



REGIONAL COMMITTEE

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Progress reports on selected Regional Committee resolutions

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

1. Expanding the scope of the South-East Asia Regional Health Emergency Fund (SEARHEF) **(SEA/R69/R6)**
2. Challenges in polio eradication **(SEA/RC60/R8)**
3. Measles elimination and rubella/congenital rubella syndrome control **(SEA/RC66/R5)**
4. Antimicrobial resistance **(SEA/RC68/R3)**
5. Patient safety contributing to sustainable universal health coverage **(SEA/RC68/R4)**
6. South-East Asia Regional Action Plan to Implement Global Strategy to Reduce Harmful Use of Alcohol (2014–2025) **(SEA/RC67/R4)**
7. Capacity-building of Member States in global health **(SEA/RC63/R6)**
8. Consultative Expert Working Group on Research and Development (CEWG): Financing and Coordination **(SEA/RC65/R3)**

The High-Level Preparatory Meeting held in New Delhi from 10 to 13 July 2017 reviewed each progress report and made recommendations, which have been consolidated as an addendum (SEA/RC70/13 Add. 1) to this Working Paper for consideration by the Seventieth Session of the WHO Regional Committee for South- East Asia.

The related Regional Committee resolutions covered in this Agenda item are appended to this Working Paper as Addendum 2 (SEA/RC70/13 Add. 2).

Following requests by Member States to conduct an assessment of five years' experience (2011–2015) in capacity-building in global health and report it to the Seventieth Session of the Regional Committee, WHO assigned the assessment to the Health Intervention and Technology Assessment Program (HITAP), Nonthaburi, Thailand – a semi-autonomous research unit under Thailand's Ministry of Public Health. The assessment report submitted by HITAP is appended as Addendum 3 (SEA/RC70/13 Add.3).

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1. Expanding the scope of the South-East Asia Regional Health Emergency Fund (SEARHEF) (SEA/R69/R6)

Background

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

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

2. The Fund is designed to provide financial support for the first three months following a disaster in a Member State to meet immediate and urgent health needs, support emergency field operations and fill in critical gaps. It also has a window for receiving funds from donors. A total amount of US\$ 350 000 can be released in two tranches. The funds can be released within 24 hours of receiving a request from a Member State. SEARHEF is known to be the fastest emergency fund to be released among those provided by UN agencies.

3. Since its inception, the Fund has allowed for an immediate and flexible response to 33 disasters in nine Member States of the Region. The first disaster supported by the Fund was Cyclone Nargis in Myanmar in 2008 and the last so far was Cyclone Mora in Bangladesh in June 2017. To date, SEARHEF has disbursed a total of US\$ 5.1 million. Oversight is provided by the SEARHEF Working Group in which each Member State is represented. Six meetings of the Working Group have been held till date.

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

4. The Sixty-ninth session of the Regional Committee endorsed resolution SEA/RC69/R6 on “Expanding the scope of SEARHEF” to include a preparedness stream that would strengthen key aspects such as disease surveillance, health emergency workforce and health emergency teams. There was also an expressed need for increasing the tranches for emergency funding from SEARHEF. It is anticipated that support for basic preparedness activities may cost US\$ 200 000 per country per biennium. Thus, the minimum corpus per biennium may be set at US\$ 2.2 million. The target date for implementation of the SEARHEF preparedness funding stream is 1 January 2018.

5. The purpose of the fund for preparedness is to complement, not replace, development programmes under the biennium workplans. Activities under SEARHEF funding aim to provide short-term, bridging funds to kick-start, add value to and/or support larger preparedness projects.

Further, the SEARHEF Preparedness Stream does not affect functioning of the response fund. The criteria for allocation for preparedness from the fund is as follows:

- a. Address a priority gap as found in the International Health Regulations (IHR) capacity assessments and/or South-East Asia (SEA) Region benchmark assessments.
 - b. Address gaps in core skills such as risk assessments or information management.
 - c. Strengthen public health emergency operations centres (PHEOCs).
6. The types of activities for emergency health preparedness to be considered under the new Preparedness Stream of SEARHEF, as endorsed by the resolution of Regional Committee (SEA/RC69/R6), are as follows:
- i. developing and strengthening of policies and capacities;
 - ii. developing and implementing training courses;
 - iii. establishing systems for disease surveillance, information and knowledge exchange across countries for risk assessment and risk communication;
 - iv. strengthening PHEOCs;
 - v. strengthening the health emergency supply chain management system;
 - vi. strengthening emergency medical teams and their coordination;
 - vii. assessing health facilities for disaster risk reduction; and
 - viii. strengthening the health emergency workforce through establishment of systems that include efficient recruitment and deployment.

Updates on SEARHEF and challenges

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

7. The following are the updates on SEARHEF:
- a. Timor-Leste made a voluntary contribution of US\$ 100 000 to the Fund at the Sixty-eighth session of the Regional Committee, and this contribution is now available for this biennium in addition to US\$ 1 million.
 - b. In May 2017, Sri Lanka reported a series of floods and landslides, reportedly the worst floods triggered by the monsoons in that country since 2003. Support from SEARHEF for response efforts related to the floods/landslides was to the tune of US\$ 175 000 in this biennium.
 - c. The SEARHEF balance as of date is US\$ 143 376 for the current biennium 2016–2017 (the Fund was fully utilized at the end of the last biennium 2014–2015).
 - d. The Regional Office organized a meeting of the SEARHEF Working Group on 6–7 June 2017 to develop the proposal for the preparedness stream of SEARHEF. On utilization of SEARHEF, Member States appreciated adherence by WHO to disbursement of funds within 24 hours.
 - e. Timely reporting on utilization of SEARHEF needs further strengthening, as we expand to this new Preparedness Stream.

8. The table below gives a list of the disasters supported by SEARHEF since its inception until June 2017, and the Member States in which they occurred.

No	Emergency	Period		SEARHEF allocation in US\$
		Month	Year	
1.	Cyclone Nargis in Myanmar	May	2008	350 000
2.	Flash floods in Sri Lanka	June	2008	23 299
3.	Kosi river floods (in two tranches), Nepal	Sept.	2008	325 000
4.	Emergency health interventions for internally displaced populations (IDPs) in conflict-affected areas in northern Sri Lanka (in two tranches)	Sept.	2008	350 000
5.	Earthquake in North Sumatra province, Indonesia (in two tranches)	Oct.	2009	300 000
6.	Emergency health interventions for relocated IDPs affected by conflict in Sri Lanka	Jan.	2010	175 000
7.	Fire in Dhaka, Bangladesh	June	2010	175 000
8.	Mt Merapi volcanic eruption in East Java province, Indonesia	Nov.	2010	139 000
9.	Critical health-care services to the resettled population affected by conflict in Sri Lanka	Feb.	2011	175 000
10.	Floods in Thailand (in two tranches)	July	2011	350 000
11.	Torrential rains in Democratic People's Republic of Korea (in two tranches)	Aug.	2011	310 000
12.	Fire outbreak/explosion in Yangon, Myanmar	Jan.	2012	25 000
13.	Support for provision of emergency health care in Rakhine State, Myanmar	June	2012	12 300
14.	Flash floods in Democratic People's Republic of Korea	July	2012	134 130
15.	Support to population affected by storm in Maldives	Nov.	2012	47 717
16.	Support to Myanmar for procuring emergency medical supplies (fire outbreak and earthquake)	Nov.	2012	30 778
17.	Support to Myanmar for establishing health-care services for communal conflict-affected townships in Rakhine State	April	2013	175 000
18.	Support to the emergency caused due to flash floods in South Phyongan, North Phyongan, Kangwon and South Hamgyong provinces of the Democratic People's Republic of Korea	July	2013	175 000
19.	Support to emergency response activities for the crises situation created due to Mt Sinabung eruption in North Sumatera province, Indonesia	Feb.	2014	144 068
20.	To establish sustainable health-care services for communal conflict-affected townships in Rakhine State, Myanmar	May	2014	175 000

No	Emergency	Period		SEARHEF allocation in US\$
		Month	Year	
21.	To complement the response and recovery activities conducted by the Ministry of Health (MoH), Sri Lanka to support the short- to medium-term needs of the health sector	Nov.	2014	35 500
22.	To complement the response and recovery activities conducted by the MoH, Sri Lanka from heavy floods and landslides in 22 (out of 25) administrative districts in Sri Lanka	Dec.	2014	30 000
23.	Support to the Nepal earthquake	April	2015	175 000
24.	To support strengthening the capacity of health institutions to meet the immediate needs of the population in drought-affected areas (88 counties and 20 cities in South and North Hwanghae, South and North Pyongang provinces) of the Democratic People's Republic of Korea	July	2015	137 160
25.	Support to MoH for operational costs of for post-disaster management w.r.t floods following heavy rain that affected health facilities in the Sagaing and Magwe Region, and Rakhine State of Myanmar	Aug.	2015	26 000
26.	Support to MoH for emergency medical interventions for flood-affected populations in Rakhine and Chin states, and Sagaing and Magway regions, Myanmar	Aug.	2015	149 000
27.	Support for emergency medical supplies and essential drugs for flood-affected populations in Rason City, North Hamgyong province, Democratic People's Republic of Korea	Sept.	2015	161 887
28.	Support to MoH, Sri Lanka for response and recovery activities for flood victims	May	2016	100 000
29.	Support to MoH Bhutan to provide health sector support to the flood-affected population	July	2016	161 624
30.	Support to MoH Myanmar for provision of emergency health care to the flood-affected population	Aug.	2016	175 000
31.	Support for provision of emergency health care due to torrential rains and flood-affected population in the northern part of Democratic People's Republic of Korea	Sept.	2016	175 000
32.	SEARHEF for Sri Lanka floods and landslides	May	2017	175 000
33.	SEARHEF for Bangladesh Cyclone Mora	June	2017	170 000
Grand total				5 087 463

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

9. The major challenges faced by SEARHEF are well articulated in the recommendations made by the Working Group during its sixth meeting held in June 2017. These include:

- challenges in mobilizing domestic resources for preparedness activities; and
- non-conducive global and regional donor environment for funding.

The way forward

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

10. During the sixth Working Group Meeting held on 6–7 June 2017, the following recommendations were made and will constitute next steps for the way forward:

- The Secretariat would develop a webpage for SEARHEF.
- The Secretariat would set up an email for the SEARHEF Working Group to enable regular communication and updates on progress.
- As 10 years have passed since the inception of SEARHEF, it was recommended that the Secretariat undertake an evaluation of the impact of the Fund.
- Regular communication to Member States at each disbursement of SEARHEF would be considered.

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

- Member States would provide updates on the progress made with regard to contributions to the SEARHEF Preparedness Stream during the High-Level Preparatory Meeting in anticipation of some pledges to be made during the Seventieth Session of the Regional Committee in Maldives. This is critical to enable operationalization of SEARHEF Preparedness Stream by 1 January 2018.
- The Secretariat would also communicate with all Member States through the country offices on requesting contributions to the SEARHEF Preparedness Stream, based on the country-specific context, and on mechanisms for disbursement of external donations.
- The Secretariat would provide updates on discussions with key donors on using SEARHEF as the main channel to support preparedness work in the Region.

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

Background

11. The Sixty-eighth session of the World Health Assembly in 2015 urged Member States to fully implement all the strategic approaches outlined in the “Polio Eradication and Endgame Strategic Plan: 2013–2018”. The strategic approaches outlined in the Plan include:

- a. detection and interruption of poliovirus transmission;
- b. phased removal of oral poliovirus vaccines (OPV), beginning with the type 2 component of OPV;
- c. containment of polioviruses; and
- d. transition planning.

Situational analysis and progress made

12. The South-East Asia Region of WHO reported the last polio case due to wild poliovirus on 13 January 2011 and was certified polio-free on 27 March 2014. Despite being polio-free for six years, all Member States in the South-East Asia Region continue to be at risk of importation of the wild poliovirus from countries currently infected and subsequent spread of the virus in the Region. At the same time, the risk of circulating vaccine-derived polioviruses (cVDPV) emerging in areas of low immunization coverage remains a concern.

13. Appropriate actions to mitigate the risk of spread of wild poliovirus following an importation are being taken by all Member States in the Region.

14. Environmental surveillance for poliovirus detection has been expanded to additional countries in the Region. Four countries in the Region – Bangladesh, India, Indonesia and Thailand – are currently conducting environmental surveillance, with plans to initiate surveillance in two more countries, Myanmar and Nepal, in 2017.

15. All Member States in the Region have withdrawn the type 2 component of OPV by switching from trivalent OPV (tOPV) to bivalent OPV (bOPV) in April 2016 and have introduced inactivated poliovirus vaccine (IPV).

16. A global shortfall of IPV is affecting countries in the Region. In view of the IPV shortage, the available IPV supplies are being prioritized towards Member States that are at a higher risk of poliovirus resurgence. Recent clinical studies have demonstrated that two fractional doses of IPV provide better protection than one full dose. Two Member States in the Region, India and Sri Lanka, have replaced the full-dose IPV schedule with two fractional (one fifth) doses in their routine immunization schedule due to the effectiveness of the fractional IPV doses and to stretch the available IPV supplies. Another two Member States, Bangladesh and Nepal, are in the process of shifting to the fractional IPV dose schedule instead of a full-dose schedule before end-2017.

17. Activities to contain type 2 polioviruses are progressing in the Region. Poliovirus essential facilities have been identified to store/handle type 2 polioviruses in India and Indonesia. National authorities for containment have been established in these two countries, and

processes to undertake certification of these facilities as per the global containment certification scheme have been established.

Challenges

18. Significant IPV supply constraints globally are affecting all Member States, including Member States of the South-East Asia Region. The supply of IPV is expected to remain constrained through 2018.

19. It is challenging to ensure appropriate containment of polioviruses and meet the timelines as per the requirements of the Global Action Plan III.

20. There are financial, human resource-related and programmatic risks associated with the winding down of the Global Polio Eradication Initiative (GPEI).

The way forward

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

22. Complete containment of polioviruses as per the Global Action Plan III must be ensured to mitigate the risk of exposure of communities to any type 2 polioviruses, following the switch from tOPV to bOPV.

23. Transition planning in five Member States that have established significant polio-funded assets over more than two decades needs to be finalized.

Transition planning and post-certification strategy

24. Over more than two decades of operation, the GPEI has built significant infrastructure for disease surveillance, social mobilization and vaccine delivery. It has developed in-depth expertise, and learned valuable lessons about reaching the most vulnerable and hard-to-reach populations. As the world comes closer to achieving polio eradication, the GPEI will begin to wind down its operations, and will come to a close in the post-eradication era.

25. Five Member States in the Region – Bangladesh, India, Indonesia, Myanmar and Nepal – have established significant polio-funded assets over the past years, which have not only contributed to the achievement and maintenance of polio eradication and the implementation of polio endgame strategies, but have also supported other priority programmes in these Member States.

26. Winding down of GPEI over the next few years poses financial, human resource-related and programmatic risks in these five Member States of the Region.

27. The human resource-related risks in the South-East Asia Region are relatively small, as the Region has only 4% of the WHO staff positions funded globally through the GPEI. Nearly 97% of the polio-funded workforce in the Region is non-staff with nearly 80% of these being in India.

28. However, the programmatic risks and challenges associated with the ramp-down of polio are substantial. These include risks to the regional priority programme of measles elimination and rubella control by 2020, as well as the control of other vaccine-preventable diseases. Other

areas at risk include the introduction of new vaccines and the elimination of neglected tropical diseases. Providing support during emergencies and disasters will be a challenge as well, since polio networks have contributed to this area of work in the past. An example of such support in the past includes the support during the Nepal earthquake and Ebola crisis.

29. Fully mindful of these risks and priorities, the transition planning process has been initiated in all five Member States of the Region. A country-by-country approach is being adopted due to a difference in the scope and type of support being provided by polio networks in different countries, as well as variability in the capacities of different countries to absorb and support functions that are currently supported by polio networks.

30. The transition planning process has progressed well in India and an incremental increase in funding support for the polio network from the domestic budget of the government is being worked out. Transition plans are also being developed in Bangladesh, Indonesia, Myanmar and Nepal, with alternative funding options being explored in these Member States.

31. Finalization of the transition plans and their implementation remains an organizational priority in the Region. The key principles being applied in the Region as part of the transition planning process include (1) close collaboration with national governments and partners to clearly articulate and realign the programmatic priorities; (2) outlining the mechanisms for transferring capacities to the government, to the extent possible; and (3) increased engagement in and ownership of the transition process by national governments to ensure increased funding by them, as well as identification of additional donors to fill future funding gaps.

32. While the transition planning process recommends maintaining and mainstreaming polio-essential functions after eradication is certified, a post-certification strategy (PCS) for polio is being developed by the GPEI to outline the technical standards for these functions, as well as a policy framework for ensuring appropriate governance and financing to protect a polio-free world. With the purpose of sustaining a polio-free world, the PCS will have three strategic goals: (a) containing poliovirus sources by ensuring that potential sources of poliovirus are properly controlled or removed; (b) protecting populations by immunizing them against unanticipated polio events; and (c) detecting any poliovirus introduction and rapidly responding to prevent transmission.

33. Development of the PCS was initiated in early 2017, and will be completed when endorsed by the World Health Assembly in May 2018.

3. Measles elimination and rubella/congenital rubella syndrome control (SEA/RC66/R5)

Background

34. In September 2013, the Sixty-sixth session of the Regional Committee through resolution SEA/RC66/R5 adopted the goal of measles elimination and rubella/congenital rubella syndrome (CRS) control in the South-East Asia Region by 2020.

35. All Member States have developed national plans for measles elimination and rubella control by 2020, which are aligned to the South-East Asia Regional Strategic Plan for Measles Elimination and Rubella/CRS Control: 2014–2020.

Progress made in the South-East Asia Region

36. All Member States have accelerated activities to achieve the goal of measles elimination and rubella/CRS control. Two countries – Bhutan and Maldives – have been verified in April 2017 by the South-East Asia Regional Verification Commission as having eliminated endemic measles virus.

37. All Member States in the Region have introduced two doses of measles-containing vaccine, resulting in the aversion of nearly 640 000 deaths due to measles in 2016 in the Region.

38. Nine Member States have introduced rubella-containing vaccine in their routine immunization schedule. Of the two remaining Member States, Indonesia is expected to introduce the vaccine in August 2017 and the Democratic People's Republic of Korea is also working on introducing the vaccine soon.

39. Nearly 105 million children have been reached with an additional dose of measles-containing vaccine through mass vaccination campaigns between 2013 and 2016, and an additional 500 million children are planned to be reached through mass campaigns in 2017 and 2018. All Member States in the Region have initiated case-based surveillance for measles and rubella. The surveillance standards in the Region have been revised to meet elimination standards.

40. The Measles Rubella (MR) Laboratory Network in the Region has expanded from 23 laboratories in 2013 to 39 WHO-accredited laboratories in 2016, and it is proposed to include six additional laboratories in the network in 2017. Nearly 35 000 samples were tested by the MR Laboratory Network for serology in 2016.

41. A Regional Verification Commission was established to review progress on measles elimination and rubella control in the Region. All 11 Member States have a functional National Verification Committee for Measles Elimination and Rubella–CRS control.

42. The overarching goal of universal health coverage and the core theme of “leaving no one behind” in the Sustainable Development Goals provide a renewed opportunity to improve national immunization programmes, enhance access to new vaccines, and help strengthen health systems to sustain the gains made thus far.

Challenges

43. Coverage with the first dose of measles-containing vaccine in routine immunization has stagnated at around 85% for the past five years in the Region. Nearly 4.7 million children remain unvaccinated with measles-containing vaccine annually in the Region. Of these, nearly 3 million are in India and 1 million in Indonesia.

44. Large-scale mass vaccination campaigns have been planned in these two large countries – India and Indonesia – in 2017 and 2018, to close the immunity gaps against measles and rubella. With more than 470 million children targeted for vaccination in these two Member States over the next 18 months, these campaigns have significant global implications. The vaccination campaigns will have an impact on the epidemiology of measles and rubella, not only in these Member States but also globally. Achieving high coverage during these large-scale mass vaccination campaigns remains a significant challenge for the Region, and the global Measles and Rubella Initiative.

45. The current sensitivity of surveillance in the Region remains below the globally recommended standard. Achieving and maintaining high-quality surveillance for measles and rubella in all Member States to meet the regional measles elimination target of 2020 remains a challenge.

46. Polio-funded human resources and systems have been established in five Member States of the Region over the past two decades to support polio eradication activities. This workforce has been increasingly supporting surveillance and immunization activities for measles elimination and rubella control over the past few years. The Global Polio Eradication Initiative has now indicated a ramp down of polio funding between 2017 and 2019, followed by an eventual cessation of this funding. This poses a huge risk to the goal of achieving measles elimination and rubella control in the Region.

The way forward

47. Almost 500 million children are planned to be vaccinated over the next two years in the Region. Nearly 470 million of these will be in just two countries – India and Indonesia. It is critical that all components of the campaign are well financed and mechanisms are in place to ensure a high quality of coverage during the campaigns. Active engagement of governments and partners will be essential to ensure high coverage.

48. A mid-term review of the “South-East Asia Regional Strategic Plan for Measles Elimination and Rubella/CRS Control: 2014–2020” is planned to be conducted in 2017 to review the progress made so far, refine the strategies to accelerate progress towards the 2020 goal, formulate the lessons learned and risks, and identify the financial, political and programmatic priorities over the next three years (2018–2020).

49. Strengthening surveillance for measles and rubella in all countries is critical for ensuring detection of all measles cases and outbreaks in the Region followed by prompt follow-up action.

50. As the Region comes closer to elimination, a cross-border notification system across countries in the Region needs to be established to ensure that the virus is tracked across borders. Responses to outbreaks should be synchronized across borders.

51. The polio transition planning process will have to be managed well in the five Member States that have substantial assets funded through the GPEI to mitigate the risks to the regional goal of measles elimination and rubella control.

52. Additional efforts to mobilize resources will be required in the Region to achieve the goal of measles elimination and rubella control by 2020. This includes commitment by national governments to sufficiently fund measles elimination and rubella/CRS control activities, including the laboratories involved, based on technically sound plans developed by national immunization programmes.

4. Antimicrobial resistance (SEA/RC68/R3)

Background

53. In 2015, the Sixty-eighth World Health Assembly adopted a resolution, WHA68.7, on the Global Action Plan (GAP) on Antimicrobial Resistance. All Member States committed to have in place, by May 2017, a national action plan (NAP) on antimicrobial resistance (AMR) that is aligned with the GAP. WHO is required to report to the World Health Assembly on the development and implementation of the NAPs.

54. In May 2017, the Seventieth World Health Assembly adopted a resolution, WHA70.7 on “Improving the prevention, diagnosis and clinical management of sepsis”. In particular, the resolution requests the WHO Director-General to collaborate with partners “in enhancing access to quality, safe, efficacious and affordable types of treatments of sepsis”. The sepsis resolution notes that sepsis causes approximately 6 million deaths worldwide every year, which are mostly preventable.

Progress made in the South-East Asia Region

55. Two high-level ministerial meetings on AMR involving the Region’s Member States were held in 2016. In February, there was a meeting “Combating AMR: public health challenge and priority” organized by the Government of India in New Delhi, where a roadmap for the creation of NAPs was developed, and where countries pledged to have these plans finalized by May 2017.

56. In April, a bi-regional meeting on AMR was held in Tokyo and organized by Japan, in collaboration with the WHO regions for South-East Asia and the Western Pacific. This meeting allowed Member States the opportunity to expedite the process of development of their NAPs, and reiterated the need to focus on reversing the rising trend of AMR.

57. In addition, a workshop was held in November 2016 in New Delhi with officials from WHO, Food and Agriculture Organization (FAO) and World Organisation for Animal Health (OIE). This workshop focused on the specific concerns of developing countries as they relate to AMR and the One Health approach. As these initiatives demonstrate, AMR has been considered a clear and present danger to health, development and prosperity across the Region.

58. Work in different departments of the Regional Office is mapped out and consolidated through a coordination group for AMR. To date, 10 South-East Asia (SEA) Region Member States have finalized their NAPs. Multisectoral endorsement is needed for cross-sectoral collaboration. The situation or baseline analysis conducted in 10 countries of the Region showed that most are at the initial stages of their national AMR prevention and containment programme and NAP implementation.

59. The Regional Office for South-East Asia has collaborated with its regional tripartite partners (OIE, FAO and other partners) to develop harmonized surveillance on AMR and antimicrobial use (AMU).

60. Studies have been conducted on a six-year retrospective analysis of antimicrobial consumption data in several Member States to determine the extent and pattern of use of antibiotics.

61. Several projects have been carried out to review the situation of AMR in the Region. The findings made it clear that AMR is an issue of critical concern for the Region. A risk assessment conducted by the Regional Office shows the Region is at high risk for the development of antimicrobial-resistant bacteria – probably the highest among the WHO regions globally. Most factors driving this can be well understood.

62. The Regional Office has supported laboratory strengthening in Member States, as laboratory activities are an important part of the AMR control programme. The topic of AMR was also raised during the launch of the immunization campaign in India in May 2017, as prevention of infection by immunization is indeed important. The topic of Environment and AMR was also being analysed, based on the recent study undertaken by WHO (snapshot survey of AMR in the East Kolkata Wetlands) this year.

63. Other aspects of this multifaceted AMR issue in the Region have been also analysed and are being published in a special issue of the British Medical Journal (BMJ). Initiatives to advance the battle against AMR were presented from three of the Region's countries – India, Indonesia and Thailand. The Regional Office also surveyed the broader situation, including progress on NAPs, surveillance, infection prevention and control, and diffusion of antimicrobial resistance genes (ARG) in the environment. Apart from articles documenting the present situation, the BMJ issue would also include a focus on areas that will be key to making progress, including implementing the One Health approach successfully, and creating and implementing stronger surveillance.

64. During the HLP Meeting, Member States also raised key issues related to the implementation of their NAPs, including:

- a. over-the-counter sale of antibiotics;
- b. focusing on and the allocation of adequate resources for research and development of new antibiotics;
- c. robust monitoring and evaluation in order to closely track progress and provide corrective actions in the implementation of NAPs;
- d. comprehensive planning and engagement across sectors, including but not limited to animal health and agriculture;
- e. investing resources across sectors to implement NAPs;
- f. participating in the Global Antimicrobial Resistance Surveillance Systems (GLASS) to foster standardized AMR surveillance globally;
- g. implementing NAPs in decentralized systems; and
- h. promoting affordable access to existing and new antimicrobials and diagnostic tools.

Challenges

65. Several challenges have been recognized, most of them during the in-country situation analysis process – a process that was recommended prior to the development of the NAP in Member States of the SEA Region. These include: (i) unregulated sale of cheap antibiotics for human health; (ii) widespread use of antibiotics in the animal industry; and (iii) poor awareness

about AMR and its drivers – particularly its relationship with sanitation, hygiene and food handling among health professionals and consumers.

66. Member States of the SEA Region will need strong political commitment to develop effective country-dependent policies and the capacity for enforcing these to address these cross-sectoral challenges.

The way forward

67. As a Flagship Priority for the SEA Region, the Regional Office will continue to support the implementation of the AMR NAP in Member States. WHO will collaborate to periodically review implementation and measure progress made using the Regional Office tool for situation analysis.

68. Another area where the Regional Office will provide technical support is to strengthen national regulatory authorities for AMR to implement the AMR NAP.

69. The Regional Office is committed to strengthen a “One Health” tripartite partnership with the regional offices of OIE and FAO to combat AMR. One major priority includes harmonized surveillance of AMR and AMU in the human and animal sectors and the environment. To support surveillance, WHO will advocate for Member States to participate in GLASS.

70. The research aspect will also be strengthened through various mechanisms. Preparations are on to observe the World Antibiotic Awareness Week in November 2017, as well as conduct other awareness-raising programmes on AMR in line with the GAP Strategic Objective 1.

71. Together with Member States, WHO continues to support the implementation of (a) the UN General Assembly High-level Political Declaration on AMR adopted in October 2016, World Health Assembly resolutions (WHA67.25 and WHA68.7) and Regional Committee resolution (SEA/RC68/R3) on AMR, and (b) the Seventieth World Health Assembly resolution (WHA70.7) on sepsis, which recommends that Member States improve the prevention, diagnosis and management of sepsis.

5. Patient safety contributing to sustainable universal health coverage (SEA/RC68/R4)

Background

72. Up to one in ten patients experiences an adverse event as a result of health care. Patient safety has been recognized as a public health problem for many years in the South-East Asia Region. In 2006, the Fifty-ninth session of the Regional Committee endorsed a resolution SEA/RC59/R3 on “Promoting patient safety in health care”. A regional survey by the Organisation for Economic Co-operation and Development (OECD) on patient safety and health-care quality in 2013 reinforced the view that a regional strategy on patient safety was needed. Member States endorsed the Regional Strategy on Patient Safety (2016–2025) in the WHO South-East Asia Region at the Sixty-eighth session of the Regional Committee (Resolution SEA/RC68/R4). The Resolution recognized that patient safety and quality of care are integral elements in progress towards universal health coverage, and noted compelling health and economic arguments for improving patient safety. It stated that improving safety requires action by multiple stakeholders, including patients and health professionals, and needs system-wide solutions. It urged Member States to take action on the six strategic objectives of the Strategy, and requested the Regional Director to report on progress every two years, starting from 2017.

Progress and challenges in the South-East Asia Region

73. As a first step, a patient safety self-assessment tool was developed by the Regional Office for use by Member States. It is organized around the six objectives of the Strategy, and designed to collect baseline information on the national policies, systems and procedures in place for promoting patient safety, and help identify priorities for action. It does not collect data on actual adverse events. The tool was pilot-tested in late 2015, and revised and shared with all Member States. Five countries have now completed national self-assessments: India, Maldives, Sri Lanka, Thailand and Timor-Leste. Self-assessments are ongoing in three more countries—Democratic People’s Republic of Korea, Indonesia and Nepal. Preliminary discussions are under way in Bangladesh. The findings have been presented in summary dashboards, with each dimension scored and rated weak to excellent by the self-assessment team, and discussed in national workshops.

Key findings:

- No country in the Region routinely reports errors in health-care settings, except for adverse events following immunization and maternal deaths.
- Many countries do not have hospital quality assurance mechanisms, nor routinely conduct patient safety assessments.
- Policy frameworks and legislation are not always adequate.
- Compliance with patient safety standards by health-care workers is often poor.
- Hard data for preparing estimates of errors in patient safety and the cost implications of these are not available.

Follow-up:

Five countries with completed assessments have prioritized interventions and developed five-year patient safety implementation plans.

- India has adopted a new policy for patient safety and a patient safety strategic framework.
- Thailand has adopted the “2P” policy (patient and personal safety).
- Maldives, Sri Lanka, Thailand and Timor-Leste have already developed routing error reporting and learning systems after the self-assessment exercise. These four countries will publish reports in early 2018, which will capture the burden of unsafe care.
- The Democratic People’s Republic of Korea, Maldives, Sri Lanka and Timor-Leste have conducted national training of trainers’ workshops on patient safety, supported by the Regional Office.

74. In addition, most Member States have appointed high-level officers responsible for national patient safety programmes. Several have developed quality and safety indicators to be used in hospitals. These best practices are being shared with other countries. Many countries are implementing national action plans for prevention of antimicrobial resistance, and blood, laboratory and medication safety.

75. The Regional Office has promoted the WHO Multi-professional patient safety curriculum guide for use in all medical, nursing and other health professional pre-service and in-service programmes. This guide was adopted by the South-East Asia Medical Council Network in 2015, to be used in future medical education curricula. The Regional Office also promotes the use of WHO checklists and guidelines on safe childbirth, safe surgery, infection prevention and control, and prevention of surgical site infection. An Asia Pacific Healthcare Quality Improvement Network has been established, supported by OECD and WHO.

The way forward

76. Well-functioning error reporting systems are needed to enhance patient safety in all Member States. Policy-makers and managers in hospitals and health centres need to move away from blaming individual health workers, and focus on encouraging error reporting and how to prevent them in future. Policy frameworks and legislation may need review and revision.

77. Member States also need to increase all health workers’ awareness of patient safety, build their capacity to practise the measures needed to minimize errors, and improve infection prevention and control, for which hand hygiene remains one of the most effective interventions. Hospital management must provide adequate logistics and materials required for good hand hygiene practices within facilities.

78. Member States may consider establishing a national mechanism for certification of health facilities that provide good quality and safe health-care services.

6. South-East Asia Regional Action Plan to Implement Global Strategy to Reduce Harmful Use of Alcohol (2014–2025) (SEA/RC67/R4)

Background

79. Alcohol consumption has a negative impact on all dimensions of health – physical, mental and social – and is related to over 60 groups of diseases. It was the cause of 3.3 million global deaths in 2012 (5.9% of all global deaths), including 634 539 deaths in the South-East Asia (SEA) Region. Alcohol use contributed to 5.1% of the global burden of diseases, in terms of total disability-adjusted life-years (DALYs) lost in 2012, and 4.0% of the burden of diseases in the SEA Region. Alcohol consumption also leads to many noncommunicable diseases (NCDs), including cardiovascular diseases and cancers, and increases the risk of developing communicable diseases such as HIV/AIDS, tuberculosis (TB) and lower respiratory tract infections.

80. Compared to other regions, the SEA Region has a relatively low drinker prevalence (13.5%), with a high gender discrepancy (males more than females). While drinker prevalence among teenagers is of concern, over 85% are abstainers, a positive aspect that needs to be maintained. However, heavy episodic or binge drinking is common among a large percentage of those who drink. The adult per capita consumption rose continuously from 2.2 L in 2005 to 3.4 L of ethanol in 2010, and is projected to further increase to close to 4 L of ethanol in 2025. It is estimated that unrecorded alcohol consumption still accounts for almost 50% of regional consumption. The majority of alcohol consumed in the Region is in the form of spirits (77.3%).

81. The Sixty-seventh session of the WHO South-East Asia Regional Committee endorsed the South-East Asia Regional Action Plan to implement the Global Strategy to Reduce the Harmful Use of Alcohol (2014–2025). The vision of the Action Plan is to reduce the health and societal burden from alcohol consumption, and the goal is to strengthen Member States with tools and build their capacity to address alcohol-related problems. The target is a 10% relative reduction in total adult per capita consumption within a calendar year in litres of pure alcohol, as appropriate, within the national context, to be achieved by 2025 in comparison to the 2010 baseline.

82. This Action Plan also fulfils the mandate given by the Political Declaration of the General Assembly (resolution WHA66.10) on the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020. To further action in this area, the Sustainable Development Goals included a target that calls for strengthening the prevention and treatment of substance abuse, including narcotic drug abuse and the harmful use of alcohol (Target 3.5).

83. This report cites the progress in implementing the Action Plan on reducing the harmful use of alcohol at the regional and country levels.

Progress in the WHO South-East Asia Region in implementing the Global Strategy to Reduce the Harmful Use of Alcohol

84. Since the endorsement of resolution SEA/RC67/R4 entitled “South-East Asia Regional Action Plan to implement the Global Strategy to Reduce the Harmful Use of Alcohol (2014–2025)”, Member States of the Region have achieved several milestones, despite challenges in enforcement of policies and resource mobilization.

85. The WHO Regional Office, in conjunction with WHO headquarters and WHO collaborating centres, plays a leading role in coordinating a response to the challenges of alcohol-related harm in the SEA Region. Technical support has been provided to build the capacity of Member States to advance implementation of the Regional Action Plan to implement the Global Strategy to Reduce the Harmful Use of Alcohol, which is in accordance with the Action Plan to implement the Global Strategy to Reduce the Harmful Use of Alcohol, as well as meet the targets for the prevention and control of NCDs.

86. Technical tools and guidance materials have been developed in consultation with experts in the Region. Community programmes have also been initiated in Member States (Bhutan and Sri Lanka) and good practices documented. Modules have been developed for the online portal for management of problematic alcohol use, which is a template for programme planners and implementers, describing the necessary components of a comprehensive policy framework to minimize the harm from alcohol use.

87. The regional network of national counterparts has been strengthened and the Regional Office has supported Member States to participate in capacity-building workshops on prevention and management of the harmful use of alcohol. Global initiatives such as the Global Survey on Alcohol and Health strengthen country capacity and culminate in the publication of the Global status report on alcohol and health. Similarly, the NCD STEPS survey provides evidence-based data and the process contributes to country capacity-building. A Technical Advisory Group on Alcohol and Health for the SEA Region is under development.

88. **National policies and legislation:** Till recently, only Thailand had a written alcohol policy. Two more countries, Bhutan and Sri Lanka, have adopted national alcohol policies since the Sixty-seventh Regional Committee Meeting. Bangladesh has taken initiatives to develop a draft national alcohol policy. India and Indonesia have begun developing national alcohol policies; Nepal has endorsed a National Alcohol Control and Regulatory Act in 2017. The progress made by individual countries is described in the Annexure.

Challenges

89. Overall, policy interventions to address the harms from alcohol use in the SEA Region need concerted attention from all stakeholders. The existing policies and legislation lack effective implementation and enforcement. Most Member States do not have effective infrastructure to support alcohol control policies and strategies, as well as laws and regulations for policy enforcement. Coordination across sectors and capacity need to be further strengthened.

90. The alcohol industry has been progressively investing in the Region. Globalization and bilateral, regional and multilateral trade agreements facilitate free flow of alcohol-related trade and investment, which might limit the ability of Member States to prevent and control alcohol-related harms.

91. Issues such as pay-day drinking, violence and domestic violence, exposure of younger age groups to alcohol promotion, informal and illegal production, and the possible impact of trade agreements are challenges faced by the Region.

The way forward

92. The Regional Office will continue to assist Member States in the development, implementation, evaluation and monitoring of alcohol control policies and plans, according to their needs, culture and socioeconomic situation. Seamless coordination within programmes, including those for NCDs, health promotion and mental health, should be ensured.

93. The alcohol policy situation in the Region has been reviewed by the Regional Office and recommendations made for country-specific actions. The following ten specific areas will be given priority:

- **Multisectoral mechanisms** at national and subnational levels, and aligning national and subnational policies. Many issues related to alcohol control are beyond the purview of the health sector, and fall under subnational policies and legislations. Therefore, priority requirements for Member States are to establish multisectoral mechanisms to align national and subnational policies and measures on alcohol control.
- **Capacity-building.** The human, technical, institutional and financial capacity for developing and implementing alcohol control policies needs to be strengthened. Member States will be encouraged to identify human, technical, institutional and financial capacity development needs. Priority will be given to strengthening the health services for screening and early identification of, and brief interventions for, alcohol use.
- **Preventing new drinkers and protecting high abstinence rates.** In most Member States, the rate of abstinence from alcohol use is over 80%, including in countries with large populations such as Bangladesh, India and Indonesia, and is almost 80% in countries such as Sri Lanka. National and subnational strategies for alcohol control in the Region need to draw attention to sustaining this high level of abstinence.
- **Surveillance and information.** Establishment of surveillance that goes beyond the collection of prevalence, morbidity and mortality data will be established to ensure a comprehensive response to the harms caused by alcohol.
- **Addressing unrecorded and illegal alcohol products.** Unrecorded alcohol products escape policy measures in most countries. Hence, in addition to law enforcement, emphasis is needed to address the social and cultural norms that promote home production and consumption of unrecorded alcohol.
- **Marketing regulation.** Advocacy for a total ban on advertising and sponsorships is supported by evidence that shows that comprehensive bans are more effective than partial ones. Member States will be encouraged to move towards a comprehensive ban on alcohol.
- **Alcohol taxation.** Member States will be encouraged to use taxation as a means of reducing alcohol-related harm. The Regional Office will provide technical support to countries to initiate studies that can guide optimum taxation approaches.
- **Addressing the effects of trade agreements.** The effects of trade agreements on present and future alcohol control policies in Member States should be taken into account in trade agreement policies.

- **Counteracting the influence of the alcohol industry.** Systems should be put in place to prevent conflicts of interest, and steps taken to ensure that alcohol industry-funded research and projects are excluded from the policy development process.
- **Community actions.** National-level policies and programmes have to be implemented at the community level to address harms and promote changes in behaviour. In addition, countries will be encouraged to implement and support community action that addresses issues specific to alcohol use in the community. Success stories and good practices will be documented and disseminated.

Annexure

Progress by individual countries on the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol

- **Bangladesh:** Bangladesh has taken the initiative to develop a draft National Policy on Alcohol. Comprehensive measures are being taken to train primary health-care workers on mental health, substance abuse and alcohol. Prevention and management of the harmful use of alcohol is included in the postgraduate psychiatry curriculum.
- **Bhutan:** The Bhutan National Policy and Strategic Framework to Reduce Harmful Use of Alcohol (2015–2020) were endorsed on 2 December 2015. In August 2016, the Executive Order was signed by the Chairman of the National-level Committee and sent to all stakeholders in Bhutan. District-level and Gewog-level committees were formed in all dzongkhags to implement actions under their purview. The implementation status will be submitted every year to the secretariat, to be submitted to the National-level Committee.
- **India:** The Ministry of Social Justice and Empowerment, which is the nodal ministry in India for alcohol control, has constituted a committee to formulate the National Alcohol Prevention and Control Policy. The process of drafting this policy is under way. The Multisectoral Action Plan on NCDs by the Ministry of Health and Family Welfare has provisions for the prevention and control of alcohol as a risk factor for NCDs. The newly endorsed National Health Policy 2017 also focuses on alcohol, linking it to other NCDs and road traffic accidents.
- **Indonesia:** The Indonesia draft law for a ban of consumption of alcoholic drinks is under discussion in Parliament. The draft law will include regulation of production and distribution, implementation of a tax on sale of alcohol for health promotion and rehabilitation, community involvement, criminal provisions, monitoring and surveillance, roles of stakeholders, and addressing illicit and traditional alcoholic drinks.
- **Maldives:** Maldives observes total prohibition.
- **Myanmar:** Alcohol is addressed as a part of the National Mental Health Plan and has levied excise tax on alcohol. It has laid down a minimum age for on-premises sales, and legally binding regulations on alcohol advertising.
- **Nepal:** the Alcohol Control and Regulatory Act 2017 and Alcohol Control and Regulatory Policy 2017 have been recently endorsed by the government. These are aligned with the Global Strategy to Reduce the Harmful Use of Alcohol. There is a differential taxation policy for alcoholic beverages based on alcohol concentration. Enforcement of marketing restrictions with a total ban on alcohol advertising, promotion and sponsorship are in place. Restriction on availability has been enforced by prohibiting the sale of alcohol in the vicinity of public places; alcohol use is prohibited in Government-sponsored programmes and events.

- **Sri Lanka:** A comprehensive National Policy on Alcohol, covering all technical areas identified in the WHO Global Strategy to Reduce the Harmful Use of Alcohol has been developed. This was approved by the Cabinet of Ministers in 2015. This complements the stringent alcohol laws contained in the National Authority on Tobacco and Alcohol Act of Sri Lanka. This law totally prohibits all forms of alcohol promotion and sponsorship, sales to those below 21 years of age, sale by vending machines, free distribution of alcohol, etc. The Ministry of Health, along with the National Authority on Tobacco and Alcohol, is working to further strengthen the related laws, for which amendments have been proposed to the Cabinet of Ministers for approval. A National Action Plan to implement the National Policy on Alcohol was developed during 2016–2017, with support from the Regional Office.
- **Thailand:** Thailand has a well-established alcohol policy in place and implementation is progressing. Thailand has set a target for reducing harmful use of alcohol by 10% by 2025. Alcohol is included as one of the risk factors in the NCD National Strategic Action Plan, which is soon going to be endorsed by the Cabinet. Thailand takes initiatives and collaborates with WHO to advance alcohol-related activities in the Region. The WHO-ThaiHealth Workshop on Technical Support for Alcohol Policy Development in Low- and Middle-Income Countries has been instrumental in increasing the capacity of countries with a high burden, such as Bhutan, Myanmar and Sri Lanka.
- **Timor-Leste:** The National Mental Health Strategy 2017–2021 provides a framework for priority mental health conditions and gives strategic directions for the implementation of the Global Strategy to Reduce the Harmful Use of Alcohol in the national context.

7. Capacity-building of Member States in global health (SEA/RC63/R6)

Background

94. The term “global health” has emerged as part of the larger political and historical process replacing the term “international health” to imply a shared global responsibility for health. It is also associated with the growing number and increased roles in health of other actors beyond governments, namely intergovernmental organizations and agencies, nongovernmental agencies, international and domestic stakeholders, civil society and academia.

95. The United Nations General Assembly (UNGA) in New York had adopted the resolutions A/RES/63/33 in November 2008 and A/RES/64/108 in February 2010, which recognized the close relationship between foreign policy and global health and their interdependence. The UN Secretary-General, in collaboration with the Director-General of WHO, and in consultation with Member States as well as pursuant to UNGA resolution A/RES/63/33, submitted a progress report to the Sixty-fourth session of UN General Assembly in September 2009, titled “Global health and foreign policy: strategic opportunities and challenges”.

96. The World Health Assembly resolution WHA59.26 on International trade and health urged Member States to create constructive and interactive relationships across the public and private sectors to promote coherence in national trade and health policies, and also requested WHO to support Member States to build capacity to understand the implications of international trade and trade agreements for health.

97. The Sixty-third session of the WHO Regional Committee for South-East Asia adopted resolution SEA/RC63/R6, urging Member States to establish policies and programmes for capacity-building in global health of staff concerned, who would be representing their respective governments at high-level policy and programme meetings.

98. The Sixty-ninth session of the WHO Regional Committee for South-East Asia requested the Regional Director to conduct an assessment of the five-year experience (2011–2015) in capacity-building in global health in the Region in response to resolution RC63/R6. The report would be provided to the Seventieth Session of the Regional Committee in order to obtain a more systematic understanding of the strengths, weaknesses and impact of activities, and to provide recommendations on effective management of capacity-building on global health.

Progress made in the Region

99. WHO embarked on a global initiative in 2010 to support Member States in developing their national health policies and strategies, and planning. The initiative provides evidence-based technical and policy advice, and support to Member States in enhancing understanding of the relationship between foreign policy and global health by commissioning research, sponsoring symposiums and developing an international network of governments and institutions – the

Network on Global Health Diplomacy – with the support of the Rockefeller Foundation and the Global Health and Foreign Policy Initiative.¹

100. Prior to the Sixty-third World Health Assembly and the 127th session of the Executive Board, the First Regional Training Course on Global Health was organized by the Ministry of Public Health, Thailand, on 1–5 May 2010, in collaboration with the WHO Regional Office for South-East Asia and the Thai Health Global Link Initiative Programme (TGLIP). The training was conducted in Nakhon Pathom, Thailand, followed by the second module on practical experience and learning through attendance at the Sixty-third World Health Assembly from 17 to 21 May 2010 in Geneva. A wrap-up session – the third module – was conducted on 22 May 2010 in Geneva.

101. Between 2011 and 2013, the Regional Office for South-East Asia annually organized three workshops on global health in collaboration with Thai Health and the Rockefeller Foundation. These workshops were attended by almost all Member States of the Region. The objectives of the workshop were to build up and strengthen the capacity of health and related professionals on global health, which could lead to the setting up of a global health agenda and policy formulation, and to ensure that participants realize the evolution and importance of global health diplomacy. In addition, related activities and courses were also undertaken in a few of the Member States at national level.

102. Besides the efforts made by the Regional Office in holding regular technical briefings, coordination and preparatory meetings before important regional and global engagements, such as Executive Board, World Health Assembly, High-Level Preparatory Meeting for the Regional Committee, intergovernmental meetings, global technical consultations on strategies and plans of action, etc., increase exposure to global health issues and strengthen global health capacities of Member States. There is recognition in the international health arena of the Region's expertise, be it in collaborating centres, professional training and research institutions of excellence, pharmaceuticals or academia. The vision of the Regional Director is envisaged in the "One by Four" plan – where "One" refers to a more responsive WHO in the Region and "Four" to the four strategic directions; the fourth being articulation of a strong regional voice in the global health agenda. The combined efforts of Member States have made a difference in protecting and promoting regional and global public health through the health strategies, plans of action and frameworks being adopted at the global level.

103. Following requests by Member States to conduct an assessment of five years' experience (2011–2015) in capacity-building in global health and report it to the Seventieth Session of the Regional Committee, WHO decided to assign the assessment to a public health agency that is familiar with Member States and international health processes, and is best placed to carry out the assessment in consultation with official focal points as well as the organizers of the exercise. The Health Intervention and Technology Assessment Program (HITAP), Nonthaburi, Thailand – a semi-autonomous research unit under Thailand's Ministry of Public Health – was finally identified to conduct the assessment.

104. The HITAP, under an agreement with the WHO Regional Office, conducted the assessment from April to mid-August 2017. During the assessment exercise, (i) the chronological development of in-country and regional programmes and activities for capacity-building and the

¹ The Global Health and Foreign Policy Initiative was launched in September 2006 as an immediate outcome of the Oslo Ministerial Declaration (by the foreign ministers of Brazil, France, Norway, Senegal, South Africa and Thailand).

number of staff trained in global health were explored to identify the enabling and impeding factors; (ii) strengths, weaknesses and impact of the capacity-building activities conducted were assessed; (iii) in-depth interviews of the country senior officials in charge of global health policy and WHO Senior Management were conducted to explore their perspectives on the development of regional collective capacity on global health; and (iv) recommendations on effective management and improvement of capacity-building on global health and possible future actions were also provided. The final report of the assessment, appended to this Working Paper as Addendum 3 (SEA/RC70/13 Add. 3), is submitted to the Seventieth Session of the WHO Regional Committee for South-East Asia.

The way forward

105. WHO would continue to support Member States to organize national, regional and global seminars and training workshops on global health that could act as an effective tool to strengthen national capacity in global health. These would enable them to participate and play active roles in international/global health forums with improved negotiation skills. At the same time, national strategies and plans have to be developed to address the increasing demand for well-trained public health professionals who could address the changing context of global health challenges, including complex and persistent health issues, increasing health inequities, new and emerging diseases, the necessity for greater collaboration, and incorporation of social models and determinants.

106. The final report of the assessment, including (i) methodology of the assessment; (ii) details on development of global health capacity-building activities; (iii) awareness and need of capacity-building in global health and priority global health issues of the Member States in the Region; (iv) strengths, weaknesses and impact of these activities in the Region; (v) details of enabling and impeding factors affecting capacity development in the Region; (vi) regional collective capacity on global health in safeguarding regional interest; (vii) plans for future development of the capacity-building activities in each Member State; and (viii) conclusions and recommendations for further strengthening of capacity-building in global health in the Region, is submitted to the Seventieth Session of the WHO Regional Committee for South-East Asia.

8. Consultative Expert Working Group on Research and Development (CEWG): Financing and Coordination (SEA/RC65/R3)

Background

107. The Regional Committee resolution on the Consultative Expert Working Group on Research and Development: Financing and Coordination (CEWG) (SEA/RC65/R3) has contributed in great measure to the outcomes of resolution WHA70.22 on CEWG. The SEA Region resolution was the outcome of national and regional consultations on the CEWG report and provided the basis for the development and adoption of resolution WHA66.22 at the Sixty-sixth World Health Assembly in May 2013. Resolution WHA70.22 encompasses and builds on regional resolution SEA-RC65-R3; hence they are considered together for outcomes and progress.

108. The follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination, addresses, in effect,

- a. terms of reference and a costed workplan for the Global Observatory on Health Research and Development;
- b. a proposal with goals and an operational plan for a voluntary pooled fund to support research and development (R&D) for Type III and Type II diseases and specific R&D needs of developing countries for Type I diseases; and
- c. progress on demonstration projects.

Progress made in the South-East Asia Region

109. The Global Observatory on Health Research and Development: The terms of reference are, *inter alia*, to produce comprehensive analysis of existing data and information on health R&D, to monitor and report on global trends, to benchmark and compare health R&D activities across countries and health conditions, to contribute to improving data collection and make it available in a web portal, to conduct comprehensive analysis and syntheses of data based on the advice of the Expert Committee on Health R&D.

110. Voluntary pooled fund: A proposal with goals and an operational plan for a voluntary pooled fund to support R&D. The success of a voluntary pooled fund will depend on its ability to attract sufficient amounts of funding, with a minimum size of US\$ 100 million per year with a diverse portfolio of 35–40 R&D projects. Various options for sustainable funding are proposed.

111. Health R&D demonstration projects: Six demonstration projects were finally selected. On 17 March 2017, the “Multiplexed Point-of-Care test for acute febrile illness” demonstration project by the Translational Health Science and Technology Institute, India, and developed in coordination with the Regional Office and the Country Office for India received Indian rupees 59.9 million from WHO. The project was selected to take resolutions SEA/RC65/R3 and WHA66.22 forward and identified at the Regional Consultation for developing a strategic workplan as a follow-up of the CEWG held on 25–26 July 2013 in Bangkok, Thailand. The scope for the demonstration project is significant as it goes beyond Type III neglected diseases and

emphasizes engaging the CEWG mechanism for all Type I, II and III diseases for providing access to affordable medical products.

112. The estimated total financial requirement over the period 2014–2017 for the implementation of the demonstration projects and establishment of the Global Observatory is US\$ 85 million. A total of US\$ 10.49 million had been contributed by Brazil, Germany, India, Norway, South Africa and Switzerland to the voluntary fund designated for demonstration projects till May 2017.

Challenges being faced

113. The progress on CEWG needs to gain momentum. This has been recognized in discussions on other resolutions at the World Health Assembly. The CEWG came up for discussion also in resolution WHA70.20 on “Addressing the global shortage of, and access to, medicines and vaccines”. The United Nations Secretary-General’s High-level Panel on Access to Medicines “to review and assess proposals and recommend solutions for remedying the policy incoherence between the justifiable rights of inventors, international human rights law, trade rules and public health in the context of health technologies” echoes the conclusions of previous reports, in particular the reports of the Commission on Intellectual Property Rights, Innovation and Public Health and the CEWG. National regulatory capacity and local production has been discussed in line with the parent CEWG resolution WHA61.21 of 2008 on the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property. Member States reiterated the importance of the Strategic Workplan of CEWG for the 2030 Agenda for Sustainable Development.

The way forward

114. The implementation of the Regional Committee resolution SEA/RC65/R3 and World Health Assembly resolutions WHA69.23 and WHA70.22 on CEWG reiterate a focus on R&D for health products related to needs of developing countries and those of Member States of the Region. Concerted efforts are necessary to take the CEWG forward, including through adequate and sustainable funding, to fully implement the CEWG Strategic Workplan agreed in resolution WHA66.22.

115. These aspects need to be reflected in the overall evaluation of the Global Strategy and Plan of Action (GSPA) that is currently under progress at WHO headquarters and in which select experts from Member countries of the region are participating.

116. It may be noted that previous deliberations on GSPA and CEWG such as the regional Member State assessment exercise and national GSPA assessment in Sri Lanka have recommended establishing a regional network to speed up regulatory approvals within the countries for access to medical products. Member States of the WHO South-East Asia Region launched the South-East Asia Regulatory Network (SEARN) to enhance information sharing, collaboration and convergence of medical product regulatory practices across the Region that aims to guarantee access to high-quality medical products. SEARN will be instrumental in encouraging convergence, effective use of resources and rapid exchange of information on regulation of medical products across the countries of the South-East Asia Region.