



REGIONAL COMMITTEE

Provisional Agenda item 9

*Seventy-second Session  
New Delhi  
2–6 September 2019*

SEA/RC72/13

12 July 2019

## Progress reports on selected Regional Committee resolutions

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

1. South-East Asia Regional Health Emergency Fund (**SEA/RC60/R7**);
2. Expanding the scope of the South-East Asia Regional Health Emergency Fund (SEARHEF) (**SEA/RC69/R6**);
3. Antimicrobial resistance (**SEA/RC68/R3**);
4. Patient safety contributing to sustainable universal health coverage (**SEA/RC68/R4**);
5. Challenges in polio eradication (**SEA/RC60/R8**);
6. Colombo Declaration on strengthening health systems to accelerate delivery of NCD services at the primary health care level (**SEA/RC69/R1**);
7. Traditional medicine: Delhi Declaration (**SEA/RC67/R3**); and
8. 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 Meeting held in New Delhi on 1–4 July 2019 reviewed each progress report and made recommendations, which have been consolidated as an addendum (SEA/RC72/13 Add. 1) to this Working Paper, for consideration by the Seventy-second Session of the WHO Regional Committee for South-East Asia.

The HLP participants and delegates unanimously agreed to omit the progress report (HLP 2019 Agenda item 4.6) on ‘Measles elimination and rubella/congenital rubella syndrome control (**SEA/RC66/R5**)’ from the list of Agenda items scheduled for discussions at the Seventy-second Session of the WHO Regional Committee for South-East Asia, since this topic has already been included within the scope of and discussions on Provisional Agenda item 8.2: ‘Revising the goal for measles elimination and rubella/congenital rubella syndrome control’.

The related Regional Committee resolutions covered in this Agenda item are appended to this Working Paper as Addendum 2 (SEA/RC72/13 Add. 2).



## CONTENTS

Page No.

1. South-East Asia Regional Health Emergency Fund ( <b>SEA/RC60/R7</b> ).....	1
2. Expanding the scope of the South-East Asia Regional Health Emergency Fund (SEARHEF) ( <b>SEA/RC69/R6</b> ) .....	6
3. Antimicrobial resistance ( <b>SEA/RC68/R3</b> ) .....	8
4. Patient safety contributing to sustainable universal health coverage ( <b>SEA/RC68/R4</b> ) .....	11
5. Challenges in polio eradication ( <b>SEA/RC60/R8</b> ) .....	16
6. Colombo Declaration on strengthening health systems to accelerate delivery of NCD services at the primary health care level ( <b>SEA/RC69/R1</b> ).....	19
7. Traditional Medicine: Delhi Declaration ( <b>SEA/RC67/R3</b> ).....	26
8. 2012: Year of Intensification of Routine Immunization in the South-East Asia Region: Framework for increasing and sustaining coverage ( <b>SEA/RC64/R3</b> ) .....	29



# 1. South-East Asia Regional Health Emergency Fund (SEA/RC60/R7)

## Background

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

2. The Fund is designed to provide financial support for the first three months following a disaster that occurs in a Member State to meet immediate and urgent health needs, support emergency field operations, and fill in critical gaps. It also has a window to receive funds from donors. A total amount of US\$ 350 000 can be released in two tranches. The funds can be released within 24 hours of receiving a request from a Member State. SEARHEF has set a record as “the emergency fund that is released fastest among all UN agencies”. SEARHEF is overseen by a Working Group comprising 11 representatives from Member States. The Working Group has met seven times since 2008.

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

3. Since its inception, the Fund has provided for an immediate and flexible response to 38 emergencies in nine Member States of the Region. Till date, SEARHEF has disbursed a total of US\$ 5.91 million since its inception in 2008. In the current biennium (2018–2019) SEARHEF has supported three emergency operations:

- a. In Bangladesh, where it supported the establishment of a laboratory in Cox’s Bazar to undertake basic diagnostics for the Rohingya population;
- b. In Myanmar, where it supported the establishment of mobile clinics in Rakhine State to provide essential health services to the affected population; and
- c. In DPR Korea, where it addressed health needs of the flood-affected population in North and South Hwanghae provinces.

4. The eighth meeting of the Working Group was held via videoconference in July 2019. The progress report of the Fund is due to be submitted to the Seventy-second Session of the Regional Committee in New Delhi in September 2019.

- 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. During the 2018–2019 biennium, three disbursements of SEARHEF were released to three Member States: of US\$ 137 842 to support the affected populations in Cox’s Bazar, Bangladesh; of US\$ 156 490 to support the affected population in Rakhine State, Myanmar; and of US\$ 171 975 to address the health needs of the flood-affected population in North and South Hwanghae provinces, DPR Korea.
- c. The SEARHEF balance from Assessed Contributions as of date is US\$ 533 693 for the current biennium of 2018–2019, while US\$ 100,000 is available from Voluntary Contribution funds. As per the business rules, there is a provision to utilize any unspent balance of SEARHEF Assessed Contribution funds for stockpiling of emergency medicines and supplies.

- d. 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 was also prioritized by the Regional Director as one of the areas of work to be evaluated in 2018. The evaluation criteria included relevance, effectiveness, efficiency, sustainability and impact. The Regional Office, as the Secretariat of the Fund, contracted an external evaluation agency to undertake this piece of work. The final report is awaited.
5. The key preliminary findings of the evaluations were:
- *Relevance*

Despite the availability of other funding sources such as Central Emergency Response Fund (CERF) and Contingency Fund for Emergencies (CFE), SEARHEF stands apart as it is a regional fund exclusively for the 11 Member States. SEARHEF is more easily accessible than other global funds with similar objective and has been the preferred source of funding for the majority of the most critical emergency cases that recorded a greater degree of severity.
  - *Effectiveness*

SEARHEF proved to be adequate through its ability to support the population in coping with disasters. SEARHEF's flexibility to address needs specific to contexts and emergencies was well demonstrated as it was used for different types of activities, which covered a wide range including procurement, surveillance, conduct of rapid assessments, operational cost of mobile health teams, etc.
  - *Efficiency*

Funds are released within 24 hours of receiving a request, for acute emergency events. However, in the case of protracted emergencies, there is sometimes a further analysis to ensure rational use of the Fund.
  - *Impact*

SEARHEF's impact (measured in terms of output and outcome) was significant because it added unique value to the emergency response which demonstrated varying requirements and crisis situations of differing magnitude.

WHO has proven to be a responsive organization through this Fund. By being available at the most critical times, WHO provides a catalytic response, which results in controlling the adverse effects of the emergency.
  - *Sustainability*

With disasters from natural and human-generated hazards expected to increase in future, it is imperative that a funding mechanism such as SEARHEF that allows for rapid response continues to operate in the Region.

SEARHEF was primarily designed based on requests from Member States and the core corpus of the Fund is created from their biennial contribution (AC) to WHO. Given that this arrangement of creating the corpus will continue to exist, SEARHEF is a sustainable Fund.
6. The table below gives a list of disasters that were supported by SEARHEF since its inception till June 2019, and the Member States in which they occurred.

No.	Emergency and related support	Period		SEARHEF allocation in US\$
		Month	Year	
1	Cyclone Nargis in <b>Myanmar</b>	May	2008	350 000
2	Flash floods in <b>Sri Lanka</b>	June	2008	23 299
3	Kosi River floods (In two tranches), <b>Nepal</b>	Sept.	2008	325 000
4	Emergency health interventions for internally displaced populations (IDPs) in conflict-affected areas in northern <b>Sri Lanka</b> (in two tranches).	Sept.	2008	350 000
5	Earthquake in North Sumatra province, <b>Indonesia</b> (in two tranches)	Oct.	2009	300 000
6	Emergency health interventions for relocated IDPs affected by conflict in <b>Sri Lanka</b>	Jan.	2010	175 000
7	Fire in Dhaka, <b>Bangladesh</b>	June	2010	175 000
8	Mt Merapi volcanic eruption in East Java province, <b>Indonesia</b>	Nov.	2010	139 000
9	Critical health-care services to the resettled population affected by conflict in <b>Sri Lanka</b>	Feb.	2011	175 000
10	Floods in <b>Thailand</b> (in two tranches)	July	2011	350 000
11	Torrential rains in <b>DPR Korea</b> (in two tranches)	Aug.	2011	310 000
12	Fire outbreak/explosion in Yangon, <b>Myanmar</b>	Jan.	2012	25 000
13	Provision of emergency health care in Rakhine State, <b>Myanmar</b>	June	2012	12 300
14	Flash floods in <b>DPR Korea</b>	July	2012	134 130
15	Population affected by storm in <b>Maldives</b>	Nov.	2012	47 717
16	Procuring emergency medical supplies (for fire outbreak and earthquake) in <b>Myanmar</b>	Nov.	2012	30 778
17	Establishing health-care services for townships affected in Rakhine State, <b>Myanmar</b>	April	2013	175 000
18	Flash floods in South Phyongan, North Phyongan, Kangwon and South Hamgyong provinces of <b>DPR Korea</b>	July	2013	175 000
19	Response to crises situation created due to eruption of Mt Sinabung in North Sumatra province, <b>Indonesia</b>	Feb.	2014	144 068
20	Establishing sustainable health-care services in townships affected in Rakhine State, <b>Myanmar</b>	May	2014	175 000
21	Complementing the response and recovery activities by the MoH to support short- to medium-term needs of the health sector in <b>Sri Lanka</b>	Nov.	2014	35 500
22	Complementing the response and recovery activities by the MoH after heavy floods and landslides in 22 (out of 25) administrative districts in <b>Sri Lanka</b>	Dec.	2014	30 000
23	Rehabilitation efforts after the earthquake in <b>Nepal</b>	April	2015	175 000

No.	Emergency and related support	Period		SEARHEF allocation in US\$
		Month	Year	
24	Strengthening capacity of health institutions to meet the immediate needs of population in drought-affected areas (88 counties and 20 cities in South and North Hwanghae, South and North Pyongang provinces) in <b>DPR Korea</b>	July	2015	137 160
25	Providing operational costs to MoHS for post-disaster management of floods following heavy rain that affected health facilities in Sagaing and Magwe regions and Rakhine State in <b>Myanmar</b>	Aug.	2015	26 000
26	Emergency medical interventions by MoHS for flood-affected populations in Rakhine and Chin states and Sagaing and Magway regions in <b>Myanmar</b>	Aug.	2015	149 000
27	Emergency medical supplies and essential drugs for flood-affected populations in Rason City, North Hamgyong province, <b>DPR Korea</b>	Sept.	2015	161 887
28	Response and recovery activities of MoH for flood victims in <b>Sri Lanka</b>	May	2016	100 000
29	Providing health sector assistance by MoH for flood-affected populations in <b>Bhutan</b>	July	2016	161 624
30	Provision of emergency health care by MoHS to flood-affected populations in <b>Myanmar</b>	Aug.	2016	175 000
31	Provision of emergency health care to populations affected by torrential rains and flood in northern parts of <b>DPR Korea</b>	Sept.	2016	175 000
32	Floods and landslides in <b>Sri Lanka</b>	May	2017	175 000
33	Rehabilitation efforts by MoHFW after Cyclone Mora in <b>Bangladesh</b>	June	2017	170 000
34	Relief activities by MoHFW for population affected by Rakhine crisis in <b>Bangladesh</b>	Sept.	2017	175 000
35	Response activities by HPA/MoH for victims of tropical storm Ockhi in <b>Maldives</b>	Dec.	2017	13 000
36	Essential health services by MoHS for the affected population in Rakhine State, <b>Myanmar</b>	Feb.	2018	156 490
37	Addressing the immediate health needs of the affected Rohingya population at Cox's Bazar (Grade 3 Emergency), <b>Bangladesh</b>	Feb.	2018	137 842
38	Flood relief operations in North and South Hwanghae provinces, <b>DPR Korea</b>	Sept.	2018	171 975
<b>Grand total</b>				<b>5 916 770</b>

## Challenges faced and the way forward

7. Based on the evaluation findings, the following recommendations were made, which the Secretariat will prioritize into actionable interventions and implement them in a phased manner:

- **Need for strategic efforts to increase the SEARHEF corpus:** There are several reasons that establish the need for an increased corpus, which include:
  - Higher number of emergencies witnessed in the Region, with the present corpus being capable of catering to a maximum of six emergencies in a biennium.
  - Prevalence of other funds such as CERF and CFE which can provide higher amount of funding in a similar timespan as SEARHEF.
  - Barring one biennium (2012–2013), the SEARHEF corpus exceeded its limit in every biennium in the last 10 years, which necessitated additional funding requirements.
  - Increase in price of goods and services globally in the last 10 years. The maximum limit of SEARHEF was fixed at US\$ 350 000 in the year 2008.

The need for increasing the corpus amount of SEARHEF was raised during various Working Group meetings. All these factors point towards the need to make dedicated efforts to increase the corpus.

- **Effective utilization of standardized templates and improved internal communication:** The evaluation findings suggest that while efforts towards standardization in the form of templates for proposal requisition or utilization reporting have been made, more specifically, there were several concerns, in the form of incomplete information and inconsistencies in interpreting the template requirements, which resulted in unavailability of comparable information, with regard to utilization reporting. For these reasons, the format for the utilization report has been re-visited and a new template has been suggested to address the issues. It was also suggested that regular sensitization workshops be organized by the country offices specifically for MoH officials responsible for managing SEARHEF funds.
- **Improvement in monitoring, reporting and evaluation:** One of the key gaps in the management of the Fund appears to be the lack of output and outcome data for use of SEARHEF. The basis for monitoring and evaluation activities of any development programme is the evaluation framework of the programme. For this reason, it is important to develop a monitoring and evaluation framework for each emergency that was supported through SEARHEF, including the development of a key set of indicators to measure outcomes.
- **Enhanced multisectoral collaboration:** Response to emergencies in any country is a multisectoral approach involving more than one national ministry or department. As SEARHEF is providing aid through the MoH, it is important to ensure collaboration with other ministries and departments involved in emergency response in the country. This will not only make the emergency response more efficient and effective but will also lead to achieving better value through all other available resources in the country for the emergency response.

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

### Background

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

9. 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.

10. 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:

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

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

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

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

12. As of June 2019, an amount of US\$ 200 000 towards the SEARHEF preparedness stream has been received from Thailand as part of its Voluntary Contribution. Out of this US\$ 75 000 has been disbursed to Bhutan (US\$ 50 000) and Sri Lanka (US\$ 25 000) (as of today) for strengthening HEOCs, rapid response teams or for surveillance, etc.

13. SEARHEF is overseen by a Working Group comprising 11 representatives from Member States. The Working Group has met seven times since 2008. The eighth meeting of the Working Group is planned via videoconference in July 2019. The progress report of the Fund is due to be submitted to the Seventy-second Session of the Regional Committee in New Delhi in September 2019.

## **Challenges being faced**

14. Major challenges of SEARHEF have been well articulated in the recommendations made by the Working Group during its seventh meeting in May 2018. These include:

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

## **The way forward**

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

- i. Member States are to provide updates on the progress made regarding contributions to the SEARHEF preparedness stream, particularly in the context of proposed Ministerial Roundtable on the subject of Emergency Preparedness at the Seventy-second Regional Committee Session in September 2019.
- ii. The Secretariat will provide updates on discussions with key donors on using SEARHEF as the main channel to support preparedness work in the Region.

### **3. Antimicrobial resistance (SEA/RC68/R3)**

#### **Background**

16. In 2010, the WHO Regional Committee for South-East Asia adopted resolution SEA/RC63/R4 on the prevention and containment of antimicrobial resistance (AMR). Subsequently, health ministers of Member States of this Region adopted the Jaipur Declaration on Antimicrobial Resistance in 2011.

17. In early 2014, antimicrobial resistance was included in the Regional Flagship Priorities launched by the Regional Director for South-East Asia.

18. In May 2015, the World Health Assembly through its resolution WHA68.7 adopted the Global Action Plan (GAP) on antimicrobial resistance and requested countries to prepare their national action plans (NAP) accordingly. The “Tripartite” (the Food and Agriculture Organization of the United Nations (FAO), the World Organisation for Animal Health (OIE) and WHO) have worked together and strengthened their collaboration to implement the GAP since.

19. In 2015, the WHO Regional Committee for South-East Asia adopted resolution SEA/RC68/R3 “Antimicrobial Resistance”, which, among other actions, directed the Regional Office to report on progress achieved in implementing this resolution at the sessions of the Regional Committee in 2017 and 2019 respectively, and conduct an assessment of regional achievements and challenges and present the same to the Seventy-fourth Session of the Regional Committee in 2021. A progress report was presented to the Seventieth session of the Regional Committee in Maldives in 2017.

20. The United Nations General Assembly (UNGA) vide resolution 71/3 adopted the “Political Declaration of the High-Level Meeting of the General Assembly on Antimicrobial Resistance” in 2016.

21. After considering the report by the WHO Director-General on the follow-up actions to the UNGA-AMR deliberations, the Executive Board at its 144th session recommended resolution EB144.R11 on antimicrobial resistance for adoption by the Seventy-second World Health Assembly. The Seventy-second World Health Assembly in May 2019 adopted the resolution on antimicrobial resistance that reiterated global agreement on combating AMR with continued high-level political commitment.

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

22. Ten of the 11 Member States have enrolled in the Global Antimicrobial Resistance Surveillance System (GLASS) as of 2019.

23. Member States of the South-East Asia Region actively participated in the World Antibiotic Awareness Week (WAAW) 2017–2018.

24. A situation analysis of antimicrobial resistance prevention and control in the Region was conducted in 2016. In July 2018, the Regional Office organized an “Intercountry Meeting to review implementation of national action plans on antimicrobial resistance” in collaboration with FAO, OIE and the United Nations Environment Programme (UNEP).

25. Countries of the SEA Region received training on the use of WHO methodology to monitor antimicrobial consumption and have initiated the process to adopt the “Access/Watch/Reserve (AWaRe) classification” in their national medicines lists. The AWaRe classification is also used with the One Health approach. In February 2019, the Regional Office provided training to Member States on how to adapt the AWaRe strategy to their national essential medicines lists and treatment guidelines and how to develop and implement antimicrobial stewardship programmes.

26. National regulatory authorities (NRAs) in four Member States have taken steps to reduce over-the-counter sale of antimicrobials through improved labelling, inspections and public education. In addition, two Member States have banned irrational and unsafe fixed-dose antimicrobial combination drugs that will reduce in the long term their misuse and the risk of resistance. The South-East Asia Regulatory Network (SEARN) annually discusses action to be taken by NRAs to improve regulation to optimize antibiotic use and ensure access to quality-assured antimicrobials.
27. National reference laboratories (NRLs) of the majority of SEA Region Member States were assessed and gaps identified. Onsite trainings and study tours are being conducted. Member countries are participating in the regional external quality assurance programme for detection and characterization of GLASS pathogens to assure quality data for GLASS.
28. WHO is continuously working with relevant stakeholders to mobilize and allocate necessary resources for the implementation of NAP and for research and development.
29. An AMR programme evaluation has been initiated in the SEA Region.
30. A regional Tripartite coordination team is based in Bangkok. The Regional Office has assigned to it a WHO liaison officer to coordinate joint Tripartite activities on AMR and other One Health activities.
31. All 11 Member States participated in the WHO/OIE/FAO AMR self-assessment exercises held in 2016–2017, 2017–2018 and 2018–2019. The self-assessment survey 2018–2019 revealed that:
  - a. All 11 Member States (100%) have their AMR national action plans (NAPs) in place.
  - b. Ten of the 11 Member States have multisectoral working group(s) or coordination committee(s) on AMR established with government leadership.
  - c. Six of the 11 Member States have been raising awareness of and understanding about antibiotic resistance risks and response in human health activities. Prevention of AMR also requires more community involvement in the animal health, environmental and food production sectors.
  - d. Nine of the 11 Member States have national monitoring systems in place for consumption and rational use of antimicrobials in human health while some Member States need to develop such a monitoring system.
  - e. Ten of the 11 Member States have guidelines in place for infection prevention and control (IPC). The level of implementation of these guidelines varies from country to country.
  - f. Ten of the 11 Member States have imparted training and professional education on antimicrobial resistance in the human sector which is conducted through continuous professional development, pre-training courses, or on an ad hoc basis. For the animal/environment sector, it is conducted on an ad hoc basis.
  - g. Ten of the 11 Member States have mechanisms for optimizing antimicrobial use in human health to some extent, whereas mechanisms for optimizing antibiotics use in animals and plants is limited.
  - h. In all 11 Member States, relevant policies and regulatory frameworks for antimicrobial resistance are in place.
  - i. National action plans on antimicrobial resistance are linked with other programmes, such as HIV, TB, malaria and NTDs, in only three Member States, while in eight other Member States they are not linked.

## **Challenges being faced**

32. Though all Member States of the Region have developed national action plans, their implementation is at various stages. Implementation needs high-level commitment from policy-makers, annual allocation of funds, and technical expertise.

33. Though multisectoral steering committees have been formed in most of Member States of the Region, they are not necessarily functioning optimally. Keeping in view the cross-cutting nature of the subject, a multidisciplinary approach is required. It is important to strengthen linkages among various programmes.

## **The way forward**

34. The Regional Office will intensify its support to Member States in accelerating the implementation of national action plans for combating antimicrobial resistance. The One Health approach with multisectoral coordination should be in place in all related AMR activities.

35. Together with Member States, WHO will reinforce its support towards implementation of (a) the UN General Assembly High-level Political Declaration on Antimicrobial Resistance adopted in October 2016, World Health Assembly resolutions (WHA67.25, WHA68.7, WHA70.7) and Regional Committee resolution (SEA/RC68/R3) on Antimicrobial Resistance, and (b) the Seventy-second World Health Assembly resolution on Antimicrobial Resistance adopted in May 2019.

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

### Background

36. Patient safety is core to the high-quality health systems needed to achieve universal health coverage. Poor safety and quality of care reduce trust in services and discourage their use, waste scarce resources and impose high costs. Progress towards universal health coverage (UHC) will be seriously constrained without improvement in the quality and safety of both frontline services and inpatient care. Adequate quality and safety, especially in frontline services, can improve public trust in health services and lead to increased use by those in need, reducing the pressure on secondary and tertiary care.

37. Member States adopted the resolution “Patient Safety contributing to sustainable Universal Health Coverage” (SEA/RC68/R4) at the Sixty-eighth session of the Regional Committee in 2015. This requires two-yearly reporting on progress in implementation of the resolution. This second progress report outlines the progress made in improving patient safety in the Region during the period 2017–2018 through implementation of the six strategic objectives of the WHO Regional Strategy for Patient Safety.

### Progress made and challenges faced in the WHO South-East Asia Region

38. Progress in implementation of the six strategic objectives of the WHO South-East Asia Regional Strategy for Patient Safety:

**a. Strategic Objective 1: To improve the structural systems to support quality and efficiency of health care and place patient safety at the core at national, subnational and health-care facility levels:**

- There has been significant progress in this regard since the previous reporting period. Most SEA Region Member States now have policies, strategies or frameworks to improve patient safety and quality of care (Bangladesh, India and Timor-Leste have recently developed such policies). Some national policies are under development with support from WHO (as in the case of Democratic People's Republic of Korea, Indonesia and Maldives).
- Several Member States (e.g. India, Indonesia and Thailand) have active health facility accreditation/quality assurance programmes. Others (e.g. Bhutan and Maldives) are establishing or strengthening them. Indonesia has used accreditation of hospitals as a key policy instrument to improve quality for over two decades. In 2015 it established an Accreditation Commission for Primary Health Care Facilities.
- A few Member States (e.g. Bangladesh, India and Sri Lanka) are moving towards incorporating a quality improvement approach as part of their national strategies and programmes on patient safety. Timor-Leste has entered into a twinning partnership for improvement with Macau Special Administrative Region, China, to obtain focused support on specific aspects of quality improvement in selected health facilities.
- Many patient safety and quality interventions are being implemented through programmes such as maternal and child health (MCH); water, sanitation and hygiene (WASH); antimicrobial resistance (AMR); infection prevention and control (IPC), injection safety; viral hepatitis control or health emergencies.
- More work is needed in establishing a culture of safety, in improving patient experience of care, and involving patients as partners in their own care.

**b. Strategic Objective 2: To assess the nature and scale of adverse events in health care and establish a system of reporting and learning:**

- Data on patient safety and quality of care in Member States remain scarce. Country-level data on estimates of the burden on unsafe care is almost non-existent.
- Most Member States now have some form of adverse event or error reporting mechanisms and others are working to establish or strengthen these systems. However, these mechanisms are often limited to specific programmes, such as to track adverse events after immunization or for pharmacovigilance, and may not include broader patient safety incidents.
- Information is limited on how these reporting systems work and are used to inform policies and actions to make care safer. There appears to be the continued lack of a non-punitive culture in health-care settings, which impedes reporting.
- Some countries have developed patient feedback systems (e.g. Mera Aspatal in India; SMS complaints/suggestions system in Bangladesh; Centro Atendimento das Reclamacoes in Timor-Leste). Some Member States such as India make such feedback available only to the stakeholders at the facility, district, state and national level, while the databases are publicly accessible in others (e.g. Bangladesh). Such data can help governments take appropriate decisions and improve accountability for the quality of health-care delivery, especially across public facilities.
- Information on service inputs and coverage of essential interventions is available from population-level surveys conducted by WHO or country governments. These data are helpful but insufficient. Most routine health information systems lack a set of indicators on quality or safety.

**c. Strategic Objective 3: To ensure a competent and capable workforce that is aware and sensitive to patient safety:**

- All Member States are increasingly carrying out trainings on patient safety and quality of care, often focused on a particular area or level of care.
- The point of care continuous quality improvement (POCQI) approach, supported by the Regional Office and partners, has fostered actions by health-care teams to improve the quality of care in labour rooms and newborn care units in hospitals across nine Member States in the Region (Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Timor-Leste). The number of participating facilities ranged from 1 in Timor-Leste and 4 each in Bhutan and the Maldives to 55 in Bangladesh and over 100 in India, as of March 2019.
- In a few facilities in India, the approach has expanded to other areas, such as surgical safety and emergency care. The approach has empowered health-care teams and led to tangible improvements in care processes and outcomes in several facilities. Bhutan has included POCQI training in pre-service education. Two Member States – India and Bangladesh – are also part of the WHO Quality Equity Dignity Network, which is working to improve the quality of care in health facilities.

**d. Strategic Objective 4: To prevent and control health-care associated infections (HAI):**

- Infection prevention and control (IPC) and water, sanitation and hygiene (WASH) feature in many national policies, strategies and guidelines. Most have implemented IPC and WASH interventions and capacity-building activities in selected health-care settings and are scaling them up nationally; some have developed standard operating procedures, guidelines and protocols but not yet begun implementation. A few are yet to develop national plans for IPC and WASH.
- **HAI surveillance:** As of 2018, Bangladesh, Bhutan, Democratic People's Republic of Korea and Indonesia have established national programmes to address hospital-acquired infections. Three Member States (Maldives, Nepal and Timor-Leste) are in the stage of initial exploration and adoption, while India and Myanmar have initiated surveillance at a limited number of sites.
- **Antimicrobial resistance (AMR):** Nine Member States (Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Maldives, Myanmar, Nepal, Sri Lanka and Thailand) are signatories to the WHO Global Antimicrobial Resistance Surveillance System (GLASS). The Regional Office has supported some of these Member States to build or strengthen their national AMR surveillance systems. All SEA Region Member States have developed national AMR action plans and conducted annual AMR self-assessments. In 2018, 10 Member States ran advocacy campaigns during World Antibiotic Awareness Week.
- **Health security and emergencies:** WHO supports quality and safety as part of strengthening preparedness and response to health emergencies. WHO tracks progress in and supports national efforts across 19 International Health Regulations (IHR) core capacities. Joint external evaluations to assess IHR core capacities in eight SEA Region Member States have found weak country capacity in areas such as AMR detection, AMR surveillance, HAI prevention and control, and antimicrobial stewardship programmes.

**e. Strategic Objective 5: To improve implementation of global patient safety campaigns and strengthen patient safety in all health programmes – safe surgery, safe childbirth, safe injections, medication safety, blood safety, medical device safety, and safe (organ, tissue and cell) transplantation:**

- Actions by Member States include the following:
  - Myanmar has distributed a surgical safety checklist to all public hospitals and incorporated the soft copy into mobile tablets distributed to township and station medical officers.
  - India launched the Labour Room Quality Improvement Initiative (LaQshya), which aims to improve the experience and quality of care around labour and delivery processes and mandates the use of the surgical safety checklists in obstetrics and gynaecology. The Government of Punjab, India, has introduced re-use prevention (RUP) syringes in therapeutic care and is the exclusive procurer for these in the state. The Indian state of Andhra Pradesh has also switched to RUP syringes.
  - Sri Lanka drafted the National Action Plan on Medication Safety.

- The Regional Office organizes advocacy campaigns for the themes launched under the Global Patient Safety Initiative – hand hygiene (this is done on an annual basis), safe surgery and medication safety. In March 2019, at a meeting titled “Promoting cleaner, safer health facilities: informal experts’ consultation on improving quality and safety”, the experts provided advice to WHO on strategic priorities, including: (i) developing a dashboard of basic indicators based on which Member States can identify targets to pursue in the medium term; and (ii) organizing a campaign targeting especially parliamentarians and the public.

**f. Strategic Objective 6: To strengthen capacity for and promote patient safety research:**

- In 2018, the *Indian Paediatrics Journal* published a special issue on quality improvement in maternal and newborn care. WHO has supported the Maldives National University to conduct a research project on the prevalence of antibiotic resistance in the country. Myanmar has conducted some research activities on the prevalence of HAIs and AMR. Research on adverse drug reactions in hospitals is planned for 2019.

## The way forward

39. There is fresh attention to positioning primary health care (PHC) as the cornerstone for accelerating progress on UHC, for example, in the Astana Declaration on Primary Health Care in October 2018. If PHC is indeed going to be the “cornerstone” for advancing UHC, then some transitions are needed. These include a re-examination of ways to improve the quality and safety of frontline services, and links to secondary care. Managing change in countries is both a technical and political challenge. The seventy-second World Health Assembly (WHA72.6) endorsed the World Patient Safety Day, to be observed annually on 17 September, starting 2019. This is expected to strengthen the focus on improving patient safety and quality.

40. The way forward could include actions such as the following by the Member States:

- i. Increase engagement of all relevant stakeholders for promoting awareness and implementing interventions to improve patient safety based on identified priorities.
- ii. Integrate quality and safety indicators into health information systems, strengthen adverse event reporting systems and participate in regional platforms to share evidence and experience with other countries on actions to improve patient safety. To achieve this goal, shift from a “blaming approach” to a learning and systems approach to error reporting.
- iii. Identify ways to increase the numbers of health workers sensitive and concerned about patient safety and quality improvement. This involves building new clinical and social competencies, including respectful, people-centred care. Foster effective teamwork and interprofessional collaboration based on strategies recommended in WHO’s framework for action on interprofessional education and collaborative practice. Incorporate such training needs into pre- and in-service educational programmes.
- iv. Build on current activities across health programme areas (AMR, IPC, POCQI, WASH, RMNCAH), engage other health programmes and ensure coordination and joint activities. Improve health-care waste management in and beyond facilities, and ensure the implementation of WHO patient safety checklists.
- v. Commemorate World Patient Safety Day on 17 September annually to promote all aspects of patient safety including progress on national milestones in collaboration with relevant stakeholders.

41. The Regional Office will continue to support Member States of the SEA Region in developing and implementing national policies and interventions to promote a system strengthening approach to improving patient safety, and promoting a patient safety culture in health facilities. WHO will also facilitate the formation of regional platforms and documentation and sharing of national experiences with interventions for improving patient safety and quality of care as an integral part of advancing UHC. For example, A regional consultation on strengthening frontline services for universal health coverage is scheduled to be organized by WHO in New Delhi on 23–25 July 2019. At this consultation Member States will share their experiences, discuss suggestions from the March 2019 informal experts consultation (see paragraph 38e) and identify ways forward to improve health service quality and safety. WHO is also organizing a workshop on infection prevention and control for countries of the Region in Bangkok in August 2019.

42. In addition, WHO will support country- and regional-level actions to mark the first World Patient Safety Day on 17 September 2019. WHO will continue to support Member States on all aspects of the patient safety and quality agenda, including by sharing good practices within and beyond the Region.

## 5. Challenges in polio eradication (SEA/RC60/R8)

### Background

43. 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.

44. The Global Polio Eradication Initiative Endgame Strategy 2019–2023 will now guide the programme until global certification is achieved. The key components of the strategy are eradication, certification and integration.

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

46. The Seventy-first World Health Assembly adopted resolution WHA71.16 in 2018 in which the Health Assembly urges Member States to intensify efforts to accelerate the poliovirus containment progress.

47. A Strategic Action Plan on Polio Transition was presented to the Seventy-First World Health Assembly in May 2018.

48. The Strategic Action Plan has three key objectives:

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

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

49. The South-East Asia Region reported the last polio case due to wild poliovirus on 13 January 2011 and was certified polio-free on 27 March 2014. The Regional Certification Commission for Polio Eradication (RCCPE) has confirmed that the Region has remained free of all wild polioviruses during its annual meetings, the last of which was held in November 2018.

50. The last wild poliovirus type 3 (WPV3) case in the South-East Asia Region was detected in October 2010. With no WPV3 reported anywhere in the world since November 2012, the global eradication of this strain could be certified by the Global Certification Commission (GCC) in 2019. In September 2015 the GCC had certified global eradication of wild poliovirus type 2 (WPV2).

51. Despite being polio-free for more than eight 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 of subsequent spread of the virus in the Region.

52. An outbreak due to a circulating vaccine-derived poliovirus type 1 (cVDPV1) was reported in Papua province of Indonesia in February 2019. The response to the outbreak is ongoing. An immediate district-level vaccination campaign is being followed by two additional mass vaccination campaigns in Papua and Papua Barat provinces of the country.

53. Environmental surveillance for poliovirus detection is established in six countries in the Region – Bangladesh, India, Indonesia, Myanmar, Nepal and Thailand. In 2018, additional sites were established in Cox’s Bazar, Bangladesh, and Papua, Indonesia.

54. All countries have national outbreak preparedness and response plans in place. However, updates may be required based on risk assessment and to align the outbreak plans with the latest global guidelines. The risk assessment tool is being modified to reflect new epidemiology and other developments.

55. All countries switched from trivalent oral poliovirus vaccine (tOPV) to bivalent oral poliovirus vaccine (bOPV) in 2016 and have also introduced inactivated poliovirus vaccine (IPV). IPV is now available and is being administered in all countries of the Region under the routine immunization programme. Four countries in the Region – Bangladesh, India, Nepal and Sri Lanka – are administering intradermal IPV.

56. Containment activities as per the WHO “Global Action Plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use” (GAP III) are steadily progressing. Two poliovirus essential facilities (PEF) have been identified to store/handle type 2 polioviruses in the Region, one each in India and Indonesia.

57. Over the past two decades polio-funded assets, that include human workforce, infrastructure, equipment and systems, have been established in five Member States of the South-East Asia Region, namely Bangladesh, India, Indonesia, Myanmar and Nepal. These polio assets have not only contributed to the elimination of polio and the implementation of the polio endgame strategies but have also been increasingly involved with other health and immunization activities in the Region. Key areas of their involvement include surveillance for other vaccine preventable diseases, strategies for elimination of measles, strengthening of routine immunization systems and introduction of new vaccines.

58. A country-centric approach is being adopted to develop polio transition plans by Member States of the Region. The pace of development and implementation of national transition plans is being guided by country readiness (technical, financial and managerial capacity), available financing as well as operational modalities.

- a. The Government of Bangladesh has endorsed the national polio transition plan and is on track with the implementation in three phases, as planned.
- b. Recent endorsement of the national plan by the Government of India and transfer of domestic resources to cover the gaps reflects its commitment to priorities outlined in the plan.
- c. The Government of Indonesia has initiated action to self-fund a large proportion of the surveillance, laboratory and immunization costs, previously funded by Global Polio Eradication Initiative (GPEI).

- d. The national transition plan of Myanmar is under consideration for endorsement by the government.
- e. Due to the ongoing federalization process, there has been a delay in the endorsement of the national transition plan by the Government of Nepal.

### **Challenges being faced**

59. The following challenges are being faced by the Member States in the Region:

- a. Maintaining polio-free status in the context of the risk of importation of WPV or emergence of cVDPVs;
- b. Sustaining high routine immunization coverage, sensitive surveillance, strong outbreak response capacity and containment of polioviruses in facilities during the post-certification period;
- c. While countries are making tangible efforts towards polio transition, advocacy with donors and partners remain critical to ensure that polio infrastructure and capacities continue to maintain polio functions and strengthen health systems.

### **The way forward**

60. The South-East Asia Region has maintained its polio-free status for more than eight years. However, all Member States in the Region continue to be at risk of importation of wild poliovirus and of emergence of vaccine-derived polioviruses.

61. There is a need to maintain and strengthen implementation of strategies outlined under the Polio Endgame Strategy 2019–2023 to ensure that the polio-free status of the Region is maintained.

62. It is essential for Member States with significant polio-funded assets to timely implement their respective polio transition plans, to maintain essential polio functions, contribute to strengthening immunization systems and help achieve coverage and equity goals.

## **6. Colombo Declaration on strengthening health systems to accelerate delivery of NCD services at the primary health care level (SEA/RC69/R1)**

### **Background**

63. The Colombo Declaration on strengthening health systems to accelerate delivery of noncommunicable disease services at the primary health care level was endorsed at the Sixty-ninth session of the WHO Regional Committee for South-East Asia on 9 September 2016 in Colombo, Sri Lanka (SEA/RC69/ R1). The Declaration highlights renewed commitment by Member States to accelerate NCD service delivery through a people-centred primary health care approach to realize the Global and Regional Voluntary Targets for NCD Prevention and Control, which includes achieving 80% availability of essential NCD medicines and technologies in health facilities and ensuring that 50% of high-risk populations receive drug and counselling therapies to prevent heart attacks and strokes by 2025.

64. The resolution entrusted the Secretariat to report progress at the Regional Committee sessions in 2019 and 2021. In September 2017, following one year of the adoption of the Declaration, the WHO Regional Office for South-East Asia had also compiled an interim progress report. The 2019 progress report on the Colombo Declaration was submitted to the High-Level Preparatory M in July.

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

65. In less than 24 months after the endorsement of the Colombo Declaration, there has been noticeable progress in mainstreaming NCD management in the primary health care system and overall NCD prevention and control in SEA Region countries.

#### ***Multisectoral NCD plans and governance in place***

66. All countries in the Region now have adopted a multisectoral action plan (MSAP) to address noncommunicable diseases (NCDs). Prior to the signing of the Colombo Declaration in 2016, only five countries – Bhutan (2015), DPR Korea, Nepal (2014), Maldives and Sri Lanka (2015) – had endorsed their national multisectoral NCD action plans. After the signing of the Colombo Declaration, Bangladesh (2018), India (2016), Indonesia (2016), Myanmar (2017), Thailand (2017) and Timor-Leste (2018) endorsed their national multisectoral NCD Action Plans.

67. Most countries have established a national NCD governance body for multisectoral coordination. The NCD coordination units are almost always located in the health ministry. Although efforts persist to improve coordination, units are understaffed, underskilled and under-resourced, thus delaying Governing Body meetings, follow-up on its decisions, outreach to other sectors and monitoring progress of MSAP implementation.

68. Countries of the Region have employed several good practices in NCD governance and multisectoral response. This includes leveraging parliamentary processes to stimulate non-health sector response in Bhutan, Bangladesh and Myanmar; legislative mandate for multisectoral coordination for tobacco control in DPR Korea; interventions that yield early visible results in India; Presidential decree on the healthy lifestyle movement in Indonesia; improved participation through shared responsibilities in NCD governance in Maldives and Thailand; non-health infrastructure for NCD service delivery in Nepal; community leaders in NCD response in Timor-Leste; and seed funding to stimulate non-health sector action in Sri Lanka.

### ***Newer policy initiatives are visible to strengthen NCD early diagnosis and management***

69. There is steady progress in integrating essential NCD services within the health systems in the Region in line with the 2016 Colombo Declaration to accelerate integration of NCD services into primary health care systems. Numerous new health policy initiatives have been taken in countries, of which some initiatives include: endorsement of the National Health Policy 2017 among other policies which focus on a range of NCD interventions including screening for hypertension, diabetes, oral, breast and cervical cancer and chronic obstructive pulmonary diseases (COPDs) in India; enactment of the “minimum service standard regulations for health” in November 2016 which make screening for NCD risk factors for people aged 15–59 years (Minister’s regulation no. 43 for the year 2016 on minimum service standard for health) and services for diabetes and hypertension an integral performance indicator for local governments in Indonesia; and health policy to strengthen early detection and management of NCDs as part of its primary health care service package in Thailand. Bangladesh endorsed NCD services in the Essential Services Package.

### ***Early detection and screening of major NCDs are expanding at the frontline***

70. The Package of Essential Noncommunicable Disease (PEN) and Healthy Lifestyle Intervention training modules for primary health care workers was developed and released at the Seventy-first session of the Regional Committee in New Delhi in September 2018. All countries of the Region were oriented on the Regional PEN training package at a three-day meeting in October 2018 in Dhaka. The SEA Region PEN training modules have expanded the scope from conventional NCDs to strengthening palliative care and addressing common comorbidities of NCDs and mental disorders. Countries are increasingly adopting protocol-based management for CVDs, hypertension, COPD and asthma to standardize care. Salient progress achieved thus far include:

- a. **Bangladesh:** Standard treatment protocols for cardiovascular risk, hypertension and diabetes have been developed, national PEN training package has been prepared (PEN, team-based approach, cardiovascular disease and risk factors, cardiovascular risk assessment and management, assessment and management of diabetes and hypertension, and brief interventions for NCD risk factors), and training of health workers has commenced. NCD service availability and readiness assessment based on PEN package is planned for Cox’s Bazar, and is led by WHO in collaboration with health sector partners. NCD modules (from the emergency kits) have been procured and an NCD working group established in Cox’s Bazar.
- b. **Bhutan:** Bhutan adopted people-centred PEN initiatives focusing on improving the systems approach of service delivery and strengthening recall and follow-up care, replenishment of medicines at basic health units, team-based approach, clinical mentoring and supportive supervision, health outcome monitoring system, and community outreach.
- c. **DPR Korea:** Adapted the PEN training modules according priority to management of hypertension and diabetes at the primary health care level, with immediate plans to scale up training.
- d. **India:** Population-based screening is available in 216 districts covering 22 874 subcentres and covering 10 823 071 individuals; 17 000 health and wellness centres have initiated point-of-care diagnostics with mid-level care providers, screening services for NCDs, and free drugs supply. As of March 2019, 67 962 186 NCD clinic visits have been recorded through the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Disease and Stroke (NPCDCS programme).
- e. **Indonesia:** Indonesia expanded screening services for cervical cancer using visual inspection acetic acid (VIA) and clinical breast examination (CBE). Screening of raised blood pressure, raised blood sugar and cholesterol and use of peak flow meter test through *posbindus* reached out to 941 422 people in 2016 and another 607 287 in 2017 from 30 350 *posbindus*.

- f. **Maldives:** PEN trainings are now completed in all islands in the country since having launched the first training in Male' and Addu Atoll in 2017. Maldives also launched an app for PEN (mPEN) to facilitate the use of PEN protocols.
- g. **Myanmar:** In Myanmar, early detection/screening for CVDs, diabetes and cancers (oral and breast cancer) have expanded from 20 townships by 2017 to 240 townships in 2018. Efforts are underway to expand the services to all 300 townships in the country.
- h. **Nepal:** Since 2017, Nepal has rolled out the PEN trainings to 16 districts. There are immediate plans to expand the PEN services to other districts using the recently adapted SEA Region PEN training modules.
- i. **Sri Lanka:** The number of healthy lifestyle clinics have now expanded to 1200, up from the 800 clinics registered in 2016.
- j. **Thailand:** Thailand has prioritized hypertension management. A national strategic technical advisory group on hypertension meets quarterly and provides oversight and policy directions to the programme. The cardiovascular disease track has been integrated into the Field Epidemiology Training (FETP) Programme. Surveillance and research undertaken by FETP trainees provide feedback for programme improvement. A rapid health facility assessment survey was undertaken to identify best practices and gaps. The 2019 Thai hypertension guidelines were prepared. A social media public awareness campaign was undertaken to create public awareness about blood pressure monitoring and treatment.
- k. **Timor-Leste:** PEN services have been initiated in the districts of Elmera and Dili (out of 13 districts), and the country plans to expand the services to all health facilities in five municipalities in 2019–2020. NCD services are being expanded through domiciliary visits (Saude na familia), mobile clinics, SISCA and the School Health Services.

### ***Health workforce is being reorganized at the primary health care level***

71. Countries have initiated numerous activities to strengthen the primary health care workforce. The range of activities include: (i) assessing workload in four districts in Bangladesh, Bhutan and Myanmar; (ii) decisions to develop primary health care coaching teams to implement package of essential noncommunicable disease interventions in Bhutan, Maldives and Timor-Leste; (iii) initiatives to introduce task sharing by non-physician health workers to manage NCDs in Myanmar and Nepal; (iv) continuing engagement of non-physician primary health care workers to diagnose and treat uncomplicated hypertension, and respiratory diseases and prescription refill for diabetes at the primary health care level in Bhutan; and (v) expansion of primary care clusters to promote health of families.

72. In Sri Lanka, 160 public health nursing officers have been recruited and trained especially to deliver lifestyle modification communication and rehabilitation. India appointed additional staff nurses at the PHC level in districts undergoing population-based NCD screening and integrated alternative systems of medicine (AYUSH) with the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS). This helped to utilize the AYUSH workforce for prevention and control of NCDs in NCD clinics as well as in outreach.

73. Nepal has also designated medical officers at the primary health care centers and health assistants at the health posts level as PEN focal points. District health offices have been assigned a PEN-trained focal point; and a focal point has been assigned at the National Health Training Centre and National Health Education Information and Communication Centre for PEN implementation at the national level.

### ***Updated essential drugs and diagnostics at health facilities***

74. After the Colombo Declaration, Bangladesh, Bhutan, Nepal, Sri Lanka, Thailand and Timor-Leste updated their essential drugs list (EDL) with NCD medicines. DPR Korea, India, Indonesia and Myanmar have reported that the EDL was revised recently prior to September 2016. Similarly, countries are equipping basic diagnostics for blood sugar and lipid profiling at the primary health care facilities. Equipment such as weight and height measurement scales have been provided to health facilities in PEN implementing countries. BMI charts and cardiac risk prediction charts have also been made available in health facilities.

### ***Increasing resources for NCD management***

75. Availability of domestic resources to finance essential NCD services at the PHC level is indicative of the country's ownership for sustaining access to NCD services. Almost all countries are providing additional funds to boost NCD services at the primary health care level from domestic resources. Countries in general do not dedicate taxes from tobacco, alcohol and unhealthy foods and beverages for health financing with the exception of Thailand. More than 90% of the revenue from 2% excise tax subsidies collected from importers and producers of liquor and tobacco is allocated to proactive projects aimed at solving major health risk issues including NCD risk factors. Bangladesh, DPR Korea, Nepal and Sri Lanka reported a rise in taxes and prices of harmful products such as alcohol and junk food which goes to the general revenue pool of the country. Indonesia strengthened the former cigarette/tobacco fiscal tax with the additional Government Regulation no. 55 for the year 2016 mandating 10% of the fiscal tax from tobacco to be equally distributed to provinces based on total population as local tax income, of which 50% is to be used for health programmes and law enforcement such as enforcement of smoke-free areas.

76. In India, tobacco and many junk foods have been classified as health-demoting goods and attract the highest slab of tax, equalling 28%, in the recently rolled out Goods and Services Tax (GST). Another notable move is the taxation on *bidis* (unprocessed tobacco wrapped in leaf) which hitherto did not attract any tax but now have been included under the tax bracket of 28%. A further levy of Indian Rupee 1 and 2 for every 1000 handmade and machine-made *bidis* respectively has been imposed as additional tax. Additional tax is also being levied on tobacco to make a total tax liability of 40%.

### ***Financial protection and universal health coverage***

77. Some other new policy frameworks were also noted in countries to protect financial risks of patients such as reducing out-of-pocket payments for NCDs through state funds or social health insurance models for the general population since September 2016. In Indonesia, there is an effort to expand the coverage for health-care costs for all NCDs at the primary, secondary and tertiary health-care centres through the National Health Insurance established in 2014. The National Health Policy of India endorsed in 2017 aims at increasing the health expenditure by the government as a percentage of GDP from the existing 1.15% to 2.5% by 2025, and decreasing the proportion of households facing catastrophic health expenditure from the current levels by 25% by 2025.

78. Various new schemes have been rolled out in India to improve the availability and access to drugs through the public sector and to reduce out-of-pocket expenditure on NCD care. Cancer treatment in many states and Union Government institutions is provided free for patients living below the poverty line and is subsidized for others. These efforts are in the right direction but will prove to be inadequate if strategic purchasing is not enhanced. In Nepal a subsidy of Nepalese Rupee 100 000 is provided for eight identified conditions including heart disease, cancers and kidney disease.

### ***NCD registries and population-based cancer registries are expanding***

79. Disease registries for cancers are improving in countries. Although hospital-based cancer registries are commonly used, after 2016 there have been a number of new initiatives to set up population-based cancer registries (PBCR). In Myanmar, PBCR had been initiated in the Naypitaw region in 2017 and in Yangon in 2018. PBCR have been established in Kathmandu and few neighbouring districts in 2018. India is generating reliable population data on cancer through 32 population-based cancer registries and 29 hospital-based cancer registries. India has started additional PBCR in the states of Uttar Pradesh and Bihar. Thailand has an ongoing population-based cancer registry. Indonesia has expanded population-based cancer registry to 14 provinces in 14 regional referral hospitals and surrounding primary health care centres (*puskesmas*) in the country. The Dharmais Hospital Cancer Registry team has an ongoing training of the 14 regional referral hospitals under the funding of the Directorate of Referral Services and Directorate of NCD and conduct regular coordination to see the progress of data collection in Indonesia. Nepal and Timor-Leste have initiated PEN registries to collect PEN-related information. Sri Lanka conducted a review of the diabetes information system and registries for stroke and cancers already exist. Bhutan is implementing a nationwide PBCR.

80. In India, the National Stroke Registry and registry of juvenile diabetes (Registry of Youth Onset Diabetes) have also been implemented. There are no national disease registries on stroke, heart attack and other chronic diseases.

### **Challenges being faced**

81. The following challenges are being faced:

- a. Inadequate budget to implement the sectoral actions, lack of technical capacity and poor understanding of the roles leading to lack of coordination are common barriers.
- b. The divergent sectoral mandates, industry interference, political pressures and lack of clarity of roles are among the other challenges to multisectoral response in the region.
- c. In general, asthma and COPD services appear to be receiving less focus compared with CVDs and diabetes in all countries.
- d. While expansion of programmes on cardiovascular diseases and diabetes has gained momentum, more focus needs to be given to respiratory diseases, cancers and integrating palliative care and quality of essential services in the frontline health services.
- e. Availability of and ensuring high competency levels of the health workforce is a concern. There is a shortage of the health workforce and countries are facing challenges in filling up vacant posts.
- f. Geographical barriers affecting the coverage of NCD services, as well as the difficulty in procurement of essential medicines and diagnostics due to economics of scale for nations with small populations.
- g. Weak data, including management of individual patient records and issues around inefficient data management for programme monitoring, difficulty in integration of patient-level data, individual patient tracking and follow-up are also areas of concern.
- h. Low financing of NCD services that are deployed to achieve national coverage of NCD prevention and control through the primary health care approach.

## The way forward

82. Addressing the NCD burden requires a PHC focus providing people-centric, comprehensive, integrated and equitable care built on the principles of primary health care. The ongoing initiatives and evolution of primary health care systems among the countries in the Region provide unprecedented opportunities to improve management of NCD services through primary health care facilities. Moving forward, the following measures will have to be considered to accelerate implementation of the commitments of the 2016 Colombo Declaration:

- a. **Build a generation of NCD managers and leaders in multisectoral agencies.** MoH officials such as NCD programme managers and directors, and other sectors such as trade, social sectors and enforcement agencies, have to be proficient in handling NCD-related agenda. Such competencies include strategic management for cross-sectoral policy partnerships, and recognizing conflict of interest of the tobacco, alcohol and food industry and managing them. Capacity-building programmes such as tailored courses are required for the management of cross-sectoral partnerships and enhancing managerial and leadership skills of officials and stakeholder representatives.
- b. **Build a competent primary health care workforce:** Countries need to invest in boosting the competencies of and improving team-based care at health settings, and in training mid-level health workers and nonspecialized and non-physician health workers to address the problem of an insufficient health workforce. Member States need to prioritize strengthening of primary health care systems focusing on capacity-building through the development of effective multitasking of the primary health care workforce and building additional cadres to respond to the increased scope and expectations of people-centred NCD prevention and control services. The ministries of health will need to promote and collaborate with health workforce training institutions to strengthen both pre- and in-service training to mainstream appropriate and timely referrals of severe and complex cases to higher centres.
- c. **Improve service delivery and gatekeeping in PHCs:** At present, there is minimal gatekeeping between primary and hospital levels leading to cost inefficiencies. Effective gatekeeping is possible only when the users have confidence in services available at the primary health care level. Health facilities should be equipped with essential medicines, and diagnostics for common NCDs agreed by national standards and managed by trained health workers to retain the trust in the primary health care services. The availability of essential medicines including opioid analgesics, and basic technologies and engagement of public and private sectors should be improved. Health-care delivery systems need to be strengthened to provide essential NCD services to vulnerable and hard-to-reach populations in order to achieve universal health coverage.
- d. **Contextualize the model of care:** Translational research and knowledge on NCD models of service delivery at the primary health care level and information system for health systems response are important. Continuous quality improvement and performance measurement of service delivery at the primary health care level should be institutionalized and cross-country sharing of initiatives such as periodic standardized quantitative assessments and evaluations of NCD services should be widely promoted.

- e. **Invest in primary health care and NCD services:** Countries need to increase fiscal allocation for primary health care NCD services from national resources that is explicitly linked to social protection of the poor and reduction of out-of-pocket payment to enhance universal health coverage. Governments should explore different arrays of financing mechanisms for primary health care services such as through dedicated taxation for health, together with the development of clear “benefit packages” from the dedicated taxation. In particular, Member States should explore domestic resources through policy advocacy and envisaging innovative financing mechanisms such as co-funding by local governments as well as dedicated taxation on tobacco, alcohol and sweetened beverages, etc.
  
- f. **Support technical training in countries:** Countries will need to be supported in the areas of training and leadership for cross-sectoral management for NCDs, setting up a population-based cancer registry, developing NCD database and patient tracking system and development of national guidelines for NCDs. WHO should continue to support Member States in their efforts to strengthen NCD prevention and control at the primary health care level and validate country-specific models of NCD service delivery through supporting rigorous evaluation. On the broader policy movement, WHO should continue advocating national leaders and change agents to accelerate the implementation of the provisions of the Colombo Declaration. WHO should also support Member States in mobilizing resources for NCD prevention and control activities, including through innovative financing mechanisms.

## 7. Traditional Medicine: Delhi Declaration (SEA/RC67/R3)

### Background

83. The majority of Member States of the WHO South-East Asia Region have a long history of Traditional and Complementary Medicine.

84. In 2013, health ministers of the South-East Asian Region signed the Delhi Declaration on Traditional and Complementary Medicine (TCM) at the International Conference on TCM. All Member States agreed to cooperate and collaborate in all fields of TCM, in accordance with national priorities, legislation and circumstances. The WHO Traditional and Complementary Medicine strategy 2014-2023 was launched in 2013, and Resolution WHA67.18 passed at the Sixty-seventh World Health Assembly in 2014.

85. Resolution SEA/RC67/R3 was subsequently endorsed at the Sixty-seventh session of the Regional Committee in 2014. Member States agreed to adapt, adopt and implement the WHO TCM strategy 2014–2023 and the 2013 Delhi Declaration. In 2018, the Astana Declaration on Primary Health Care acknowledged the need to include traditional medical knowledge and technologies in the delivery of PHC.

86. Resolution SEA/RC67/R3 requests the Regional Director to report on the progress of the implementation of WHO TCM strategy 2014–2023 and the 2013 Delhi Declaration to the Seventy-second and Seventy-seventh sessions of the Regional Committee for South-East Asia in 2019 and 2024. This is the report on progress in TCM since 2014.

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

#### Progress by the Member States

87. **National policies for TCM, including education and employment of TCM practitioners:** All eleven countries have national policies on TCM. Nine countries have formal training and education systems for TCM practitioners. Nine countries have TCM practitioners formally employed in the public sector at different levels of the health system and to varying degrees.

88. **Increased inter-country cooperation in education, training and capacity-building in TCM.** Member States of the SEA Region have strengthened cooperation in the area of education, including mutual recognition of educational qualifications and research. For instance, in the past five years, the Government of India has signed MoUs with 16 countries including three SEA Region Member States and with 17 International institutions for research/academic collaboration in areas of mutual interest. Many Member States of the South-East Asia Region have been bolstering international cooperation and collaboration in different areas of TCM through ASEAN, BIMTEC and other organizations and forums.

89. **Regional TCM research and evidence sharing.** The majority of the Member States in the Region attended an International Symposium on TCM in Sri Lanka in 2017, which resulted in the Colombo Declaration. Two TCM Journals (*Journal of Ayurveda Case Reports (AyuCaRe)*, issued by the All India Institute of Ayurveda, and a *Quarterly Journal of Research in Ayurveda (AYU)* issued by Institute for Post Graduate Teaching & Research in Ayurveda, Gujarat Ayurveda University in Jamnagar, and which is indexed in PubMed) have been distributed to all Member States since 2014.

90. **Regulation and quality assurance of TCM products.** According to the 2019 Global Traditional and Complementary Medicine Report, regulation of TCM products has expanded from seven Member States in 2005 to 10 by 2018. All these countries have a registration system for TCM products. Eight of the 11 countries have been participating in the WHO Programme for International Drug Monitoring. Four of them (Bhutan, India, Indonesia and Thailand) have a pharmacovigilance system which covers TCM products.

91. **Current status of integration of TCM services into national health system.** Ten Member States have a national policy for integrating TCM into their national health service delivery systems. Nine countries have their national TCM offices located in their health ministries. In six countries, TCM and conventional medicine services are co-located in their health-care delivery systems at some or all levels of their health facility.

92. **Guidance on use of TCM products:** As of 2018, six Member States have national pharmacopeia or monographs for TCM products, while others are using the pharmacopeia or monographs of similar systems of TCM of other countries as quality and formulation standards. Five countries include TCM products in EMLs, which promote the use of TCM products for PHC. Eight countries have mechanisms to monitor TCM system performance to some extent. These include information relating to TCM in national policy, reforms, health laws, health development and national health plan including TCM workforce and facilities in national annual health reports.

93. Some Member States utilize/mobilize TCM practitioners for public health programmes, such as disease surveillance and control programmes, to promote or achieve universal health coverage and also to overcome human resources shortages for primary health care services.

### **Regional Office support**

94. A regional workshop in 2015 identified five priority areas for Regional Office support. These included monitoring traditional medicine systems performances; improving adverse event reporting; strengthening traditional medicine research; the TCM workforce; and integration of traditional medicine into the health system. Progress since 2015 has been as follows:

- a. **Monitoring TCM performance:** A standardized set of 16 core and 21 reference indicators and their metadata were agreed on in 2017 through a series of expert consultations. These indicators have been tested in four countries in 2018, and indicators will be refined based on that experience.
- b. **TCM product safety and pharmacovigilance:** A briefing note on pharmacovigilance (PV) for TCM products was developed in 2016. It explains why PV is important for TCM products, why it is challenging, and what to monitor, and it introduces the Global Safety Monitoring Programme (Uppsala Centre). Two country case studies on PV for TCM products were conducted in 2017, to help Member States learn how such systems were established and evolved. A regional survey on PV for TCM products was conducted in 2018; and the report will be on the WHO website shortly. Findings will guide the regional TCM programme to move ahead.
- c. **TCM research capacity-building:** Clinical research protocols for TCM have been developed by the WHO collaborating centre in India in 2018, and a regional workshop on clinical research methodologies in TCM will be held in September 2019.

- d. Knowledge generation and exchange, particularly on appropriate integration of TCM into the health system, has been supported by WHO. Officials from Sri Lanka visited India to study the integration of TCM into the health-care delivery system in 2017; officials from Bhutan undertook a study tour in India in 2018; and delegates from DPR Korea visited India and Sri Lanka in 2017 and 2018. Member States attended a range of global WHO workshops on TCM during the period 2014 to 2018. A country case study on intellectual property rights for traditional medicine knowledge and consequences for trade in TCM was undertaken in 2017.

## **Challenges being faced**

95. There remains a lack of clarity on what “appropriate integration” of TCM into the national health-care delivery systems mean in practice, in terms of national legislation and local circumstances, and how it can contribute towards achieving the “triple billion” targets of the Thirteenth General Programme of Work 2019–2023, UHC and SDGs.

96. There is a continuing need to strengthen regulatory systems for TCM services to ensure safety, quality and efficacy of these services, particularly the safety of TCM products.

97. There is insufficient evidence on TCM, due to lack of sound and standard research methodologies as well as due to lack of resources.

98. Lack of well-functioning health information systems to monitor TCM system performance, despite agreements in place on standard indicators, affects informed decision-making.

## **The way forward**

99. In order to contribute to the “triple billion” targets of the Thirteenth General Programme of Work 2019–2023, UHC and SDGs, the WHO SEA Region will continue efforts to:

- a. implement the WHO TCM Strategy 2014–2023 and Delhi Declaration on TCM in accordance with country priority, legislation and circumstances;
- b. strengthen national capacity for appropriate integration of TCM into national health systems through technical support and training workshops;
- c. strengthen regulatory systems to ensure safety and quality of TCM products and services;
- d. further strengthen monitoring of TCM systems to promote informed decision-making; and
- e. share experiences, expertise and best practices with other countries through documentation, intercountry collaboration as well as through regional cooperation in different areas of TCM as per country needs and demands.

## **8. 2012: Year of Intensification of Routine Immunization in the South-East Asia Region: Framework for increasing and sustaining coverage (SEA/RC64/R3)**

### **Background**

100. 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”.

101. 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.

102. All Member States prepared their action plans, focusing primarily on high-risk population groups and hard-to-reach areas, to intensify 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 South-East Asia Region**

103. The overall coverage with three doses of DPT vaccine (DPT3) in the Region increased from 84% in 2011 to 89% in 2018.

104. Eight Member States in the Region have achieved more than 90% DPT3 coverage in 2018. These Member States include Bangladesh, Bhutan, Democratic People’s Republic of Korea, Maldives, Myanmar, Nepal, Sri Lanka and Thailand. Four Member States have achieved the target of 80% or more coverage with DPT3 in all districts. These are Bangladesh, Democratic People’s Republic of Korea, Maldives, and Sri Lanka. 95% of districts in Bhutan and 90% of districts in Thailand have reported more than 80% coverage.

105. Member States in the Region that have not yet achieved the desired 90% DPT3 have, however, shown an improvement in coverage since 2012, including India (89% in 2018 compared with 82% in 2011) and Timor-Leste (83% in 2018 against 67% in 2011).

106. The Region developed the South-East Asia Regional Vaccine Action Plan: 2016–2020. This 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.

107. The 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.

108. 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. Efforts to strengthen capacity of NITAGs have continued in the Region. The Regional Immunization Technical Advisory Group monitors the progress of implementation of national immunization plans and the recommendations of the EPI reviews.

109. All Member States in the Region have incorporated plans for intensification of routine immunization 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.

110. Many interventions have been undertaken by Member States in the Region to improve routine immunization 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:

- **Bangladesh:** Bangladesh targeted 32 districts and four city corporations for intensification of routine immunization in 2012; additional vaccine transportation costs were provided for hard-to-reach areas; and every child was tracked using tally sheets/registration books. A review of the immunization and vaccine preventable disease surveillance programme was conducted in 2018 to identify gaps/challenges and propose actions. The national DPT3 coverage has been sustained above 90% and coverage in all districts above 80% during the last five years. Bangladesh is further intensifying routine immunization by mapping hard-to-reach areas using GIS mapping tools, revising micro-plans for immunization and providing additional funding support for improving full immunization coverage in hard-to-reach areas. Several innovative actions such as electronic registration of beneficiaries, evening and Friday sessions for working mothers, experience sharing visits among city corporations, mobilization of local leaders and mapping of slum areas have been initiated to overcome challenges of rapid urbanization in four densely populated city corporations with sub-optimal coverage. An urban immunization strategy for all urban areas in the country is under development.
- **Bhutan:** The country has achieved and maintained high coverage nationally and in all districts except one and continues to focus on the areas with significant migration as well as 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). Pneumococcal-conjugate vaccine was introduced into routine immunization schedule from January 2019 and fully funded by the Bhutan Health Trust Fund. Coinciding with the World Immunization Week 2019, a catch-up campaign with polio, measles and rubella vaccines was conducted in the only district with sub-optimal immunization coverage. The country is planning to introduce influenza vaccine for health workers and pregnant women by end-2019.
- **DPR Korea:** DPR Korea has maintained more than 90% DPT3 coverage nationally and in all districts. A coverage evaluation survey conducted in 2017, validated the high RI coverage in the country. Nationwide micro-planning, installing solar driven drive (SDD) refrigerators at rural Ri levels to overcome electricity issues, tracking and immunization of children who missed out immunization on the planned day of immunization on an alternate day by household doctors have contributed to sustain high national and provincial routine immunization coverage and minimal inter-provincial variation of RI coverage. The EPI and surveillance review conducted in 2018 made recommendations to improve the quality of immunization service delivery, to further strengthen vaccine preventable disease surveillance to reach regional surveillance standards, and to expand and strengthen vaccine supply chain. Most of the technical recommendations have been addressed with support of in-country technical partners and most of the operational and logistic recommendations have been linked to Gavi's health system strengthening support and performance-based funding (PBF).

- **India:** With a target of achieving 90% immunization coverage, India launched “Mission Indradhanush”, a major multiphase campaign to boost Routine Immunization. This equity-focused mission identified high-risk populations in traditionally low-coverage or underserved areas with insufficient health services. From 2015 to 2017, 6.7 million children were fully immunized while 6.8 million pregnant women received vaccines during this intensification effort. During 2017–2018 India reassessed the achievements and targeted 173 districts and 17 cities through the “Intensified Mission Indradhanush”, followed by Gram Swaraj Abhiyan (GSA) in 16 850 villages and Extended Gram Swaraj Abhiyan (EGSA) in 117 districts, followed by another round of Mission Indradhanush in 75 districts with less than 50% fully immunized coverage. About 1.5 million children were fully immunized and 1.9 million pregnant women vaccinated during this effort. In 2018, a coverage evaluation survey (CES) was conducted in 190 districts to measure the impact of Mission Indradhanush. The percentage of fully immunized children in those districts has increased from 50.5% (as per the National Family Health Survey conducted in 2015) to 69% in CES 2018. A comprehensive review of the Universal Immunization Programme has been conducted in five high priority states and based on the results coverage improvement plans have been developed in these states. The Government of India has developed a roadmap to ensure that 90% children receive all vaccines during the first year of life.
- **Indonesia:** The Ministry of Health has identified EPI as one of the three national priority programmes and declared 2018 as the “year of immunization acceleration”. Remote islands and hard-to-reach areas were identified and supported for immunization coverage improvements; additional operational costs were allocated for these areas; additional new cold chain equipment was provided; and a communication strategy for immunization that includes directives from religious leaders in support of the immunization programme was developed. Additional IEC materials including messages from religious leaders have been prepared and disseminated. Eighty districts are being targeted for intensification of RI through various strategies such as sustained outreach strategy and drop-out follow-up and immunization sweeps. Five major urban areas with large number of immunization drop-outs are being supported through a “Rapid Pro” programme. Defaulter-tracking guidelines for health centers have been revised for better tracking of partially vaccinated children. Private sector reporting is being intensified, and a web-based electronic routine reporting pilot is being developed. An immunization forum has been established in Aceh province to address subnational vaccination demands.
- **Maldives:** Immunization is a high-priority programme in the country. One of the best practices followed is the verification of completion of childhood vaccine doses at the time of entry into school. 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 with human papillomavirus vaccine (HPV) as the most recent introduction in early 2019.
- **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 and close monitoring. Several innovative approaches such as prioritization of townships for service delivery improvement, improved micro-planning, intensified EPI data management activities, monitoring and evaluations, improved demand creation and robust leadership management capacity as well as coordination activities are being implemented utilizing the health system strengthening support from Gavi. Catch-up immunization of the underserved population in various conflict affected areas was organized in the last quarter of 2018.

- **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 follow 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 is done only after all subdistrict-level units have been validated. As of April 2019, 56 out of 77 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 intensification of routine immunization and conducts various innovative activities during the month to motivate health workers as well as to enhance RI coverage. Nepal has maintained >90% national coverage (WHO/UNICEF Estimates of National Immunization Coverage (WUENIC)) for all basic EPI vaccines in infancy in 2018.
- **Sri Lanka:** Sri Lanka maintained 99% DPT3 coverage nationally and more than 90% coverage in all districts. The Parliament and the Cabinet approved the National Immunization Policy 2014 that envisages a political, economic and highly technical environment to support the intensification and strengthening of routine immunization. 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.
- **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 to support actions to enhance coverage, where required. A MoU for health service data sharing between Ministry of Public Health (MoPH) and Bangkok Metropolitan Administration (BMA) was signed in 2018. This will provide a platform for MoPH to track vaccination coverage in BMA. The vaccination coverage survey conducted every 5 years has been used to validate data quality from the routine data recording system. The latest survey conducted in 2018 suggested optimal vaccination coverage is maintained at national level. However, the survey confirmed suboptimal vaccine coverage is maintained in the provinces of Thailand that are located in the deep south. The strong routine immunization platform has been used to introduce many new vaccines in Thailand. Thailand introduced HPV in 2017 and is planning to replace tetravalent (DTP-HB) with pentavalent (DTP-HB-Hib) vaccine in June 2019. In addition, the targets for vaccination have been expanded throughout the life-course. In 2019, Thailand launched the nationwide Adult Vaccine Programme.
- **Timor-Leste:** The DPT3 immunization coverage of Timor-Leste increased from 67% in 2011 to 83% in 2018. 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. In 2018 the coverage evaluation survey was conducted to validate the reported coverage. In view of the fragility of the health systems in the country, Gavi has extended its health system strengthening support to Timor-Leste to ensure continued national and sub-national technical assistance, cold-chain expansion and introduction of new vaccines.

111. Overall implementation of the Regional Vaccine Action Plan - In addition to the achievements listed above related to RI coverage, Member States have made progress towards achieving the other goals of SEA Regional Vaccine Action Plan. Implementation of these goals has strengthened immunization systems in Member States of the Region.

- **Measles is eliminated, and rubella/CRS controlled:** The SEA Region adopted the goal of measles elimination and rubella and congenital rubella syndrome (CRS) control by 2020 as a Regional Flagship Programme. Bhutan, DPR Korea, Maldives, Sri Lanka and Timor-Leste have been verified for having achieved measles elimination. Between 2011 and 2017, immunization coverage of first dose of measles-containing vaccine (MCV1) in the SEA Region 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.
- **Polio-free status is maintained:** The SEA Region reported the last wild poliovirus case on 13 January 2011 and was certified polio-free on 27 March 2014. All Member States have introduced inactivated poliovirus vaccine (IPV) between 2014 and 2016. Bangladesh, India, Nepal and Sri Lanka have replaced the full-dose IPV schedule with two fractional (one fifth) doses in their RI schedule. IPV supplies have been restored to all countries that faced a shortage of vaccine in 2017-18 and no shortages of IPV are now reported from any SEA Region country. Activities for poliovirus containment are progressing in alignment with Global Action Plan III.
- **Elimination of maternal and neonatal tetanus (MNT) is sustained:** 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.
- **New and underutilized vaccine introduction:** Since 2012 all Member States have introduced two new or underutilized vaccines while 10 Member States have introduced three or more new or underutilized vaccines. Priority vaccines that have been introduced are Hepatitis B vaccine, Haemophilus (haemophilic) influenza-b vaccine, pneumococcal conjugate vaccine (PCV), HPV, Japanese encephalitis (JE) vaccine, rotavirus vaccine and rubella containing vaccine. In the process of a new vaccine introduction specific activities that were conducted include analyzing disease burden, involvement of national technical advisory group in decision making, conducting cost effectiveness of the introduction, develop comprehensive plans for vaccine introduction, training of health personnel, monitoring after introduction and conducting post introduction evaluations. These efforts have contributed to the efforts in intensification of routine immunization.

## Challenges being faced

112. Challenges faced during implementation of the activities related to intensification of routine immunization include the following:

- Despite the increase in the regional coverage of DPT3 to 88% in 2017, an estimated 4 million children in the SEA Region do not receive three doses of DPT vaccine, with an estimated 2.9 million of them being in India and 0.9 million in Indonesia.
- Outbreaks of vaccine preventable diseases (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 routine immunization. Measles outbreaks have occurred recently in Bangladesh, India, Indonesia, Myanmar, Nepal and Thailand, indicating subnational pockets with immunity gaps.

- Many migrating and displaced populations have low routine immunization coverage and outbreaks of vaccine preventable diseases often occur in these populations.
- Quality of data at sub-national levels and challenges in ascertaining the denominator for the coverage estimates leading to difficulties in ascertaining the true coverage in districts.
- Polio-funded human resources are supporting overall immunization activities. However, funds from Global Polio Eradication Initiative (GPEI) have declined since 2017 and GPEI has indicated funds will eventually stop. 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 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. Financial sustainability is a challenge to maintain the gains of equity and coverage that have been achieved, even in countries that have achieved high coverage. Nepal is currently undergoing transition to a federal three-tiered governance structure. While the newly empowered autonomous urban and rural municipalities are enthusiastic about the immunization programme there are challenges owing to human capacity gaps at the local level.
- 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 especially laboratory support remains suboptimal in most Member States of the Region.

## **The way forward**

113. Several initiatives to intensify routine immunization have been taken by Member States of the Region and these have enhanced immunization coverage and equity.

114. The Region has made progress to strengthen routine immunization through various time-tested and innovative initiatives. However, efforts will need to be made to ensure equitable subnational coverage of routine immunization by all Member States by increasing 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.

115. To sustain the immunization gains in the South-East Asia Region, immunization partners need to support critical needs, including human resources, until they are fully transitioned to the government health system.