In addition to this Region-wide effort, support was provided to two countries – the Democratic People’s Republic of Korea and Maldives – for strengthening capacity for clinical management of cervical cancer through fellowships and study tours.
Ageing as a public health issue

38. A wide range of innovative and situation-specific projects and programmes targeting the elderly population have been formulated in all Member States in the Region. In alignment with the World Health Day 2012 theme of ageing and health, the Democratic People’s Republic of Korea organized a “greatest festival of veterans” with the participation of its elderly population. The national policy for the elderly under formulation in Maldives has identified inputs from several sectors such as: gender, family and human rights; family and child development; and health. Myanmar has introduced an innovative elderly health care project in 88 townships that offers a wide range of services at the district and township level including weekly clinics.

39. Age-friendly city initiatives have been adopted in some countries. Two communities in Delhi, India and in a district in Sri Lanka have introduced the age-friendly community initiative. Similar activities are taking place at locations in Indonesia, Myanmar, and Thailand.

40. A Regional Strategy for Healthy Ageing was formulated with the goal of encouraging Member States to initiate, develop, and sustain a multisectoral approach and measures for the promotion of healthy ageing among all population groups following a life-course approach. The draft regional strategy was reviewed by the managers of the national healthy ageing programmes of the Member States and a group of experts, leading to its finalization.

41. Technical support was provided to Maldives, Myanmar, and Sri Lanka to strengthen national capacities in formulating healthy ageing strategies, geriatrics training for primary care physicians in Myanmar and Sri Lanka, and development of advocacy and communication materials in all Member States. In response to a request from the Ministry of Health, training in geriatrics for primary care staff was organized in Timor-Leste and is expected to continue in the next biennium. Efforts have been made by Member States in recent years to promote ageing and health, but the overall administrative and implementation components of elderly care and healthy ageing in several Member States still need to be strengthened.

42. The Region observed World Health Day 2012 on ageing and health with the theme “Good health adds years to life”. This designated day provided the impetus for countries to pay more attention to this important growing public health challenge. At the Thirtieth Meeting of Ministers of Health of the Countries of the
Healthy ageing in Myanmar

Several social, health, and economic support programmes for the elderly have been introduced in Myanmar including: homes for the aged; the Republic of Korea–Association of South-East Asian Nations (ASEAN) Home Care Programme; the Older People’s Self-help Group programme; the Rural Development on Ageing programme; and two pilot studies to provide a day-care centre and paid home care.

There are 70 homes for the aged in the country covering about 2300 older persons, providing rice, funds for food, clothes, and salary for the administrators, along with necessary technical assistance. The first phase (2004–2006) of the Republic of Korea-ASEAN Home Care Programme was introduced in two townships with the involvement of the national YMCA. The second phase (2006–2009) was introduced in 25 townships with the involvement of three partners. The third phase (2009–2012) has maintained the delivery of home-care activities while expanding the project’s reach to 154 townships involving 10 partner organizations.

The Older People’s Self-help Group programme includes 18 villages in the secondary region, 43 villages in the Ayeyarwady Region, and 2 wards in the Sagon township of Yangon. The programme covers 20,000 older persons and their families. An Older People’s Self-help Group comprises a main committee and several subcommittees dealing with fund-raising, health, and home care. The groups’ activities include fund-raising, improving livelihoods, and income generation.

The Rural Development on Ageing programme has the principle of “reducing economic vulnerability through an equitable/inclusive approach to livelihoods”. The programme covers 30 villages and 10,000 older persons and their families as beneficiaries. The key activities are livelihood support to households with older people, including cash and kind, social care at home, risk reduction during disasters, community capacity development, and income generation activities.

South-East Asia Region, ministers adopted the Yogyakarta Declaration on Ageing and Health 2012 – a commitment to improve national responses to the health of their ageing populations. A report on the progress made in the implementation of the Yogyakarta Declaration on Ageing and Health was presented to the Thirty-first Health Ministers Meeting in September 2013. Technical assistance was provided to Bhutan, the Democratic People’s Republic of Korea, and Nepal to develop national information bases on the elderly population.
43. The Regional Office participated in a global consultation on long-term care of the elderly. Support was provided to Bhutan, India, Indonesia, Myanmar, and Thailand to participate in this meeting. A regional consultation was organized that identified several approaches for ensuring long-term care of the elderly population in Member States.
5 Health in emergencies, disasters, and crises

2012–2013 programme delivery highlights

- As part of the Emergency and Humanitarian Action programme, assessments related to emergency risk management systems were completed during 2012–2013 in Bangladesh, Bhutan, the Democratic People’s Republic of Korea, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, and Timor-Leste. India is scheduled to complete the assessment during the 2012–2013 biennium, and all countries in the Region are expected to have plans to address capacity gaps in place.

- Support for capacity-building and development of human resources as part of emergency risk management included a training session and the revision of the curriculum related to the training.

- A regional meeting on disaster risk management defined strategic directions and identified good practices that will assist in appropriate planning for this public health area.

- The South-East Asia Regional Health Emergency Fund (SEARHEF) provided support during emergencies including funding, health kits, and supplies to various Member States.
The Region and its partners in ministries of health, nongovernmental organizations, and technical and donor agencies provided technical and financial support to Member States in their efforts to make health facilities safer in emergencies. Emphasis was placed on mitigating, designing, and building flood-resilient health facilities – as flooding is one of the Region’s most devastating and regular disasters.
Overview

1. Countries within the South-East Asia Region are vulnerable to disasters caused by natural and man-made hazards such as storms, flooding, earthquakes, tsunamis, conflicts, civil strife, and devastating fires. The magnitude of disasters and their effects have considerable impact on the morbidity and mortality of the Region, which is home to approximately 25% of the world’s population. Deaths in Member States of the Region accounted for 37% of global mortality from natural disasters in 2003–2012 (Figure 5.1).

Figure 5.1: Total number of deaths from natural disasters globally, 2003–2012

2. As such, health action in emergencies remains a vital area of WHO’s support to countries. It is within this context that the Emergency and Humanitarian Action programme in the South-East Asia Region has been conceptualized. The programme, together with focal points in all WHO country offices, works with national governments as well as development partners to reduce avoidable mortality and morbidity. The Emergency and Humanitarian Action programme has four areas of work: risk reduction; preparedness and response; information management and research; and capacity development.

Strengthening national capacities for emergency risk management

South-East Asia Region Benchmarks assessment

3. The Emergency and Humanitarian Action programme focuses on capacity-building and development through its South-East Asia Region Benchmarks for emergency preparedness and response – a uniform and systematic tool for assessing and monitoring capacities that enables WHO to track the progress made in strengthening emergency and disaster risk reduction/management programmes in Member States. It also provides an evidence-based assessment tool to WHO for formulating support to countries in their identified priorities.

4. Assessments were conducted using the Benchmarks to ascertain the capacities of national emergency and disaster risk reduction/management programmes in the health sector in Member States. These assessments helped identify strengths, weaknesses, and gaps in emergency and disaster risk reduction/management programmes. All Member States have completed the assessment and used the results in their next phase of planning, except India, which will complete its assessment in 2014. In many of these countries, capacity-building has become the basis for developing new strategies and strengthening emergency and disaster risk reduction/management programmes.

Interregional training programme

5. The Regional Office provided support for capacity-building and development of human resources as part of the emergency and disaster risk reduction/management programme. The Public Health and Emergency Management in Asia and the Pacific (PHEMAP) training programme – jointly organized by WHO Regional Office for
South-East Asia, WHO Regional Office for the Western Pacific, and the Asian Disaster Preparedness Center – focuses on public health professionals who are responsible in managing critical areas for emergency preparedness, response, recovery, and coordination in their respective countries.

6. Based on feedback and with support from the Emergency and Humanitarian Action unit, the PHEMAP course materials were modified and improved to reflect the rapidly changing area of emergency and disaster risk reduction/management. On the basis of previous evaluations and current practices, new content and methodology now emphasizes the following areas of work: monitoring and evaluation; approaches to all-hazard, comprehensive and complex emergency and disaster risk reduction/management; and addressing new development challenges such as urbanization, mobile populations, and climate change and its impacts.

**Regional meeting on disaster risk management in the health sector**

7. In the context of the Region’s high vulnerability to disasters, including increasing public health risks, a regional meeting on disaster risk management in the health sector was organized by the Regional Office. Meeting attendees included concerned officials from ministries of health and national disaster management authorities from Member States, UN agencies, international organizations, nongovernmental organizations, donor agencies, and academic institutions.
8. The meeting emphasized the health sector’s responsibilities towards vulnerable communities and identified several strategic directions in the rapidly evolving discipline of emergency risk management, national and international mechanisms in disaster management, and global changes such as urbanization, migration, and climate change. The main outcomes of the meeting provided strategic directions and actions that are expected to guide the next round of planning and prioritization for programmes in the Region and countries. Some of these included:

- strengthening regional cooperation through comprehensive information gathering and management;
- greater attention to capacity-building at both the technical and community levels;
- accelerating efforts for safer health facilities;
- advocacy for a systematic approach to post-disaster management.

**Second SEARHEF working group meeting**

9. Established in 2008, the SEARHEF has allowed for an immediate and flexible response to critical needs in 14 different emergencies in the Region, beginning with Cyclone Nargis in Myanmar in 2008, and including responses to the end of the Sri Lankan conflict, the eruption of Mount Merapi in Indonesia, a factory fire in Dhaka, Bangladesh, and violence and riots in Myanmar’s Rakhine State. Within 24 hours of an emergency request from a Member State, and even before the UN’s funding mechanisms are activated, the SEARHEF’s resources are channelled to disaster management responses.

10. The second SEARHEF working group meeting held in New Delhi, India in August 2012 resolved to continue with current policies and use of the fund for launching rapid responses. Taking into account the challenging global financial situation, it also requested that SEARHEF working group members assist in finding new contributors to the fund from countries and partners to build up capacities for preparedness activities in the Region.

**Making health facilities safer in emergencies and disasters: structural, nonstructural, and functional assessments of health facilities in the Region**

11. Member States are in the process of assessing and strengthening preparedness plans and mitigating risks in an effort to make health facilities safer during disasters. These efforts follow key areas identified in the Kathmandu Declaration on Protecting
Making health facilities safer from disasters in Bhutan and Nepal

Nepal – coordinating risk reduction brings sectors together

In May 2009, the Government of Nepal launched the comprehensive Nepal Risk Reduction Consortium that brings together financial institutions, development partners, the Red Cross/Red Crescent movement and the UN, in partnership with the Government. The consortium is developing a long-term disaster risk reduction action plan, building on the National Strategy for Disaster Risk Management. Within this consortium, WHO works as coordinator of the safe hospitals portion of the flagship for safe schools and hospitals. Since then, assessments for priority health facilities in Kathmandu, functional assessments and readiness, as well as work with nongovernmental organizations for preparedness have been completed. Specific interventions are now required and the work continues. The consortium has provided the impetus for investment and provided a facilitative platform for coordination across sectors.

Bhutan – implementation of a safe health facilities plan

In 2012, in collaboration with GeoHazards International, WHO conducted a detailed assessment of the Jigme Dorji Wangchuck National Referral Hospital in Thimphu. As this is the only hospital in the capital of Bhutan, it is critical for serving the community during any emergency. In 2013, DIPECHO provided additional funds to implement the recommendations of the assessment. Working together, the Ministry of Health and WHO have started retrofitting activities to protect the hospital from large earthquakes. Two additional district hospitals will conduct structural, nonstructural, and functional assessments including training for engineers and health staff. Smaller health centres are in the process of safety assessments supported by UNDP. These efforts are all part of a comprehensive national safe hospitals plan that the Ministry of Health, together with partners, has drafted and is implementing.
12. As a follow-up to the regional meeting on disaster risk management, a informal regional consultation to review and consolidate efforts for safe health facilities for water-related hazards was organized in December 2012. The objective was to develop a technical and managerial guide to advise health facilities on ways to be better prepared for/during disasters caused by water-related hazards. This is the first in a series of consultations, and the final product is envisioned to be a practical guide that will assist Member States in developing plans for health facilities to address such hazards.

Preparedness in WHO country offices

13. In order to adhere to new standards for response, as outlined in the WHO Emergency Response Framework, training workshops were conducted at WHO country offices in Bangladesh, Nepal, Sri Lanka, and Thailand on launching rapid response and recovery operations and to update country preparedness plans and standard operating procedures.

Coordinated health sector response and recovery in humanitarian emergencies

14. As the lead organization for the Global Health Cluster, WHO has a clear responsibility and expected deliverables when responding to emergencies. This response is conducted through implementation of a coordination function, provision
of technical support, management and dissemination of credible public health information, and ensuring that core response services are in place and public health interventions are implemented with partners such as ministries of health and nongovernmental organizations. SEARHEF resources, supply provisions, and staff support are all part of the response interventions and are provided as part of these emergency functions.

15. The emergencies listed in Table 5.1 were supported with resources and mechanisms from the Regional Office through WHO country offices to Member States. In some emergencies, funding support was augmented by partners and the UN Central Emergency Response Fund.

Table 5.1: Emergencies in 2012–2013: WHO support to country requests and needs

<table>
<thead>
<tr>
<th>No.</th>
<th>Date</th>
<th>Location</th>
<th>Type of emergency</th>
<th>Support provided by Secretariat</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2012 January</td>
<td>Yangon Division, Myanmar</td>
<td>Factory explosion and fire</td>
<td>SEARHEF resources provided to support the work of the Ministry of Health, as well as provision of essential antibiotics and treatment for burn victims.</td>
</tr>
<tr>
<td>2</td>
<td>2012 June</td>
<td>Rakhine State, Myanmar</td>
<td>Communal conflict</td>
<td>SEARHEF resources and coordination support to the operations as per health cluster requirements. Technical support to early warning and surveillance systems, basic health services and referral systems.</td>
</tr>
<tr>
<td>3</td>
<td>2012 July</td>
<td>Democratic People’s Republic of Korea</td>
<td>Flash floods</td>
<td>SEARHEF resources and technical and coordination support.</td>
</tr>
<tr>
<td>4</td>
<td>2012 November</td>
<td>Maldives</td>
<td>Tropical cyclone and floods</td>
<td>SEARHEF resources and coordination support, technical support for assessments and response planning, and release of emergency health kits from the New Delhi stockpile.</td>
</tr>
<tr>
<td>5</td>
<td>2012 November</td>
<td>Kachin State, Myanmar</td>
<td>Earthquake and fire</td>
<td>SEARHEF resources for burn medicines and other essential medicines.</td>
</tr>
<tr>
<td>6</td>
<td>2013 April</td>
<td>Myanmar</td>
<td>Earthquake and fire outbreak</td>
<td>SEARHEF support for procuring emergency medical supplies.</td>
</tr>
<tr>
<td>7</td>
<td>2013 July</td>
<td>Democratic People’s Republic of Korea</td>
<td>Flash floods</td>
<td>SEARHEF resources to provide health sector support in the affected areas.</td>
</tr>
</tbody>
</table>
The Regional Office’s technical, financial, and operational support to the programme

- A pilot study was commissioned and conducted in Saharsa, Bihar, India for onsite reporting and initial assessment of the emergency situation through mobile application of rapid assessment. Upon outcomes of the pilot, the project will be further improved in 2014–2015 through regular use.

- Technical and operational support was provided to WHO country offices in Member States with activated health clusters.

- Contribution to the review and finalization of the business continuity plan for the WHO Country Office Indonesia for response in emergencies, and inputs provided to the UN contingency planning document.

- Continuous technical and operational support was provided through resource mobilization, co-facilitation, handling of issues, dialogue with Ministry of Health personnel, and monitoring and organizing WHO’s response to the communal conflict in Rakhine State, Myanmar.

- Financial support was provided from SEARHEF and emergency health supplies were given to the Democratic People’s Republic of Korea, Maldives, and Myanmar to support emergency operations.

- Technical inputs and feedback were provided to the development of the health emergency risk management framework, which provides Organization-wide standards for response to a wide range of emergencies.

- Collaboration with the nursing unit of the Regional Office on the Asia Pacific Emergency and Disaster Nursing Network (APEDNN) meetings organized in Kuala Lumpur, Malaysia in October 2012 and Bangkok, Thailand in December 2013. The main output of these meetings was a checklist for the use of nurses in any phase of a disaster.

- Implementation of the project monitoring mission to review progress of the Improving Women’s and Children’s Health Project in the Democratic People’s Republic of Korea was supported, which is directed towards reducing morbidity and mortality of women and children through strengthening the national health system.

- Collaboration with the WHO Kobe Centre to conduct a consultation in Bangkok, Thailand on strategic directions for urban health emergency management in June 2012.
Country initiatives for the programme

16. **Bangladesh**: Simulation exercises were completed in six batches and 190 professionals were trained. Over 1200 health professionals for disaster and emergency health management were also trained. With technical support from WHO and other stakeholders, the Directorate General of Health Services (DGHS), Ministry of Health and Family Welfare, developed a national strategy on disaster health management and guidelines on hospital safety. A draft curriculum on comprehensive emergency preparedness and response was prepared.

17. **Bhutan**: A health sector emergency preparedness plan is in place. To strengthen health sector emergency preparedness and response, funds were received from DIPECHO for development of contingency plans and development of capacity for preparedness and risk mitigation from earthquakes.

18. **Indonesia**: In coordination with the UN Office for the Coordination of Humanitarian Affairs (OCHA) and other UN agencies, a health cluster contingency plan for Indonesia and a cluster preparedness package were developed, and are being aligned with the Government’s plan. The safe health facility programme was strengthened by developing strong linkages with the Integrated Emergency System Network and Hospital Accreditation. The Center for Health Crises, Ministry
of Health, was designated a WHO Collaborating Centre for Training and Research on Disaster Risk Reduction in November 2012. As part of the collaborative workplan of the WHO Collaborating Centre, support was provided, as follows.

- The regional crisis centres were strengthened through the development of software to map emergency preparedness status in all districts.
- Emergency preparedness capacity of regional crisis centres was assessed, based on a Benchmark assessment conducted in collaboration with the Research Institute, Trisakti University, Jakarta.
- A survey is to be conducted on the community perspective on health workers’ performance during floods, in collaboration with Trisakti University, Jakarta.
- The International Training Consortium in Disaster Risk Reduction was strengthened through a workshop on training module revision and translations done based on international standards.

19. **Democratic People’s Republic of Korea**: Improved service delivery for recovery and rapid response was provided to the country for floods in 2012 and 2013 through the release of SEARHEF resources.

20. **Maldives**: Disaster preparedness plans were finalized for four atolls, while the disaster preparedness plan for one atoll was revised and updated. SEARHEF
resources and funding from Brazil was released to respond to tropical cyclone Nilam. In addition, technical support was provided for disaster preparedness and planning as well as for the Benchmark assessment through horizontal collaboration with the WHO Country Office Thailand.

21. **Myanmar**: WHO played, and continues to play, a lead in health cluster coordination. The Regional Office recruited and provided funding for a staff member to lead operations in the country. The draft country emergency preparedness plan using the Benchmarks tool was updated. Capacity-building of health sectors in disaster-prone townships was strengthened.

22. **Nepal**: Timely support was provided to the Ministry of Health and Population on health sector response during emergencies in the country, and stocks of interagency emergency health kits were arranged by the Regional Office. WHO is the consortium lead in a DIPECHO project on “Enhancing the health sector crisis preparedness in the event of a high intensity earthquake in Kathmandu Valley, Nepal”. Through this consortium, WHO has been able to develop health sector contingency plans in three districts of Kathmandu Valley. GeoHazards International conducted structural studies in selected hospitals of Kathmandu, Nepal with support from the Regional Office. The Regional Office supported the WHO Country Office Nepal to finalize the Benchmarks on emergency preparedness and response. The findings of this Benchmark exercise were published and shared with all stakeholders involved in the process in Nepal.

23. **Sri Lanka**: Activities were conducted to support the health cluster before it was deactivated late in 2012. The Jaffna field office was phased out, in line with Government priorities. Communicable disease surveillance in emergencies was strengthened. Guidelines and standard operating procedures to support operations for emergencies were further strengthened.

24. **Thailand**: The knowledge and skills of health workers in preparing for and responding to disaster situations were enhanced at all levels. A climate change programme was implemented as part of the disaster risk management programme with an emphasis on climate change adaptation, and is also reflected in the United Nations Partnership Framework (UNPAF) of Thailand.

25. **Timor-Leste**: The Benchmark assessment was conducted in all 13 districts. The emergency health cluster and contingency plans have been finalized.
Tobacco, alcohol, psychoactive substances, unhealthy diets, and physical inactivity

2012–2013 programme delivery highlights

- Following high-level advocacy through a regional conference for parliamentarians and health ministers from Member States, prevention of NCDs is now receiving priority in national health agendas.

- The Regional Strategy for Tobacco Control and the Regional Strategy for Utilization of Tobacco Questions for Surveys (TQS) were finalized and adopted by Member States.

- As part of ongoing efforts to strengthen tobacco control, a regional meeting and intercountry consultation on tobacco and trade, involving health and trade sectors, was supported. A regional meeting on countering tobacco industry interference was conducted, followed by national workshops with the same theme in Bangladesh, Indonesia, Nepal, Myanmar, and Sri Lanka. Countries developed action plans to promote awareness on the techniques of tobacco industry interference with tobacco control and how to counter them.

- The Regional Office supported several Member States in drafting legislation, regulations, and policies, and implementing tobacco control programmes. The Regional Office also provided support to Member States in applying for grants from the Bloomberg Initiative to Reduce Tobacco Use.
The Regional Office provided technical expertise to draft tobacco control law in Timor-Leste, amend tobacco legislation in Bangladesh, and develop rules and regulations for tobacco control in Indonesia. The Regional Office also provided technical support to the following countries facing litigations for tobacco laws: Nepal, Sri Lanka, and Thailand. Nepal won its case to put graphic health warnings on tobacco products, and has implemented the legislation: all tobacco packaging now has pictoral health warnings covering 75% of the surface area.

The Regional Office coordinated with WHO headquarters and country offices to engage with ministries of finance to improve tax systems on tobacco products. The Regional Office worked with the ministries in Bangladesh, India, Indonesia, and Thailand, and is in the early phase of engagement with Maldives, Myanmar, Nepal, and Timor-Leste.

STEPS surveys collecting information on multiple NCD risk factors were completed in Maldives and Nepal.

A regional training workshop was organized to train Member States on the GSHS in Hua Hin, Thailand, in December 2013.

In the area of tobacco surveillance, the Regional Office mobilized resources and provided technical support to several Member States through the Global Youth Tobacco Survey and the Global Adult Tobacco Survey. Based on survey results, Bangladesh amended its tobacco control law and Indonesia adopted a health bill and tobacco control regulation.

The Global Tobacco Surveillance System was implemented in 10 of the 11 Member States.

A bi-regional workshop on building capacity for reducing the harmful use of alcohol at country level in coordination with NCD prevention and control was held in Bangkok, Thailand in October 2012. The objectives of the workshop were to enhance the capacity of national counterparts on alcohol policy formulation and implementation, and to increase commitment for addressing the harmful use of alcohol as a risk factor for NCDs at the country level through implementation of the global and regional strategies. A draft integrated roadmap to advance alcohol policy development in the countries was also developed during the workshop.
Overview

1. Major risk factors for NCDs are highly prevalent and on the rise in the South-East Asia Region. The prevalence of tobacco use (smoking and smokeless) among males is high in countries. The consumption of unhealthy diets high in salt and fats is also highly prevalent. Childhood obesity is increasing in urban areas in some countries, and levels of physical activity are low in many countries.

2. Due to tobacco industry interference, there are an increasing number of court cases in Member States that are undermining the efforts of governments. Regulatory law enforcement and the capacity to implement legislation are generally weak throughout the Region. However, countries have shown innovative approaches, such as regulating tobacco imagery in films and television in India, passing a healthcare bill and tobacco regulation in Indonesia, and increasing taxation on shredded tobacco products in Thailand.

3. The alcohol industry in the Region is growing. With many parts of the world reaching stable and saturated consumption, and with declining trends of alcohol consumption in the other WHO regions, alcohol consumption is on the rise in South-East Asia. The Region can be characterized as having a low but increasing level of alcohol consumption with detrimental patterns, dominated by the consumption of spirits as well as a high degree of unrecorded alcohol consumption. The major problem in the Region is heavy episodic or “binge” drinking. With the influence of global economies and changing cultural norms, more and more young people are experimenting with alcohol at an early age.
Health promotion and prevention of major risk factors

4. Recognizing the need to address social determinants of health and rising risk factors for NCDs, the Regional Office for South-East Asia has been working in the area of policy advocacy and capacity-building. Multisectoral actions for health are being operationalized through the development of guidance for implementation of health impact assessment tools. The regional framework on Health in All Policies has been developed along with country frameworks for actions to address health issues and determinants of health through multisectoral efforts.

5. Capacity-building for health promotion was delivered through ProLead, a health promotion leadership training programme, in Bangladesh, Bhutan, and Indonesia. Bhutan established a health promotion division and initiated the process of developing a comprehensive national health promotion plan and strategies. The Regional Office developed a new approach for creating health-promoting hospitals, using a life-course approach for preventive care and health promotion, and supported Member States through consultation and participation in international meetings. As a consequence of these activities, a network of health-promoting
hospitals has expanded across Indonesia and Thailand. In Timor-Leste, a specific school health programme and strategic plan has been developed, and monitoring and evaluation guidance for school health programmes has been disseminated. The International Network of Health Promotion Foundations is being led by the Thai Health Promotion Foundation to expand and strengthen capacity of health promotion in South-East Asia.

**National systems for surveillance of major risk factors**

6. Technical support and training was provided to the health ministries in Maldives and Nepal in the analysis and report writing for STEPS.

7. As part of the Global Tobacco Surveillance System, a Global Adult Tobacco Survey was completed in Indonesia and widely disseminated. In a similar vein, a Global Youth Tobacco Survey was completed in Maldives, Myanmar, Nepal, and Sri Lanka. A Global Health Professions Student Survey was completed in Nepal, Sri Lanka, and Thailand. The data from these surveys were used effectively for advocacy and planning.
Tobacco use

8. Smoking is the predominant mode of tobacco use among men in Bangladesh, Indonesia, Nepal, Sri Lanka, and Thailand, whereas the use of smokeless tobacco is the predominant practice among women in Bangladesh, India, and Myanmar. Smoking rates among women in the Region remain generally low – well under 5%. Myanmar (7.8%) and Nepal (15.9%) are exceptions. Smokeless tobacco use among women is generally more common than smoking, but again Myanmar and Nepal are exceptions (Figures 6.1 and 6.2).

Bangladesh – national tobacco control law amended

The National Assembly of Bangladesh passed the Tobacco Control Law Amendment Bill on 29 April 2013, closing many loopholes in the country’s previous tobacco control law.

The amendment was a major step forward in tobacco control in Bangladesh, where 43% of adults use some form of tobacco. The scope of existing tobacco control measures were extended to include smokeless tobacco products, which are used by 28% of women and 26% of men in the country. In contrast, 45% of men and just 1.5% of women smoke cigarettes. This change will protect and inform more than 13 million women.

The most important measures contained in the Amendment are as follows.

- Smokeless tobacco has been brought under the definition of “tobacco”.
- Restaurants and indoor workplaces have now been included among the public places that are to be completely smoke-free.
- Fines for non-compliance with smoke-free regulations have increased from 50 Bangladeshi Taka (approximately US$ 0.6) to 300 Bangladeshi Taka (US$ 3.9), in addition to the penalties for violations of other measures covered by the law.
- Advertisements at points of sale are now banned and “corporate social responsibility” activities restricted.
- Anti-tobacco messages will be shown if tobacco use is included in a movie.
- Sale of tobacco to and by minors has been banned.
- Graphic health warnings are to be printed on tobacco packs that cover at least 50% of each principal surface area. Misleading descriptors such as “light”, “mild”, and “low tar” can no longer be used.
- The Ministry of Health and Family Welfare is now mandated by law to establish and operate the “National Tobacco Control Cell” (previously, the Cell functioned under an administrative order).
- The Government is mandated to formulate policies to discourage tobacco cultivation.
Figure 6.1: Prevalence of smoking and smokeless tobacco use among men in selected Member States, 2008–2011

Sources: Global Adult Tobacco Survey (Bangladesh, India, Indonesia, Thailand); STEPS (Bhutan, Myanmar Nepal, Sri Lanka); Demographic and Health Survey (Maldives and Timor-Leste).

Figure 6.2: Prevalence of smoking and smokeless tobacco use among women in selected Member States, 2008–2011

Sources: Global Adult Tobacco Survey (Bangladesh, India, Indonesia, Thailand); STEPS (Bhutan, Myanmar Nepal, Sri Lanka); Demographic and Health Survey (Maldives and Timor-Leste).
Alcohol, drugs, and other psychoactive substances

9. Member States are adapting strategies recommended by WHO with regard to developing alcohol policy, engaging in community action to reduce harm from alcohol, and establishing controls for home-brewed illicit liquor.

Advocacy and support to reduce the harmful use of alcohol

10. The Regional Office’s activities to provide support to reduce the harmful use of alcohol focuses around six broad areas: advocacy with governments; intercountry workshops; support for development of alcohol policy; support for community action to reduce harm from alcohol use; development of advocacy documents; and, support to Member States on implementation of the Global Strategy to Reduce the Harmful Use of Alcohol.

11. The Regional Office advocates a “policy mix” to find the right balance for reducing the overall public health burden of alcohol consumption. The Regional Office advocates to Member States that successful implementation of alcohol
control strategies need a high degree of public awareness and support. Without sufficient popular support, the enforcement and maintenance of any restriction on alcohol consumption will be jeopardized and resistance and circumvention are likely to develop, as alcohol consumption is ingrained in the social life of many Member States and alcohol is considered a cultural and personal choice. The Regional Office advocated with Member States for multiple stakeholder involvement with ministries of industry, revenue, agriculture, customs, and transport, as well as law enforcement departments, medical associations, and nongovernmental organizations to encourage them to lobby for clear formulation and effective implementation of a rational, integrated, and comprehensive alcohol control policy. Support was provided to Bhutan to develop a national policy and strategic framework.

**Unhealthy diets and physical inactivity**

12. As part of the regional action plan and targets for NCD prevention and control, regional targets were set for salt reduction and halting the rise in obesity. As part of the advocacy campaign for the 2013 World Health Day theme of “high blood pressure”, messages on salt reduction were communicated through print, online, and other media. A proposal was prepared for promoting physical activity in Bhutan.
Social and economic determinants of health

2012–2013 programme delivery highlights

- The Regional Office provided technical support to Member States to implement the Rio Political Declaration on Social Determinants of Health through the Health in All Policies (HiAP) approach. This included close collaboration with other UN organizations on advocacy, research, and capacity-building.

- The Urban Health Equity and Response Tool (Urban HEART) was introduced in the Region, and concrete country plans to scale up implementation were developed during a regional workshop. A regional workshop to build capacity for an urban health equity assessment and intersectoral response was also held. Plans for the further implementation of Urban HEART, as well as for taking action on tackling determinants of health in cities of all Member States, were developed.

- Actions for health and inclusion of equity measurement were discussed at an Expert Meeting on Health Impact Assessment and Health Equity Measurement towards HiAP.

- The Framework on Health in All Policies for South-East Asia was finalized and disseminated. The framework will serve as operational guidance for countries initiating HiAP processes in their respective countries, and as an advocacy tool to share with other sectors.
- *Health in All Policies: Report on Perspectives and Intersectoral Actions in Selected Countries in the South-East Asia Region* was published and disseminated. Some Member States began the roadmap for country actions toward implementation of HiAP, namely Thailand, Indonesia, and parts of Bhutan and Sri Lanka.

- At the Sixty-fifth Session of the Regional Committee for South-East Asia, Member States reported their achievements in national consultations with relevant stakeholders on the Report of the Consultative Expert Working Group on Research and Development: Financing and Coordination (CEWG). The countries adopted resolution SEA/RC65/R3, with detailed recommendations and action points for Member States and WHO. This resolution enabled the open-ended meeting of all Member States held in November 2012 to arrive at a consensus draft resolution for the Sixty-sixth World Health Assembly.

- The South-East Asia Region was the only WHO region to hold a regional consultation for the development of a strategic workplan as a follow-up to the report of the CEWG. This consultation developed a matrix for norms and standards for classifying research and development (R&D) for health products, and selected priority areas for demonstration projects in line with World Health Assembly resolution WHA66.22.

- An intercountry training of trainers workshop on human rights-based and gender-sensitive approaches to health programmes was jointly organized with UNAIDS for Bangladesh, Indonesia, Myanmar, Thailand, and Timor-Leste. The workshop enhanced participants’ awareness, knowledge and skills on human rights-based and gender-sensitive approaches, the links between human rights-based approaches and results-based management, and its application in national health programmes. The workshop will be replicated with the other countries of the Region.

- In collaboration with WHO headquarters, the WHO Regional Office for the Western Pacific, and UNFPA’s Asia and the Pacific Regional Office, a workshop was conducted to roll out WHO’s clinical and policy guidelines on health response to intimate partner violence and sexual violence against women. The workshop raised awareness that violence against women has become a major public health issue and the health sector has crucial role to play in prevention and provision of care.
Overview

1. The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. They are the underlying “causes of the causes” of poor health and inequitable access to health and social services. Measuring, analysing, and interpreting health inequality by using sociocultural stratifiers is crucial for decision-making on strategic actions to address health inequities between individuals, families, communities, and countries.

2. Health equity impact assessment has become an important tool for multisectoral actions that address structural determinants of health and policies that have potentially negative impacts on the physical, psychological, and social well-being of people. All sectors – public and private – are increasingly encouraged to show responsibility, fairness, social justice, equity, gender-sensitivity, and respect for human rights. HiAP formulation and implementation will ensure systematic social protection for the most vulnerable populations.

3. In the South-East Asia Region, there has been a heightened emphasis on the status of innovation, intellectual property rights, trade, and the pharmaceutical industry, including promoting access to health products, new and existing medicines, and developing new diagnostics and vaccines to treat diseases that disproportionately affect developing countries.
Social and economic determinants of health

4. In response to World Health Assembly resolution WHA65.8 – endorsing the Rio Political Declaration on Social Determinants of Health – the Regional Office and WHO country offices provided technical support to Member States to implement the Declaration through the HiAP approach and worked closely with other organizations in the UN system on advocacy, research, and capacity-building in Member States. Support included providing documentation of country experiences, organizing and facilitating workshops and meetings where countries shared best practices, and convening an expert group, as well as a regional consultation, to draft the Framework on Health in All Policies for South-East Asia. Additional activities supported by the Regional Office included: a national consultation on mainstreaming social determinants of health and the role of public health in Thailand; a national workshop on health education and health-sector roles to address determinants of health in Indonesia; and, an international meeting on social determinants of health.

5. In each of these meetings, the health and non-health sectors were made aware of important multisectoral actions for addressing determinants of health. One outcome was that the public health sector needs to provide a strong evidence base between health and structural determinants that are influenced by other sectors’ policies and actions. The Regional Office also provided guidance during the meeting on health equity assessment and intersectoral response, and advocated for improvement of health information and disaggregated data.
6. The Regional Office provided support to document intersectoral actions to address structural determinants of health at the policy level to all countries. Case-studies from Bhutan, India, Nepal, Sri Lanka, Thailand, and Timor-Leste were completed and published in a regional report on HiAP.

7. Capacity-building support through a regional workshop on urban health equity assessment and intersectoral responses was provided to municipalities and local governments, together with the health sector, to utilize Urban HEART and design intersectoral responses to address the needs of urban populations. The tool provided useful analysis that identified people’s needs and priorities to be addressed with multisectoral partners and stakeholders. The HiAP approach was advocated along with healthy urban planning and a human rights-based approach to health.

8. The Regional Office organized a meeting of experts to draft a Framework on Health in All Policies for South-East Asia, and conducted a regional consultation to finalize the framework. The framework helps Member States to effectively plan for implementation of HiAP, and address public policies for health issues and its determinants. The regional framework and activities contributed to a global plan of action to address social determinants of health and was included in the technical background documents in support of the Eighth Global Conference on Health Promotion. The theme of the conference for 2013 was “Health in All Policies”, and discussion on further strengthening intersectoral actions was included. The regional framework on HiAP and country frameworks for action have been published and disseminated.

Intersectoral collaboration on social and economic determinants of health, including public health implications of trade and trade agreements

9. The Regional Office, in collaboration with Thammasat University in Thailand, supported the organization of a workshop entitled “Globalizing Asia: Health Law, Governance, and Policy – Issues, Approaches, and Gaps”. The workshop highlighted the impact of globalization on the wealth and health of nations and brought international recognition to important principles, such the right to health.

10. At the request of Member States, the Regional Office organized a regional technical consultation that identified detailed recommendations and action points to: promote and strengthen R&D capacities; promote coordination of R&D; establish
or strengthen health R&D observatories; promote partnerships; and, explore funding for health R&D. Wide engagement with health R&D experts from the University of Dhaka, Bangladesh; Department of Biotechnology, Ministry of Science and Technology, India; Translational Health Science and Technology Institute, India; National Institute of Health Research and Development, Indonesia; and, the Southeast Asian Ministers of Education, Tropical Medicine and Public Health Network (SEAMEO TROPMED) Office in Bangkok, Thailand provided detailed recommendations for the Global Observatory for Health R&D. A second meeting of experts on demonstration projects was organized by the Regional Office in October 2013 to further develop criteria and select demonstration projects.

11. The Regional Office contributed to a number of technical workshops, including:

- the Eleventh International Congress on AIDS in Asia and the Pacific held in Bangkok, Thailand in November 2013, on access to safe and affordable medicines and antiretrovirals in the light of international trade agreements such as the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement of the World Trade Organization (WTO), and TRIPS plus provisions being negotiated under various bilateral and plurilateral international agreements;

- the “Use of TRIPS Flexibilities to Access Affordable ARVs in Asia” consultation and planning workshop, which aimed to improve participants’ knowledge about TRIPS flexibilities and legal options for facilitating access to antiretrovirals, and to facilitate establishment of country coordination mechanisms to develop roadmaps for securing and expanding full use of TRIPS flexibilities;

- an informal consultation on the implementation of the Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and other benefits, held to enable development of country positions on the framework and identify next steps;

- training on “Compulsory Licensing and TRIPS” for the Judicial Training Programme for Controllers of Patents, at the National Law University in Delhi, India;

- the “Regional Seminar for Certain Caucasian, Central Asian and Eastern European Countries and Central European, Baltic and Mediterranean Countries on the Implementation and Use of Several Patent-Related Flexibilities” in October 2013 in Kazakhstan, with technical presentations made on: the use of patent-related flexibilities and main constraints thereon within the Region;
Member States of the Region develop a classification grid for capturing information on R&D for health products

A regional consultation to develop a strategic workplan as a follow-up of the CEWG was held in July 2013 in Bangkok, Thailand. During the meeting, Member States of the South-East Asia Region developed an important grid for classification of norms and standards for health products R&D. This classification grid will be invaluable for the proposed Global Observatory for Health R&D under consideration in WHA66.22.

The WHO country offices took up this exercise with Member States, who in turn associated with institutes having proven health R&D expertise. Senior researchers from recognized institutes participated, including the Department of Pharmaceutical Chemistry, Faculty of Pharmacy, University of Dhaka, Bangladesh; National Institute of Health Research and Development, Jakarta, Indonesia; and, the Department of Community Medicine, Faculty of Medicine, University of Colombo, Sri Lanka. In-depth analysis formed the basis of this exercise. The Translational Health Science and Technology Institute, Gurgaon, India and the Biotechnology Industry Research Assistance Council, New Delhi, India, examined more than 5200 health R&D projects sanctioned under the current Five Year Plan of the Government of India to develop a model.

SEAMEO TROPMED Thailand undertook a series of consultations with various stakeholders that were key to developing the classification. Major consultations were first held with health policy-makers and planners including representatives of the different departments in the Ministry of Public Health, Food and Drug Administration, National Vaccine Institute, Department of Disease Control, National Research Council of Thailand, National Science and Technology Development Agency, National Science Technology and Innovation Policy Office, and Thailand Center of Excellence for Life Sciences. A second consultative meeting was attended by researchers and academicians including heads and/or representatives from various departments in the faculties of science, tropical medicine, medicine, and pharmacy at Mahidol University and Chulabhorn Research Institute. A final consultation was taken up with representatives of local pharmaceutical organizations and companies such as the Pharmaceutical Research and Manufacturers Association, the Government Pharmaceutical Organization, and Siam Bioscience, as well as the Faculty of Pharmaceutical Sciences, Chulalongkorn University.

The classification systems currently in vogue were discussed, including the Organisation for Economic Co-operation and Development’s (OECD) Frascati Manual: Proposed Standard Practice for Surveys on Research and Experimental Development, and those spearheaded by various agencies in the United States of America such as the Research, Condition, and Disease Categorization system developed by the National Institutes of Health; Medical Subject Headings developed by the National Library of Medicine; the Common Scientific Outline developed and used by the National Cancer Institute; and, G-FINDER survey funded by the Bill & Melissa Gates Foundation specifically to monitor resource flows for neglected diseases including tuberculosis, malaria, and HIV/AIDS. The Health Research Classification System (HRCS) developed by the United Kingdom Clinical Research Collaboration in 2008 and the HRCS manual were also deliberated upon.

After due consideration, Member States evolved a simplified grid for classification that is appropriate for health products R&D, as well as being suitable for the Region and developing countries in particular. The horizontal axis delineates measuring the problem, understanding the cause, developing a solution, implementation, and evaluation of impact on health products R&D. The vertical axis delineates the classification of disease type, as taken up in the CEWG report. This simplified classification system has the potential to unite developed and developing countries on mapping for health products R&D.
the effective administrative process for the grant of a compulsory license; and, the use of the research and regulatory review exception.

12. In addition, WHO provided direct country support, including:

- technical support in Timor-Leste to the Ministry of Health and the WHO Country Office in response to the letter of H.E Dr Sergio GC Lobo, Minister of Health, to the Regional Director, including technical presentations on provisions in free-trade agreements impacting health products (such as medicines, medical products and food) for the Health Information Division of the Ministry of Health, the Health Management Information Systems Advisor, Ministry of Commerce and Trade officials, and other relevant officials;

- technical input to the WHO Country Office Indonesia through a national workshop on WHO’s initiatives in public health, and related aspects of intellectual property rights, held in Bandung, Indonesia in November 2013;

- a workshop on “Colloquium on Intellectual Property Rights for Policy-makers in India: Strengthening Capacity to Influence Public Health Policy Decisions Relating to Pharmaceuticals”, held in September 2013 in New Delhi, India;

- briefing papers for the WHO Country Office India on compulsory licences for three commonly used anticancer drugs: trastuzumab (or Herceptin, used for breast cancer), ixabepilone (used for chemotherapy) and dasatinib (used to treat leukaemia);

- technical support to the Ministry of Public Health, Thailand for an intercountry conference to be held in 2014 on public health issues in free-trade agreements.

13. During the High-level Subregional Forum on Accelerating Achievement of the Millennium Development Goals in South Asia and the launch of the Asia-Pacific Regional MDG Report 2011–2012, contribution was made on intellectual property and trade issues related to public health and policy options in this area to accelerate the achievement of the MDGs by 2015.

14. During an intercountry consultation on tobacco and trade, technical presentations were made by the Regional Office on the agreement on trade-related aspects of intellectual property rights and the tobacco challenge. To increase awareness of the relationship between the WHO FCTC, the WTO and public health, documents from other regions were shared with Member States.

15. The Intellectual Property Rights and Trade and Health unit’s activities on policy guidance, training, enhancing capacity, and direct country support for technical
cooperation programmes on public health and intellectual property were reflected in the WTO documents, Technical Cooperation Activities: Information from Other Intergovernmental Organizations: World Health Organization (WHO), Addendum (IP/C/W/581/Add.2), and (IP/C/W/591/Add.2), which were developed for WHO headquarters and resulted in visibility for the Region’s activities among all Member States and the trade community.

**Collection, collation, and analysis of social and economic data relevant to health**

16. The Regional Office shared technical guidance with countries via video conferencing and in-country workshops to ensure disaggregated data on determinants of health are being considered. It also collaborated with other UN agencies and international partners, including the Department for International Development (United Kingdom) (DFID), International Organization for Migration (IOM), United Nations Organization for Education, Science and Culture (UNESCO), United Nations Human Settlements Programme (UN-HABITAT), UNICEF, and United States Agency for International Development (USAID), to address issues of migration in countries such as India and Thailand. However, without disaggregated data at the national and subnational levels, gender analysis and other equity issues could not be performed at the regional level.

**Gender analysis and responsiveness**

17. A South-East Asia regional taskforce on gender, equity, and human rights was established to oversee and support staff and Member States in mainstreaming related activities into their respective programmes and national health policy strategies and plans. Training modules to mainstream gender, equity, and human rights into WHO programmes as well as guidelines to integrate gender, equity, and human rights into workplans and country cooperation strategies are being finalized by the Gender, Equity and Human Rights global team. The inclusion of gender, equity and human rights in project evaluation was highlighted in the WHO Evaluation Practice Handbook, launched in 2013.

18. The Regional Office has worked closely with the Gender, Equity and Human Rights global team to roll out the UN System-wide Action Plan (UN SWAP) on
gender equality and women’s empowerment, in collaboration with other UN agencies, to enhance accountability and measure progress towards the achievement of gender equality and empowerment. The Regional Office also provided inputs to the Organization-wide draft action plan on gender, equity, and human rights, in which the WHO Secretariat is required to report on the accountability framework at WHO’s Executive Board meetings and the World Health Assembly.

19. A meeting on mainstreaming gender, equity, and human rights into WHO’s programmes was organized for Regional Office staff and gender, equity, and human rights country focal points in June 2013, which led to better understanding of the concepts. Lessons learnt from nongovernmental organizations helped to enhance understanding on how to mainstream gender, equity, and human rights into health programmes. The first meeting of gender, equity, and human rights focal points showed that the country offices have recognized the need to mainstream these concepts into programmes and have attempted to work with Member States to integrate gender, equity, and human rights into the new country cooperation strategies.

20. Violence against women rooted in gender inequality and violation of human rights has become a public health issue, and the health sector has a role in prevention and care of the victims. To raise awareness of WHO staff and Member
States on ending violence against women, the Regional Office and country offices joined with UN Women and other UN agencies in the “Orange Campaign”. The Regional Office collaborated with WHO headquarters, the Regional Office for the Western Pacific, and UNFPA’s Asia and the Pacific Regional Office on a workshop to roll out the WHO clinical and policy guidelines on the health response to intimate partner violence and sexual violence against women, held in Bangkok, Thailand in June 2013. The workshop raised awareness of the participants and led to country roadmaps to adapt and disseminate the guidelines at national and subnational levels, as well as to build capacity of health-care providers.
2012–2013 programme delivery highlights

- Several successful conferences and meetings were held in the Region. Conferences included the Third East Asia Ministerial Conference on Sanitation and Hygiene, the Fifth South Asian Conference on Sanitation, and the Third Ministerial Regional Forum on Environment and Health in Southeast and East Asian Countries. Meetings included the Asian Asbestos Initiative, a regional workshop on chemical safety, international meetings on health-care waste management, regional meetings on climate change and health, a regional meeting on water safety plans, and an international meeting on water safety plans and household water treatment and safe storage. Participants from all Member States attended these meetings.

- The Regional Strategy for Protecting Health from Climate Change was developed.

- Support was given for studies on a health vulnerability index, prevalence and incidence of diarrhoea, acute respiratory tract infection, malaria, and livelihood and health conditions after sea storms.

- Bangladesh, the Democratic People’s Republic of Korea, Indonesia, Myanmar, Sri Lanka, and Thailand developed multisectoral climate change strategies and action plans, either as a separate document or under their national environmental health action plans.

- Bangladesh, Bhutan, India, Indonesia, Nepal, and Sri Lanka conducted health vulnerability assessments.

- Bhutan, Indonesia, Thailand, and Sri Lanka made progress in reviewing national action plans, strengthening multisectoral cooperation, and prioritizing interventions designed to tackle priority occupational carcinogens and related diseases, notably those caused by asbestos.
Training support and capacity-building on occupational health was enhanced in the Region and through the development of a draft regional strategy. Technical support for training was provided in India and Maldives.

Advocacy was increased for the elimination of lead paint in conjunction with the Global Alliance to Eliminate Lead Paint. Member States participated in a number of national activities in support of the first International Week of Action on Prevention of Lead Poisoning.

A specific target to reduce indoor air pollution resulting from the use of solid fuel for household cooking was included in the *Action plan for the prevention and control of noncommunicable diseases in South-East Asia, 2013–2020*.

More than 280 water and sanitation professionals were trained on water safety plans through regionally-organized training of trainers and national-level training. A regionally-focused training manual on urban water safety plans was prepared. Bangladesh has incorporated water safety plan training into the university curriculum.

Water safety plans have been scaled up in Bangladesh, Bhutan and Nepal, piloted in Myanmar, Indonesia and Timor-Leste, and introduced in Maldives and Sri Lanka. They have also been expanded to four cities in India.

Member States of the South-East Asia Region contributed to two global reports – the WHO/UNICEF Joint Monitoring Programme (JMP) for Water Supply and Sanitation report and the UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS), which were launched in 2012.

A number of countries were supported to establish national programmes to address priority occupational risks and diseases. Implementation of the Regional Chemical Helpdesk is ongoing, facilitated though the WHO Collaborating Centre for Capacity Building and Research in Environmental Health Science and Toxicology in Thailand. Consultation with Member States was carried out to extend the regional helpdesk and strengthen poisons centres in the Region.

A video was produced on sound management of health-care waste.

A guideline for total sanitation was developed and piloted in 10 village development committees in Nepal. Amarpuri village development committee was declared the first “total sanitation” village in Nepal.

Water, sanitation and handwashing facilities have been improved in 40 primary health centres in coastal areas of Bangladesh.
CAR FREE DAY
MINGGU CERIA LAMONGAN
SAT LANTAS POLRES LAMONGAN
Healthy environments and environmental threats to health

Overview

1. WHO’s work in this area aims to strengthen the capacity of Member States to ensure safe environments, provide tools and guidelines for assessing health vulnerability and planning adaptation, and provide support to develop monitoring systems.

2. During the biennium, the Region and countries strengthened evidence for priority environmental hazards and increased awareness of environmental and health issues by the health sector and other partners in environment, labour and water, as well as parliamentarians. The major focus was on building the capacity of national counterparts in the areas of climate change, chemical safety, water safety, health-care waste management, and sanitation. Capacity was developed through national-level training programmes, regional meetings and study visits to countries where good practices exist.

Assessment and normative work on major environmental hazards

3. Member States contributed to the preparation of two global reports, namely the progress report of the JMP and the GLAAS report. The GLAAS survey was carried out in 10 Member States and data were compiled through a consultative workshop with all relevant stakeholders, including health, water and sanitation, planning, finance, and education.
4. According to the JMP report, about 91% of the population in the South-East Asia Region have access to improved drinking water and about 45% have access to improved sanitation. The progress on drinking-water in the 11 Member States is illustrated in Figure 8.1 and progress in reducing the practice of open defecation is illustrated in Figure 8.2.

Figure 8.1: Access to improved drinking-water sources, by country, 1990, 2000 and 2012

![Chart showing access to improved drinking-water sources, by country, 1990, 2000 and 2012.](image)

DPR Korea: Democratic People’s Republic of Korea


5. A study to understand the efficacy of various point-of-use water treatment technologies was carried out in Bangladesh. The findings of the study will help households to choose the right technologies for treating their drinking water and reducing waterborne diseases. The country has also developed a guidance document on green hospitals, as well as a strategy for climate change and health. In addition, Bangladesh has revised its arsenic mitigation strategy for drinking water, as reported by the country office in its mid-term report.

6. Bhutan has developed information, education and communication materials on climate change and health, and guidelines for integrated surveillance of vector-borne diseases and meteorological data. Assessment of fluoride levels in the drinking water in urban areas, and vulnerability and adaptation assessments on the health
outcomes of climate change, were completed in Bhutan. The studies will help in improving drinking-water quality surveillance and developing adaptation measures to mitigate climate change impacts on health. In the long term, these interventions will reduce waterborne and climate-sensitive diseases.

Figure 8.2: Progress in reducing open defecation, by country, 1990, 2000 and 2012

7. Guidelines for addressing environmental health risks have been drafted in the Democratic People’s Republic of Korea. Guidelines on drinking-water quality have been updated in Sri Lanka.

8. To understand the vulnerability of the health sector from the impact of climate change and to develop adaptation measures, vulnerability assessments were carried out in Bangladesh, India, Indonesia, Myanmar, and Sri Lanka. The Indian study developed a vulnerability index while the Bangladeshi study was basically a follow-up on the aftermath of Cyclone Aila in 2009. The findings of these studies have been disseminated among policy-makers and programme managers to encourage them to prioritize funding of mitigation and adaptation actions.

9. The water safety plan in Nagpur, India was assessed and recommendations for further improvement were provided to Nagpur Municipal Corporation. These recommendations will help to improve the integrity of Nagpur’s water supply
system, thereby improving the safety of drinking water and ultimately reducing waterborne diseases.

10. Equity studies for water safety planning were completed in Bangladesh and initiated in Nepal. In Nepal, baseline surveys of injection safety practices were done in 70 government hospitals; assessments of health-care waste management in health facilities and of the burden of disease caused by environmental hazards were completed; guidelines for total sanitation and healthy villages were prepared; the effect of climate factors on kala-azar vectors along an altitudinal transect was studied; and, four rounds of air quality sampling in Lumpini were completed.

11. Guidelines for the prevention of water contamination of household rainwater-harvesting systems and ground water were finalized in Maldives. These guidelines will be used by communities where rainwater is used for drinking and will be helpful in ensuring water safety.

Primary prevention interventions to reduce environmental hazards to health, enhance safety, and promote public health

12. More than 280 water supply technicians and engineers have been trained on water safety plan concepts. Water safety plans for improving drinking-water quality have been implemented in six urban municipalities in Bangladesh, five towns in Bhutan, three cities in India, and in one rural and three urban areas in Sri Lanka. These trainings will help water suppliers to implement water safety plans as per WHO guidelines for drinking-water quality and, when the plans are implemented, reduce waterborne diseases which are caused by microbes and chemicals. A water safety plan training package has been prepared. Advocacy and training on water safety planning has been carried out in India, Indonesia, Myanmar, and Timor-Leste and work is in progress to develop systems to institute water safety plans as normal practice in these countries.

13. About 24 officials from the health and water supply sectors from Bhutan, Myanmar, and Timor-Leste were sent on study tours in Nepal, India, and Indonesia to learn about water safety plans, water-quality monitoring and revival of spring-water sources. Participants from Myanmar and Timor-Leste learnt to plan and kickstart phase 3 of the water-quality project in their countries. The participants from Bhutan learnt about the revival of spring-water sources and have implemented two pilot projects in the country. The initial results are quite positive, and the final outcomes will be seen in 2014.
Nagpur – a go-ahead municipality, with water safety plans integral to its push for 24/7 supply

Nagpur is a city in Maharashtra at the very centre of India, with a population of about 2.5 million. Water supply is controlled by Nagpur Municipal Corporation (NMC) with about 80% coverage (through 225,000 connections). Current non-revenue water is 50% and customers get between 4 and 24 hours supply per day. The water supply system is progressively being upgraded to a 24/7 supply, and water security is being significantly increased through large investments.

The Water Quality Partnership for Health has been supporting water safety plan (WSP) work in India through the WHO Regional Office for South-East Asia. In 2011, following WHO-supported training, NMC prepared a WSP. The National Environmental Engineering Institute, the WHO Collaborating Centre for Water Supply and Sanitation in Nagpur, participated in the training and has since been working with NMC as they prepare and update the WSP. In 2012, NMC commenced a public–private partnership agreement in which Orange City Water (OCW) operates the Nagpur water system. The contract includes operation of the water treatment plants and the distribution system, as well as billing and collection. In November 2013, an informal review of Nagpur’s WSP was conducted by an external team.

The risk assessment carried out in the WSP preparation was explicitly used to inform NMC and OCW of the main risks affecting water quality, and actions to take in the upgrade programme of the water supply related to water quality protection. OCW has prepared numerous standard operating procedures for the key risks identified in the WSP, especially related to water treatment plants’ operation. More standard operating procedures are planned in the near future.

Although the WSP is not yet in its fully operational phase, the work done by NMC and OCW in relation to follow up of the WSP key risks and understanding of the WSP is extremely encouraging. It demonstrates a strong commitment to the risk-based approach in WSPs. Of special note are the new standard operating procedures at the water treatment plants, the staff training associated with the standard operating procedures, and ongoing staff technical training. As part of an informal review, the visiting team posed many questions to managers, operational staff, and treatment plant operators relating to “what would you do if…”, and it was apparent that the operators and managers had considered a wide range of risk scenarios in developing the standard operating procedures. This is extremely commendable.

Many examples from the Nagpur WSP implementation will be useful to other utilities in India and elsewhere in the Region, both in relation to technical risk-based management and organizational culture. In the case of organizational culture, for example, NMC created a not-for-profit limited company (Nagpur Environmental Services Ltd) under the chairmanship of the mayor. This enabled NMC to legitimately bypass some of the most onerous constraints on government bodies for project development and implementation. More importantly, it means that all water service revenues can be ring-fenced for maintenance and for future investment in water and sanitation services, and not lost to the wider NMC revenue budget. Most NMC water and sanitation staff were transferred to OCW to manage as appropriate. As a result, human resource management became more dynamic with staff being incentivized to improve performance or be let go if performance was poor.
14. Nepal has developed baseline information about injection safety practices based on a study carried out in 40 hospitals in the country. The study helped develop injection safety measures for health-care workers and more than 400 health workers have been trained on safe handling and disposal of syringes. In the long term, needle stick injuries will be reduced. Total sanitation has been piloted in 10 village development committees and Amarapuri village development committee has been declared the first “total sanitation” village in Nepal.

15. Forty primary health centres catering to about 800,000 people in coastal areas of Bangladesh were provided with safe water, toilets for males and females, and handwashing facilities. This will contribute to a reduction in nosocomial infections, and improve general hygiene standards and patient safety. It will also contribute to overall quality of care and encourage patients, especially pregnant women, to visit the health centres for regular check-ups and delivery.

16. Intersectoral consultation was undertaken in Bhutan, Indonesia, and Sri Lanka aimed at strengthening prevention interventions for chemical hazards. In Thailand, significant work was undertaken for eliminating asbestos-related diseases.

17. There is increasing use of chrysotile asbestos by countries in the Region compared with the rest of the world. While global asbestos usage fell dramatically in the 1970s, there has been a steady increase in the use of chrysotile asbestos in many countries of the Region. In response, a number of Member States have committed to increase their efforts to eliminate asbestos-related disease. Accordingly, the development of multisectoral plans for the management of asbestos and other priority carcinogens are under way in Bhutan, Indonesia, Sri Lanka, and Thailand supported financially by the Strategic Approach to International Chemicals Management. As a result of this work, a national study on the prevention of asbestos-related diseases, including a cost-benefit analysis of preventive measures, was completed in Thailand.

18. Four countries – Bangladesh, India, Indonesia, and Thailand – are collaborating under the auspices of the Asian Asbestos Initiative to report on the status of asbestos in their countries and contributing to the implementation of the WHO Workers’ health: global plan of action.

19. Regional conferences to advocate the importance of health-care waste management in protecting health and the environment were organized in India and Thailand. National workshops to sensitize health-care workers and other stakeholders in health-care waste management were held in Bhutan, Indonesia, Nepal, and Sri Lanka. An environmental health risks awareness workshop was organized in the
Democratic People’s Republic of Korea. Along with other development partners, the Regional Office supported the Third East Asia Ministerial Conference on Sanitation and Hygiene in Indonesia and the Fifth South Asian Conference on Sanitation in Nepal in 2013. Short videos on the model health-care waste management system in Bir Hospital in Kathmandu, Nepal have been produced through support from the Regional Office, and videos are now being exhibited throughout hospitals in Nepal.

20. The Regional Strategy for Protecting Health from Climate Change was disseminated to focal points in Member States to assist them in the development of their own health sector and generic intersector strategies. WHO supported the development of a model health-care waste management system in Nepal and is observing the positive results in this model. The Government of Nepal also enforced its Waste Management Act in 2012. Training and an assessment of occupational health in selected industries was conducted in Maldives.

21. Poisons centres are specialized centres that advise on and assist with the prevention, diagnosis, and management of all forms of poisoning from natural toxins, venomous snakes, and the unsound management and use of pesticides and industrial chemicals. At the end of 2013, six countries in the Region had poisons centres – India, Indonesia, Myanmar, Nepal, Sri Lanka, and Thailand – and work was initiated to create a regional network of poisons centres. This will strengthen
overall capacity in the Region and extend the centres’ ability to play a part in national capacities for dealing with the impacts of unsound chemical management, as well as implementation of the chemicals aspects of IHR (2005).

Policies to improve health, the environment, and safety

22. Awareness-raising with non-health sectors has continued to be a strong feature of work on environment and health. Non-health sector stakeholders were engaged in the development of a strategy for assisting with the implementation of IHR (2005) in relation to chemical and radionuclear events of public health significance. Information materials on 10 public health priority chemical issues were developed and disseminated at multisectoral meetings. Advocacy materials, including key messages and technical information on the health impacts of using lead in paint, were developed for distribution at the time of the first International Week of Action on Prevention of Lead Poisoning. National activities advocating the elimination of lead paint took place in Bangladesh, India, Nepal, Sri Lanka, and Thailand coinciding with the International Week of Action. Case-studies relevant to implementing a healthy settings approach were developed with five countries and plans were finalized to pilot the provision of essential interventions for workers’
health at the primary care level. Nepal has developed a concept note and guidelines for healthy villages, and piloting is ongoing.

23. Air pollution, especially indoor air pollution that is prevalent mostly in rural and poor communities, is recognized as an important hazard contributing to NCDs. At the Sixty-sixth Session of the Regional Committee, Member States adopted the inclusion of the indicator “the proportion of households with solid fuel as the primary source of cooking” as one of the regional targets for prevention and control of NCDs.

24. A regional tool for assessing health vulnerability was developed in collaboration with experts, Member State focal points, and WHO country office focal points for climate change and health. The tool includes aspects of non-climatic vulnerabilities, such as public leadership, governance, regulations, policy and strategy, capacity and strengthening of local and national institutions, population capacity to adapt and reduce exposure and sensitivity (including socioeconomic status), knowledge-related vulnerability, environmental vulnerability, and disease-based vulnerability.

Health-sector leadership for creating healthier environments

25. Advocacy events on environmental health determinants were held for health officials from Member States to strengthen their understanding of the linkages and direct benefits to health from prevention of environmental hazards. One such event was the Third Ministerial Regional Forum on Environment and Health in Southeast and East Asian Countries held in Bali, Indonesia, and organized in collaboration with the Government of Indonesia, the WHO Regional Office for the Western Pacific, and the United Nations Environment Programme (UNEP).

26. Studies to understand the impact of climate change on diarrhoea, respiratory tract infection, malaria, and dengue were carried out in Myanmar, Nepal, and Sri Lanka. Information from these studies will assist the Member States to develop adaptation plans to control these diseases, while looking at the impact of climate change on these diseases.

27. Bhutan, Indonesia, and Thailand participated in the third session of the International Conference on Chemicals Management and contributed to the adoption of a strategy for strengthening the engagement of the health sector in implementation of the Strategic Approach to International Chemicals Management.
Health-sector focal points, as called for under the strategy, were established in six countries – Bhutan, India, Indonesia, Sri Lanka, Thailand, and Timor-Leste.

28. Health officials from all Members States were actively engaged in various high-level regional meetings and conferences such as the Regional Forum on Environment and Health, the thematic working groups on water and sanitation and climate change, the regional meeting on chemical safety, international conferences on water quality, health-care waste management and solid-waste management, and high-level ministerial conferences (the Third East Asia Conference on Sanitation and Hygiene, and the Fifth South Asian Conference on Sanitation), which were all held in the Region.

29. The Member States contributed to the MDG monitoring reports on water and sanitation, and most countries participated in the GLAAS surveys in 2011 and 2013 (reported on in 2012 and 2014).
Nutrition, food safety, and food security

2012–2013 programme delivery highlights

- Review of national nutrition programmes in six Member States showed they had prioritized nutrition action in alignment with the Regional Nutrition Strategy. All Member States established national control and prevention programmes for key micronutrient deficiencies. A regional meeting of nutrition and food safety programme managers and focal points identified integrated approaches to address common food safety and nutrition issues.

- The draft Regional Food Safety Strategy was reviewed by Member States along with discussion on strengthening the food safety component of the IHR (2005). The strategy was then reviewed by an expert group, finalized, and disseminated to all Member States and partners.

- A review of the “regional consensus protocol” for the management of severely malnourished children showed that it was in alignment with the national protocols or guidelines of six Member States (Bangladesh, India, Indonesia, Myanmar, Nepal, and Timor-Leste). The consensus protocol was presented at a regional meeting on the management of severe acute malnutrition, organized by the Nutrition Unit of the International Atomic Energy Agency.
A regional workshop to strengthen national Codex committees and a bi-regional meeting to strengthen national INFOSAN networks and food chain systems were organized. Two publications providing information on the activities, achievements and constraints of the national Codex committees and INFOSAN focal points have been prepared and shared with Member States.
Overview

1. Several public health nutrition challenges exist in the Member States of the South-East Asia Region. These include malnutrition in all its forms in infants, children, adolescents, adults, and the elderly; micronutrient deficiencies; overnutrition and obesity; food safety; household food insecurity through the life-course; and, weakly integrated intersectoral programmatic approaches.

2. The Regional Office for South-East Asia provided support to Member States in the following areas: an integrated approach to nutrition and food safety issues; dissemination of new recommendations and guidelines on micronutrient deficiencies and management of childhood malnutrition; participation in the Codex Alimentarius Commission and International Food Safety Authorities Network (INFOSAN) meetings; expanding capacities of national food analyses laboratories; promotion of breastfeeding and appropriate complementary feeding; and, development of national food safety and nutrition strategies and plans of action.

3. Member States are undergoing a rapid and sustained socioeconomic, demographic, nutritional, and health transition. Nutrition orientation on food production policies by the Member States could ensure sustainable food production while fully meeting the nutritional requirements of the population. Available information indicates a declining trend with regard to malnutrition in children; this trend can be maintained or even accelerated through effective implementation and monitoring of the several national interventions in existence.
Partnerships and coordination for intersectoral actions, increased investment, and research

4. Member States made progress in dealing with the safety aspect of food in stable and emergency situations and in their involvement in food standards-setting activities, particularly in Bhutan, Indonesia, Maldives, Nepal, Sri Lanka, and Thailand. Member States were assisted to participate in various global and regional-level Codex and INFOSAN meetings. To further strengthen the national Codex committees, national INFOSAN networks and food chain systems, one regional and one bi-regional meeting were organized.

5. Member States participated in the FAO/WHO Codex Coordinating Committee for Asia meeting in November 2012. A regional meeting for nutrition and food safety programme managers was organized to provide a common platform to develop integrated approaches to various nutrition and food safety issues and to review the draft Regional Food Safety Strategy. Efforts are also continuing to improve the alignment of national food safety programmes with the IHR (2005).

6. The Regional Office has provided support to initiate wheat flour fortification with micronutrients, including folic acid and iron, in one state in India in collaboration with US CDC and other partners. A proposal for a baseline and end-line study is being developed to demonstrate the feasibility of wheat flour fortification in an
Successful nutrition interventions in Nepal

Significant improvement in the nutritional status of the population in Nepal has occurred over the past few years. Nepal has been able to achieve this level of success through a combination of well-designed interventions. Maternal undernutrition declined from 28% in 1996 to 18% in 2011, stunting in children below the age of 5 years declined from 57% in 2001 to 41% in 2011, and children who were underweight declined from 43% to 29% during the same period. Similar improvements in the control and prevention of various micronutrient deficiencies have been noted. Over 90% of households consume iodized salt, vitamin A supplementation has been maintained, and the prevalence of anaemia in children below the age of 5 years declined from 78% in 1998 to 46% in 2011. An estimated 70% of infants are exclusively breastfed for the first 6 months of life, 93% continue breastfeeding at 1 year and 2 years, and appropriate complementary foods are introduced in 66% of infants between 6 and 8 months of age. Reduction of underweight children in relation to the MDGs is on track, but stunting and wasting will not be achieved and inequity is increasing. The control and prevention of iodine deficiency disorders and anaemia are on track.

WHO has provided technical support in the management of children with malnutrition, development of complementary food using local ingredients, working with civil society on intrahousehold food security, strengthening the Baby-Friendly Hospital Initiative, improved enforcement of the International Code of Marketing of Breast-milk Substitutes, and a pilot project on nutrition surveillance systems. WHO is also collaborating with other international and national partners in several nutrition interventions.

Norms and standards for assessment and response to malnutrition and zoonotic and nonzoonotic foodborne diseases

7. Global guidelines, standards, and protocols on micronutrients developed by WHO headquarters and the Regional Office were disseminated to Member States and other stakeholders. These will assist countries to address emerging nutrition and food safety challenges more effectively and in conformity to the current
approaches. Information on global initiatives were disseminated to Member States and collaborating partners, including the “Scaling-Up Nutrition” initiative, a comprehensive implementation plan for improving infant, young children, and women’s nutrition, supplementation with iron and other micronutrients, and management of severe malnutrition in children. Supplementation and fortification of basic staple foods with iron and folate or folic acid were promoted for the prevention of neural tube defects as part of a joint collaboration between the Regional Office’s work on child and adolescent health and food safety. Networking and partnerships were established with several agencies and interested partners.

8. Along the same approach, an early childhood development package with integrated good feeding practices was introduced in Member States. Management of severe malnutrition in children was supported in India through early childhood development activities, while Bhutan and India were supported for weekly iron–folic acid supplementation in adolescents. Sri Lanka was supported to develop district nutrition and maternal, neonatal and child health plans using the OneHealth Tool. Eight countries – Bangladesh, Bhutan, the Democratic People’s Republic of Korea, India, Indonesia, Nepal, Myanmar, and Timor-Leste – have adopted or adapted WHO protocols and guidelines for the management of severe childhood malnutrition, iodine deficiency disorder control and prevention, food fortification, and infant and young child feeding. These efforts will enable proper approaches to address the nutrition challenges and undertake comparisons between similar interventions in different Member States.

**Monitoring, surveillance, assessment, and evaluation of nutrition**

9. Although all Member States monitor their national nutrition programmes, comprehensive integrated nutrition surveillance systems do not exist in most countries. At the time this report was prepared, all Member States of the South-East Asia Region have adopted or adapted the WHO growth standards for young children, and growth references for adolescents have been widely consulted upon. The Regional Office provided technical support for the development of appropriate growth monitoring cards in Bhutan and the Democratic People’s Republic of Korea. A regional meeting of the nutrition programme managers further stressed the importance of comprehensive national nutrition surveillance systems.

10. Foodborne disease surveillance systems in several Member States need to be strengthened, as foodborne illnesses are reported in general terms. Indonesia and Thailand have well-established information and response systems. Bhutan has
recently established a laboratory-based foodborne diseases surveillance system. A background document on the status of foodborne diseases in the Region has been prepared. Discussions have taken place with the Department of Food Safety and Zoonoses at WHO headquarters and other partners about strengthening the national foodborne disease surveillance systems.

**Development, strengthening, and implementation of nutrition plans, policies, and programmes**

11. A strategic component of the Regional Nutrition Strategy is on effective control and prevention of micronutrient deficiencies. All Member States have established national control and prevention programmes for key micronutrient deficiencies – folic acid, iodine, iron, and vitamin A. National salt iodization programmes performed well in all countries based on the availability of adequately iodized salt at household level and excretion of urinary iodine. A background document on sodium reduction and salt iodization approaches in the Region was prepared, and discussions have been held with partner agencies on organizing a regional meeting.

12. A weekly iron and folic acid supplementation strategy has been adopted for adolescents in Bangladesh and India to address anaemia and for potential benefits towards prevention of neural tube defects. It is proposed to undertake research to assess the impact of weekly folic acid supplementation on prevention of neural tube defects. Funds will be mobilized in collaboration with US CDC to conduct this research.

13. Technical support was provided to Bhutan to assess the periodic occurrence of suspected peripheral neuropathy cases in the population.

**Surveillance, prevention, and control of zoonotic and nonzoonotic foodborne diseases, food hazard monitoring, and evaluation**

14. Strengthening national food analysis laboratories and detection of food contamination, including the infrastructure and technical capacity development of the food analysis laboratories, was undertaken in Bhutan, the Democratic People’s Republic of Korea, and Maldives. The Regional Office continued to follow up with Member States on the status of national roadmaps for improving street foods. Six Member States – Bangladesh, India, Indonesia, Nepal, Sri Lanka, and Thailand – established mechanisms for assessing the magnitude of foodborne diseases and food hazards, which will enable them to investigate and respond to foodborne disease outbreaks effectively.
15. Additional work on the development of core capacities for surveillance and response to foodborne diseases and food contamination as required for implementation of IHR (2005) has been undertaken by the Disease Surveillance and Epidemiology unit in the Regional Office. The unit has been advocating Member States to establish a functional foodborne disease surveillance and response mechanism through multisectoral collaboration, as one of the core capacities required for implementation of IHR (2005).

16. Member States have been provided with assessment tools for monitoring progress in the implementation of IHR (2005) core capacities, including national capacity to detect and respond to foodborne diseases and food contamination. Improvement in the linkage between the national focal points for IHR (2005) and food safety programmes was reviewed, and collaborative areas were identified during a regional meeting of nutrition and food safety programme managers and focal points in Indonesia.

17. Following reports of marketing of formalin-contaminated poultry meat and fish in Bangladesh, Nepal, Thailand, and Timor-Leste, WHO facilitated availability of testing kits and exchange of information among affected countries. A national workshop assessed foodborne disease surveillance in India and developed an action plan for Global Foodborne Infections Network training activities in Chennai, Kolkata, Manipal, and New Delhi.

International standard-setting and development of national food control systems, with links to international emergency systems

18. Increased participation in the FAO/WHO Codex Coordinating Committee for Asia meeting, held in Japan in November 2012, enabled Member States to become involved in international standard-setting exercises as well as express their own concerns and needs and ensure that these are addressed adequately. Building technical capacity in Member States for increased participation and contribution to the activities of Codex was identified as a key area to be strengthened, and a regional workshop was organized to strengthen national Codex committees. Ten Member States established national Codex committees, and technical support was provided to Timor-Leste for its proposed membership of Codex. All 11 Member States are now linked with INFOSAN for responding to food safety alerts and food safety emergencies. In collaboration with FAO and the WHO Regional Office for
the Western Pacific, a meeting was organized to strengthen national INFOSAN networks and national food chains, and a further meeting was organized to improve risk assessment of chemicals in the food chain.

19. Two regional publications – *Overview of the International Food Safety Authority Network (INFOSAN) in the Member States of the WHO South-East Asia Region* and *Overview of national Codex committees in the Member States of the WHO South-East Asia Region* – containing current information on the national INFOSAN and Codex committees – were produced and shared with Member States, in addition to the ongoing updating of the regional database on national INFOSAN and Codex committees.
Health services, governance, financing, staffing, and management

2012–2013 programme delivery highlights


- Training programmes were developed in national capacity-building for development of national health policies, strategies, and plans; national health accounts; and health economics. Indonesia, Sri Lanka, and Thailand were supported to conduct a study on sustainable financing and reform of national health insurance systems. In December 2012, a regional workshop was organized to build capacity on evidence-based priority setting for universal health coverage. In 2013, a technical discussion on universal health coverage was undertaken to take stock and share experiences, including dissemination of global and regional findings of operations research on universal health coverage in selected countries. This allowed for broader discussion on universal health coverage at the Sixty-sixth Session of the Regional Committee.
- Six Member States made a commitment to implement the 10 recommendations of the Commission on Information and Accountability for Women’s and Children’s Health (COIA).

- Nine Member States have completed the rapid assessment of national civil registration and vital statistics (CRVS) systems, which is essential to better monitor births, deaths and causes of death, and to contribute to evidence-based policy-making.

- Two key publications on the MDGs were released presenting health-related MDG data from country reports, which showed trends for key indicators at country level as well as Region-wide analysis.

- The Regional Office’s “Health in South-East Asia” newsletter, published during the Sixty-sixth Regional Committee in September 2013, focused on universal health coverage.

- Capacity-building to strengthen research was undertaken. Support was provided to strengthen a health research unit in Timor-Leste and for the development of the Druk Medical Journal in Bhutan.

- The 400 WHO South-East Asia Region fellowships were supported in their efforts to build capacities in various public health programmes.

- A regional meeting on the role of medical education in addressing current health challenges, and a regional meeting to review progress in implementation of the strategic framework for strengthening teaching of public health in medical schools, were organized. An informal consultation on developing protocol for the assessment of health workforce education and training was held to provide standards for comprehensive country assessments of health workforce education and training.
Overview

1. The Member States of the South-East Asia Region have reaffirmed their commitment to health systems strengthening based on the principles of primary health care. The objectives of primary health care will be further realized by implementation of the Regional Strategy for Universal Health Coverage to ensure accessibility to quality health services for all. While health-care financing remains a challenge, perceptible improvements in allocations for health were evident in the Region. Efforts have been made in strengthening health infrastructure systems, human resources for health including a community-based health workforce, country capacity in development of national health policy, strategy, and plans and their management, the availability of good-quality medicines and their rational use, and health information systems including monitoring and reporting of health status and progress towards the MDGs.

2. The diversity of the social, cultural, and political situations in Member States of the South-East Asia Region is reflected in country policies and plans, health systems, and social services infrastructures. Each country has its own strategies for organizing and managing its respective health service for the benefit of its people.
Management and organization of integrated population-based health-service delivery

3. In order to face current challenges, all of the Member States in the Region have adopted an integrated population-based health-service delivery through a primary health care approach to strengthen country health systems. WHO is providing support to countries based on their agreed country cooperation strategies. All of the countries have long-term and medium-term health development plans and are at some stage of the cycle. WHO is providing continuous support for Member States to develop their national health policies, strategies, and plans in line with national development agendas, as well as the Paris Declaration on Aid Effectiveness, the Accra Agenda for Action, and other conventions, declarations, and global health agendas.

4. Bhutan, Indonesia, Myanmar, Sri Lanka, and Timor-Leste commenced their medium-term plans in 2012 and India developed a comprehensive plan to achieve universal health coverage by 2020. All these plans have been developed with a primary health care approach, considering the challenges that they have to address. A community-based integrated health services delivery system is one of the strategies adopted in these plans.

National capacity for governance and leadership

5. The Regional Office supported the strengthening of national capacity in development of national health policies, strategies, and plans. Health challenges facing each country are taken into account, especially in light of the rising burden of NCDs in the Region. Regional training programmes were developed in national health policies, strategies, and plans; national health accounts; and health economics. In 2012, the Regional Office together with Mahidol University in Bangkok, Thailand developed six training modules on national health policies, strategies, and plans. In 2013, a six-day training workshop was conducted for 30 participants from six selected countries in the Region to familiarize them with the modules. These participants received all training materials and modules to enable them to conduct national and subnational training programmes. Additionally, the Regional Office assisted in generating evidence for policy and supported the evaluation of the first decade of Thai universal health coverage by the Health Systems Research Institute and Chulalongkorn University in Bangkok, which conducted a three-country study on sustainable financing and reform of national health insurance systems in Indonesia, Sri Lanka, and Thailand.
Thailand’s Universal Coverage Scheme: achievements and challenges

After four decades of health infrastructure development and three decades of designing and implementing a number of different financial risk protection schemes, Thailand achieved universal health coverage in 2002. This meant that all Thais were covered by health insurance, guaranteeing them access to a comprehensive package of health services. Although many factors contributed to this achievement, the most significant was an ambitious reform known as the Universal Coverage Scheme.

Within one year of its launch in 2001, the Universal Coverage Scheme covered 47 million people, or 75% of the Thai population, including 18 million people who were previously uninsured. The remaining 25% of the population were government employees, retirees, and dependents who remained under the Civil Servant Medical Benefit Scheme, and private-sector employees, who continued to have their healthcare costs paid for by the contributory Social Security Scheme. The Universal Coverage Scheme was remarkable not only for the speed of its implementation, but also because it was pursued in the aftermath of the 1997 Asian financial crisis, when gross national income was only US$ 1900 per capita, and against the advice of some external experts who believed the scheme was not financially viable.

Even more impressive was the impact made by the Universal Coverage Scheme in its first 10 years. The scheme improved access to necessary health services, improved equity of service utilization, and prevented medical impoverishment. Between 2003 and 2010, the number of outpatient visits per member per year rose from 2.45 to 3.22 and the number of hospital admissions per member per year rose from 0.094 to 0.116. Data from 2010 point to a very low level of unmet need for health services in Thailand. Impoverishment, as measured by the additional number of nonpoor households falling below the national poverty line as a result of paying for medicines and health services, decreased significantly from 2.71% in 2000 (prior to the Universal Coverage Scheme) to 0.49% in 2009.

Despite this impressive list of accomplishments, some other important areas that were part of the ambitious Universal Coverage Scheme – such as the strengthening of primary health care, effective primary prevention, and reliable referral systems – saw less evidence of the anticipated impacts. Moreover, assessing the lack of significant progress towards harmonizing the three insurance schemes revealed a set of important challenges related to politics and the power dynamics of institutional reform.

Coordination of mechanisms to achieve national targets for health systems development and global health goals

6. There are many different partners and donors assisting the Member States to develop and strengthen country health systems and special health programmes. The International Health Partnership (IHP+) funding platform in Nepal and donor assistance to Myanmar are examples of multisectoral donor assistance, which needs to be well coordinated in the countries. WHO actively supports Member States in donor coordination, in line with the Paris Declaration on Aid Effectiveness.

7. The WHO Regional Office for South-East Asia, together with the Regional Office for the Western Pacific, organized a biregional workshop to monitor the GAVI Alliance’s health systems strengthening projects and to speed up implementation by resolving issues. WHO headquarters, UNICEF, and GAVI Alliance also participated in this workshop. In addition, Bhutan, Myanmar, and Timor-Leste were supported to conduct health systems assessments during 2012–2013 and Timor-Leste was supported to develop a health systems strengthening proposal to be submitted to GAVI Alliance for funding.

Country health information systems

8. Following the 10 recommendations of COIA to strengthen accountability for results and resources, six Member States were prioritized by the Commission – Bangladesh, the Democratic People’s Republic of Korea, India, Indonesia, Myanmar, and Nepal. A regional workshop attended by 10 Member States was conducted to translate the recommendations of COIA into action plans. Five of the six Commission countries have completed national consultative workshops to develop roadmaps for action. The roadmaps identified priority areas of focus: birth and death registration; results monitoring; maternal death reviews and surveillance; strengthening the use of information and communication technology (ICT); resource tracking; national mechanisms for reviews and accountability; and advocacy. Catalytic funding has been provided and implementation of the COIA roadmaps is ongoing with several activities accomplished.

9. National health information systems strengthening through implementation of the 10-Point Regional Strategy for Strengthening Health Information Systems was addressed during various country visits and meetings. The application of open source systems for the collection, validation, analysis, and presentation of aggregate
data – such as the Open Medical Record System (OpenMRS) enterprise electronic medical record system platform – are being implemented in Bangladesh, Bhutan, the Democratic People’s Republic of Korea, and Nepal to improve the disaggregated information recording and reporting from the grass roots level. This will support in monitoring of universal health coverage by capturing disaggregated information on the population’s access to health facilities and health programmes.

10. The Regional Office has been providing technical support to Member States for strengthening CRVS systems. Rapid assessments of CRVS systems have been completed in all 11 countries. Following the rapid assessment, comprehensive assessments of the CRVS system have been completed in seven countries and are under progress in a further three, with a focus on improving birth, death, and causes of death data to better contribute to evidence-based policy-making. Based on the findings of the assessment, strategic plans for improvement of CRVS systems are being developed in the countries. For the one remaining country, India, given the population size, a different approach to strengthening CRVS is being discussed, whereby a representative sample of the population will be used before eventually moving towards full coverage. Based on the lessons learnt from the comprehensive assessments about health’s contribution to strengthening CRVS, an electronic cause of death integrated reporting system (eCODIRS) concept has been developed. The eCODIRS will support achieving better coverage and completeness of the birth and death registration component of civil registration while improving the vital statistics. The rationale behind the eCODIRS is to mobilize and empower community health workers to conduct verbal autopsies for all deaths to improve mortality statistics from routine CRVS data. The eCODIRS is being piloted in Bangladesh, Indonesia, Nepal, and Timor-Leste.

Knowledge and evidence for health decision-making

11. To promote proper health decision-making based on accurate health information and evidence, MDG monitoring has been intensified. A brochure on Health-related Millennium Development Goals 2012 and a publication Achieving the health-related Millennium Development Goals in the South-East Asia Region: measuring indicators 2012 were published, providing health-related MDG data by country and analysis of key indicators at country and regional levels.

12. The Regional Office continued to work on the Regional Health Observatory to increase access to available data and stimulate the future collection of complete,
reliable, and accurate data. The Regional Health Observatory addresses the growing demand for health information at regional and country levels. It integrates multiple datasets into a single, easy-to-use database; this enables comparisons between global estimates available in the Global Health Observatory and nationally reported indicators and statistics. The prototype for the Observatory has been designed and developed by the Regional Office, and full-scale implementation will follow. Nationally reported and regionally compiled data on 12 programmes and an extensive list of health indicators, including MDGs, are available by country and year.

13. Recognizing that the field of eHealth is rapidly transforming the delivery of health services and systems, technical support in developing eHealth policy and strategy was provided to Member States. To provide unified direction and political support for eHealth policies at the national level, a Regional eHealth Strategy was developed by the Regional Office and adopted by Member States at the regional high-level meeting on eHealth/mHealth held in Bangkok, Thailand in November 2013. The Bangkok Declaration on eHealth to galvanize political commitment for prioritizing eHealth at the highest level was also endorsed by Member States at the aforesaid meeting. The Regional Office is providing technical support to countries for the development of eHealth national strategies, human resources and ICT plans for eHealth, and the establishment of national eHealth steering committees. A WHO and International Telecommunication Union (ITU) regional workshop on supporting countries to use the WHO/ITU tool to develop national eHealth strategies was held in October 2013, and representatives from ministries of health and/or ICT participated from 10 Member States of the Region.

14. Workshops in health data standards awareness were conducted at the country level. To institutionalize health data standards as part of eHealth architecture, a concept paper has been developed to introduce the Open Health Information Exchange (OpenHIE) as a standard for all health and hospital information subsystems at the national level. OpenHIE has been engaged to integrate standard registries for providers, facilities, assets, locations, and terminologies with the eCODIRS system, in order to provide a platform for national shared health records.

15. A telemedicine service network was established to increase accessibility and equality of health-care services to people living in remote and hard-to-reach areas in Bhutan, the Democratic People’s Republic of Korea, Maldives, and Sri Lanka. This contributes to the overall goal of achieving universal health coverage by providing means to reach the unreached with services.
National health research for development of health systems

16. The underlying complexity of human health problems necessitates that research for health development requires the involvement of disciplines from other sectors that have a bearing on health. These sectors include agriculture, industry, environment (water supply and sanitation, climate change), housing, social sectors, and transportation. Studies to collect information on research for health carried out by non-health sectors were conducted in Bangladesh, Indonesia, and Thailand. Draft strategic directions in building and strengthening research for health carried out by non-health sectors have been developed for the Region.

17. National capacity in health research has been further strengthened in most countries in the Region. National training on research methodology has been conducted in several countries. In Bangladesh, training on operations research in reproductive health for programme managers and phase-wise capacity-building has been completed for a group of 20 health professionals. Training on research methodology and technical support for the development of the Druk Medical Journal have been provided to Bhutan. Several small research grants have been provided to young researchers in Bhutan and Nepal. In Myanmar and Sri Lanka, an ethics workshop and training were supported. Training and technical support to strengthen the health research unit in Timor-Leste was provided.

18. To establish linkages between researchers and decision-makers, two intercountry workshops on using research evidence for policy-making were organized in Maldives and Nepal and attended by participants from Bangladesh, Bhutan, Maldives, Myanmar, Nepal, Sri Lanka, and Thailand. Public health studies have also been promoted in Bangladesh and Sri Lanka.

19. The Thirty-third Session of the South-East Asia Advisory Committee on Health Research took place in Bangkok, Thailand in July 2013. The final recommendations stated that ethics on research will not only cover ethics on proposal development, but all the stages of research from proposal development through to data management and publication. All aspects of research need ethical consideration, including: codes of ethics for the researcher; health systems research to strengthen management and development of any programme; and clinical research, particularly in the context of the globalization of research.

20. To address the major issues in clinical trials, the Regional Office organized an expert group consultation in New Delhi, India, which recommended: capacity-building
of stakeholders involved in clinical trials, including training in the development of the WHO International Clinical Trials Registry Platform; improving the quality and safety of clinical trials; and, providing technical support to Member States of the Region.

Knowledge management

21. The specific needs of health libraries were identified through technical visits and a direct consultative process with the institutions concerned in all countries of the Region. Based on a needs assessment, essential public health and medical publications were provided to libraries in Bhutan, Indonesia, Maldives, Nepal, Thailand, and Timor-Leste. Offline resources on DVD-ROM and external hard disks (to be regularly updated) were provided for libraries in the Democratic People’s Republic of Korea. “Blue trunk libraries” were sent to Bhutan, the Democratic People’s Republic of Korea, Indonesia, Maldives, Myanmar, Nepal, and Timor-Leste.

22. The regional website was redesigned and restructured, allowing for faster and easier online access to regional publications, databases, and repositories. Web conferencing tools for training activities have been promoted and more systematically used, both with WHO country offices and counterparts in countries.
A Health InterNetwork Access to Research Initiative training was organized in the Democratic People’s Republic of Korea, and a training of trainers programme was started in Nepal.

23. A library management workshop was organized in Colombo, Sri Lanka with participants from Bangladesh, Indonesia, Maldives, Nepal, Sri Lanka, Thailand, and Timor-Leste, including focal points from WHO country offices. Study tours on library management were organized for participants from the Democratic People’s Republic of Korea, Myanmar, and Sri Lanka.

24. The WHO South-East Asia Journal of Public Health continues to provide a platform for researchers in the Region, and is gaining a wider audience: the journal pages are some of the most visited of the WHO South-East Asia Region’s website. Peer review of articles received has been strengthened with the addition of a statistics review panel.

25. In collaboration with WHO headquarters, the knowledge management team in the Regional Office and country offices contributed to organizational learning by providing briefing and training sessions on essential online resources, the Cochrane Library, PubMed searching techniques, publishing policy, copyright and related issues, publishing research articles, and writing and revising texts.

26. The Regional Office bookshop participated in book fairs in India, Nepal, and Sri Lanka, thereby providing higher visibility and improved access to the work and publications of WHO.

Health workforce information and knowledge

Human resources for health

27. Suggested actions for development of national human resources for health (HRH) observatories in the Region were formulated to support Member States in developing a platform where key stakeholders from all concerned sectors could interact in addressing HRH challenges in their respective countries through the use of valid and reliable HRH information. The Regional HRH Observatory is available on the South-East Asia Region’s website. Four HRH country profiles – Bangladesh, Indonesia, Thailand, and Timor-Leste – are available. Countries are encouraged to upload a profile to their national HRH observatory.
28. The WHO Fellowship programme, including study tours, continues to be one of the key methods for strengthening human resource capacity in Member States. During 2012–2013, 400 fellowships were awarded (see Table 10.1). Among those, 234 (59%) studied or trained in public health, with 166 (41%) in clinical areas. A reasonable gender balance in nominations made by Member States was achieved and resulted in 222 men (55%) and 178 women (45%) as fellows.

29. Studies in regional training institutes ($n=384$) continued to receive priority over studies in institutes outside the Region ($n=16$). India and Thailand continue to host the most venues for training. During the past few years, there has been an increasing trend towards use of short-duration group trainings or study tours.

**Nursing and midwifery**

30. Quantity and quality of the nursing and midwifery workforce needs to be strengthened. In order to increase the workforce, Bhutan sent students to study for bachelor degrees in nursing and midwifery in India and Thailand. Meanwhile, India is gradually increasing the number of nursing schools and expanding its admission capacity. The Nursing Council in Sri Lanka is being supported to draft
its first nursing educational standards. In collaboration with WHO headquarters and other regional offices, the *Midwifery educator core competencies* have been developed and published.

31. Myanmar was supported in developing their strategic directions for nursing and midwifery development plan, 2013–2017. The directions will lead to strengthening of the nursing and midwifery workforce, education, and service in support of health system strengthening, as well as for resource mobilization.

32. Ten Member States participated in the Sixth Asia Pacific Emergency and Disaster Nursing Network meeting (APEDNN) in 2012. Nurses who participated in the response to disasters in Indonesia (earthquake) and Thailand (floods) and Sri Lanka’s preparedness and response activities shared their experiences. Indonesia’s Disaster Nurse Association received support to develop an educational framework and course for undergraduate nursing students. The Seventh APEDNN was held in Bangkok, Thailand in 2013. The theme was community resilience. The experiences of governments, civil society, the Thai Red Cross Society and community were shared. A draft checklist on the role of nurses and midwives in supporting community resilience was agreed.

<table>
<thead>
<tr>
<th>Member State</th>
<th>Fellowships awarded</th>
<th>Study tours awarded</th>
</tr>
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<tbody>
<tr>
<td>Bangladesh</td>
<td>49</td>
<td>17</td>
</tr>
<tr>
<td>Bhutan</td>
<td>8</td>
<td>30</td>
</tr>
<tr>
<td>Democratic People’s Republic of Korea</td>
<td>111</td>
<td>82</td>
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<tr>
<td>India</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Indonesia</td>
<td>8</td>
<td>6</td>
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<tr>
<td>Maldives</td>
<td>25</td>
<td>9</td>
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<tr>
<td>Myanmar</td>
<td>101</td>
<td>54</td>
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<tr>
<td>Nepal</td>
<td>14</td>
<td>96</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>62</td>
<td>32</td>
</tr>
<tr>
<td>Thailand</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>11</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>400</strong></td>
<td><strong>362</strong></td>
</tr>
</tbody>
</table>
33. In order to accelerate the commitment of Member States to invest in HRH and strengthen HRH management and health systems-based primary health care, a regional consultation was organized. Countries reported their respective progress towards implementation of the HRH declarations and resolutions. Priority issues, challenges, and strategic actions in HRH management in the Region, along with country plans, were discussed.

34. A regional meeting on the role of medical education in addressing the current health challenges critically reviewed the proposed strategic framework for strengthening undergraduate medical education in addressing health challenges. This framework will guide countries on factors to be considered, as well as strategic directions and actions to be carried out, in order to produce medical doctors who have clinical and public health competencies and other broader competencies to meet the needs of health systems.
Health system financing

Health financing policy and interpretation

35. The Sixty-fifth Session of the Regional Committee for South-East Asia adopted resolution SEA/RC65/R6 – Regional Strategy for Universal Health Coverage. The strategy consists of four strategic directions: (1) placing primary health care-oriented health systems strengthening at the centre of universal health coverage; (2) improving equity through social protection; (3) improving efficiency in service delivery; and (4) strengthening capacities for universal health coverage.

36. During 2012–2013, in collaboration with ministries of health in Member States, efforts were renewed towards universal health coverage by reviewing national health policies and strategies in an effort to accelerate progress. Under the leadership of the WHO representatives, support was provided to countries to strengthen universal health coverage. This included: Bangladesh’s draft of a health investment plan linked into a five-year national plan, as well as annual plans and endorsement of the health-care financing strategy, 2012–2032; a health systems assessment for scaling up universal health coverage in Bhutan, including methods to measure coverage; the establishment of a multiagency group of development partners – the Partnership for Universal Coverage – to support the Government of Indonesia’s planning process; a review of Maldives’ health financing and health system functions; consultations in Myanmar to identify options for a national universal health coverage strategy; Nepal’s drafting of a national health insurance policy and scheme design for universal health coverage; and, dialogue in Timor-Leste based on the second five-year national health plan to advance universal health coverage, including alignment for donor contributions.

Norms, standards, and tools for tracking resources, estimating the economic consequences of illness, and the costs and effects of interventions

37. In addition to direct support on policy and strategies, WHO also supported national capacity-building as a priority area. National health accounts institutionalization has been completed in Bhutan and initiated in Maldives and Nepal. Trained technical team members are now providing cross-country support.

38. A two-week health economics module was piloted in partnership with the University of Public Health in Yangon, Myanmar, which has been developed as a
part of the Master’s in Public Health degree programme. The module was also conducted in Nepal in collaboration with the Institute of Medicine, Tribhuvan University, Kathmandu.

39. The Regional Office documented experiences in the application of the strategic directions for universal health coverage in the Region through operations research involving experts and ministry of health officials. These studies focused on key linkages between financing and the health-system building-blocks for a comprehensive universal health coverage policy and strategy effort. Furthermore, the studies have been written up as journal articles and supported by the Regional Office for publication as a special supplement to the international journal Health Policy and Planning. To flag the importance of health intervention and technology assessment in making efficient investment choices and setting priorities for universal health coverage, resolution SEA/RC66/R4 – Health Intervention and Technology Assessment in Support of Universal Health Coverage – was adopted by Member States during the Sixty-sixth Session of the Regional Committee in September 2013.

40. Training on national health accounts, based on the System of Health Accounts 2011, was conducted in Indonesia and Timor-Leste. A regional training on the OneHealth Tool was held to facilitate national health planning. This tool has been
designed in collaboration with development partners to align support to country processes. It allows costing by systems areas as well as interventions.

**Norms, standards, and tools to support Member States to quantify and decrease the level of unsafe health care provided**

41. Quality and safety of health care is still not a high priority in the Region’s health agenda, but it is an upcoming area as the Region becomes more popular for medical tourism. India, Sri Lanka, and Thailand are the most popular medical tourism destinations and Indonesia is also gaining in popularity. Member States have realized the importance of the safety of health care provided, and are taking measures to prevent health care-acquired infections and medical mismanagement. The South-East Asia Region is making good progress towards introducing patient safety programmes.

42. The Regional Office, together with Member States, promoted and participated in the “SAVE LIVES: Clean Your Hands” campaign and shared promotional materials with countries. The annual May campaign was very successful in the Region. The Regional Office for South-East Asia also joined the Regional Office for the Western Pacific and OECD in organizing the first Consultation on the Health Quality Improvement Network in the Asia-Pacific Region, held in Manila, Philippines in November 2012, as part of an effort to identify country needs and plan patient safety programmes for the next five years.

43. The Regional Office supported and contributed to the patient safety and quality of care programme in Sri Lanka by supporting the first national consultation on patient safety and initiating a series of regional seminars. The Regional Office also contributed to the work of the National Accreditation Board for Hospitals and Healthcare Providers of India, to promote hospital accreditation and develop collaboration between the Board and the Quality Secretariat of the Ministry of Health in Sri Lanka.
Access, quality, and use of medical products and technologies

2012–2013 programme delivery highlights

- Technical support was provided to all countries on various aspects of drug management, including updating essential medicines lists and clinical guidelines, revision of national drug policies, and strengthening of drug supply and regulatory systems.

- Following the adoption of Regional Committee resolution SEA/RC64/R5 in 2011, situational analyses of the pharmaceutical sector have been completed in all 11 Member States (including two states in India).

- A regional consultation on effective management of medicines was conducted in April 2013 in Bangkok, Thailand. All Member States presented their experiences of the situational analyses and subsequent progress. A set of recommendations were made that were incorporated into resolution SEA/RC66/R7 on Effective Management of Medicines, adopted in September 2013.
The national regulatory authorities of the three major vaccine-producing countries – India, Indonesia, and Thailand – were assessed functional in 2012, which contributed significantly to improved access to vaccines of assured quality both in the Region and globally. The national control laboratories network (including India, Indonesia, and Thailand) produced reference material for testing of pertussis vaccine and will expand (with China and Viet Nam) to produce reference material for testing of Japanese encephalitis and monovalent oral polio vaccines.
Overview

1. Medicines, medical products, and technologies are an essential part of health care. An effective, efficient, and equitable health system requires a well-controlled, responsive, and functional pharmaceutical sector. A country pharmaceutical profile questionnaire sent to ministries of health in 2007 and 2011 indicated that numerous drug policies in many Member States, both globally and within the South-East Asia Region, were either not implemented or were only partially implemented. Situational analyses of the pharmaceutical sector performed during 2010–2013 in South-East Asian countries indicated that often drug supply systems are poorly organized and managed, quality of drugs available in the market cannot be assured, drug regulation is weak, and irrational use of medicines is rampant.

2. In the past decade, the Region has emerged as a major producer of medicines, with pharmaceutical industries within some countries supplying essential medicines on a global scale. However, the national regulatory authorities – the institutions in charge of regulation of medicinal products – do not receive the investment and financial support needed to cope with the regulatory challenges posed by new technologies and the increased complexity of medicines (produced domestically or imported). Private investors have been fast to mobilize resources to build state-of-the-art production lines, whereas governments have been slow to reform, restructure, and invest in regulatory systems to keep up with their duties in regulating the pharmaceutical industry and ensuring the production/import of medicinal products of assured quality.
3. WHO collaborates with partners to collect, process, and disseminate evidence of the situation and use it in advocacy for action. International and regional conferences and meetings on drug policy, regulation, and use are regularly undertaken to facilitate exchange of information, increase awareness of problems, and develop plans to effectively address any issues.

4. Major international partners and stakeholders on drug policy and the rational use of medicines include the WHO collaborating centres for pharmaceutical policy in Newcastle, Australia, and at Harvard University in the United States of America. Important partners in countries include drug regulatory authorities and departments responsible for drug supply in the respective ministries of health. The Government of Thailand’s Bureau of Drug and Narcotic, Department of Medical Sciences – a WHO collaborating centre – tests drug samples from many Member States in an effort to ensure drug quality.

5. For the safety, quality, and efficacy of medicines, WHO – through the five-step capacity-building approach – provides technical assistance to countries in the Region to strengthen their national regulatory authority for vaccines, to comply with the WHO prerequisite to prequalified vaccines that requires an assessed, functional national regulatory authority.
Supporting access, quality, and use of essential medical products and technologies

6. WHO supported a number of international conferences including the Asia Pacific Conference on National Medicines Policies held in Sydney, Australia in May 2012, attended by approximately 30 participants from the Region, where advocacy was undertaken with regard to drug policy and access to medicines. The Regional Office participated in the Scientific Committee of the conference. In addition, India participated in the Ministers Summit on “The benefits of responsible use of medicines: setting policies for better and cost-effective healthcare” held in October 2012 in Amsterdam, the Netherlands; however, no resolution came out of the summit.

7. Support was provided to all countries on updating essential medicines lists and clinical guidelines, revision of national drug policies, and strengthening of drug supply systems.

8. The Regional Office continued to collaborate with partners, including the WHO Collaborating Centre for Pharmaceutical Policy at Harvard University in the United States, to manage the WHO database on drug use, as well as the University of Newcastle, Australia and the WHO Regional Office for the Western Pacific to run the Asia Pacific Conference on National Medicines Policies.

Traditional medicine

9. The South-East Asia Region provided support to undertake a global survey on the development of traditional medicine and continued to support the HerbalNet Digital Repository. Two centres in India – the Morarji Desai National Institute of Yoga, New Delhi, and Gujarat Ayurved University, Jamnagar – were designated as WHO collaborating centres for traditional medicine in 2013.

10. In addition, WHO supported the First International Conference on Health Science, Thai Traditional and Alternative Medicine, hosted by the Faculty of Medicine, Mahasarakham University, Thailand. The main objectives of this conference were to: exchange knowledge, content, experience, and academic skills; present research in health sciences and traditional and alternative medicine; and establish a network to improve the opportunity and ability to do collaborative research among academics.

11. WHO supported Thailand in the production of a new medicine plant list and Indonesia in translation of the herbal pharmacopoeia, which contains 171 monographs, from Bahasa into English. The Organization also provided technical
and financial support to Bhutan for the development of monographs on the use of traditional medicine for 27 common conditions treated in primary care.

12. WHO supported the Government of India to conduct an international conference on traditional medicine for countries of the Region, which was held in New Delhi in February 2013. At this conference, Member States adopted the Delhi Declaration on Traditional Medicine for South-East Asian Countries. This Declaration affirms increased cooperation, collaboration, and mutual support among all South-East Asian countries in all spheres of traditional medicine in accordance with national priorities, legislations, and circumstances.

13. A regional expert group meeting on strengthening research capacity on safety, efficacy, and quality of traditional medicine was conducted in December 2013 in New Delhi, India. This meeting was attended by 10 Member States, who presented their experiences with regard to research in traditional medicine. Recommendations for Member States and WHO were made covering the areas of research on efficacy, safety, quality of care, and integration of traditional medicine into conventional health care.

**Strengthening research capacity in traditional medicine**

A regional expert group meeting on strengthening research capacity in traditional medicine was held in December 2013. Ten of the 11 Member States of the South-East Asia Region participated. The general objective of the meeting was to promote good quality of care and appropriate use of safe, quality, and efficacy-assured traditional medicine through research capacity-building in Member States.

The following are some selected key recommendations for WHO:

- to develop research methodology (not currently available) to evaluate procedure-based therapies;
- to facilitate development of standard operating procedures/generic protocols/clinical practice guidelines/benchmarking for the practice of traditional medicine treatments including procedure-based therapies;
- to provide technical support for research methodologies to evaluate quality of care and integration of traditional medicine into national health-care systems;
- to strengthen pharmacovigilance systems to ensure the safety of traditional medicines.
Blood safety

14. The WHO Global Database on Blood Safety is a system to collect data on blood transfusion services of Member States worldwide. It addresses concerns about the availability, safety, and accessibility of blood for transfusion. All the Member States of the Region contributed to this system of the WHO global database. Submitted data are being further refined and completed with the help of Member States. The focus of the data analysis is to provide information on the current status of blood transfusion services, assess country needs in improving blood safety, formulate strategic recommendations, plan and implement activities, and evaluate progress.

15. World Blood Donor Day was celebrated on 14 June 2012 and 2013 in all Member States. Through advocacy, voluntary blood donation has increased across the Region, and now approximately 15.6 million units of blood are collected annually. WHO continues to provide technical support for equitable access to, and rational use of, safe blood.

16. Infrastructure for enhancing capacity of blood transfusion services to improve screening of donated blood for transfusion transmissible infections was strengthened in Bangladesh, Bhutan, and Nepal utilizing resources made available by the Organization of Petroleum Exporting Countries (OPEC) Fund for International Development. The countries in the Region each screen nearly all (98–100%) donated blood for HIV and hepatitis B and C. The project is directed towards: mapping existing facilities; assessing gaps; facilitating policy dialogue; developing national standards, guidelines, and standard operating procedures; implementing quality systems; facilitating participation in external quality assurance; and instituting internal quality systems to strengthen blood transfusion services. Trainings have being conducted on data and information management systems. Study tours to strengthen blood transfusion services were organized at the WHO Collaborating Centre for Training in Blood Transfusion Medicine in Bangkok, Thailand.

17. The Regional Office is also supporting 14 laboratories across the Region for their participation in an external quality assessment scheme for HIV serology conducted by the National Reference Laboratory in Melbourne, Australia (a WHO collaborating centre) to ensure quality screening of donated blood.

International norms for quality, safety, efficacy, and cost-effective use of medical products and technologies

18. The Fifteenth International Conference of National Regulatory Authorities was held in Tallinn, Estonia, in October 2012 and attended by 10 of the 11 Member
States of the South-East Asia Region. In addition, many Member States from the Region participated in, and India was vice-chair at, the first meeting of the new global Member State mechanism on substandard/spurious/falsified/falsely-labelled/counterfeit medicines. Technical support was provided to Bhutan and Maldives concerning drug supply, a workshop on good manufacturing practice and dossier evaluation for drug registration was organized in Sri Lanka, and drug quality testing was facilitated in Bangladesh. Training of drug regulators was supported through the WHO collaborating centres in Malaysia, Singapore, and Thailand, which also helped to ensure the quality of medicines by testing samples sent from Member States. A regional meeting on drug testing laboratories was held in April 2013 at which all Member States presented their current situation and recommendations were made for the way forward.

**Vaccine safety**

19. WHO provided technical and financial support to Myanmar and Nepal for an orientation on adverse events following immunization (AEFI) causality assessment. Technical support and seed funds were provided to India for the establishment of a national AEFI Secretariat. Indonesia implemented a pilot project on post-marketing surveillance in 11 districts with funding and technical support from WHO. In Bangladesh, refresher training was provided for AEFI committee members. The AEFI causality assessment algorithm under development by WHO was field-tested in Myanmar and Sri Lanka prior to its finalization.
20. In the area of regulation, following an assessment of the national regulatory authority of Bangladesh in 2009, the institutional development plan was revised to include additional activities for implementation in 2013. These included building staff capacity in regulating clinical trials and conducting regulatory inspections of vaccine producers. The national control laboratory, including the drugs control laboratory, was upgraded and refurbished with new supplies and equipment. Staff training on quality management systems and regulatory inspection was conducted. The laboratories will soon be operational following repairs to the facility in response to an accident. The Government of Bangladesh is strongly committed to establishing quality systems because of emerging vaccine production in the country. In October 2012, the WHO Vaccine Supply and Quality team visited the Bangladesh national regulatory authority and the vaccine manufacturer Incepta, initiated the self-assessment of the national regulatory authority and national control laboratory, and updated the institutional development plan. In December 2013, the Bangladesh national regulatory authority worked further on analysing the self-assessment within a WHO workshop organized in Bali, Indonesia.

21. WHO assessed the national regulatory authorities in Indonesia, India, and Thailand, and all three were declared to be functional. These countries are vaccine-producing countries, whose portfolio of vaccines include WHO prequalified products. The three vaccine-producing Member States produce vaccines for the domestic and export markets. Additionally, the national regulatory authorities of Myanmar and Nepal were assessed in order to update institutional development plans and initiate self-assessments.

22. Myanmar has recently expressed interest in expanding their production of hepatitis B vaccine. To assist the Government of Myanmar to make an informed decision in regards to vaccine procurement policy, WHO in partnership with the National Agency of Drug and Food Control in Indonesia (the national regulatory authority) organized a study tour for a group of vaccine specialists from Myanmar to observe the regulatory requirements for oversight of the safety, quality, and efficacy of locally-produced vaccine in-country, and allowed the exchange of experience and ideas with Indonesian regulators, manufacturers, and immunization programme managers.

23. An informal technical meeting of the national control laboratories network – comprising the members India, Indonesia, and Thailand – was held in Yogyakarta, Indonesia. National control laboratory representatives from China and Viet Nam were invited as observers. During this meeting, significant progress was made
towards development of Regional Working Reference Standards (RWRS) for Japanese encephalitis and polio vaccines, establishment of a central storage facility for RWRS, and establishment of a proficiency testing programme. A framework agreement to obtain government commitment to formally establish the national control laboratories network was presented and a new draft was developed.

24. Support was provided for the development of guidelines on regulation of variations and Good Manufacturing Practices for biological products, as well as for the implementation of the Guidelines for independent lot release of vaccines by regulatory authorities.

Use of medical products and technologies by health workers and consumers

25. WHO continued to provide technical advice and support for training programmes, as requested. A regional course on promoting the rational use of medicines in the community was supported through the Indian Institute of Health Management Research. The Regional Office supported an ASEAN workshop on promoting the rational use of antibiotics in Indonesia. The Better Medicines for Children project in India, funded by the Bill & Melinda Gates Foundation, trained pharmacists in
Situational analyses of the pharmaceutical sector in 11 countries

During 2010–2013, situational analyses of the pharmaceutical sector were undertaken in 11 Member States (including two states in India). Each analysis was followed by a national workshop where the results were presented, problems were identified and prioritized, and recommendations for a national plan to promote rational use of medicines were made. A rapid survey of drug use in primary care was undertaken in each country and the following results were found:

- over 70% of patients with upper respiratory tract infection received antibiotics inappropriately;
- the percentage of prescribed drugs belonging to the national essential medicines list was, on average, 94% in public primary care facilities, 80% in public hospitals, and 52% in private retail pharmacies;
- the percentage of drugs prescribed by generic name was, on average, 77% in public primary care facilities and public district hospitals, and 50% in referral hospitals, but only 23% in private retail pharmacies;
- 25% of all patients were prescribed vitamins inappropriately (mostly vitamin B complex or multivitamins);
- countries where governments supply drugs to the public sector complained of stock-outs and were hampered in stock management by manual systems and lack of monitoring.

The findings were discussed in a regional consultation conducted in April 2013, attended by all Member States. It was recommended that Member States should:

- establish and sustain a multi-stakeholder committee at the national level to formulate and monitor policy; update the national essential medicines list, formulary and clinical guidelines; and allocate resources and identify executive units to implement its policies;
- establish drug and therapeutic committees in all hospitals to monitor medicines use and oversee policy implementation;
- establish, implement and sustain pharmacovigilance programmes;
- institutionalize continuous professional development on the essential medicines concept and rational use of medicines for all health-care professionals;
- include the essential medicines concept and rational use of medicines in undergraduate curricula of health professionals;
- include the safe and prudent use of medicines in public health education messages and consumer forums;
- appropriately regulate the private retail pharmacy services and promote good pharmacy practice;
- establish/strengthen capacity for health technology assessment to support evidence-informed decision-making for medicines selection, financing and supply.

These recommendations were included in resolution SEA/RC66/R7 – Effective Management of Medicines – which was adopted by Member States of the South-East Asia Region in September 2013.
Odisha state and paediatricians in Chhattisgarh state on the appropriate use of children’s medicines. Situational analyses undertaken in 11 countries during 2010–2013 found high rates of irrational use of medicines (see Situational analyses of the pharmaceutical sector in 11 countries), and weak and poorly-resourced drug supply and regulatory systems in most countries. The findings were discussed during a regional consultation held in April 2013. Recommendations from the regional consultation covered drug supply, use, regulation and policy, and included the following actions.

- Investing in drug supply systems by: establishing an electronic drug inventory system from central to peripheral levels and analysing the data for better stock management; establishing prequalification systems to ensure drug quality; ensuring adequate and timely financial allocation for procurement; and, considering outsourcing of procurement and distribution to specialized agencies.

- Investing in drug regulatory authorities to ensure adequate human and financial resources to undertake all functions; and working towards regional regulatory convergence and information sharing.

- Establishing and sustaining a multi-stakeholder committee to formulate and monitor policy, maintain essential medicines lists and standard treatment guidelines, promote rational use of drugs, and identify executive units and allocate resources to them.

26. These recommendations were incorporated into resolution SEA/RC66/R7 – Effective Management of Medicines – which was adopted in September 2013, and endorsed the approach of undertaking a situational analysis every four years and requested that the Regional Office develop a tool for countries to conduct such analyses themselves. WHO was also requested to hold a regional consultation every four years to share information and discuss progress.

27. WHO’s technical and financial support are crucial in making progress since few other partners are working in this field. Country visits to undertake situational analyses, followed by a national stakeholder workshop to plan future activities, have worked well because the outlay of staff and time is minimal. Efforts to increase capacity of human resources with expertise in pharmaceuticals and the ability to follow up and implement recommendations made during the situational analyses would be improved with increased funding and resources. A regional consultation to discuss progress and future capacity-building in this field was held in April 2013 and countries endorsed the utility of the situational analysis approach.
Leadership, governance, partnership, and country collaboration

2012–2013 programme delivery highlights

- The Sixty-fifth and Sixty-sixth sessions of the WHO Regional Committee for South-East Asia, the Thirtieth and Thirty-first meetings of Ministers of Health of Countries of the South-East Asia Region (preceded by the meetings of their senior advisers) and other high-level meetings were held with Member States, featuring country focus, development and alignment of national and regional priorities.

- The WHO Director-General attended the Sixty-fifth and Sixty-sixth sessions of the Regional Committee and the Thirtieth and Thirty-first meetings of Ministers of Health, providing a vital global link.

- Active engagement of Member States to strengthen governance was promoted through preparation for, organization of, and follow up to the Regional Committee and other high-level meetings in the Region, as well as in the WHO Executive Board and World Health Assembly.

- Ongoing, regular communication and support was provided throughout the biennium to the WHO country offices to ensure timely and quality participation from the Member States in the meetings.

- In the area of programme development and management, the Fifth and Sixth meetings of the Subcommittee on Policy and Programme Development and Management, high-level preparatory meetings for the Sixty-fifth and Sixty-sixth sessions of the Regional Committee, and meetings of the Regional Director with the WHO representatives (in
Leadership, governance, partnership, and country collaboration

- Eight Member States – Bhutan, Bangladesh, India, Maldives, Myanmar, Nepal, Sri Lanka and Thailand – were supported in the development of WHO country cooperation strategies.

- In the area of implementation of WHO reform, the Region contributed to the development of the Twelfth General Programme of Work and the proposed programme budget for 2014–2015. In addition, strategic budgeting was encouraged proactively at country and regional levels. In the area of governance reform, the link between global and regional governing bodies has been strengthened. In the area of programme management, three country offices benefited from internal review and technical assessment missions with the objectives of strengthening technical performance, oversight, accountability, and compliance.

- Technical and administrative support was provided to budget centres, at regional and country level, in monitoring and evaluation. Evidence reflecting the relevance and impact of WHO’s work was collated to respond to the Multilateral Organisation Performance Assessment Network (MOPAN) review.

- Active support was provided to WHO country offices for all partnership-building efforts, resource mobilization, and also for effective engagement in United Nations Development Assistance Framework (UNDAF) processes and UN-related funding mechanisms. A regional workshop on resource mobilization was conducted in Myanmar as an important capacity-building exercise (training of trainers) for representatives of Members States and WHO county office staff.

- WHO communication training was conducted in India, Indonesia, Maldives, Myanmar, Thailand, and Timor-Leste for WHO country office staff, ministries of health, and UN staff. The Region’s website was revamped making it more searchable, user-friendly, accessible, and up-to-date. Media relations were strengthened through media workshops in India, Indonesia, Nepal, and Timor-Leste.

- Support was provided for sustainable development of health information and knowledge management, including the introduction of access to online health journals. New public health schools and libraries were established in several countries and existing public health libraries were strengthened.
Overview

1. Health issues related to the South-East Asia Region and beyond were effectively represented at global and regional governing bodies, thus strengthening governance and fostering strategic partnerships to advance the health agenda. Emphasis on universal health care, equity and rights issues, and attention to implementation of policies, strategies and plans enhanced understanding and advocacy to meet the health needs of the population of respective Member States in an equitable manner. Proactive involvement of Member States at regional and country levels enabled regional and global governing bodies to cohere effectively, which is one of the objectives of WHO reform. Successful conduct of the governing bodies’ meetings in the Region resulted in the adoption of resolutions relevant to Member States that facilitated enhancement of stewardship through participatory processes and technical support focusing on prioritized implementation. Resource mobilization was facilitated through coordination, database development, and continued partnership-building.

2. Challenges faced during the biennium included competing global priorities; dwindling external financial support; a multiplicity of participants in the health arena; issues related to gender, equity, and rights that have a deleterious impact on health; and, persisting weaknesses in the health systems of Member States. In 2013, there were additional challenges related to monitoring of initiatives to enhance implementation of the programme budget 2012–2013; developing a shared vision on “ways forward” for the programme budget 2014–2015, within and outside the Organization; budget allocation to budget centres, specifically in
view of the overall budget space reduction for the Region for the next biennium; improving the process of prioritization so as to provide a better focus on country needs; and, aligning actions and resources with regional and national health development agendas for the programme budget 2014–2015. Meeting such challenges rendered this cross-cutting area of work as of crucial importance in focusing WHO’s comparative advantage and programmatic alignment in support of national health priorities.

3. Key strategic approaches included: promoting active engagement of Member States through sustained and planned communication with the WHO country offices; advocating and helping to build consensus for WHO reform, through engagement with Member States and fostering partnerships; organizing high-level policy meetings, and providing technical support for meetings involving the Regional Director, WHO representatives and programme managers, and for undertaking country missions; ensuring timely and quality participation from the Member States in meetings; ongoing, regular communication and support to WHO country offices and units in the Regional Office; strengthening capacity to document and communicate regional experience, lessons learned, and challenges ahead; fostering interregional and interagency cooperation and coordination with the UN system organizations; and, advocating and building consensus for WHO reform. Extended support was provided for country- and regional-level meetings, resource mobilization, and streamlining internal processes.
**Leadership and direction**

4. Active engagement of Member States to strengthen governance through preparation for, implementation of, and follow up to the Regional Committee and other high-level meetings in the South-East Asia Region, as well as in the WHO Executive Board and World Health Assembly, enabled regional and global governing bodies to cohere effectively.

5. Various important governing bodies meetings were convened, organized and supported. The Regional Office successfully organized meetings of the regional governing bodies, including the Thirtieth and Thirty-first meetings of Ministers of Health of the Countries of the South-East Asia Region; meetings of the Senior Advisers to the Ministers of Health from the Region; the Sixty-fifth and Sixty-sixth sessions of the Regional Committee and its accompanying High-level Preparatory meetings; and the Fifth and Sixth meetings of the Subcommittee on Policy and Programme Development and Management. At the Sixty-sixth session of the Regional Committee, Dr Poonam Khetrapal Singh (India) was nominated as Regional Director for South-East Asia. These meetings provided an opportunity to discuss a range of technical subjects, including WHO reform in the context of the South-East Asia Region, programme budget development, and strategies to overcome challenges and barriers to address regional health concerns through effective participation of Member States.

6. Successful conduct of governing bodies meetings resulted in adoption of resolutions relevant to the South-East Asia Region, focusing on stewardship and implementation. WHO’s leadership and management at regional and country levels facilitated regional participation in global policy dialogue and direction, especially in the WHO reform process, development of the Twelfth General Programme of Work, and the proposed programme budget for the 2014–2015 biennium.

**WHO country presence and cooperation**

7. The Regional Office has strengthened support to develop WHO country cooperation strategies in alignment with national health challenges and corporate guidance. Particular focus was given to the consultative process and strategic agenda development. Third-generation WHO country cooperation strategies were published for India (2012–2017), Maldives (2013–2017), Nepal (2013–2017), Sri Lanka (2012–2017), and Thailand (2012–2016).
8. Internal review and technical assessment missions to three country offices were conducted during 2012 and 2013. The objectives were to strengthen oversight, programme management, administration and financial management, accountability, appropriate implementation of delegation of authority, and help improve technical performance.

9. Technical and administrative support was provided to departments in the Regional Office and in WHO country offices as part of the management of a mid-term review and end of biennium review on technical monitoring of the work conducted throughout the Region.

10. In support of WHO’s country presence and relating to WHO’s overarching health leadership mandate, there were regular meetings between the Regional Director and the WHO heads of country offices. These provided an opportunity for strategic technical and managerial discussions and decisions, with the aim of providing optimal Secretariat support at the country level.

11. Active engagement of Member States was promoted through sustained and planned communication with the WHO country offices for organization of, and follow up to, Regional Committee and other high-level meetings. Advocating and helping to build consensus for WHO reform through engagement with Member States, regional and global development debates, and fostering partnerships; strengthening capacity to document and communicate regional experience gained, lessons learnt and challenges ahead; fostering interregional and interagency cooperation and coordination with UN system organizations, regional associations and intergovernmental bodies also worked well.

**Partnerships and resource mobilization**

12. UNDAF development processes have been supported in India, Nepal, and Sri Lanka. Country capacity for effective engagement in UNDAF has been strengthened, with WHO representing the Regional UN Development Group Team as the co-convening agency for the UNDAF development process in Bhutan. Support was provided for United Nations Development Group (UNDG) Asia-Pacific engagement through briefings and participation in UNDG Asia-Pacific meetings and regular inputs to the peer-support group meetings.
13. Active support was provided to all WHO country offices and technical units in the Regional Office to enhance existing and develop new partnerships with stakeholders, particularly in the area of resource mobilization. The main achievements were the organization of a regional workshop on resource mobilization in Yangon, Myanmar in November 2013 for 43 representatives of Member States and WHO country office staff, as an important capacity-building exercise; development of the document “Strategic partnerships: Forging new paths for WHO in South-East Asia”; development of case-studies on best practices in partnerships for health in the South-East Asia Region; successful negotiation of a joint memorandum of understanding between the WHO regional offices for South-East Asia and the Western Pacific and ASEAN on a collaborative framework for the period 2014–2017; organization of a regional consultation of nongovernmental organizations and civil society on the post-2015 health development agenda; successful development of resource mobilization training modules to address the identified needs of country offices in the area of resource mobilization; and, effective negotiation and coordination of clearance of 86 agreements and amendments with donors. With particular emphasis on improving timeliness and consistency of submissions of donor reports, the Partnership and Resource Mobilization unit supported the WHO country offices and the Regional Office technical units through the use of the donor report management system.

14. Active support was provided to senior management for participation in the Global Resource Mobilization Task Force, and input was provided for other high-level meetings related to this field, including ASEAN and SAARC, all with the objective of supporting future financing dialogue with Member States.

Health knowledge and advocacy materials

15. Two online portals for national health journals were developed in Indonesia and Thailand, and 29 portals on institutional repositories in six Member States – Bhutan, the Democratic People’s Republic of Korea, Indonesia, Myanmar, Sri Lanka, and Thailand – were developed or sustained. As a result, national health information is becoming more visible and accessible. WHO’s website was revamped and developed to make it a more user-friendly and useful repository of public health information. Increased awareness about public health resulted in the establishment of new public health schools equipped with public health libraries, and the strengthening of existing health science libraries in the Region. Capacity-building, fellowships, and study tours were organized for health professionals, health librarians, researchers,
and policy-makers with the aim of improving access to information services in Member States. In addition, advocacy and support to strengthen policy, strategic, and operational areas of health information were provided to Bhutan and the Democratic People’s Republic of Korea.

16. The Regional Office provided inputs to the WHO global communication strategy through consultations with WHO representatives and technical experts to ensure that a country perspective is included in WHO’s communication strategy at all levels.

17. The Regional Office supported health campaigns in Member States throughout the biennium by developing and disseminating advocacy materials.

18. Continued communication coordination for WHO days and events through the Regional Office’s communication network was maintained. The Regional Office supported health campaigns in countries throughout the biennium by developing and disseminating advocacy materials such as newsletters, flyers, posters, and brochures. In addition to the dissemination of printed materials, more than 40 new technical publications and summaries from over 70 expert or high-level meetings were also made available to external audiences through the Region’s website.
2012–2013 programme delivery highlights

- The Region’s biennial financial records were fully reconciled and closed under compliance with International Public Sector Accounting Standards (IPSAS).
- Overall improvement in financial, administrative, and audit compliance across the Region resulted in a significant decrease in the number of outstanding items. This was achieved through improved reporting, monitoring of duty travel, and post facto monitoring of WHO country offices’ financial transactions.
- The Region successfully closed all outstanding audit recommendations from both internal and external audit functions. Internal review and technical assessment missions in three country offices in 2012–2013 aimed to improve administrative and technical performance, quality assurance, and accountability in programme implementation.
- Proactive human resource and staff development activities have resulted in better distribution of functions among staff, increased efficiency of the Organization, greater alignment of functions, and a reduction in the number of administrative queries.
- WHO’s globally managed computing environment and unified communication platform was rolled out in the Regional Office and some country offices. In addition to providing ongoing cost-efficiencies, these platforms have enabled more effective information sharing and communication between regional staff and across WHO.
- Handling of the Region’s fixed assets was further strengthened with the roll-out of improved inventory management for all fixed assets. The Region was praised by WHO headquarters as an example of best asset management practices.
Overview

1. The enabling functions of WHO – programme management, monitoring and evaluation, budget and financial management, human resources management, procurement, information technology, public information, administrative and building services, publications, and staff medical services – are structured to support the Organization in achieving its programmatic work while also attaining the best value for money spent, as represented not only in the outcome of the work products but in the manner in which the work is conducted.

2. This contribution to the work of the South-East Asia Region continues to be achieved through guiding and monitoring the development and implementation of collaborative programmes, ensuring compliance with the rules and regulations of the Organization, proactive human resources planning and management, implementation of sound procurement practices, travel planning, increased administrative efficiencies, and increased knowledge sharing. Steps have been taken to strengthen staff competencies, application of experiences, and synergistic working arrangements through staff training, rotation, and the relocation of several WHO country offices.

3. As it is essential that WHO offices are able to work during emergencies or other unanticipated work disruptions, the Organization has continued to give increased attention to risk management, business continuity planning, and cross-training of personnel.

4. The staff of the administrative teams throughout the Region, as well as those providing direct administrative support within the technical offices, remain committed
to sound and ethical business practices, efficient and cost-effective services, and quality support to WHO collaborative programmes.

**Strategic and operational programming, monitoring, and evaluation**

5. WHO country offices were supported in strengthening programme management through enhanced efforts for capacity-building on concepts of results-based management. WHO’s support of national health planning was strengthened and backstopping provided. Support was provided to country offices and departments in the Regional Office for South-East Asia for finalizing collaborative workplans and enabling appropriate changes in the programme budget for 2012–2013, wherever required. Implementation of the workplans for the 2012–2013 biennium was regularly monitored by executive management and the Regional Director, and subsequent discussions at governing body meetings led to redirection of priorities and realignment of resources. This resulted in more effective and efficient implementation of the WHO collaborative programmes and leveraging of health ministries’ funds towards prioritized areas, which in turn positively impacted the access to and quality of health care in Member States. During 2012, proactive support was provided to enable contributions by the Regional Office and WHO country offices in the development of the programme budget for 2014–2015 at
the strategic level. In this regard, efforts were made to streamline the process and expedite programme changes. Furthermore, during the last quarter of 2013, support was provided to the Regional Office and country offices for development of the programme budget for 2016–2017 by utilizing a bottom-up planning process that laid emphasis on the prioritization of areas for support.

6. All budget centres used well-defined workplans, with articulated strategic objectives and expected results, for monitoring and evaluating achievements within the Organization and throughout the Region. Performance monitoring, assessment, and reporting by budget centres in the Region was supported for both mid-term review as well as end of biennium reporting. An ad hoc analysis of mid-term office-specific expected results reporting and the relationship between expenditure and Organization-wide expected results was carried out and shared.

7. Support was provided to internal review and technical assessment missions conducted in two country offices during 2012 and one in 2013. These reviews and assessments resulted in recommendations for improvement regarding a range of financial, administrative, and programming matters. These included human resource issues, duty travel, various contracting modalities, programme management, resource mobilization, WHO country cooperation strategies, and horizontal collaboration. Both the Regional Office and country offices adapted their procedures as a result of the lessons learned in these assessments in an effort to facilitate management improvements.

8. The culture of evaluation was strengthened by sensitizing WHO representatives and colleagues in the Regional Office, collation of evaluation reports, analysis of available reports, and preparations for a regional needs analysis and survey on evaluation.

**Human resources management**

9. Human resources constitute a critical element in WHO’s programme delivery and support to Member States. The human resources management team provided guidance and support to WHO country offices and Regional Office staff on a range of human resource issues relating to recruitment and reassignment of staff, employment conditions, entitlements, performance appraisal, code of conduct, and staff development and learning in accordance with the established policies and guidelines. Re-profiling missions were conducted at WHO country offices to address specific human resource issues/challenges raised by the individual offices,
resulting in better distribution of duties among staff, increased organizational efficiency, and greater alignment of functions. New guidelines were introduced that improve procedures aimed at achieving greater transparency and objectivity in recruitment processes for selection of national professional officers in WHO country offices, general service staff, hiring of consultants, and employment of spouses. Recruitment processes managed by the regional human resources management unit were streamlined and executed effectively, resulting in recruitment of 347 temporary staff (991 contracts) and fixed-term selection processes for 110 positions.

10. A regional training workshop was conducted for all WHO country office human resource focal points in May 2013, in Bangkok, Thailand, to further disseminate and promulgate policies, procedures, and effective human resource practices throughout the Region. Two training sessions on human resource management essentials were organized in the Regional Office to strengthen the capacity of human resource focal points and administrative staff, and to further reinforce compliance in relation to human resource actions.

11. The staff development and learning programme, which was integrated with human resources management in October 2012, took major strides in improvement in the planning, management, implementation, and evaluation of regional learning and development programmes. Based on learning needs of staff across the Region, over 232 training programmes were designed and implemented during 2012–2013, targeting 3653 staff members. Three new online training initiatives – online staff
orientation programme, online staff resources, and online exit interview – were also launched. The training programmes achieved their objectives, which were visible through improvement in the administrative and managerial processes, and resulted in better utilization of available resources.

**Financial management**

12. The Region continued further strengthening of controls and enhancement of processes to ensure correct application of fiduciary responsibilities in both administrative and technical staff. The establishment of a regional financial compliance unit in 2012 has started to yield positive results, including: substantial improvement in conformity with rules and regulations of all country offices, specifically in relation to the quality of imprest returns; significant reduction in outstanding financial transactions; and, improved quality and compliance of services procurement. As a direct result of post facto reports of country office imprest transactions, monitoring of duty travel, and reporting on direct financial cooperation and agreements for the performance of work, there was a noticeable improvement in compliance standards and accountability throughout the Region.

13. Efforts were continued to improve management of the Organization’s financial resources and to respond to both the changing programme requirements and the needs of Member States. Reports and online managerial dashboards have been deployed to support decision-making by the Regional Office as well as country office managers in an efficient and cost-effective manner.

**Information systems**

14. Access to accurate, timely, and relevant information is critical to the success of WHO’s work in the Region. Design and technology improvements have been made to the Regional Office’s internet and intranet sites to provide more accessible public health data to WHO constituents, and more readily provide staff with relevant policies, rules and regulations, forms, standard operating procedures, and other key information.

15. Continuing the work started in 2012, major enhancements in communications technology now allow staff to avail and securely access information resources and the Global Management System (GSM), even when working remotely. The
Regional Office for South-East Asia was the first of WHO’s regional offices to adopt the global standard WHO computer desktop environment and to implement the globally agreed unified communication infrastructure. New data storage systems were implemented in the Regional Office as well as in a number of country offices, with automated off-site backup functionality for business contingency.

16. The regional service desk implemented an automated call management system to improve reports and visibility on service desk calls, and thereby allowing for better deployment of resources to meet the needs of internal customers throughout the Region.

17. The Regional Office’s ICT resources are often called upon to deliver solutions for WHO globally. During 2012–2013, the ICT team successfully coordinated the testing for the GSM upgrade to version R12. The team also continued to depute staff to work on global projects, including those associated with WHO reform. To support these and other activities, new regional infrastructure projects have been implemented (for example, an applications form for corporate applications) to provide more effective management and cost-efficiencies.

**Administrative support services**

18. Administrative support services cover a broad spectrum of activities ranging from facilities and assets management to travel and meetings management, as well as supporting operational relations with host Member States in the Region.

19. As part of WHO’s delivery to Member States, hundreds of conferences, meetings, and special events were supported both at the Regional Office as well as at other venues throughout the Region. Significant events included the arrangements for the Sixty-sixth Regional Committee and, in particular, the nomination process for Regional Director, which WHO headquarters Office of the Legal Counsel lauded as “impeccable”. In relation to asset management, new tools and staff trainings were rolled out for inventory management in an effort to improve and maintain control of WHO assets and remain IPSAS compliant. The Regional Office continues to support country offices, in coordination with WHO headquarters Office of the Legal Counsel, to resolve matters associated with the special privileges and immunities bestowed to UN agencies and their staff in the countries of the South-East Asia Region.
20. Assistance was provided to WHO country offices in Bangladesh and the Democratic People’s Republic of Korea for the revision of operational business continuity plans, and to the country office in Myanmar for analysis and selection of new office premises. Technical assistance was also provided to the WHO Representative to Bhutan with regards to the electrical/generator supply distribution system and load management. In addition, direct administrative assistance was provided to Bhutan via the short-term assignment of one administrative assistant to the WHO Country Office Bhutan.

Working environment, staff well-being, and safety

21. Staff safety and security is of utmost importance. Offices of the South-East Asia Region work closely with the United Nations Department of Safety & Security (UNDSS) to monitor threats and take preventative measures to ensure staff safety. In countries prone to such events, activities to train staff in the UN interagency continuity plan, the WHO country office business continuity plan, fire safety, and basic first aid were initiated. In coordination with UNDSS, compulsory security trainings have been completed and, where appropriate, warden systems have been put in place. In the Regional Office, in order to comply with new minimum operating
security standards for India, metal detectors and parcel/baggage scanners were installed at both entry/exit gates. The CCTV surveillance system was upgraded, thus increasing capacity to meet international standards.

22. Addressing the deficiencies of the ageing buildings of the Regional Office in New Delhi continued to be a major challenge. Following structural studies made in recent years, and after new findings during preventive maintenance work, guidance was sought from the Government of India. The results of these studies, as well as the input from the Government, will be consolidated into a facilities plan for the Regional Office campus. Further negotiations, feasibility studies, architectural and engineering plans, and budgetary considerations will be discussed and compiled for WHO governing bodies’ review and advice.

23. Meanwhile, routine repairs and maintenance continue and, as part of WHO’s approved Capital Master Plan, repairs and painting of the entire Regional Office complex were completed along with renovation of the second floor of the main building to accommodate the critical relocation of the data centre. In addition, the Sri Lanka Room was renovated under the auspices of the High Commission of Sri Lanka. Identification and selection of a contractor for design and installation of a fire detection and suppressant system for the buildings was conducted, with work scheduled to be completed in 2014.
Annex 1

List of strategic objectives and Organization-wide expected results

Strategic objective 1

To reduce the health, social and economic burden of communicable diseases

1.1 Policy and technical support provided to Member States in order to maximize equitable access of all people to vaccines of assured quality, including new immunization products and technologies, and to integrate other essential child health interventions with immunization.

1.2 Effective coordination and support provided in order to achieve certification of poliomyelitis eradication, and destruction, or appropriate containment, of polioviruses, leading to a simultaneous cessation of oral poliomyelitis vaccination globally.

1.3 Effective coordination and support provided to Member States in order to provide access for all populations to interventions for the prevention, control, elimination and eradication of neglected tropical diseases, including zoonotic diseases.

1.4 Policy and technical support provided to Member States in order to enhance their capacity to carry out surveillance and monitoring of all communicable diseases of public health importance.

1.5 New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases developed and validated, with scientists from developing countries increasingly taking the lead in this research.

1.6 Support provided to Member States in order to achieve the minimum core capacities required by the International Health Regulations (2005) for the establishment and strengthening of alert and response systems for use in epidemics and other public health emergencies of international concern.

1.7 Member States and the international community equipped to detect, assess, respond to and cope with major epidemic and pandemic-prone diseases (e.g. influenza, meningitis, yellow fever, haemorrhagic fevers, plague and smallpox) through the development and implementation of tools, methodologies, practices, networks and partnerships for prevention, detection, preparedness and intervention.

1.8 Regional and global capacity coordinated and made rapidly available to Member States for detection, verification, risk assessment and response to epidemics and other public health emergencies of international concern.

1.9 Effective operations and response by Member States and the international community to declared emergency situations due to epidemic and pandemic-prone diseases.
Strategic objective 2

To combat HIV/AIDS, tuberculosis and malaria

2.1 Guidelines, policy, strategy and other tools developed for prevention of, and treatment and care for patients with, HIV/AIDS, tuberculosis and malaria, including innovative approaches for increasing coverage of the interventions among poor people, and hard-to-reach and vulnerable populations.

2.2 Policy and technical support provided to countries towards expanded gender sensitive delivery of prevention, treatment and care interventions for HIV/AIDS, tuberculosis and malaria, including integrated training and service delivery; wider service-provider networks; and strengthened laboratory capacities and better linkages with other health services, such as those for sexual and reproductive health, maternal, newborn and child health, sexually transmitted infections, nutrition, drug dependence treatment services, respiratory care, neglected diseases and environmental health.

2.3 Global guidance and technical support provided on policies and programmes in order to promote equitable access to essential medicines, diagnostic tools and health technologies of assured quality for the prevention and treatment of HIV/AIDS, tuberculosis and malaria, and their rational use by prescribers and consumers, and, in order to ensure uninterrupted supplies of diagnostics, safe blood and blood products, injections and other essential health technologies and commodities.

2.4 Global, regional and national systems for surveillance, evaluation and monitoring strengthened and expanded to keep track of progress towards targets and allocation of resources for HIV/AIDS, tuberculosis and malaria control and to determine the impact of control efforts and the evolution of drug resistance.

2.5 Political commitment sustained and mobilization of resources ensured through advocacy and nurturing of partnerships on HIV/AIDS, tuberculosis and malaria at country, regional and global levels; support provided to countries as appropriate to develop or strengthen and implement mechanisms for resource mobilization and utilization and increase the absorption capacity of available resources; and engagement of communities and affected persons increased to maximize the reach and performance of HIV/AIDS, tuberculosis and malaria control programmes.

2.6 New knowledge, intervention tools and strategies developed and validated to meet priority needs for the prevention and control of HIV/AIDS, tuberculosis and malaria, with scientists from developing countries increasingly taking the lead in this research.

Strategic objective 3

To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment

3.1 Advocacy and support provided to increase political, financial and technical commitment in Member States in order to tackle chronic noncommunicable diseases, mental and behavioural disorders, violence, injuries and disabilities together with visual impairment, including blindness.

3.2 Guidance and support provided to Member States for the development and implementation of policies, strategies and regulations in respect of chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities together with visual impairment, including blindness.
3.3 Improvements made in Member States’ capacity to collect, analyse, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities together with visual impairment, including blindness.

3.4 Improved evidence compiled by WHO on the cost-effectiveness of interventions to tackle chronic noncommunicable diseases, mental and neurological and substance-use disorders, violence, injuries and disabilities together with visual impairment, including blindness.

3.5 Guidance and support provided to Member States for the preparation and implementation of multisectoral, population-wide programmes to promote mental health, and to prevent mental and behavioural disorders, violence and injuries, together with hearing and visual impairment, including blindness.

3.6 Guidance and support provided to Member States to improve the ability of their health and social systems to prevent and manage chronic noncommunicable diseases, mental and behavioural disorders, violence, injuries and disabilities together with visual impairment, including blindness.

**Strategic objective 4**

**To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals**

4.1 Support provided to Member States to formulate a comprehensive policy, plan and strategy for scaling up towards universal access to effective interventions in collaboration with other programmes, paying attention to reducing gender inequality and health inequities, providing a continuum of care throughout the life-course, integrating service delivery across different levels of the health system and strengthening coordination with civil society and the private sector.

4.2 National research capacity strengthened as necessary and new evidence, products, technologies, interventions and delivery approaches of global and/or national relevance available to improve maternal, newborn, child and adolescent health, to promote active and healthy ageing, and to improve sexual and reproductive health.

4.3 Guidelines, approaches and tools for improving maternal care applied at the country level, including technical support provided to Member States for intensified action to ensure skilled care for every pregnant woman and every newborn, through childbirth and the postpartum and postnatal periods, particularly for poor and disadvantaged populations, with progress monitored.

4.4 Guidelines, approaches and tools for improving neonatal survival and health applied at country level, with technical support provided to Member States for intensified action towards universal coverage, effective interventions and monitoring of progress.

4.5 Guidelines, approaches and tools for improving child health and development applied at the country level, with technical support provided to Member States for intensified action towards universal coverage of the population with effective interventions and for monitoring progress, taking into consideration international and human-rights norms and standards, notably those stipulated in the Convention on the Rights of the Child.
4.6 Technical support provided to Member States for the implementation of evidence-based policies and strategies on adolescent health and development, and for the scaling up of a package of prevention, treatment and care interventions in accordance with established standards.

4.7 Guidelines, approaches and tools made available, with provision of technical support to Member States for accelerated action towards implementing the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health, with particular emphasis on ensuring equitable access to good-quality sexual and reproductive health services, particularly in areas of unmet need, and with respect for human rights as they relate to sexual and reproductive health.

4.8 Guidelines, approaches, tools, and technical assistance provided to Member States for increased advocacy for consideration of ageing as a public health issue, for the development and implementation of policies and programmes aiming at maintaining maximum functional capacity throughout the life-course and for the training of health-care providers in approaches that ensure healthy ageing.

**Strategic objective 5**

**To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact**

5.1 Norms and standards developed, capacity built and technical support provided to Member States for the development and strengthening of national emergency preparedness plans and programmes.

5.2 Norms and standards developed and capacity built to enable Member States to provide timely response to disasters associated with natural hazards and conflict-related crises.

5.3 Norms and standards developed and capacity built to enable Member States to assess needs and for planning interventions during the transition and recovery phases of conflicts and disasters.

5.4 Coordinated technical support provided to Member States for communicable disease control in natural disaster and conflict situations.

5.5 Support provided to Member States for strengthening national preparedness and for establishing alert and response mechanisms for food-safety and environmental health emergencies.

5.6 Effective communications issued, partnerships formed and coordination developed with other organizations in the United Nations system, governments, local and international nongovernmental organizations, academic institutions and professional associations at the country, regional and global levels.

5.7 Acute, ongoing and recovery operations implemented in a timely and effective manner.

**Strategic objective 6**

**To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex**

6.1 Advice and support provided to Member States to build their capacity for health promotion across all relevant programmes, and to establish effective multisectoral and multidisciplinary collaborations for promoting health and preventing or reducing major risk factors.

6.2 Guidance and support provided in order to strengthen national systems for surveillance of major risk factors through development and validation of frameworks, tools and operating procedures and their dissemination to Member States where a high or increasing burden of death and disability is attributable to these risk factors.

6.3 Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease and death associated with tobacco use, enabling them to strengthen institutions in order to tackle or prevent the
public health problems concerned; support also provided to the Conference of the Parties to the WHO Framework Convention on Tobacco Control for implementation of the provisions of the Convention and development and implementation of protocols and guidelines.

6.4 Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease or death associated with alcohol, drugs and other psychoactive substance use, enabling them to strengthen institutions in order to combat or prevent the public health problems concerned.

6.5 Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease or death associated with unhealthy diets and physical inactivity, enabling them to strengthen institutions in order to combat or prevent the public health problems concerned.

6.6 Evidence-based and ethical policies, strategies, interventions, recommendations, standards and guidelines developed, and technical support provided to Member States to promote safer sex and strengthen institutions in order to tackle and manage the social and individual consequences of unsafe sex.

**Strategic objective 7**

To address the underlying social and economic determinants of health through policies and programmes that enhances health equity and integrates pro-poor, gender responsive, and human rights-based approaches

7.1 Significance of social and economic determinants of health recognized throughout the Organization and incorporated into normative work and technical collaboration with Member States and other partners.

7.2 Initiative taken by WHO in providing opportunities and means for intersectoral collaboration at national and international levels to address social and economic determinants of health, including understanding and acting upon the public health implications of trade and trade agreements, and to encourage poverty-reduction and sustainable development.

7.3 Social and economic data relevant to health collected, collated and analysed on a disaggregated basis (by sex, age, ethnicity, income, and health conditions, such as disease or disability).

7.4 Ethics- and human rights-based approaches to health promoted within WHO and at national and global levels.

7.5 Gender analysis and responsive actions incorporated into WHO’s normative work and support provided to Member States for formulation of gender responsive policies and programmes.

**Strategic objective 8**

To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health

8.1 Evidence-based assessments made, and norms and standards formulated and updated on major environmental hazards to health (e.g. poor air quality, chemical substances, electromagnetic fields, radon, poor-quality drinking-water and wastewater reuse).

8.2 Technical support and guidance provided to Member States for the implementation of primary prevention interventions that reduce environmental hazards to health, enhance safety and promote public health, including in specific settings (e.g. workplaces, homes or urban settings) and among vulnerable population groups (e.g. children).

8.3 Technical assistance and support provided to Member States for strengthening national occupational and environmental health risk management systems, functions and services.
8.4 Guidance, tools and initiatives created in order to support the health sector in influencing policies in other sectors to allow policies that improve health, the environment and safety to be identified and adopted.

8.5 Health-sector leadership enhanced for creating a healthier environment and changing policies in all sectors so as to tackle the root causes of environmental threats to health, through means such as responding to emerging and reemerging consequences of development on environmental health and altered patterns of consumption and production and to the damaging effect of evolving technologies.

8.6 Evidence-based policies, strategies and recommendations developed, and technical support provided to Member States for identifying, preventing and tackling public health problems resulting from climate change.

Strategic objective 9

To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development

9.1 Partnerships and alliances formed, leadership built and coordination and networking developed with all stakeholders at country, regional and global levels, in order to promote advocacy and communication, stimulate intersectoral actions, increase investment in nutrition, food-safety and food-security interventions, and develop and support a research agenda.

9.2 Norms, including references, requirements, research priorities, guidelines, training manuals and standards, produced and disseminated to Member States in order to increase their capacity to assess and respond to all forms of malnutrition, and zoonotic and nonzoonotic foodborne diseases, and to promote healthy dietary practices.

9.3 Monitoring and surveillance of needs and assessment and evaluation of responses in the area of nutrition and diet-related chronic diseases strengthened, and ability to identify best policy options improved, in stable and emergency situations.

9.4 Capacity built and support provided to target Member States for the development, strengthening and implementation of nutrition plans, policies and programmes aimed at improving nutrition throughout the life-course, in stable and emergency situations.

9.5 Systems for surveillance, prevention and control of zoonotic and nonzoonotic foodborne diseases strengthened; food-hazard monitoring and evaluation programmes established and integrated into existing national surveillance systems, and results disseminated to all key players.

9.6 Capacity built and support provided to Member States, including their participation in international standard-setting in order to increase their ability to assess risk in the areas of zoonotic and nonzoonotic foodborne diseases and food safety, and to develop and implement national food control systems, with links to international emergency systems.

Strategic objective 10

To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research

10.1 Management and organization of integrated, population-based health-service delivery through public and non public providers and networks improved, reflecting the primary health care strategy, scaling up coverage, equity, quality and safety of personal and population-based health services, and enhancing health outcomes.
10.2 National capacities for governance and leadership improved through evidence-based policy dialogue, institutional capacity-building for policy analysis and development, strategy based health system performance assessment, greater transparency and accountability for performance, and more effective intersectoral collaboration.

10.3 Coordination of the various mechanisms (including donor assistance) that provide support to Member States in their efforts to achieve national targets for health system development and global health goals improved.

10.4 Country health-information systems that provide and use high-quality and timely information for health planning and for monitoring progress towards national and major international goals strengthened.

10.5 Better knowledge and evidence for health decision-making assured through consolidation and publication of existing evidence, facilitation of knowledge generation in priority areas, and global leadership in health research policy and coordination, including with regard to ethical conduct.

10.6 National health research for development of health systems strengthened in the context of regional and international research and engagement of civil society.

10.7 Knowledge management and eHealth policies and strategies developed and implemented in order to strengthen health systems.

10.8 Health workforce information and knowledge base strengthened, and country capacities for policy analysis, planning, implementation, information sharing and research built up.

10.9 Technical support provided to Member States, with a focus on those facing severe health workforce difficulties in order to improve the production, distribution, skill mix and retention of the health workforce.

10.10 Evidence-based policy and technical support provided to Member States in order to improve health-system financing in terms of the availability of funds, social and financial-risk protection, equity, access to services and efficiency of resource use.

10.11 Norms, standards and measurement tools developed for tracking resources, estimating the economic consequences of illness, and the costs and effects of interventions, financial catastrophe, impoverishment, and social exclusion, and their use supported and monitored.

10.12 Steps taken to advocate additional funds for health where necessary; to build capacity in framing of health-financing policy and interpretation and use of financial information; and to stimulate the generation and translation of knowledge to support policy development.

10.13 Evidence-based norms, standards and measurement tools developed to support Member States to quantify and decrease the level of unsafe health care provided.

**Strategic objective 11**

To ensure improved access, quality and use of medical products and technologies

11.1 Formulation and monitoring of comprehensive national policies on access, quality and use of essential medical products and technologies advocated and supported.

11.2 International norms, standards and guidelines for the quality, safety, efficacy and cost-effective use of medical products and technologies developed and their national and/or regional implementation advocated and supported.

11.3 Evidence-based policy guidance on promoting scientifically sound and cost-effective use of medical products and technologies by health workers and consumers developed and supported within the Secretariat and regional and national programmes.
Strategic objective 12
To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfill the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work

12.1 Effective leadership and direction of the Organization exercised through enhancement of governance, and the coherence, accountability and synergy of WHO’s work.

12.2 Effective WHO country presence established to implement WHO country cooperation strategies that are aligned with Member States’ health and development agendas, and harmonized with the United Nations country team and other development partners.

12.3 Global health and development mechanisms established to provide more sustained and predictable technical and financial resources for health on the basis of a common health agenda which responds to the health needs and priorities of Member States.

12.4 Essential multilingual health knowledge and advocacy material made accessible to Member States, health partners and other stakeholders through the effective exchange and sharing of knowledge.

Strategic objective 13
To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively

13.1 Work of the Organization guided by strategic and operational plans that build on lessons learnt, reflect country needs, are elaborated across the Organization, and used to monitor performance and evaluate results.

13.2 Sound financial practices and efficient management of financial resources achieved through continuous monitoring and mobilization of resources to ensure the alignment of resources with the programme budgets.

13.3 Human resource policies and practices in place to attract and retain top talent, promote learning and professional development, manage performance, and foster ethical behaviour.

13.4 Management strategies, policies and practices in place for information systems, that ensure reliable, secure and cost-effective solutions while meeting the changing needs of the Organization.

13.5 Managerial and administrative support services necessary for the efficient functioning of the Organization provided in accordance with service-level agreements that emphasize quality and responsiveness.

13.6 Working environment conducive to the well-being and safety of staff in all locations.
### Annex 2

**List of active WHO collaborating centres in the South-East Asia Region (countrywise)**

<table>
<thead>
<tr>
<th>Institution name</th>
<th>WHO Collaborating Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bangladesh</strong></td>
<td></td>
</tr>
<tr>
<td>National Institute of Preventive and Social Medicine (NIPSOM)</td>
<td>Training and Development of Public Health Workforce</td>
</tr>
<tr>
<td><strong>Democratic People’s Republic of Korea</strong></td>
<td></td>
</tr>
<tr>
<td>Ministry of Public Health</td>
<td>Primary Health Care Development</td>
</tr>
<tr>
<td><strong>India</strong></td>
<td></td>
</tr>
<tr>
<td>Indian Institute of Health Management and Research</td>
<td>District Health System based on Primary Health Care</td>
</tr>
<tr>
<td>National Tuberculosis Institute (NTI)</td>
<td>Tuberculosis Research and Training</td>
</tr>
<tr>
<td>Centre for Chronic Disease Control (CCDC)</td>
<td>Surveillance, Capacity Building and Translational Research in Cardio-metabolic Diseases</td>
</tr>
<tr>
<td>National Institute of Communicable Diseases (NICD)</td>
<td>Epidemiology and Training</td>
</tr>
<tr>
<td>Indian Council of Medical Research (ICMR)</td>
<td>Occupational Health</td>
</tr>
<tr>
<td>All India Institute of Medical Sciences (AIIMS)</td>
<td>Substance Abuse</td>
</tr>
<tr>
<td>Society for Applied Studies</td>
<td>Research, Community-based Action and Programme Development in Child Health</td>
</tr>
<tr>
<td>National Environmental Engineering Research Institute</td>
<td>Water and Sanitation</td>
</tr>
<tr>
<td>Institute of Palliative Medicine</td>
<td>Community Participation in Palliative Care and Long Term Care</td>
</tr>
<tr>
<td>Christian Medical College</td>
<td>Development of Rehabilitation Technology, Capacity Building and Disability Prevention</td>
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*As of 13 June 2014*
<table>
<thead>
<tr>
<th>Institution name</th>
<th>WHO Collaborating Centre</th>
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<tbody>
<tr>
<td>Regional Medical Research Centre for Tribals (RMRCT)</td>
<td>The Health of Indigenous Populations</td>
</tr>
<tr>
<td>All India Institute of Medical Sciences (AIIMS)</td>
<td>Capacity Building and Research in Community-based Noncommunicable Disease Prevention and Control</td>
</tr>
<tr>
<td>Trivandrum Institute of Palliative Sciences (TIPS)</td>
<td>Training and Policy on Access to Pain Relief</td>
</tr>
<tr>
<td>Indian Council of Medical Research (ICMR)</td>
<td>Research and Training in Reproductive Health</td>
</tr>
<tr>
<td>Diabetes Research Centre and M.V. Hospital for Diabetes</td>
<td>Research, Education and Training in Diabetes</td>
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<tr>
<td>National Institute of Virology</td>
<td>Strengthening Capacity for Emerging Infectious Diseases</td>
</tr>
<tr>
<td>All India Institute of Medical Sciences (AIIMS)</td>
<td>Training and Research in Newborn Care</td>
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<tr>
<td>Gujarat Ayurved University</td>
<td>Traditional Medicine</td>
</tr>
<tr>
<td>Morarji Desai National Institute of Yoga</td>
<td>Traditional Medicine</td>
</tr>
<tr>
<td>National AIDS Research Institute (NARI), Indian Council of Medical Research (ICMR)</td>
<td>HIV Diagnosis and Monitoring of Antiretroviral Therapy</td>
</tr>
<tr>
<td>All India Institute of Medical Sciences (AIIMS)</td>
<td>Prevention of Blindness</td>
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<tr>
<td>Tata Memorial Hospital</td>
<td>Cancer Prevention, Screening and Early Detection</td>
</tr>
<tr>
<td>All India Institute of Medical Sciences (AIIMS)</td>
<td>Training in Clinical and Laboratory Genetics in Developing Countries</td>
</tr>
<tr>
<td>Sri Ramachandra Medical College and Research Institute</td>
<td>Research and Training in Occupational and Environmental Health</td>
</tr>
<tr>
<td>Postgraduate Institute of Medical Education and Research (PGIMER)</td>
<td>Research in Human Reproduction</td>
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<tr>
<td>National Centre for Disease Control (NCDC)</td>
<td>Rabies Epidemiology</td>
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<tr>
<td>Christian Medical College and Hospital</td>
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<td>Post Graduate Institute of Medical Education and Research (PGIMER)</td>
<td>Nursing and Midwifery Development</td>
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<td>Research and Training in Lympahtic Filariasis and Integrated Methods of Vector Control</td>
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<tr>
<td>National Institute of Malaria Research</td>
<td>Laboratory Testing and Evaluation of Public Health Pesticides</td>
</tr>
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<td>Institution name</td>
<td>WHO Collaborating Centre</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>National Institute of Mental Health and Neurosciences (NIMHANS)</td>
<td>Injury Prevention and Safety Promotion</td>
</tr>
<tr>
<td>Bhabha Atomic Research Centre</td>
<td>Secondary Standard Radiation Dosimetry</td>
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<tr>
<td>Indian Institute of Technology</td>
<td>Research and Training in Safety Technology</td>
</tr>
<tr>
<td>Indian Council of Medical Research (ICMR)</td>
<td>Diagnosis, Reference, Research and Training in Leptospirosis</td>
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<td>Noncommunicable Diseases Prevention and Control</td>
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<td>National Institute of Mental Health and Neurosciences (NIMHANS)</td>
<td>Reference and Research in Rabies</td>
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<tr>
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<tr>
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<td>Mental Health Research and Training</td>
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<tr>
<td>Mahatma Gandhi Institute of Medical Sciences</td>
<td>Research and Training in Community Based Maternal, Newborn and Child Health</td>
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<tr>
<td>National Institute for Research in Tuberculosis</td>
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<tr>
<td>Jawaharlal Institute of Postgraduate Medical Education and Research (JIPMER)</td>
<td>Training and Research in Essential Medicines and Rational Use of Medicines</td>
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<td>National Institute of Cholera and Enteric Diseases (NICED)</td>
<td>Research and Training on Diarrhoeal Diseases</td>
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<thead>
<tr>
<th>Indonesia</th>
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<tr>
<td>University of Indonesia</td>
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<tr>
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<td>Ministry of Health</td>
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<tr>
<td>Institution name</td>
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<tr>
<td><strong>Myanmar</strong></td>
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<tr>
<td>University of Nursing</td>
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<tr>
<td><strong>Nepal</strong></td>
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<tr>
<td>SAARC Tuberculosis and HIV/AIDS Centre</td>
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<tr>
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<tr>
<td>University of Colombo</td>
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<tr>
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</tr>
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<td>Institution name</td>
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<td>Asian Institute of Technology</td>
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<td>Armed Forces Research Institute of Medical Sciences (AFRIMS)</td>
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<td>Chulalongkorn University</td>
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<tr>
<td>Ministry of Public Health, National Institute of Health</td>
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<td>Department of Medical Sciences, Ministry of Public Health</td>
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### Annex 3

#### Budget implementation by strategic objective (as on 31 December 2013)

<table>
<thead>
<tr>
<th>Strategic objective</th>
<th>Budget</th>
<th>Approved budget</th>
<th>Funds available</th>
<th>Funds available (% of approved budget)</th>
<th>Utilization (expenditure plus encumbrances)</th>
<th>Utilization (% of approved budget)</th>
<th>Utilization (% of funds available)</th>
<th>AC</th>
<th>VC</th>
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<td>70 862 114</td>
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<td>64 731 114</td>
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<td>10 716 676</td>
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<td>92</td>
<td>3 801 000</td>
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<td>15 507 850</td>
<td>93</td>
<td>14 166 234</td>
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<td>91</td>
<td>8 374 670</td>
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<td>27 323 706</td>
<td>17 111 855</td>
<td>63</td>
<td>15 912 798</td>
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<td>93</td>
<td>23 109 706</td>
</tr>
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<td>9 656 190</td>
<td>6 797 751</td>
<td>70</td>
<td>6 270 501</td>
<td>65</td>
<td>92</td>
<td>6 935 190</td>
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<tr>
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<td>3 107 300</td>
<td>3 069 875</td>
<td>99</td>
<td>3 015 785</td>
<td>97</td>
<td>98</td>
<td>1 787 300</td>
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<tr>
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<td>9 451 900</td>
<td>8 863 574</td>
<td>94</td>
<td>8 398 597</td>
<td>89</td>
<td>95</td>
<td>4 122 900</td>
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<td>97</td>
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<td>6 920 427</td>
<td>6 149 012</td>
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<td>5 973 230</td>
<td>86</td>
<td>97</td>
<td>3 346 427</td>
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<td>38 133 237</td>
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<td>37 248 796</td>
<td>96</td>
<td>98</td>
<td>22 044 248</td>
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<tr>
<td><strong>Grand total</strong></td>
<td><strong>99 231 000</strong></td>
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<td><strong>430 379 695</strong></td>
<td><strong>390 563 307</strong></td>
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<td><strong>362 547 781</strong></td>
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<td><strong>93</strong></td>
<td><strong>331 148 695</strong></td>
</tr>
</tbody>
</table>

AC: assessed contribution; VC: voluntary contribution
## Annex 4

### Budget implementation by budget centre (as on 31 December 2013)

<table>
<thead>
<tr>
<th>Budget centre</th>
<th>Budget</th>
<th>Approved Budget</th>
<th>Funds available</th>
<th>Funds available (% of approved budget)</th>
<th>Utilization (expenditure plus encumbrances)</th>
<th>Utilization (% of approved budget)</th>
<th>Utilization (% of funds available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
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<td>27 844 848</td>
<td>24 425 877</td>
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<tr>
<td>Bhutan</td>
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<td>2 054 068</td>
<td>5 051 850</td>
<td>4 908 761</td>
<td>97</td>
<td>4 706 978</td>
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<tr>
<td>India</td>
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<td>122 951 762</td>
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<td>115 644 899</td>
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<td>31 916 415</td>
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<td>28 134 145</td>
<td>72</td>
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<tr>
<td>Democratic People’s Republic of Korea</td>
<td>4 403 130</td>
<td>16 711 000</td>
<td>21 114 130</td>
<td>18 756 982</td>
<td>89</td>
<td>17 762 754</td>
<td>84</td>
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<td>Maldives</td>
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<td>41 160 123</td>
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<td>89</td>
<td>6 749 944</td>
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<tr>
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<td>9 545 444</td>
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<tr>
<td>Timor-Leste</td>
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<td><strong>273 764 183</strong></td>
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<td>19 367 444</td>
<td>22 917 187</td>
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<td>Administration and Finance</td>
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<td>4 647 900</td>
<td>6 806 998</td>
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<td><strong>27 983 717</strong></td>
<td><strong>77 403 195</strong></td>
<td><strong>105 386 912</strong></td>
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<td><strong>93</strong></td>
<td><strong>88 783 598</strong></td>
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<td><strong>Grand total</strong></td>
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<td><strong>331 148 695</strong></td>
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<td><strong>91</strong></td>
<td><strong>362 547 781</strong></td>
<td><strong>84</strong></td>
</tr>
</tbody>
</table>

AC: assessed contribution; VC: voluntary contribution
Annex 5

Bibliography and additional resources

Section 01: Communicable diseases


Section 02: HIV/AIDS, tuberculosis, and malaria


Section 03: Noncommunicable diseases, including mental and neurological disorders and injuries


Section 04: Reproductive, maternal, newborn, child and adolescent health, and healthy ageing


Section 05: Health in emergencies


Section 06: Tobacco, alcohol, psychoactive substances, unhealthy diets, and physical inactivity


Section 07: Social and economic determinants of health


Section 08: Healthy environments and environmental threats to health


Section 09: Nutrition, food safety, and food security


Section 10: Health services, governance, financing, staffing, and management


Section 11: Leadership, governance, partnerships, and country collaboration


The First International Conference on Health Science, Thai Traditional and Alternative Medicine. The role of traditional/alternative medicine and global health care. Faculty of Medicine Mahasarakham University. 21–23 November 2012, Convention Hall, Taksila Hotel, Mahasarakham, Thailand.


Section 12: Leadership, governance, partnerships, and country collaboration


This Report describes the work of the World Health Organization in the South-East Asia Region during the period 1 January 2012 to 31 December 2013. It highlights the achievements in public health and WHO’s contribution to achieving the Organization’s strategic objectives through collaborative activities.

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

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The Work of WHO in the South-East Asia Region
Biennial Report of the Regional Director | 1 January 2012 – 31 December 2013