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Provisional Agenda item 9

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Progress reports on selected Regional Committee resolutions

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

1. Covering every birth and death: Improving civil registration and vital statistics (**SEA/RC67/R2**)
2. Promoting physical activity in the South-East Asia Region (**SEA/RC69/R4**)
3. Expanding the scope of the South-East Asia Regional Health Emergency Fund (SEARHEF) (**SEA/RC69/R6**)
4. 2012: Year of intensification of routine immunization in the South-East Asia Region: Framework for increasing and sustaining coverage (**SEA/RC64/R3**)

The High-Level Preparatory (HLP) Meeting held in New Delhi from 30 July to 2 August 2018 reviewed each progress report and made recommendations, which have been consolidated as an addendum (SEA/RC71/13 Add. 1) to this Working Paper for consideration by the Seventy-first 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/RC71/13 Add. 2).

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1. Covering every birth and death: Improving civil registration and vital statistics (SEA/RC67/R2)

Background

1. Civil registration is defined as the compulsory, permanent, continuous and universal recording of vital events. Registration records are essential for establishing legal identity, nationality and accessing services based on human rights. Vital statistics on births, deaths and causes of death (CoD) are essential for population health assessment and health policy analysis, such as for monitoring progress towards universal health coverage (UHC) and the Sustainable Development Goals (SDGs), and addressing emerging priorities such as premature mortality due to noncommunicable diseases (NCDs). The health sector plays a critical role in accelerating the development and strengthening of the civil registration and vital statistics (CRVS) system as part of the overall national health information system (HIS). Its role is often described in terms of the activities of health institutions, which act as informants of the occurrence of births and deaths, and enable the certification of CoD by physicians. This information is crucial for generating statistics to guide health policy and planning.

2. The WHO South-East Asia “Regional Strategy for strengthening the role of the health sector for improving civil registration and vital statistics (CRVS) (2015–2024)¹ was adopted at the Sixty-seventh session of the WHO Regional Committee held in Dhaka, Bangladesh, during 9–12 September 2014 (SEA/RC67/R2). It focuses on health sector initiatives at the regional, national and local levels to support the notification and universal civil registration of births and deaths, and improve the production of accurate, complete and timely vital statistics.

3. The Regional Strategy addresses the following:

- **Strategic Area 1:** Legal and organizational framework for CRVS;
- **Strategic Area 2:** Political commitment and intersectoral collaboration for national capacity-building, partnership, advocacy and outreach;
- **Strategic Area 3:** Birth and death registration – completeness and coverage;
- **Strategic Area 4:** Recording cause of death, ensuring completeness and quality; and
- **Strategic Area 5:** Creating demand for health and vital statistics, enabling service delivery and planning through use in (a) evidence-based decision-making, and (b) linkages to other activities.

4. The Regional CRVS Strategy, goals and indicators are aligned with the Regional Action Framework for CRVS in Asia and the Pacific,² developed through the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP), and which includes all countries in the WHO South-East Asia Region. The WHO Regional Office for South-East Asia, along with other UN agencies and development partners, also collaborated on the development of the UNESCAP CRVS Regional Action Framework. Several UN agencies are focused heavily on improving civil registration (including UNICEF, UNESCAP, UNDP and UNHCR). WHO is leading the

¹ Regional Strategy for strengthening the role of the health sector for improving CRVS (2015–2024). New Delhi: WHO Regional Office for South-East Asia; 2015 (http://www.searo.who.int/entity/health_situation_trends/regional_strategy_for_strengthening_the_role_of_the_health_sector_for_improving_crvs.pdf?ua=1, accessed 23 May 2018).

² Regional Action Framework. In: Civil Registration and Vital Statistics in Asia and the Pacific (<http://getinthepicture.org/regional-action-framework>, accessed 23 May 2018).

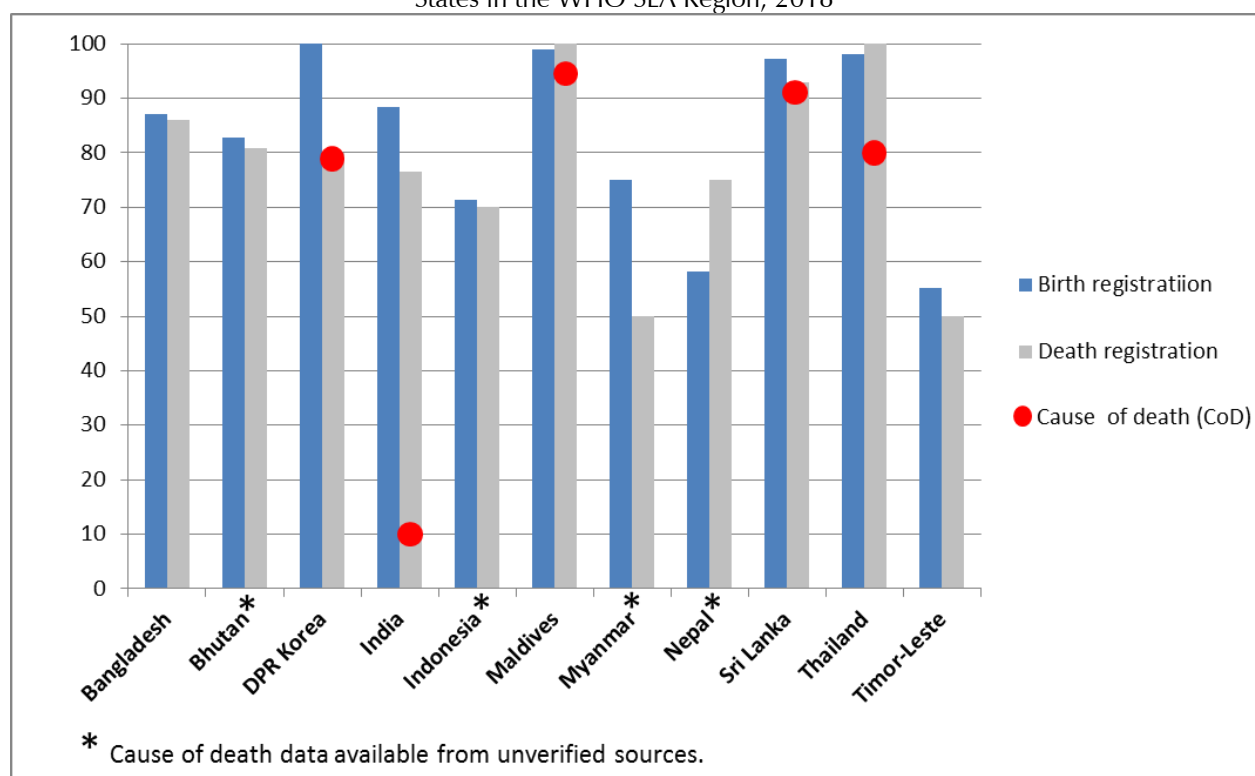
support from development partners in the Region to strengthen the generation and use of reliable mortality statistics.

5. The goals and objectives of the Regional Strategy amplify the UNESCAP Regional Action Framework and the health sector's roles and responsibilities for their achievement. Resolution SEA/RC67/R2 also includes a request for periodic progress updates to be presented to the Seventy-first, Seventy-fourth and Seventy-eighth Sessions of the Regional Committee for South-East Asia in 2018, 2021 and 2025, respectively.

Progress made in the WHO South-East Asia Region

6. Improving birth and death registration and availability and coverage of CoD data are goals of the Regional Strategy and progress thereof is being monitored. Fig. 1 presents the status of Member States in the SEA Region from the best available recent information. Baseline data collected at the time of development of the CRVS Strategy in 2013 and 2014 are not presented below as much of this information could not be adequately validated.

Figure 1: Birth and death registration coverage and cause-of-death (CoD) data availability of Member States in the WHO SEA Region, 2018



Source: CRVS regional action framework reporting 2013–2017. UNESCAP, 2018. For Bangladesh only, Report on Bangladesh Sample Vital Statistics 2017. Bangladesh Bureau of Statistics, 2018.

7. Birth registration coverage is more than 80% in seven Member States and above 50% in all Member States in the Region. Death registration coverage lags behind birth registration coverage across the Region. CoD data availability varies considerably in the Region and is mostly of poor quality. Several Member States continue to use sample vital registration sites and surveys (Bangladesh, India, Indonesia and Nepal) in the absence of fully functioning CRVS systems capable of generating adequate CoD data and statistics for policy and planning.

8. Member States of the SEA Region have been actively engaged in regional and national activities to strengthen CRVS systems. Following the launch of the Regional CRVS Strategy and the Ministerial CRVS Declaration, and endorsement of the UNESCAP Regional Action Framework in

November 2014,³ there has been an increase in political commitment to health sector initiatives for CRVS development, support for CRVS development plans, coordination by stakeholders and partners, expansion in knowledge-sharing, and use of tools and techniques for improving CRVS performance.

9. In order to accelerate improvement in CRVS through health sector interventions, WHO in collaboration with regional and national development partners, has supported government efforts to implement several CRVS-strengthening activities as highlighted below:

- *Assessments* – Ten of 11 Member States in the Region have conducted a CRVS rapid assessment within the past five years, with eight Member States having completed or planning to implement a more comprehensive CRVS assessment (Bangladesh, Bhutan, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand).
- *Coordination* – Nine Member States have established a multisectoral CRVS coordination mechanism (Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Thailand and Timor-Leste) to improve accountability, collaboration, and data-sharing and use.
- *Strategies and plans* – Three Member States are already implementing their national CRVS strategy (Bangladesh, Indonesia and Maldives) and five Member States are in the process of developing or adopting their CRVS strategy (Bhutan, India, Myanmar, Nepal and Thailand).
- *WHO-supported actions*:
 - WHO released a Start-Up Mortality List (SMoL) tool in 2015 based on a simplified set of International Classification of Diseases, version 10 (ICD-10) codes, and provided training to countries in August 2017 (Bangladesh, Bhutan, Indonesia, Nepal and Timor-Leste). The SMoL can improve the completeness, quality and use of mortality statistics for deaths occurring in hospitals.
 - A harmonized set of new WHO standards for verbal autopsy (VA) was published in 2016 and is being used by three Member States (Bangladesh, India and Indonesia) and under review for use by other Member States (Myanmar, Nepal and Sri Lanka) to improve the quality of CoD data for deaths occurring outside of health facilities.
 - A workshop on analysis of CoD data for four Member States (India, Myanmar, Sri Lanka and Thailand) co-supported by WHO in 2018 can help improve the usability of mortality statistics for understanding the burden of disease to improve evidence-based policy and planning.
 - Use of the WHO standard for death certification, and classifying and coding CoD according to the ICD-10 standard, is expanding in all Member States in the Region. However, the completeness and timeliness of available CoD data vary considerably, and the quality remains relatively poor. Strategies for transitioning from coding using ICD-10 to the new ICD-11 is needed.

The way forward

10. Civil registration of births and deaths is increasing, though at different rates. There is still very little information available on CoD. Where CoD data are available, they are of relatively poor quality. To understand why, WHO headquarters and the Regional Office will be conducting a

³ Ministerial Declaration. In: Civil Registration and Vital Statistics in Asia and the Pacific (<http://www.getinthepicture.org/ministerial-declaration>, accessed 23 May 2018).

questionnaire with Member States of the Region in 2018 to better assess the status of mortality data and inform the next steps.

11. Greater advocacy within governments is needed for larger investments in CRVS to improve the completeness, reliability and utility of mortality statistics tracked in the SDGs, and to understand the burden of diseases, particularly NCDs, for improved health policy and planning.

12. The HLP recommended that WHO should continue to support setting targets, tracking progress, and implementation of national CRVS strategies and plans. Priorities in going forward will be as follows:

- to scale up and use medically certified and ICD-coded CoD classification for deaths occurring in health facilities and the use of VA for capturing CoD data for deaths in communities;
- to provide further CRVS systems implementation guidance and support, organize relevant training to improve mortality data availability and use, facilitate knowledge-sharing and exchange of opportunities between Member States, and support approaches regarding the future adoption of ICD-11;
- to better link CRVS systems with the overall HIS to improve completeness and availability of mortality data; and
- to improve analysis, interpretation, and use of CoD data and mortality statistics to better learn what people are dying from, design and implement better health policies and plans, and improve monitoring of the progress towards UHC and the health-related SDGs.

2. Promoting physical activity in the South-East Asia Region (SEA/RC69/R4)

Background

13. Physical inactivity is a leading risk factor for premature death from noncommunicable diseases (NCDs), which cause 3.2 million global deaths a year.⁴ Physical inactivity together with sedentary behaviours increases all causes of mortality, disease-specific mortality and the risk of many NCDs, including cardiovascular diseases, diabetes, obesity, colon cancer, high blood pressure, osteoporosis, lipid disorders, depression and anxiety. Conversely, regular physical activity is associated with a reduced risk to physical health and improved mental health and quality of life. Physical activity has multiple social, economic and environmental benefits beyond health. Investment in promoting physical activity can contribute directly to achieving many of the Sustainable Development Goals (SDGs).

14. *The WHO Global status report on noncommunicable diseases*⁴ shows that worldwide, 23% of adults and 81% of adolescents (aged 11–17 years) do not meet the global recommendations for physical activity, based on the current guideline. The prevalence of physical inactivity in the adult population of the WHO South-East Asia (SEA) Region was 15% and that of inadequate physical activity among adolescents was 74%.

15. The Region also has a high gender discrepancy in physical activity levels. The spectrum of insufficient physical activity among adolescents ranges from 94% among girls in Timor-Leste to 58% among boys in Bangladesh.⁵ The prevalence of insufficient physical activity varies considerably within and between Member States. Apart from adolescents, women, older adults, underprivileged groups and poor people, those with disabilities and chronic diseases are more likely to be physically inactive. In Sri Lanka, 89% of adult women do not have any vigorous-intensity activity, followed by women in Maldives and Myanmar (both at 88%), while only 35% of Bhutanese men do not have any vigorous activity.⁶

16. Increase in sedentary behaviours among children, adolescents and young adults, in particular in the form of screen time, is of concern. Data from 2015 show that 53% of Thai adolescent girls spent more than three hours a day in front of their screens.⁵

17. Effective promotion of physical activity needs a comprehensive framework, covering interventions that focus on individuals, targeted population groups and universally across populations. Physical activity has to be promoted strategically in all settings and communities to cities, and to all levels. Promoting physical activity through existing social structures and common public spaces, and building upon social assets such as yoga and other traditional approaches brings great benefits to the population while also being responsive to developmental agendas.

18. Thailand hosted the Sixth International Congress on Physical Activity and Public Health (ISPAH) in November 2016. The Congress led to the Bangkok Declaration, which among other points, called for WHO to provide leadership, commitment and technical support to advocate for

⁴ Global status report on noncommunicable diseases 2014. Geneva: World Health Organization; 2014 (http://apps.who.int/iris/bitstream/handle/10665/148114/9789241564854_eng.pdf;jsessionid=4870129E7E2FC83BCFC8B2ABEA8FD92B?sequence=1, accessed 22 June 2018).

⁵ Noncommunicable diseases risk behaviours among youth in the South-East Asia Region: findings from GSHS and GYTS. New Delhi: World Health Organization, Regional Office for South-East Asia; 2016 (<http://apps.who.int/iris/bitstream/handle/10665/249590/9789290225232.pdf?sequence=1>, accessed 22 June 2018).

⁶ Noncommunicable diseases risk behaviours among adults in the South-East Asia Region: findings from STEPS and GATS. New Delhi: World Health Organization, Regional Office for South-East Asia; 2016 (http://www.searo.who.int/entity/noncommunicable_diseases/documents/ncd-risks-adults/en/, accessed 22 June 2018)

promoting physical activity. This call was re-echoed by the WHO Governing Bodies, resulting in the 140th Executive Board passing a resolution requesting WHO to develop the Draft Global Action Plan for Physical Activity (GAPPA). The Draft GAPPA built upon on the Global Plan of Action on NCD Prevention and Control and its linkage to the Sustainable Development Goals 2030. The content of the GAPPA is in line with the SEA Regional Committee resolution SEA/RC69/R4. Among the many consultative mechanisms, experts from SEA Member States participated in the regional consultation on GAPPA (23–25 August 2017 in Bangkok). The GAPPA was later endorsed by consensus at the Seventy-first World Health Assembly.

Progress made in the WHO South-East Asia Region

19. All SEA Member States have a clear national policy to promote physical activity. For most Member States, promotion of physical activity is an integral part of a bigger policy framework, such as NCD prevention and control, healthy lifestyle campaign and health promotion. The school health programmes in all Member States also include some element on promotion of physical activity. In addition, some population groups, such as the elderly, preschool children and informal workers, are not well covered in existing policy frameworks. Few Member States, moreover, have a clear policy to address sedentary behaviours at the national level.

20. Experts and nominated delegations from SEA Region Member States have been supported by the Regional Office to participate in the Sixth ISPAH, as well as the SEA regional consultation on GAPPA. These two events provided a good opportunity for these “champions” in the Region to share knowledge and experiences, and make clear recommendations and requests to the Regional Office.

21. With the increasing popularity of outdoor gymnasium equipment, the Regional Office supported the development of national physical activity guidelines and training of trainers in Bhutan, in collaboration with Thailand’s Ministry of Public Health. Good practices in the Region have been shared through WHO channels, including the *WHO Bulletin* and websites. These include promoting physical activity in public spaces and discussing the roles of the local government in Thailand, School Health Programme in Sri Lanka and open-air gymnasiums in Bhutan.

22. WHO Governing Body meetings and other meetings have increasingly had a health-promoting component. Under the Regional Office’s Be-the-Change package, morning exercises have been conducted at the regional committees since the Sixty-eighth session. Healthy meetings concept, with micro-exercise sessions, have been observed in many WHO meetings in the Region. The Regional Office has established a repository webpage for physical activity-promoting materials, including short video clips received from Member States. WHO also conducted the walk-the-talk initiative at the Seventy-first World Health Assembly on 20 May 2018, which was attended by delegations and staff from the SEA Region. SEA Region staff enjoyed physical activity-promoting opportunities, including in-house gym facilities and recreational spaces, yoga and other special activities. Physical activity and a healthy environment are core values that will be incorporated in the design of the new building of the Regional Office.

23. Most Member States have installed surveillance systems, which contain elements on physical activity among adult and youth populations. These are, for example, the NCD STEPs Survey, Global School Health Survey, District Health Survey and National Health Exam Survey. Room for improvement includes coverage, representation of each population group, regularity of surveys, national ownership and capacity, and standardization of survey tools. Moreover, sedentary behaviour is not well integrated into these surveys, partly due to the lack of an agreed definition of sedentary behaviour.

24. The SEA Regional Status Report on Physical Activity and Health is in the process of finalization. This report contains current data on both health behaviours and their determinants, as well as the physical activity policy and infrastructure in the Region. With an additional section on the epidemiology of physical activity provided by WHO headquarters, the SEA regional report will serve as the template for the other five regions.

Challenges being faced

25. The following challenges are being faced while promoting the concept of physical health:

- **Common misconceptions:** Narrowing the scope of physical activity to sports or exercise is still common in the Region. This myth limits the intervention spectrum, instead of comprehensive multiple interventions as recommended. For example, this includes conducting a physical education class in order to promote physical activity among children but does not promote a school environment, transportation to and from school, and neglects sedentary behaviours. Another common misunderstanding is that physical activity is only for children, adolescents and young adults, not the entire population.
- **Coordination across sectors:** Promotion of physical activity needs collaboration beyond the health sector to develop and operate interventions focusing on policy, the natural and built environment, media, schools, the transportation sector, workplaces, communities and urban settings. Poor coordination and buy-in from other sectors will lead to commitment only to a one-time mass event and public campaign, and not influence the daily lives of the population.
- **Clear guideline:** Current guidelines (national and WHO) have limitations in the coverage of and applicability to some population groups, and do not address sedentary behaviours. The upcoming new WHO guidelines will help to solve these issues.
- **Resources:** Effective promotion of physical activity requires justifiable investment and adequate resources from the relevant sectors. Financial, human and technical resources are all critical for the sustainability of the physical activity promotion programme.

The way forward

26. The Regional Office will continue to implement this resolution (SEA/RC69/R4) together with the recent Seventy-first World Health Assembly resolution on the same topic. In this context, the Regional Office will:

- organize the SEA regional launch of GAPP (and, if possible, the new WHO physical activity guideline), tentatively planned as a side event to the Prince Mahidol Award Conference 2019 (with the theme of NCDs);
- continue to support Member States in developing/revising their national strategy, policy and plan of action to promote physical activity, taking into account the endorsed GAPP, and in particular the new target for the 2030 timeframe;
- continue to promote the Ministry of Health and WHO as role models for physical activity, including by implementing and disseminating the Region's Be-the-Change initiative package and materials;
- develop technical tools and advocacy material for promoting physical activity, focusing on the potential contribution of stakeholders beyond the health system;

- explore, together with WHO headquarters, the possibility of WHO providing technical support for outdoor gyms, including promoting local capacity for production, installation and maintenance; and
- strengthen the promotion of physical activity in schools, including through the SEA Region School Health Network.

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

Background

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

28. The Fund is designed to provide financial support for the first three months following a disaster occurring in a Member State to meet immediate and urgent health needs, support emergency field operations, and fill in critical funding gaps. It also has a window to receive funds from donors. A total amount of US\$ 350 000 can be released in two tranches in any emergency. The funds can be released within 24 hours of receiving a request from a Member State. SEARHEF has set for itself the record of being “the fastest emergency fund to be released among all UN agencies”.

29. Since its inception, the Fund has allowed for an immediate and flexible response to 37 emergencies that had occurred in nine Member States of the Region. In the current biennium (2018–2019), SEARHEF has supported two emergency operations: for the establishment of a laboratory in Cox’s Bazar, Bangladesh, to undertake basic diagnostics for the displaced Rohingya population, and for providing support towards the establishment of mobile clinics in Rakhine State, Myanmar, to provide essential health services to the conflict-affected population.

30. Till date, SEARHEF has disbursed a total of US\$ 5.9 million since its inception in 2008.

31. 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 tranches for emergency funding from SEARHEF. It was anticipated that support for basic preparedness activities may cost US\$ 200 000 per country per biennium. Thus, the minimum corpus per biennium was set at US\$ 2.2 million. The target date for implementation of the SEARHEF preparedness funding stream was decided to be 1 January 2018. As of June 2018, a pledge of US\$ 200 000 towards the SEARHEF preparedness stream has been received from Thailand. Proposals to utilize preparedness funds are under development from Bhutan, Maldives, Sri Lanka and Timor-Leste.

32. 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 the functioning of the response fund. The criteria for allocations for preparedness from the Fund are as follows:

- Address a priority gap as found in the International Health Regulations (2005) (IHR) capacity assessments and/or SEA Region Benchmark Assessments.
- Address gaps in core skills such as risk assessment or information management.
- Establish public health emergency operations centers (PHEOCs).

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

- (1) development and strengthening of policies and capacities;
- (2) development and implementation of training courses;
- (3) setting up systems for disease surveillance, information and knowledge exchange across Member States for risk assessments and risk communications;
- (4) strengthening PHEOCs;
- (5) strengthening health emergency supply chain management systems;
- (6) strengthening of emergency medical teams and their coordination;
- (7) assessment of health facilities for disaster risk reduction;
- (8) strengthening the health emergency workforce through the establishment of systems that include efficient recruitment and deployment.

34. SEARHEF is overseen by a Working Group comprising representatives from the 11 Member States. The Working Group has met seven times since 2008. The progress report of the Fund is due to be submitted to the Seventy-first Session of the WHO Regional Committee in New Delhi in September 2018.

Progress made in the WHO South-East Asia Region

35. 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. Thus far, Thailand has contributed US\$ 200 000 towards the SEARHEF preparedness stream.

36. In February 2018, to support the conflict-affected populations in Cox's Bazar, Bangladesh, and Rakhine State, Myanmar, two disbursements of SEARHEF – of US\$ 350 000 and US\$ 156 490 – were released to both Member States, respectively.

37. The SEARHEF balance as of date is US\$ 593 510 for the current biennium of 2018–2019 (both Assessed Contribution and Voluntary Contribution funds).

38. The Regional Office organized the seventh meeting of the SEARHEF Working Group via videoconference on 3 May 2018.

39. The sixth meeting of the Working Group for governance of the SEARHEF (6–7 June 2017) recommended that as the Fund reaches its 10-year milestone, the Secretariat should undertake an evaluation of its utilization and impact. This evaluation was also prioritized by the Regional Director as one of the areas of work to be evaluated in 2018. The evaluation criteria would include relevance, effectiveness, efficiency, sustainability and impact. The Secretariat is in the process of contracting a suitable evaluation agency to undertake this piece of work, and is expected to be completed by September 2018.

40. The sixth meeting of the Working Group also recommended that the Secretariat develop a webpage for SEARHEF. This action has been completed.

41. The table below gives a list of the disasters that were supported by SEARHEF during the period January 2012 till June 2018, 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 DPR 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 DPR 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 townships affected by conflict in Rakhine State	April	2013	175 000
18.	Support to emergency caused due to flash floods in South Phyongan, North Phyongan, Kangwon and South Hamgyong provinces of DPR Korea	July	2013	175 000
19.	Support to emergency response activities to the crisis situation created due to eruption of Mt Sinabung in North Sumatra province, Indonesia	Feb.	2014	144 068
20.	Establish sustainable health-care services for townships affected by communal conflict in Rakhine State, Myanmar	May	2014	175 000
21.	Complement the response and recovery activities conducted by the MoH to support short- to medium-term needs of the health sector, Sri Lanka	Nov.	2014	35 500
22.	Complement the response and recovery activities conducted by the MoH related to heavy floods and landslides in 22 (out of 25) administrative districts in Sri Lanka	Dec.	2014	30 000

No	Emergency	Period		SEARHEF allocation in US\$
		Month	Year	
23.	Support in the aftermath of Nepal earthquake	April	2015	175 000
24.	Support strengthening 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, and South and North Pyongang provinces) of DPR Korea	July	2015	137 160
25.	Support MoH to support operational cost for post-disaster management following floods and 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 emergency medical supplies and essential drugs for flood-affected populations in Rason City, North Hamgyong province, DPR Korea	Sept.	2015	161 887
28.	Support to MoH for response and recovery activities for flood victims, Sri Lanka	May	2016	100 000
29.	Support to MoH to provide health sector support to the flood-affected population in Bhutan	July	2016	161 624
30.	Support to MoH for provision of emergency health care to flood-affected population in Myanmar	Aug.	2016	175 000
31.	Support for provision of emergency health care to population affected by torrential rains and floods in the northern part of DPR Korea	Sept.	2016	175 000
32.	Floods and landslides in Sri Lanka in May 2017	May	2017	175 000
33.	Support to MoH for Cyclone Mora in Bangladesh	June	2017	170 000
34.	Support for MoH to support activities for the population affected by the Rakhine crisis, Bangladesh	Sept.	2017	175 000
35.	Support for MoH to support response activities by Health Protection Agency/MoH over tropical storm Ockhi in Maldives	Dec.	2017	13 000
36.	Support to address the immediate health needs of the displaced Rohingya population at Cox's Bazar (a Grade 3 Emergency), Bangladesh (in two tranches of US\$ 175 000 each)	Feb. and June	2018	350 000
37.	Support to MoHS to provide essential health services to the conflict-affected population in Rakhine State, Myanmar	Feb.	2018	156 490
Grand total				5 956 953

Challenges being faced

42. The major challenges of SEARHEF are well articulated in the recommendations made by the Working Group during its seventh meeting in May 2018. These include:

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

The way forward

43. During the seventh SEARHEF Working Group Meeting held on 3 May 2018, the following recommendations were made that will constitute the next steps and the way forward:

- Member States are to provide updates on the progress made with regard to contributions to the SEARHEF preparedness stream through their delegates to the High-Level Preparatory Meeting in New Delhi on 30 July–2 August 2018. It is anticipated that pledges for funding may be made during the Seventy-first Session of the Regional Committee in New Delhi in September. This is critical to fully operationalize the SEARHEF preparedness stream.
- The Secretariat to provide updates on discussions with key donors on using SEARHEF as the main channel to support preparedness work in the Region.

4. 2012: Year of intensification of routine immunization in the South-East Asia Region: Framework for increasing and sustaining coverage (SEA/RC64/R3)

Background

44. Recalling World Health Assembly resolution WHA58.15 on Global Immunization Vision and Strategy, the Sixty-fourth session of the WHO Regional Committee for South-East Asia in September 2011 declared 2012 as the “Year of Intensification of Routine Immunization in South-East Asia” vide resolution SEA/RC64/R3. Member States committed “to develop national and subnational-level plans of action based on risk analysis to intensify routine immunization (RI) coverage and reach the large number of children who have not been immunized over time”.

45. The goal of intensification of routine immunization is to achieve at least 90% immunization coverage at the national level and at least 80% coverage in every district (or equivalent administrative unit) for the six basic antigens, as measured by coverage of the third dose of diphtheria, pertussis and tetanus vaccine (DPT3), in all Member States.

46. All Member States prepared their action plans, focusing primarily on high-risk population groups and hard-to-reach areas, to intensify routine immunization (RI) activities for enhancing coverage and reaching out to more children with immunization services. Subsequently, this regional initiative was aligned with the Immunization and Vaccine Development Strategic Plan 2014–2017 and then with the Regional Vaccine Action Plan (RVAP) 2016–2020.

Progress made in the WHO South-East Asia Region

47. The overall coverage with three doses of DPT vaccine (DPT3) in the Region increased from 84% in 2011 to 88% in 2017.

48. Seven Member States in the Region have sustained overall DPT3 coverage of 90% or more in 2017. These Member States include Bangladesh, Bhutan, Democratic People’s Republic of Korea, Maldives, Nepal, Sri Lanka and Thailand. Five Member States have achieved the target of 80% or more coverage with DPT3 in all districts. These Member States include Bangladesh, Democratic People’s Republic of Korea, Maldives, Sri Lanka and Timor-Leste.

49. Member States in the Region that have not yet achieved the desired 90% DPT3 coverage, but have shown an improvement in coverage since 2012, include India (88% compared with 82% in 2011) and Timor-Leste (76% against 67% in 2011).

50. The Region developed the South-East Asia Regional Vaccine Action Plan: 2016–2020 that defines a clear vision for immunization and is backed by a set of guiding principles – ownership, responsibility and partnership, equity, integration, sustainability and innovation. The Action Plan describes a set of regional goals and objectives for immunization and highlights priority actions, targets and indicators that address specific needs and challenges of Member States of the Region. The overarching goal of the Action Plan is the strengthening of immunization systems and services with the objective of improving immunization coverage in all Member States of the Region.

51. Periodic Expanded Programme on Immunization (EPI) and surveillance reviews continue to be conducted in Member States of the SEA Region to assess immunization system performance. Recommendations from these reviews are being followed up to ensure improvement in immunization coverage.

52. National immunization technical advisory groups (NITAGs) have been established in all SEA Region Member States. The NITAGs are involved with the monitoring of progress in RI coverage. The Regional Immunization Technical Advisory Group monitors the progress of implementation of national immunization plans and the recommendations of the EPI reviews.

53. All Member States in the Region have incorporated plans for intensification of RI into their comprehensive multi-year plans for immunization and continue to implement country-specific actions as per needs to improve coverage and equity with all vaccines provided under their immunization schedule.

54. Many interventions have been undertaken by Member States in the Region to improve RI coverage with a focus on identification of high-risk populations and underserved areas for targeted and tailored approaches to reach children in these areas. Notable among these interventions are the following:

- (a) **Bangladesh:** Bangladesh targeted 32 districts and four city corporations for intensification of RI in 2012; additional vaccine transportation costs were provided for hard-to-reach areas; and every child was tracked using tally sheets/registration books.
- (b) **Bhutan:** The country has achieved and maintained high coverage, but continues to focus on the areas with significant migration as well as on hard-to-reach populations by identifying these areas and populations, and conducting periodic catch-up vaccination campaigns to maintain high population immunity against all vaccine-preventable diseases (VPDs).
- (c) **DPR Korea:** DPR Korea has maintained more than 90% DPT3 coverage nationally and in all districts. Five northern provinces were given additional focus to sustain high coverage. A coverage evaluation survey conducted in 2017, validated the high RI coverage in the country.
- (d) **India:** India established an Immunization Technical Support Unit to support the Ministry of Health; and launched “Mission Indradhanush” from 2015 to 2017 – a major multi-phase campaign to boost RI. This equity-focused mission applied a range of polio strategies and assets to focus on identified high-risk populations in traditionally low-coverage or underserved areas with insufficient health services; 6.7 million children were fully immunized while 6.8 million pregnant women received the vaccine during this intensification effort. India reassessed the achievements and targeted 173 districts and 17 cities through the “Intensified Mission Indradhanush” in 2017–2018; 1.4 million children were fully immunized and 1.2 million pregnant women were vaccinated during this effort.
- (e) **Indonesia:** Remote islands and hard-to-reach areas were identified and supported for immunization coverage improvements; additional operational costs were allocated for these areas; new cold chain equipment was provided; and a communication strategy for immunization developed that included directives from religious leaders in support of the immunization programme. Eighty districts are being targeted for intensification of RI through various strategies such as sustained outreach strategy and drop out follow-up and sweepings. Defaulter-tracking guidelines for health centres have been revised for better tracking of partially vaccinated children. Indonesia has declared 2018 as the “immunization acceleration year”.
- (f) **Maldives:** Immunization is a high-priority programme in the country. One of the best practices followed is the verification at the time of entry into school about the completion of childhood vaccine doses. The country has maintained very high coverage with DPT3 since 2012. The strong RI platform has been used to introduce many new vaccines in Maldives.

- (g) **Myanmar:** New approaches such as providing immunization services through 98 major hospitals, developing township-level operational annual workplans, improvement of cold chain capacity and data management capacity by using modern information technologies have contributed to improved coverage in Myanmar. The country has focused on closing immunity gaps in hard-to-reach areas through improvements in microplanning for “Reaching Every Community”.
- (h) **Nepal:** Nepal introduced the concept of achieving fully immunized districts through the Full Immunization Declaration (FID) initiative in 2012. The initiative aimed to increase community ownership and commitment through positive behavioural reinforcement of individuals and groups. Health workers followed a rigorous method of line-listing target children and immunizing them, followed by a validation by the district team. A full immunization declaration of the district was done only after all subdistrict-level units had been validated. As of April 2018, 42 districts in the country have been declared fully immunized. An Immunization Act was passed in Parliament in 2016 ensuring the right to vaccination and the provision of quality vaccines for children. The country celebrates the month of April as the month of RI Intensification and conducts various innovative activities during the month to motivate health workers as well as to enhance RI coverage.
- (i) **Sri Lanka:** Sri Lanka maintained 99% DPT3 coverage and more than 90% coverage in all districts. Parliament and Cabinet approved the National Immunization Policy 2014 that envisages a political, economic and highly technical environment to support the intensification and strengthening of RI. Regular supervision, national and subnational EPI/VPD reviews and field-level coverage surveys are used by the national programme to identify gaps in immunization programme performance and address these in a timely manner.
- (j) **Thailand:** Thailand has maintained high vaccination coverage at the national level through its strong routine immunization system. The country has also started to monitor subnational data from 2016 to provide regular feedback and input to the subnational level to enhance coverage where required. The country has strongly focused on data quality and used high-quality data to identify gaps in RI and develop performance improvement plans. The strong RI platform has been used to introduce many new vaccines in Thailand.
- (k) **Timor-Leste:** The DPT3 immunization coverage of Timor-Leste increased from 67% in 2011 to 85% in 2016. The country ensured strong advocacy for adequate funding for outreach immunization services, and rapidly built capacity of the immunization workforce with close monitoring by external consultants at the subnational level. The country has increased the number of vaccine storage cold chain points from 68 (community health centre level) to 127 (health post level). An effective vaccine management (EVM) assessment was conducted and an improvement plan is under implementation. A twinning programme has been initiated with the EPI programme in Sri Lanka to strengthen the technical capacity of national and subnational programme managers.

Overall implementation of the Regional Vaccine Action Plan

55. In addition to the achievements listed above related to RI coverage, Member States have made progress in the disease-specific goals of the SEA Regional Vaccine Action Plan. Implementation of disease-specific goals has strengthened immunization systems in Member States of the Region.

Measles is eliminated and rubella/CRS controlled

56. The SEA Region adopted the goal of measles elimination and rubella and congenital rubella syndrome (CRS) control by 2020 as a Regional Flagship Programme. Two Member States were verified for measles elimination in April 2017. Ten Member States have introduced rubella-containing vaccine in their routine immunization schedule. The Democratic People's Republic of Korea is planning to introduce rubella vaccine. Between 2011 and 2017, immunization coverage in the SEA Region for first dose of measles-containing vaccine (MCV1) has increased from 85% to 87% while coverage with the second dose of measles-containing vaccine (MCV2) increased from 35% to 77% in the same period.

57. Supplementary immunization activities were conducted in 10 Member States of the Region since 2012 and 182 million children were reached with an additional dose of measles-containing vaccine through mass vaccination campaigns, and an additional 364 million children in the Region are targeted by end-2018/early-2019 in India and Indonesia. These supplementary immunization activities have improved the microplanning, cold chain, health worker training and adverse events following immunization (AEFI) management capacity for RI. All Member States in the Region have initiated case-based surveillance for measles and rubella.

Polio-free status is maintained

58. The SEA Region reported the last wild poliovirus case on 13 January 2011 and was certified polio-free on 27 March 2014. However, the risk of spread of wild poliovirus following importation from one of the currently polio-infected countries and risk of emergence of vaccine-derived polioviruses (VDPV) in areas with low immunization coverage remains.

59. All Member States have introduced inactivated poliovirus (IPV) between 2014 and 2016. As part of the risk mitigation strategies associated with the global IPV shortage, the available IPV supplies are being prioritized towards Member States of the Region that are at a higher risk of poliovirus resurgence. Bangladesh, India and Sri Lanka have replaced the full-dose IPV schedule with two fractional (one fifth) doses in their RI schedule.

60. The polio transition planning process has been initiated in five Member States of the Region that have substantial polio assets. These countries include Bangladesh, India, Indonesia, Myanmar and Nepal. 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. 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.

Elimination of maternal and neonatal tetanus (MNT) is sustained

61. On 19 May 2016, the SEA Region became the second among the six WHO regions to have achieved MNT elimination. High coverage of tetanus toxoid (TT) vaccination of women in the childbearing age group and pregnant mothers through RI, supplementary immunization campaigns in high-risk districts, together with implementation of other strategies such as safe deliveries and proper antenatal care contributed to this achievement.

Challenges being faced

62. Challenges faced during implementation of the activities related to intensification of RI include the following:

- Despite the increase in the regional coverage of DPT3 to 88% in 2016, an estimated 4.4 million children in the SEA Region do not receive DPT3 vaccine, with an estimated 3.1 million of these being in India and 1 million in Indonesia.
- Outbreaks of VPDs continue to occur in many Member States of the Region, indicating low vaccination coverage pockets, even in countries/provinces/districts with high coverage. Diphtheria outbreaks in India, Indonesia, Myanmar and among migrants from Myanmar in Bangladesh have exposed pockets of low vaccination coverage and the need to further intensify activities to improve equity in RI. Measles outbreaks have occurred recently in Bangladesh, India, Indonesia, Myanmar, Nepal and Thailand, indicating subnational pockets with immunity gaps.
- Polio-funded human resources are supporting overall immunization activities. The Global Polio Eradication Initiative (GPEI) has indicated that polio funding will decline from 2017 to 2019 and eventually stop in 2020. Even though transition planning is ongoing in all five priority Member States, this could potentially inhibit progress towards the achievement of immunization goals unless alternative sources of funding are identified.
- Some low- and middle-income Member States in the Region (examples: Indonesia and Timor-Leste) are transitioning out of support by the GAVI Alliance and have suboptimal immunization coverage. This poses a risk for the improvement of immunization coverage in these Member States unless alternative funding sources, including from the national government, are quickly mobilized.
- While surveillance standards for polio and measles have been maintained to support the maintenance of a polio-free status and achieve measles elimination efforts, surveillance for other VPDs remains suboptimal in most Member States of the Region.

The way forward

63. The World Health Assembly through resolution WHA70.14 urged Member States to demonstrate stronger leadership and governance of national immunization programmes to achieve the goals of the Global Vaccine Action Plan and continue to report on progress to the regional committees. This would further reinforce the contents of SEA/RC64/R3 Resolution on Intensification of Routine Immunization in South-East Asia.

64. All Member States need to increase the effectiveness and efficiency of national immunization programmes in their efforts to achieve universal health coverage, and allocate adequate financial and human resources to immunization programmes according to national priorities, considering the

ongoing polio transition, GAVI transition and well-documented information on the economic benefits of immunization.

65. In line with the goal and objectives of the Regional Vaccine Action Plan, all Member States should strengthen the monitoring and evaluation of their immunization coverage and other programme indicators to identify the gaps and areas for further strengthening with the active involvement of National Immunization Technical Advisory bodies.

66. There is an urgent need to promote awareness on immunization, underlining its benefits to communities and the safety of vaccines, and strategic actions to counter vaccine hesitancy.

67. Member States should use the opportunity that comes with the regional measles elimination Flagship Programme and the introduction of new and underutilized vaccines to further improve RI coverage, recognizing the importance of high RI coverage to achieve measles elimination and the benefits of new vaccine introduction.

68. There is a need for a robust system to manage and ensure the quality of national/district/subdistrict data on immunization coverage and VPD surveillance data, which need to be reviewed regularly with implementation of data quality improvement plans.

69. Adequate vaccine availability should be ensured through timely forecasting of vaccine needs and purchasing of vaccines, robust vaccine delivery systems, minimizing vaccine waste and enhancing vaccine-manufacturing capacity in the Region through supporting national regulatory authorities.